NHS Direct National Health Service Trust

Annual Report and Accounts 2013/14

NHS Direct National Health Service Trust Annual Report & Accounts 2013/14

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Sue Hunt - Chair's Statement

I write this introduction to the final Annual Report and Accounts for NHS Direct NHS Trust with a mixture of pride and sadness.

The trust was formally dissolved on 1 April 2014, some 16 years after its original establishment as a pioneer in the provision of publicly funded, remotely delivered, urgent healthcare services.

I am proud to have been associated with an organisation which touched the lives of millions of patients, carers and relatives, by providing professional healthcare advice through modern and novel methods of communication and which kept pace with the way that people want services delivered in the new digital age.

The final year of the trust's existence was probably its most difficult, having started with the promise of being the largest local provider of the new NHS 111 service. NHS 111 was designed to replace the national 0845 46 47 service with which NHS Direct was synonymous. However, it soon became apparent that the new service could not be delivered within the income available from the competitively awarded contracts, to the standards that we wanted to achieve for our patients. The Board developed and presented a revised service delivery plan to our commissioners for consideration, who instead decided to secure step-in providers to take over the service. Throughout the summer of 2013, we supported the transfer of our NHS 111 services to a number of ambulance service trusts and the transfer process was completed successfully, to plan, by the middle of November.

In October 2013, the Board reviewed the future viability of the trust and, in the light of its withdrawal from the provision of NHS 111 services, decided that the organisation was unable to continue to operate as a going concern. The Board took this decision with great regret, however in view of the financial impact of meeting the decommissioning costs of £69.2m associated with the closure of the 0845 service in 2012/13, and a forecast income and expenditure deficit of £26.2m in 2013/14, it was the only conclusion that the board could reach.

This position was agreed with the NHS Trust Development Authority and for the latter part of the year and in preparation for the dissolution of the trust, we remained committed to ensuring that our services and staff that were to continue beyond April 2014 were safely transferred to a number of new providers. We also maintained a relentless focus on minimising the cost of operation and closure to the public purse and significantly reduced the forecast deficit for the year from £26.2m to £13.1m. Additional costs of closure in 2013/14 relating to the decommissioning of the remaining sites, redundancy costs and early termination of supplier contracts amounted to £17.6m. Further detail is included in the body of this annual report.

Although NHS Direct as an entity has ceased to exist, it is not the end of its story. I take some comfort from the knowledge that NHS Direct has left behind a legacy of innovation in service development and delivery, which attracted international attention and won many national awards. Many of the digital services that were developed by the trust will continue to be delivered by the same dedicated staff that have recently transferred to different organisations. I remain convinced that remotely delivered multi-channel digital healthcare will play an important part in the development of cost effective health services in the future, especially those that are clinically led and focus on empowering patients to care for themselves, thereby reducing avoidable demand on face-to-face services.

In reflecting over the events of the last year, I am particularly proud of and grateful to all of our staff, who continued to deliver high quality safe services to our patients throughout a year of turbulent and uncertain times for themselves and their families. Sadly, many staff had to face redundancy, including both experienced clinicians and those providing vital support services. I wish all of these staff the very best for the future and thank them for their service to the trust.

Finally, I would like to pay tribute to my predecessor, Joanne Shaw, whose period of office as Chair of the trust ended in December 2013, after 10 years' service to the trust. Joanne led the Board with great dignity and loyalty throughout her time in office, and was fiercely supportive of all that the trust stood for.

Sue Hunt - Acting Chair of NHS Direct

Joanne Shaw's term as Chair of NHS Direct Trust Board ceased on 31 December 2013. Sue Hunt's term as Acting Chair commenced 1 January 2014.

Roger Rawlinson - Chief Executive's Statement

As the year 2013/14 opened, the trust was faced with the contrasting challenges of continuing to manage a major programme of decommissioning of the national 0845 46 47 urgent telephone service, for which it had originally been created, whilst seeking to recover from profound difficulties with the recent implementation of the new locally commissioned NHS 111 service.

With hindsight, it is clear that the fundamental changes the trust was facing were more difficult to deliver than the organisation had anticipated, in spite of a comprehensive programme to train staff in the new service, the creation of a test environment to simulate the new operational conditions and the implementation and testing of complex IT and telephony infrastructure equipment. Whilst the plan to introduce a new primary service to 35% of the England population was in progress, the trust had also to manage a significant organisational down-sizing programme, which led to over 600 redundancies and 250 staff members transferring to new service providers.

The trust met the challenge to create and recruit to new operational and management structures, which were designed to provide a safe, clinically effective and resource efficient organisation that could thrive in a new competitive NHS commissioning environment.

It is unlikely that any other NHS organisation has faced such fundamental change over the course of a six month period, which also took in the traditional escalation of pressures on frontline services, a common characteristic of the winter. It is essential in my opinion, that the valuable lessons learned from this experience are not lost to the NHS which continues to face an uncertain future, and inevitable large-scale changes of this nature.

The details of how the year unfolded are presented in the body of this report. Although the ultimate sad outcome was the dissolution of the trust, I would like to draw attention to a number of impressive achievements by the trust during the course of the year. They include:

- Conclusion of a contract to adapt the digital online health and symptom checker system for use in Australia
- High standards of quality and safety across all services as measured by a range of Key Performance Indicators
- The rapid restoration of access times for all telephone based services, consistently achieving over 99% of calls answered within 60 seconds from April 2013
- Retention of the 0845 46 47 service as a national contingency, originally commissioned to June 2013 but extended to February 2014
- Improved clinical governance systems, which achieved senior clinical quality and safety review of three calls each month for all call handlers
- The safe transfer of a total of 12 patient services to new providers, working closely with local and national commissioners
- Financial results which were significantly better than original forecasts
- Transfer of employment for 624 staff to new service providers

These achievements are a tribute to a hugely dedicated group of employees, both in direct patient facing services and also in support and back office functions. NHS Direct employees worked tirelessly during the year to maintain safe services, effect the successful transfers of services and complete an orderly and cost effective closure. Faced with an uncertain future for themselves and their families, NHS Direct employees continued to give outstanding care to patients and commitment to the organisation.

Since its formation, NHS Direct was a pioneer of new forms of remote clinical care using telephony and cutting edge digital technology, which was popular and effective for our patients, and offered respite to the over-burdened urgent care services provided by other NHS frontline organisations. The trust also provided genuine value to the taxpayer, and a lasting tribute to the organisation is the number of other nations across the world that are now developing similar models of remote healthcare.

Closure of an NHS provider organisation is not a common activity, so the process of dissolution was in itself a challenge. In spite of the finality of the actions to dissolve the trust, it served as a reminder to me of the dedication, resilience and loyalty of all who have worked for the organisation since its beginning 16 years ago, and of the many achievements and innovations achieved in the delivery of unique and modern care to our patients.

Finally I would like to pay tribute to my predecessor, Nick Chapman, who retired as Chief Executive in December 2013. Nick joined NHS Direct in April 2009 and led the organisation with passion and flair through a series of difficult challenges, including the H1N1 flu pandemic in 2009 and the procurement exercises for NHS 111 contracts in 2011 and 2012. His total commitment to the patients of the NHS throughout his career was abundantly demonstrated during his period in office at NHS Direct.

Accountable Officer: Roger Rawlinson, Acting Chief Executive

Date: 9 June 2014

Nick Chapman's term as Chief Executive Officer ceased on 16 December 2013. Roger Rawlinson took up post as Acting Chief Executive Officer on 17 December 2013.

Organisational Overview

Statutory Basis

NHS Direct NHS Trust was established from 1 April 2007, under Statutory Instrument 2007, number 478, by the NHS Direct National Health Service Trust (Establishment) Order 2007. In 2008, Statutory Instrument 2008 No. 2769 amended the original Establishment Order so that the trust was able to extend its services to provide the National Pandemic Flu Line Service, including advice in relation to pandemic influenza and the authorisation of medication.

Prior to its dissolution, the NHS Direct National Health Service Trust ('the trust') provided remotely-delivered clinical care and services across a number of channels using its network of call centres and home workers. It worked in partnership with commissioners to provide major elements of the urgent care pathway to help patients achieve the best possible clinical outcomes. Some services closed but others continue to be provided by alternative providers.

Overview of services provided during 2013/14

0845 46 47 helpline

The national 0845 46 47 telephone health advice and information service which was historically synonymous with the name NHS Direct continued throughout the year to support areas of the country where NHS 111 had not been launched. Following complete national roll-out of the NHS 111 service, the 0845 46 47 service was closed on 28 February 2014.

NHS 111

NHS 111 aims to make it easier for people to access healthcare services when they need clinical help urgently, but it is not a life-threatening situation. 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, transfers clinical assessment data to other providers and books appointments for patients where appropriate. NHS 111 works alongside the 999 emergency services to despatch an ambulance when needed without delay and without the patient needing to repeat any information. All NHS 111 services were successfully transferred to alternative providers by November 2013.

Digital Assessment Service (DAS)

Accessed through NHS Choices or iPhone/Android apps, this service provides users with the ability to assess clinical signs and symptoms using an online symptom checker and with the option where appropriate to request a call back to discuss their symptoms in more detail with a nurse. The clinical content underpinning the symptom checkers was also licensed internationally to support the launch of a similar service with Healthdirect in Australia. DAS transferred to the Health and Social Care Information Centre at the end of March.

Complex Health Information and Medicines Enquiry Services (CHIMES)

This service provided callers with telephone advice from health information or medicines specialists in response to complex enquiries regarding non-symptomatic health or medicines needs following initial assessment in the NHS 111 service or through the DAS service. The service closed on 26 March.

Dental nurse assessment service (DNAS)

This service provided callers with telephone access to qualified dental nurses who offered an advanced assessment and advice service for urgent and complex dental care needs following initial assessment in the NHS 111 service or through the DAS service. The service closed on 26 March.

Care Connect

A multi-channel service that enables people across England to 'share experience' (provide 'reviews', raise 'problems', or ask ' questions') in relation to any NHS Service they have received in the last two years.

Comprising a national telephone line, SMS text messaging, live Twitter and Facebook feeds and website, the service is being piloted in trusts across London and the North East prior to wider roll-out. This service transferred to the North East Ambulance Service on 1 April 2014.

Nottingham Healthy Change

Assesses the needs of service users in Nottingham with one or more behavioural risk factors for cardiovascular disease and other long term conditions, supports them to access appropriate health improvement services and to receive coaching to support lifestyle behavioural changes This service transferred to Nottingham City Care on 1 April 2014.

The Appointments Line

Using Choose and Book, supports patients to select from any hospital provider in England offering a suitable treatment by making bookings, amendments or cancellations of first outpatient appointments and supporting patient choice discussions using NHS Choices and the national Directory of Services. The service and staff transferred to Conduit Global after contract expiry and competitive tender, from 1 April 2014.

National Pandemic Flu Service

The trust managed the National Pandemic Flu Service (NPFS) in dormancy during the year, to ensure it could be quickly and effectively activated if required. The service transferred to the South Central Ambulance Service on 1 April 2014.

Other services

In addition, the trust provided a number of other smaller services:

Category C ambulance calls: Assessment of low priority 999 calls on behalf of two ambulance services. This service was discontinued in March 2014.

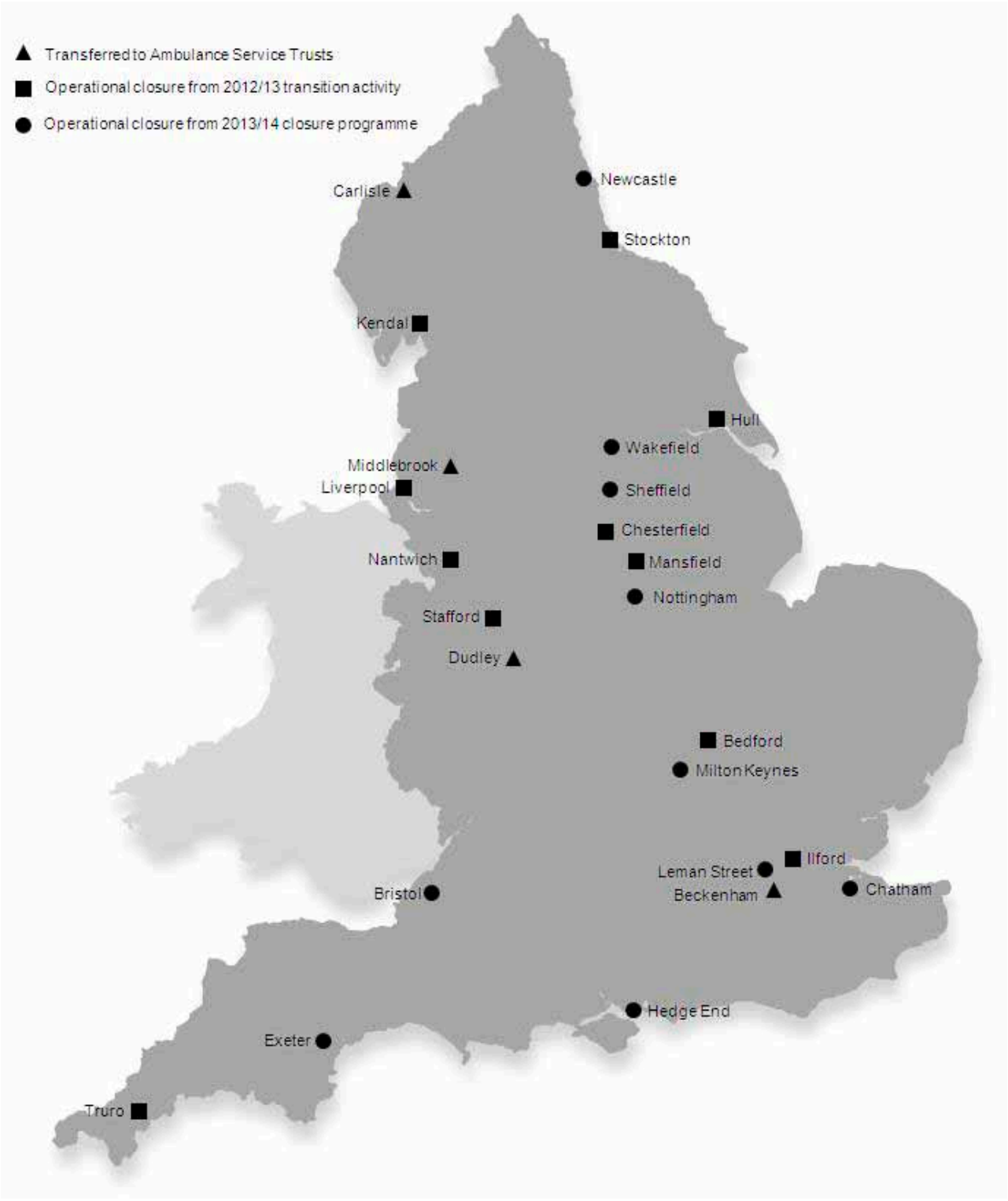
Telehealth monitoring: Monitoring patients with long-term conditions in their own homes via equipment which transmit daily about information about their conditions to health advisors, ready to follow-up as necessary. This service ceased 31 March 2014

NHS Direct's network of contact centres

NHS Direct had 24 operational call centres at the beginning of the year, 11 of which had already been identified for closure in the 2012/13 transition programme. These sites were no longer required operationally as a result of the decision to cease the 0845 service and were all closed by June 2013.

A further four sites were transferred to other NHS 111 providers as part of the transfer of NHS 111 services by November , although it was agreed that a number of staff would remain working at the Middlebrook, Dudley and Beckenham NHS 111 sites to support DHAS services until the end of March.

The remaining nine sites ceased operationally on 31 March 2014 and, together with the trust headquarters at 120 Leman Street, London E1 8EU were decommissioned after the year end.



Directors' Report – Review of the year

This year was one of prolonged uncertainty and significant change for NHS Direct. Despite this, the trust's priority throughout the year remained the provision of safe, effective and efficient services for patients. Whilst taking forward work on arrangements for decommissioning and transferring its services, the trust followed five key principles in all of it's activities and decisions:

- patients will be safeguarded at every stage
- service continuity will be maintained
- the public purse will be protected
- continuity of employment will be preserved for people with ongoing roles
- high standards of governance and accountability will be maintained

These were the principles that the trust had used in its approach to the initial change programme undertaken in 2012/13 in preparation for the decommissioning of the 0845 46 47 service. This activity was still being undertaken during 2013/14.

During the course of 2013/14 the trust had to implement radical changes to its original plans and objectives.

Decision to withdraw from NHS 111

In March 2013, NHS Direct launched the majority of its NHS 111 services. However, upon launch, it encountered severe performance problems. The trust took immediate action to address the issues and to ensure that the services provided to patients were safe and effective. This included both an internal investigation into the primary causes of the performance problems and the joint commissioning of an independent report with NHS England and the NHS Trust Development Authority.

Both the internal investigation and the independent review carried out by Deloitte concluded that the root cause of the poor service performance was a lack of sufficient operational capacity. The main factors were:

- the length of calls received was more than double the length that had been originally assumed in the operating model
- there was a shortfall in the number of trained nurses available at launch because of the longer call times
- there was a shortfall of call handlers who had completed their training prior to deployment for the launch of the services, also as a result of inaccurate operating assumptions

Performance recovered after the first few difficult days following introduction of the service and thereafter NHS Direct provided a consistently high level of NHS 111 service. However, the trust was unable to take the full volume of calls it was contracted to handle and, in some areas, arrangements were made with commissioners for alternative providers to handle the additional calls. The trust also cancelled the planned launches of the North Essex and Cornwall and the Isles of Scilly services, following agreement with the commissioners.

The trust prepared recovery plans which identified not only the need for significant additional workforce resources in order for it to handle the full contracted call volumes but also that this would require additional funding of £32m above the contracted income.

The plans were shared with NHS England and individual commissioners but were rejected by the commissioners. This position meant that the NHS 111 contracts were, and would remain, financially unsustainable for NHS Direct and agreement was reached with NHS England and the NHS Trust Development Authority (NHS TDA) that it would continue to deliver its NHS 111 services only until they could be safely transferred to alternative providers.

Despite having agreed to withdraw from the NHS 111 market, the trust continued to improve the quality of its services. Performance monitoring reports demonstrated that by the point of transfer the services were consistently meeting and exceeding national requirements, and that patients reported high levels of satisfaction with the service they received. This allowed the trust to work positively with commissioners during the summer and autumn to transfer the services and played an important part in maintaining the morale of the staff who continued to provide high quality care to their patients despite the uncertainty generated by the process of change.

By 30 November 2013, all the trust's NHS 111 services were successfully transferred to alternative providers and a total of 437 NHS Direct employees who worked predominantly for specific NHS 111 contracts transferred with services to ambulance trusts in accordance with TUPE regulations.

Additionally, the trust agreed to extend the timescale of operation of its 0845 46 47 service to provide contingency to areas where NHS 111 had not been fully implemented. The extension was initially requested by NHS England, the service commissioners, to the end of November, but was subsequently extended to the end of February to support increased call volumes over the winter period.

Table 1.1 – Transfer of NHS Direct's NHS 111 services to alternative providers

Service	Alternative provider	No of transferred staff
North West	North West Ambulance Service NHS Foundation Trust	156
West Midlands	West Midlands Ambulance Service NHS Trust	117
North Somerset	South West Ambulance Service NHS Foundation Trust	46
East London and City	Partnerships of East London Collaboratives (PELC)	No staff transferred with this service
South East London	London Ambulance Service	118
Sutton and Merton	Harmoni	No staff transferred with this service
Buckinghamshire	South Central Ambulance Service	No staff transferred with this service
		Total 437

Decision to cease operations

During July and August, in light of the imminent cessation of the 0845 46 47 service and the decision to transfer its NHS 111 contracts, the trust carried out a review of its future financial viability, taking into account:

- **Level of 2014/15 income** - the total secured income from its non-NHS 111 Digital Health and Advice Services (DHAS) would be £17m and there was no guarantee of any income beyond March 2015
- **Potential for contracts to be extended** - commissioners' requirements for the future had not been confirmed and were subject to change in light of new national policy on emergency care. The maximum additional income that the trust could expect in 2014/15 was estimated at a further £13m making a potential income of £30m in total
- **The minimum level of corporate overheads required** - the level of overheads required in order to operate as an NHS trust, when combined with the operating costs of providing the DHAS services, would leave a deficit of £4.5m on a turnover of around £17m. If annual income was £30m, the trust would still remain unable to break even
- **The trust's ability to achieve its statutory duty to break even** - NHS Direct failed its duty to balance its books in 2012/13 because the cost of decommissioning the 0845 46 47 service led to a cumulative deficit of £39m. Given the future financial prospects described above, the trust would have no realistic prospect of recovering this deficit within the three-to-five year timeframe required of NHS trusts. Additionally, the trust was forecasting a planned deficit of around £21m for 2013/14, largely as a consequence of the financial burden of providing NHS 111 services.

Following this assessment, at its September 2013 meeting, the NHS Direct Board formally agreed that the trust was not financially viable and there was no prospect of it operating as a going concern. It agreed, with support from the NHS TDA, that it would cease to provide any services beyond 31 March 2014. A public announcement of this decision was made on 24 October, which included the briefing of NHS Direct staff, members, stakeholders and the media.

What this meant for patients and services

Between September and March, the trust and NHS TDA worked with the trust's commissioners to:

- confirm commissioners' intentions for the services that the trust was continuing to provide
- decommission services which would not continue beyond March 2014
- identify and secure alternative providers for the services that the commissioners wanted to continue beyond March 2014

The following table sets out the arrangements for provision of services, which continued after the closure of the trust:

Table 1.2 – Arrangements for services which will continue after March 2014

Service	Outcome	New provider	Transferring Staff
Digital Assessment Service (online health and symptom checkers)	Transfer	Health & Social Care Information Centre (HSCIC)	27
Telephony Managed Service	Transfer	HSCIC	4
Repeat Caller Service	Transfer	HSCIC	No staff on service
Care Connect	Transfer	North East Ambulance Service	62
The Appointments Line – Choose and Book (TAL)	Re-procurement	Conduit UK	75
National Pandemic Flu Service	Transfer	South Central Ambulance Service	2
Healthy Change	Transfer	Nottingham City Care	16
Healthlines	Transfer	Solent NHS Trust	0*
Total			**186**

*staff working on the Healthlines research service were doing so on secondment from their substantive roles on the Complex Health Information and Advice Service and therefore did not transfer

Although the provision of services transferred to a number of different organisations, as indicated above, it is important to emphasise that service users were not greatly affected; the services provided are to the same specification, and are delivered by former NHS Direct staff who have transferred with the services to new providers.

The decommissioned services are as follows:

- **0845 46 47** service, in its winter contingency form, was replaced with the NHS 111 service and was formally closed on 28 February 2014.
- **Complex Health Information and Medicines Enquiry Service** and the **Dental Nurse Assessment Service**, which were elements of the 0845 46 47 service, were commissioned by NHS England for the financial year 2013/14 as a contingency arrangement whilst local commissioning of alternative services was secured. Both services were closed by 31 March 2014.
- The **'Speak to Advisor'** element of the online Health and Symptom Checkers (HASCs) service was decommissioned in line with a review of online services strategy by NHS England. This service closed on 31 March 2014.

The implications for staff of the decision to cease operations are described in detail in the staff matters section.

Dissolution of the trust

On 23 December, as a consequence of the agreements on the decommissioning or transfer of all its services, the trust, in agreement with NHS TDA, NHS England and the Department of Health, agreed to undertake a statutory public consultation to enable it to apply to the Secretary of State for dissolution of the trust and the completion of related transfer orders to ensure that all residual assets and liabilities of the trust were accounted for.

Public consultation took place between 2 and 30 January with the local Healthwatch organisations for areas in which the trust was managing an establishment or facility, and with the trust's trades unions representing staff interests.

Submissions were received from two of the 12 Healthwatch organisations consulted, which were responded to in detail by the trust. The main points raised related to the future of the services that the trust then provided, rather than to the proposed closure of the trust.

The trust held meetings on 8 January and 22 January with representatives of RCN and UNISON, the two active unions in the trust. The consultation was discussed in some detail at the meetings and, whilst the members of both unions expressed intense disappointment at the outcome of events, there was no formal submission from either union during the consultation period. All NHS Direct employees were informed of the consultation in staff newsletters during the consultation period and the trust received no formal response.

On 24 February the Trust Board agreed to apply to the Secretary of State to dissolve the trust and to prepare the relevant transfer orders. This application was endorsed by the Board of the NHS TDA and was made on the grounds that:

- The trust was not and had no prospect of becoming financially viable
- The trust had made appropriate arrangements with the NHS TDA and commissioners for the decommissioning or transfer to alternative providers of all its services by 31 March 2014
- The trust had carried out the prescribed consultation with the appropriate statutory bodies on the proposal to apply to the Secretary of State for dissolution and transfer orders, and having considered the responses to that consultation had concluded that there were no grounds not to proceed with the proposal for dissolution
- Without dissolution, the trust would be in breach of its establishment order following the cessation of all its services by 31 March 2014.

NHS Direct NHS Trust ceased operating and was dissolved by order of Jeremy Hunt, the Secretary of State for Health on 1 April 2014.

Legacy arrangements following the dissolution of the trust

A closure board, led by the NHS TDA was established In December 2013 to oversee the detailed arrangements necessary to secure the safe transfer of services to new providers, and to ensure clarity of management and responsibility for ongoing activities related to the trust's dissolution beyond March 2014.

The South Central Ambulance Service NHS Foundation Trust took on the role of successor body to manage the closure work required between April and June 2014 on behalf of the NHS TDA. For the period from April to June this involved hosting around 70 former NHS Direct staff who had been retained in order that they could undertake the final closure work such as:

- finalising the trust's annual report and accounts
- decommissioning of technology and property
- final payments and redundancy payments
- completion of activity on the management of complaints/incidents etc.

The Department of Health Departmental Records Office (DRO) took on residual responsibility for ownership of non-clinical data and records and the NHS TDA has assumed ownership of clinical records. The NHS Litigation Authority is the successor body for any relevant criminal liabilities. NHS Property Services has taken on responsibility for the trust's estate on behalf of the Department of Health.

Performance review

The trust board reviewed a monthly Corporate Scorecard that summarised service volumes, accessibility, quality, safety and outcomes, alongside organisational measures of staffing and financial performance.

NHS 111 services

Access performance for the trust's NHS 111 services was consistently above target for the 970,000 calls handled in 2013/14, right up to the point that the final contract was transferred to its step-in provider in November 2013.
There were some initial difficulties with meeting the target to transfer all calls requiring a clinical assessment to a nurse while the patient was still on the phone, which required them to wait a short period for call-back. The trust quickly addressed this through additional staff recruitment and performance improvement plans that delivered operational efficiencies.
Outcomes recommended to patients were in line with other NHS 111 providers, with 18% of callers receiving an urgent referral to 999 or A&E.

0845 46 47 Services

The 0845 46 47 service was extended into 2013/14 as a contingency for areas with delayed NHS 111 launches.
The service handled around 590,000 calls, a marked decrease on the 4 million calls in the final year of full operation in 2012/13. The service started the year with 38% of the call volume in the previous April, which steadily decreased until the last call was taken on 12 February 2014 when the final local NHS 111 service went live.

The service met all access targets, but saw some slight dips below target for time to secondary nurse referrals within the first six months, which was resolved through implementation of performance improvement plans.

Digital Health and Advice Services (DHAS)

Late March 2013 saw the launch of a portfolio of one-year pilots under the 'DHAS' banner, consisting of specialist dental health and medicines information and nurse telephone advice for patients referred from the 0845 46 47 service, selected NHS 111 services, and the online Health and Symptom Checkers. Access performance was strong across the 300,000 contacts received during the 2013/14 year, and the pilots closed as expected at the end of March 2014.

The Appointments Line (TAL)

TAL maintained its annual volumes at 3.2m and performed well across the year up until the contract transferred to Conduit at the end of March 2014.

Care Connect

The patient feedback service Care Connect saw small contact volumes in its pilot state, and was transferred to North East Ambulance Services NHS Trust in March 2014.

Health and Symptom Checkers

Use of the online Health and Symptom Checkers functions and apps fluctuated across the year as a result of changes to its promotion to users from various healthcare related websites.
The service transferred to the HSCIC in March 2014 and continues as part of the NHS Choices brand.

Financial performance

The trust set a re-based budget in July with a forecast deficit of £26m. This deficit was agreed with the NHS TDA and approved by the Trust Board in July 2013. The deficit reflected the cost of the trust continuing to provide NHS 111 services for the whole of the financial year.

The operational budget was re-set to a deficit of £21m once the transfer of NHS 111 services to the step in providers was completed. The trust continued to maximise income and reduce costs for the rest of the financial year and ended the year with a deficit of £13m.

Decommissioning costs of £69.2m were reflected in the accounts for 2012/13. The final costs of closing NHS Direct are also included in the accounts for the year and these are a net additional £17.6m. This makes the total cost of decommissioning NHS Direct services £86.8m.

Patient engagement

Patient experience

Over 90% of our patients said they were satisfied or very satisfied with the services provided by NHS Direct. In 2013/14 the trust surveyed patients each month from the following services: NHS 111, Complex Health and Medicines Inquiry Service, Dental Nurse Advice Service, Speak to Advisor Service and the 0845 46 47 Contingency Service. In total the trust received 9,253 survey responses from patients. The trust's Friends and Family test score revealed that across all services 88% of patients would be extremely likely or likely to recommend them to friends and family.

Complaints and compliments

The trust actively encouraged patients, carers and health professionals from the wider NHS and social care system to provide feedback on its services. In 2013/14 the trust received 3,208 items of feedback on all services. Of 62 complaints from patients and service users, 92% were resolved first time with the complainant. This represents fewer than six complaints for every 100,000 calls handled and compares positively to 164 compliments received, representing more than 10 for every 100,000 calls.

Of the complaints received, 40 (64%) were upheld, and appropriate action was taken to make improvements to prevent the issues identified recurring.

The main area of concern expressed by complainants in 2013/14 related to patients being referred to an incorrect service, 55% of which were upheld. These concerns were focussed around the period when the new NHS 111 service was launched. Routine random reviews of over 1% of all calls per month to the service were carried out by senior clinicians to identify good practice and any potential areas for development for staff. During the year, four complaints were reviewed by the Parliamentary and Health Service Ombudsman, but were not upheld and the investigations have been closed.

Patient and public involvement

An initial approach to capturing stakeholder insight was put in place during the first quarter of the financial year. This approach took a monthly snapshot of suggestions for improvement from both internal and external stakeholders. The feedback was gathered from a range of sources:

- Patient complaints and comments
- Social media channels - Facebook and Twitter
- Surveys to support improvement in the experience and outcomes for patients
- Involving patients and the public in research, service evaluation and clinical audit projects
- Seeking patients' and public views on the development of multi-channel services, such as the online health and symptom checkers
- Public involvement in research and clinical audit
- NHS Choices patient reviews

On a monthly basis feedback was analysed to determine trends and themes which were collated into an insight report. This captured the essence of the suggestions for improvement which were then considered at the monthly meeting of the executive directors. Those suggestions for improvement which were approved were then added to an action plan, which was monitored to ensure that the improvements agreed were actioned.

Stakeholder engagement

As a result of the challenges in launching NHS 111 services, the majority of stakeholder engagement activity in 2013/14 was spent working closely with local and national commissioners; stabilising services and managing their later transfer to the step-in ambulance service providers.

Stakeholder engagement was led by the Board and regional directors and included regular briefings and meetings (including visits to contact centres), so stakeholders could see operational delivery first-hand and be assured of its clinical safety.

The Medical Director, Chief Nurse/Clinical Director and wider senior clinical teams also continued throughout to meet both national and local clinical stakeholders to reinforce the experience and capabilities that NHS Direct contributed to the urgent care landscape.

We also engaged with stakeholders via social media channels and the live web streaming of Trust Board meetings.

Staff matters

The start of the year

2013/14 began in the aftermath of a major staff consultation exercise between December 2012 and March 2013, which was undertaken to form a new organisation ("future NHS Direct"), designed to deliver NHS 111 services plus a range of other digital services.

In order to be able to operate within the constraints of a highly competitive procurement process of NHS 111 services, the "Future NHS Direct" operational and management structure was significantly smaller than the original organisation. Consequently, at the beginning of the year, over 500 substantive NHS Direct employees were declared at risk of redundancy.

Although a significant number of employees attained suitable alternative employment across the NHS and some were retained to undertake decommissioning activity, a total of 428 employees became redundant between May and July 2013.

Transfer of NHS 111 services to "step in" providers

Following the agreement in July 2013 with the NHS Trust Development Authority and NHS England to transfer all NHS Direct's NHS 111 services to "step in" providers before the onset of winter pressures, four separate projects commenced in August 2013 to transfer the NHS 111 services and the NHS Direct employees in accordance with TUPE regulations to ambulance service trusts in the North West, West Midlands, London and the South West. Following a period of consultation, a total of 437 employees transferred successfully to four different ambulance trusts by 12th November 2013.

In addition, 50 of NHS Direct's NHS 111 employees working at the Milton Keynes call centre were seconded to South Central Ambulance Service to undertake an NHS 111 Winter Contingency Service on behalf of NHS England.

Staff Consultation on the closure of the trust

At its October 2013 meeting, the Trust Board agreed to begin a formal 45 day consultation with staff on the implications for them of the intended future of the services and of the operational closure of the trust. The consultation was launched formally at a meeting between managers and staff side representatives on 31 October.

Twenty three consultation meetings led by executive directors were held across all active NHS Direct sites between 31 October and 10 November and specific functional (e.g. Finance) and service (e.g. TAL) meetings were also held across the organisation.

Engagement with the consultation process was good and was supported by a range of activities additional to the formal consultation meetings, which included:

- The offer of formal individual 1:1 meetings, which were taken up by over 95% of staff
- A weekly informal teleconference for all managers with the HR & Transition Director
- A weekly consultation update issued to all employees throughout the consultation
- A dedicated consultation site on the trust intranet
- The release of six frequently asked questions documents
- The development of a confidential e-mail account for individual questions

In the final week of the consultation a Board seminar was held to give staff side representatives the opportunity to describe their members' experience of the consultation, and to discuss any emerging themes with the Board of NHS Direct. In their submission to the seminar, staff side representatives said they felt that there had been a good level of engagement and partnership working during the consultation.

Following completion of the consultation, 482 of a possible 674 staff were put at risk of redundancy in addition to 62 staff whose redundancy had been deferred in order to support NHS 111 service transfers and associated decommissioning activity.

Redundancy

In early January, formal redundancy notices were issued to staff who had been put at risk, with a termination date of 31 March. There were a small number of exceptions to this as a group of staff was required to remain in post to complete formal closure and dissolution activity between 1 April and 30 June.

The trust continued with the successful colleague support programme which had been put in place during the 2012/13 change programme and which sought in part to mitigate the final number of redundancies by supporting staff to find alternative employment within the wider NHS.

Transfer to other providers

Following the consultation carried out between October and December, around 190 members of staff who worked solely or predominantly for the services that were continuing transferred to a new provider in accordance with TUPE regulations.

Each transferring group of staff underwent a separate formal consultation period between January and March. Although the details of each service transfer were specific to each instance, wherever a transfer involved the movement of staff, the trust engaged with staff-side representatives, held formal group consultation meetings and offered every individual a 1:1 meeting to discuss their circumstances in relation to the change.

Equality Impact Assessment

The trust undertook an equality impact assessment (EIA) on the impact of the decommissioning and transfer of its services, and of the proposed closure of the trust, in line with its obligations under the Equality Act 2010. The Trust Board considered the EIA and concluded that there was nothing in its proposals for implementing the changes which unlawfully discriminated against any group of employees who share a protected characteristic. There were, however, some particular groups for whom potential redundancy could have a greater impact than for other employees. The trust ensured that these groups were offered specialist focussed support through the colleague support programme.

Summary of workforce changes

The table below shows exit reason by headcount for substantive staff employed between 1 April 2013 and 30 June 2014

	Attrition	Redundant	TUPE	Total
Dental Nurse	4	58		**62**
Dental CQI		5		**5**
Frontline Manager	7	87	67	**161**
Health Advisor	87	115	289	**491**
Health Info CQI		7		**7**
Health Info	13	77		**90**
Health Trainer	1		13	**14**
Nurse Advisor	65	289	116	**470**
Nurse CQI		16		**16**
Support	47	385	80	**512**
TAL Call Handler	7		55	**62**
Total	**231**	**1,039**	**620**	**1,890**

50% of the redundancies shown were given notice and accounted for in 2012/13 and around 60 joined the legacy management office between April-June 2014.

Colleague support programme

The colleague support programme was initially launched during the first wave of organisational change in 2013 in order to help all colleagues facing change, not just those facing redundancy, to consider the next phase of their career and to offer practical information and guidance on taking the next steps. It was open to all employees of the trust.

The trust worked with an external partner provider, 10Eighty, to provide specialist elements of the programme and to support its strategic development; the initial programme was both popular with staff and so successful that the trust agreed to a continuation of the service to support the dissolution and decommissioning activities. In October 2013, the programme was re-launched with a range of services delivered on a three-tier basis:

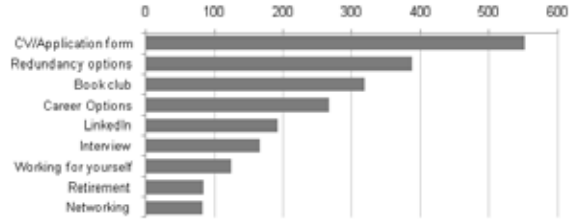
- Universal level – access for all colleagues to basic information, advice and guidance about a range of common areas, such as preparing CVs, interviews and networking
- Specialist level – access for colleagues with more complex needs to an online diagnostic tool (the CareerCENTRE), personalised feedback from in-house trained facilitators and access to specialist in-house career counselling
- Complex level – access for colleagues with highly complex needs or a clear coaching need to accredited, specialist career coaches provided by 10Eighty.

Since April 2013:

- 58 webinars were delivered to 575 members of staff on topics including: writing great CVs, successful 'elevator pitches', interview preparation, developing career options, getting the most out of the online portal, networking, and using LinkedIn
- Around 100 book club requests were received
- Nearly 200 staff completed a career needs survey, with well over 100 of them going on to complete online CareerCENTRE self-assessments of their personal and career values, career motivators, talents, and agility
- Around 750 users accessed the 10Eighty online portal, completing 7,313 tool and module activities

During January, a programme of events co-ordinated with Jobcentre Plus and the National Careers Service was provided across all sites. Around 300 colleagues attended presentations and workshops, were given information about the colleague support programme and had group and 1:1 sessions with the trust's learning and development team.

Fig: Colleague Support zone page visits:



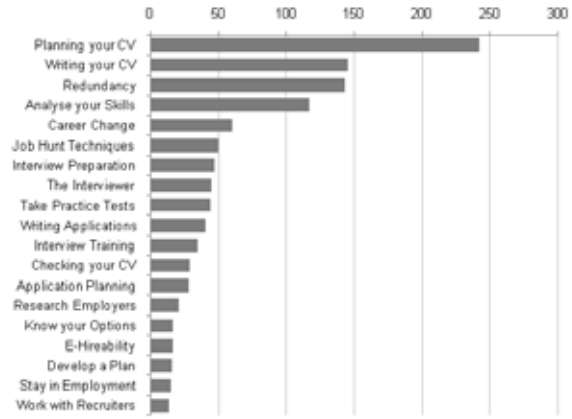
Colleagues reported that their knowledge of the benefits available to them after leaving NHS Direct had greatly improved, as had their awareness of options for training. Most identified actions they were going to take as a result of the Roadshow. As one colleague put it:

"There is a lot of help available given the right guidance. It is not so bleak as I had believed it to be. Updating skills can even be done at this late stage."

The success of the programme led to a reduction in redundancy costs as colleagues were helped to find new jobs, as well as an increase in career confidence across the organisation.

During the autumn, the trust developed an awareness campaign for staff who may have been feeling stressed or anxious as a result of the prolonged period of change and uncertainty.

Fig: Colleague Support session attendances



Communicating with staff

Throughout the year, the trust maintained its commitment to ensuring that staff had access to information about the organisation, any important developments and information needed to do their job. The trust also aimed to give opportunities to provide feedback and ask questions where it really mattered.

During the year the trust continued to make use of 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 the widespread and changing geography of the organisation.

To support staff in engaging with the enormous change process the trust developed additional channels of communication to ensure everyone had access to open and honest information that affected their future; these included executive-led town hall-style meetings offering opportunities to discuss issues and get clarification, dedicated intranet pages, regularly updated frequently asked questions and specialist weekly updates.

Staff survey

Due to the scale and nature of the changes that took place during the year, NHS Direct did not undertake a staff survey during 2013/14. The survey would have taken place during the period of the transfer of the NHS 111 services to new providers and in the lead-up to an all-staff consultation process. However, as part of the nationwide response to the Francis Report into Mid-Staffordshire, the trust carried out a programme of activity to listen to what staff had to say about the services that they were delivering during August and September.

Sessions were held at every NHS Direct site, led by directors or other senior clinicians and managers, and attended by over 400 staff. The purpose of the listening events was to enable staff to make suggestions about how services could be improved.

Staff expressed their views freely, and welcomed the opportunity to discuss these with senior staff and colleagues. Staff made an extensive range of suggestions on how services and their delivery could be improved. Feedback can be summarised under the following headings:

- Views about what patients wanted and whether their needs were met all of the time.
- What care and compassion means in the context of the services provided
- Suggestions for improvements in the service
- Specific issues related to: Rotas and staffing levels, ICT and System Issues, patient surveys and gathering patient views, raising awareness of which services were available and what they could provide, ensuring Commissioners were aware of patient needs to design services appropriately, training, other service and patient issues.

Action was taken on short term issues to make improvements wherever this was possible. Feedback on longer term issues for services that continued beyond March 2014 was passed on to the new providers and commissioners of the services.

Staffing information

The NHS Terms and Conditions of Service covered 91% of the trust's staff with the remainder being on local or executive contracts of employment.

A breakdown of staff performing roles within the organisation that required registration with a formal body is below. Percentages are of the total staff establishment as at operational peak:

- Nursing & Midwifery Council (NMC) 28.4%
- General Dental Council (GDC) 4.2%
- General Medical Council (GMC) 0.3%

Staff benefits

NHS Direct continued to offer a number of benefits in addition to the NHS terms and conditions of service, as follows:

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

Sickness absence

Two major improvements were made during the year. Firstly, the continuation of a centralised sickness recording process increased the accuracy of information. Secondly, the introduction of enhanced administration processes around people returning to work after a period of absence significantly improved the quality of data, helping to reduce the risk of pay errors associated with sickness. These initiatives, together with a continued focus on sickness absence management, reduced both short and long term sickness absence significantly, despite the uncertainties of the future of the trust.

The number of days lost to staff sickness absence is detailed within section 9.3 on Page 57 of this report.

Equality and diversity

Significant progress was achieved with 96% of staff completing the e-learning package.

The trust continued to be accredited as a Two Ticks Symbol employer which reflected compliance with job centre plus standards on the employment of people with disabilities.

At the end of January 6.3% of staff had a disability. This remained the same as the previous year.

Health and Safety

Roger Rawlinson, Acting Chief Executive was the trust's executive lead for health and safety.

The national health and safety committee provided strategic health and safety direction to the trust and was responsible for reviewing changes to legislation, commissioning annual audits, and for quality assuring health and safety training and new policy development.

Within the past year the trust reviewed and rewrote all of its health and safety policies which ensured compliance with latest legislation and external guidance. Following the 2013/14 assessment, the trust remained at Level 1 against the NHS Litigation Authority Standards.

Risk assessments continued to be applied and contributed to the ongoing reduction in reported accidents and near misses and all actions relating to annual health and safety audits were completed, thus contributing to a safer environment for all staff.

Over the last year, due to innovative ideas and systems, the trust dramatically increased compliance with fire training attendance.

The trust was provided with occupational health services through an external agreement.

Security management

Over the past year, the trust's two local security management specialist posts (LSMS) were reduced to one in line with the continuing reduction in the number of staff employed. The remaining LSMS ensured that reported incidents were investigated and followed through to their appropriate conclusion.

Security incidents and near misses were reviewed at Audit Committee meetings.

Rather than running an awareness month, as it had in previous years, from November the trust ran a rolling campaign focusing on different areas of security awareness to ensure that staff maintained vigilance as the organisation worked toward closure.

Counter fraud and anti-bribery 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 work plan that details how it will approach anti-fraud and corruption work.

The trust was committed to ensuring fraud, bribery and corruption did not proliferate within in the organisation. It was 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 was provided by Mazars Public Sector Internal Audit Limited. The accredited Local Counter Fraud Specialist (LCFS) reported to the Director of Finance and attended the Audit Committee meetings to report on the work completed. The LCFS worked to ensure that counter fraud was integrated into all trust activity in a positive way.

Throughout the past financial year the trust continued to embed the counter fraud and anti-bribery culture, and work was undertaken to measure compliance 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 complied with legislative requirements and with the NHS Counter Fraud and Corruption Manual. The trust's LCFS liaised with other LCFS personnel and relevant external bodies on investigations, as appropriate. The LCFS was available to receive referrals and reports on the results to the Director of Finance and the Audit Committee. All sanctions available to the trust were considered following a reactive investigation, together with efforts to recover losses incurred.

Sustainability report

As a provider of remotely delivered healthcare, the trust was a sustainable organisation: by offering quality healthcare advice to patients in their own homes without the need for travel. This had a significant impact on energy consumption and CO2e emissions.

The organisation kept an up to date sustainable development management plan and complied with all environmental legislation; it also sought to meet the requirements of other policies and strategies set out by government, the Department of Health and the NHS. Throughout the year, the trust

- was committed to minimising waste by evaluating its operations and ensuring that they were as efficient as possible.
- communicated and promoted its sustainability policy, procedures and practices to staff and others working on our behalf, ensuring that all employees were aware of their responsibilities in sustainability.
- measured its impact on the environment and set targets for improvement, continually improving performance by setting and reviewing the targets each year.
- encouraged its suppliers to adopt similar attitudes toward improving sustainability and actively promoted reuse and recycling amongst suppliers, and internally to staff.
- was committed to reducing wider environmental and social impacts associated with the procurement of goods and services, as set out within policies on sustainable procurement.
- worked on calculating the carbon emissions associated with goods and services it procured.

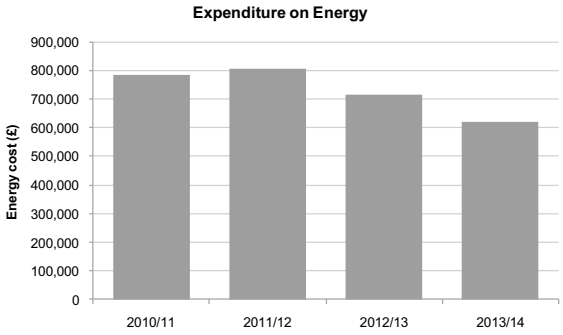
A Board-level lead for sustainability ensured that sustainability issues had visibility and ownership at the highest level of the organisation. Roger Rawlinson, Acting Chief Executive was the board level lead for sustainability.

Since this is the trust's final report, the format replicates the 2012/13 report for consistency of information without the need for complex restatement of previous years' values. Data relating to the NHS 2007 sustainability base year is not available, and it was not considered a prudent use of resources to create this at a time when the trust itself was closing. A summary of the major areas of sustainability information 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.

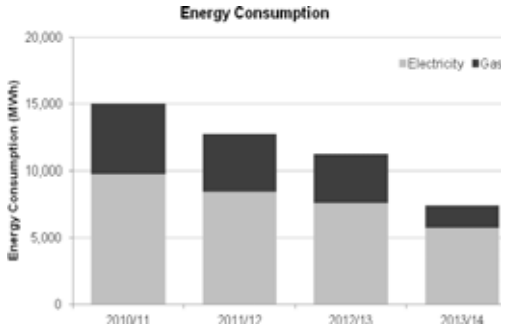
There is also a financial benefit which comes from reducing our energy bill. By reducing our energy costs by 13% in 2013/14, we have saved £93k.



Energy Consumption

Our total energy consumption fell during the year, from 11,234 MWh to 7,421 MWh.

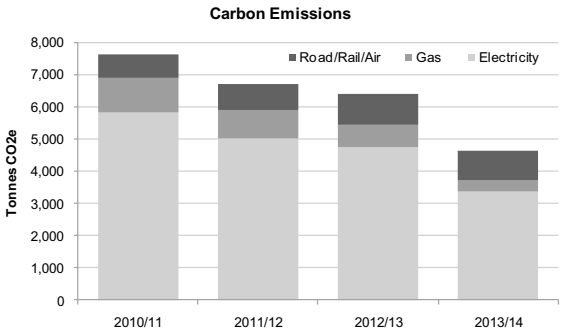
Our relative energy consumption reduced during the year, from 0.55 to 0.42 MWh/m2.



Carbon Emissions

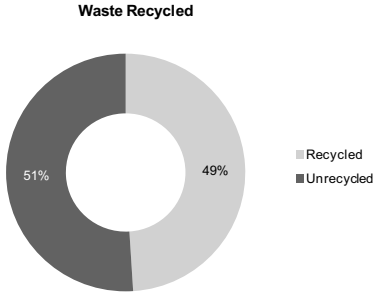
Our measured greenhouse gas emissions reduced by 1,471 tonnes CO2e during the year.

During 2013/14 our total expenditure on business travel was £737k.



Waste Recycling

We recovered or recycled 154.25 tonnes of waste, which was 49% of the total waste we produced.

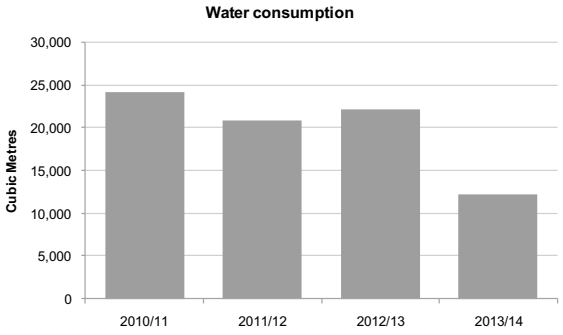


Waste expenditure

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

Water consumption

Our water consumption decreased by 9,810 Cubic Metres in the year. In 2013/14 we spent £27k on water.



Public Interest and Governance

Non-executive Director biographies

Sue Hunt

Sue was appointed as Acting Chair of the trust in January 2014. She 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

Peter Catchpole

Peter joined the Board on 1 April 2004. He 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 was a Council Member of the General Dental Council until October 2013 and has also served 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.

Tim Walton

Tim is an independent consultant and joined the Board on 1 April 2007. He is a director of Timothy Walton and Associates Limited and he has been a non-executive director at Sourcerer Limited, BERR (now BIS), Accent Group and the Highways Agency. Previously he held a number of executive roles in aerospace, engineering and technology sectors. He is a Fellow of the British Computer Society and a Chartered Engineer.

Tim Heymann

Tim 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.

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.

Steve Duncan

Steve 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. Steve has recently been appointed as Chairman of Westpoint veterinary business.

Executive Director biographies

Roger Rawlinson, Acting Chief Executive

Roger joined the Executive Management Team on 1 September 2007 as Human Resources Director, having worked for 15 years in a variety of human resource positions in clothing manufacturing, retail and the NHS. He was appointed Group Human Resources Director of William Baird in 2000 and in 2003 he joined Bedfordshire & Hertfordshire Strategic Health Authority as HR Director and Chief Executive of the Workforce Development Confederation. He joined NHS Direct following a restructure of Strategic Health Authorities. Having added Internal Communications, Estates and Learning and Development to his portfolio, he was appointed HR & Transition Director in June 2012 and Acting Chief Executive in January 2014.

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.

Ruth Rankine, Director of Strategy & Business Development

Ruth joined NHS Direct in October 2007 from the Department of Health where she was Principal Private Secretary to the NHS Chief Executive and the Permanent Secretary. She was responsible for developing the trust's medium-term strategy and business plan in addition to service development, sales and marketing and communications. Latterly, Ruth was also responsible for the operational delivery of the trust's Digital Health and Advice Services. Ruth has held senior positions at a national and local level in the NHS and public sector, both in strategic and operational roles. This has included 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.

Tricia Hamilton, Clinical Director / Chief Nurse

Tricia has over 30 years' nursing experience in a variety of settings, including acute care, neuro-intensive care and general surgery. Since joining NHS Direct in 1999 as a Nurse Advisor, and 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 NHS Direct's services, Tricia's main area of interest was in exploring and developing technology to deliver safe and effective care remotely. She had overall responsibility for NHS Direct's pioneering online Health and Symptom Checkers which are now used by 4 million people each year. These have revolutionised healthcare, giving patients access to safe, clinically-validated advice and information wherever and whenever they need it, through 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.

Jackie Dunn, Director of Finance

Jackie Dunn joined NHS Direct in 2008 as Deputy Director of Finance and became the Acting Director of Finance from January 2013 until December 2013 when she became substantive Director of Finance. 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.

Chris Morgan, Acting Director of Service Delivery

Having worked for 12 years with British Gas in a variety of roles including call centre leadership, process re-design, call centre forecasting, capacity planning and management information support, telephony implementation, large scale back office management and leadership of off shoring activities, Chris joined the NHS five years ago and his role as the Executive Director of Service Delivery for NHS Direct involved leading initiatives on organisational change and performance improvement. Chris is a member of the Contact Centre Association excellence awards judging panel.

Kat Noble, Medical Director

Kat is a practising GP and a GP with a Specialist interest in Emergency Care with 10 years working experience in primary care, out of hours and in A&E. She has a particular interest in pre-hospital care and is a BASICS doctor. Originally from Aberdeenshire she lives and works in Durham in the North East of England. Kat previously held a position as a Department of Health National Advisor for NHS 111 and co-designed the national Clinical Governance assessment process. She completed a Clinical Fellowship in Medical Leadership in 2010. Kat joined NHS Direct as Medical Director in May 2013. Her responsibilities were: ensuring that NHS Direct provided safe and effective services for patients and that NHS Direct was optimally positioned with external relationships.

Information governance, risks 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 2013/14

Statement on information risk	NHS Direct did not formally report any action on protected personal data related incidents to the Information Commissioner's Office in 2013/14. Throughout the year NHS Direct monitored and assessed information risks in order to identify and address any weaknesses and ensure continuous improvement of its systems. The Senior Information Risk Owner (SIRO) and the Head of Information Governance 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 Governance also undertook refresher training courses for their roles, to help to ensure that their responsibilities were carried out effectively, and so that their knowledge and skills were 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 2012/13 were still effective and to identify and assess any potential new information risks. During 2013/14 the trust further developed the Risk Assessment & Management Strategy Plan & Programme to ensure the protection of information assets from a wide range of potential threats.

Date of incident (month)	Nature of incident	Nature of data involved	Number of people potentially affected	Notification steps
No Incidents	n/a	n/a	n/a	n/a

Further action on information risk	• None

Summary of other protected personal data related incidents in 2013/14

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

Category	Nature of incident	Total
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	2
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	2
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	3
IV	Unauthorised disclosure	85*
V	Other	3

* a significant proportion of these disclosures involved deliberate referral to other organisations, where consent was not obtained because doing so would endanger a person or persons, such as cases involving child protection or vulnerable adults

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 the internal auditors and carried out in support of the submission of the Information Governance toolkit v11 in March 2014. The purpose was to provide independent assurance of our returns.

Information governance steering group

The information governance steering group provided 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 oversaw the management of and reporting against the standards of the NHS Information Governance Toolkit, and ensured the terms and conditions of the Information Governance Assurance Statement were upheld.

Better Payments Practice Code

	2013/14		2012/13	
	Number	£000	Number	£000
Total Non-NHS Trade Invoices Paid in the Year	13,550	76,315	17,148	78,709
Total Non-NHS Trade Invoices Paid Within Target	13,431	76,154	17,040	78,657
Percentage of Non-NHS Trade Invoices Paid Within Target	99.12%	99.79%	99.37%	99.93%
Total NHS Trade Invoices Paid in the Year	192	4,691	244	3,937
Total NHS Trade Invoices Paid Within Target	189	4,675	237	3,921
Percentage of NHS Trade Invoices Paid Within Target	98.44%	99.66%	97.13%	99.59%

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 £66,000. No other audit services were provided in this period.

Disclosure of relevant information

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

Directors' declaration of interests during 2014/15

Name	Interest Declared
Sue Hunt	CfBT Education Trust – Appointed Trustee Notting Hill Housing Trust- Board member The Satellite Applications Catapult- Non-Executive Director
Tim Walton	Timothy Walton and Associates Limited – Director Highways Agency - Non Executive Director (end of term ceased January 2014)
Peter Catchpole	British Association of Psychotherapy and Counselling Conduct Committee – Lay Member West Sussex County Council – County Councillor 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 Chairman Westpoint (veterinary business)
Trevor Jones	Womens' Royal Voluntary Service – Trustee WellChild – Trustee Tetbury Hospital Trust Ltd – Trustee
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
Roger Rawlinson	None declared
Tricia Hamilton	None declared
Alan Bentall	None declared
Jackie Dunn	None declared
Chris Morgan	None declared
Kat Noble	None declared
Ruth Rankine	Carers First (charitable organisation), Tonbridge - Trustee
Nick Chapman	Spouse – self-employed consultant (NPC Associates Limited) who does work from time to time with and for NHS bodies
Trevor Smith	None declared

Remuneration report

Remuneration Committee

In accordance with Standing Order 4.8.2 the trust established a Remuneration Committee as a standing committee of the Board, to which it made recommendations and was accountable to. It was chaired by a Non-Executive Director (Peter Catchpole) and membership was made up of two further Non-Executive Directors (Tim Walton & Steve Duncan). The terms of references were considered as part the overall Corporate Governance Manual review and approved by the Trust Board in December 2013.

Within its terms of reference the principal duties of the Remuneration Committee related to the Chief Executive and other Executive Directors and other senior employees (those who were not subject to the Agenda for Change agreement) 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 and HR Director were invited to attend the committee in an ex-officio capacity to address matters which did not affect them directly.

Remuneration policy and framework

The Executive Remuneration Policy was linked to the Pay Framework for Very Senior Managers (VSM) in Strategic and Special Health Authorities, Primary Care Trusts and Ambulance Trusts, the most recent version of which was issued by the Department of Health in June 2013.

In line with the amended framework, which gave remuneration committees the authority to award a 1% uplift from 1 April 2013 to executives who had performed at least to a satisfactory level for the financial year 2012/13, the Remuneration Committee awarded a 1% salary uplift to Alan Bentall, Jackie Dunn and Roger Rawlinson at its meeting on 28 October 2013.

The provision of Performance Related Pay for eligible executives was not considered appropriate for the financial year 2013/14, so no targets were set.

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

Name	Role	Start	Notice	Nature	CSD
Alan Bentall	Chief Information Officer	16/04/2010	3 months	Permanent	16/04/2010
Jackie Dunn	Director of Finance	30/06/2008	3 months	Permanent	01/07/1993
Patricia Hamilton	Chief Nurse/Director of Clinical Services	01/09/1999	3 months	Permanent	01/10/1981
Roger Rawlinson	Acting Chief Executive	01/09/2007	3 months	Permanent	01/09/2003
Ruth Rankine	Director of Strategy & Business Development	01/06/2010	3 months	Permanent	01/06/2010
Katherine Noble	Medical Director	20/05/2013	3 months	Permanent	01/08/1998
Chris Morgan	Acting Director of Service Delivery	19/01/2009	12 weeks	Permanent	19/01/2009
Nick Chapman	Chief Executive	01/04/2009	6 months	Permanent	25/11/1979
Trevor Smith	Managing Director	02/01/2009	3 months	Permanent	22/04/1996

*Note: Nick Chapman left December 2013, and Trevor Smith left in July 2013.

Salaries and allowances

Salaries & Allowances

Name & Job Title	2013-14 Salary (bands of £5,000) £000	2013-14 Salary includes PRP awarded £000	2013-14 All Pension related benefits (bands of £2,500) £000	2013-14 Benefits in Kind (Rounded to nearest £00) £00	2013-14 Total Remuneration of all types £000	2012-13 Salary (bands of £5,000) £000	2012-13 Salary includes PRP awarded £000	2012-13 All Pension related benefits (bands of £2,500) £000	2012-13 Benefits in Kind (Rounded to nearest £00) £00	2012-13 Total Remuneration of all types £000
Nicholas Chapman, Chief Executive to 22.12.13 - redundant	110-115	0	5-7.5	0	115-120	150-155	0	0-2.5	0	150-155
Trevor Smith, Managing Director to 14.7.13 - resigned	35-40	0	10-12.5	0	50-55	135-140	0	17.5-20	0	155-160
Roger Rawlinson, Director of Human Resources , then Acting Chief Executive from 22.12.13	120-125	0	37.5-40	0	160-165	105-110	0	17.5-20	0	125-130
Ruth Rankine, Director of Strategy & Business Planning	115-120	0	17.5-20	0	135-140	110-115	0	20-22.5	0	135-140
Alan Bentall, Chief Information Officer	120-125	0	17.5-20	0	135-140	120-125	0	20-22.5	0	140-145
Patricia Hamilton, Clinical Director/Chief Nurse	95-100	0	5-7.5	36	105-110	100-105	0	2.5-5	32	105-110
Jackie Dunn, Acting Director of Finance and Performance from 01.1.13 to 3.12.13, then Director of Finance and Performance	120-125	0	105-107.5	0	225-230	25-30	0	NA	0	25-30
Brian Gaffney, Director of Public Health left 31.07.2012	0	0	0	0	0	25-30	0	0	0	25-30
Katherine Noble, Medical Director from 20.5.13 to 31.3.14	45-50	0	NA	0	115-120	0	0	0	0	0
Keith Gait, Chief Operating Officer to 17.5.13 - end of fixed term contract	15-20	0	0	0	15-20	90-95	0	0	0	90-95
Christopher Morgan, Acting Chief Operating Officer from 18.5.13	100-105	0	NA	28	100-105	0	0	0	0	0
Joanne Shaw, (Non Executive Chair) to 31.12.13	25-30	0	0	1	25-30	35-40	0	0	2	35-40
Sue Hunt, (Non Executive) and Chair from 1.1.14	15-20	0	0	8	15-20	5-10	0	0	8	5-10
Peter Catchpole, (Non Executive)	10-15	0	0	13	10-15	10-15	0	0	8	10-15
Trevor Jones, (Non Executive) to 30.6.13	1-5	0	0	10	1-5	0-5	0	0	8	5-10
Tim Walton, (Non Executive)	5-10	0	0	14	5-10	5-10	0	0	16	5-10
Luisa Dillner, (Non Executive)	5-10	0	0	0	5-10	5-10	0	0	0	5-10
Tim Heyman, (Non Executive)	5-10	0	0	1	5-10	See below		0	1	See below
Steve Duncan, (Non Executive)	5-10	0	0	7	5-10	5-10		0	0	5-10

Except as detailed above all non executive directors left the trust on 31.3.14

Nick Chapman's post was originally made redundant wef 30.06.13 once the 0845 46 47 service was planned to close. Nick's redundancy was deferred to 22.12.13 to oversee the transfer of
111 services to alternative providers

Trevor Smith was appointed Managing Director from 01.01.13 and resigned from the post wef 14.07.13
Roger Rawlinson was Director of HR for the whole year and took on the additional duty of Acting Chief Executive following Nick's departure to oversee the closure of the Trust.

Amounts paid to third party organisations
Tim Heyman (Non Executive) was an employee for 2013-14 but in the previous year payment was made to a third party.
The payment to the third party organisation for Tim Heyman is to reimburse them as his employer for time spent on NHS Direct affairs.
No PRP has been awarded for either of the above years

There is a new requirement to disclose the increased pension entitlement of directors and senior managers in respect of their employment for the above years.
This increase will include the benefit arising from a further year's service and increased salary through promotion and is based on the assumption each pension will be payable for 20 years following retirement and the lump sum entitlement.

In the first year of employment only current year pension benefits are available from NHS Pensions Agency. If the employee has previous pensionable service in the NHS, current information would represent their accumulated pension benefit and not that relevant to the year of employment. Therefore pension benefit is treated as not available for the purposes of this report.

As the trust is closing all executive directors and senior managers are being made compulsorily redundant.
Some were to be made redundant as part of the implementation of the 111 service but following withdrawal from that, were deferred as part of the closure plan.
Consequently some redundancies were agreed in 2012-13 and some in 2013-14 in accordance with the exit packages disclosed in note 9.4 to the accounts.
The details of the redundancies for each individual included in note 9.4 are as follows:

2013/14	**Redundancy (bands of £5,000) £000**
Ruth Rankine Director of Strategy & Business Planning	210-215
Patricia Hamilton Clinical Director/Chief Nurse	200-205
Jackie Dunn Acting Director of Finance and Performance from 01.1.13 to 3.12.13, then Director of Finance and Performance	270-275
Katherine Noble, Medical Director from 20.5.13 to 31.3.14	65-70
Christopher Morgan, Acting Chief Operating Officer from 18.5.13	40-45

2012-13

Nicholas Chapman, Chief Executive to 22.12.13 - redundant	300-305
Roger Rawlinson, Director of Human Resources , then Acting Chief Executive from 22.12.13	125-130
Alan Bentall Chief Information Officer	40-45

For the following directors, redundancy was agreed in the years shown but have not yet been paid and may not be if they remain an employee of another NHS organisation

Roger Rawlinson
Alan Bentall
Jackie Dunn

Non executive directors are required to attend Board and various committee meetings to fulfill their duties. The travel costs related to this 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.

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 age 60 at 31 March 2014 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2014 £000	Cash Equivalent Transfer Value at 31 March 2013 £000	Real increase in Cash Equivalent Transfer Value £000
Nicholas Chapman, Chief Executive to 22.12.13 - redundant	0-2.5	(2.5)-(5.0)	60-65	190-195	0	1,295	NA
Trevor Smith, Managing Director to 14.7.13 - resigned	0-2.5	0-(2.5)	45-50	140-145	761	710	36
Roger Rawlinson, Director of Human Resources , then Acting Chief Executive from 22.12.13	2.5-5	0-(2.5)	15-20	40-45	361	278	66
Ruth Rankine Director of Strategy & Business Planning	0-2.5	0	5-10	0	76	54	21
Alan Bentall Chief Information Officer	0-2.5	0	5-10	0	139	102	35
Patricia Hamilton Clinical Director/Chief Nurse	0-2.5	0-(2.5)	35-40	110-115	691	650	27
Jackie Dunn Acting Director of Finance and Performance from 01.1.13 to 3.12.13, then Director of Finance and Performance	5-10	0-(2.5)	40-45	125-130	841	636	191
Katherine Noble, Medical Director from 20.5.13 to 31.3.14	NA	NA	25-30	75-80	380	NA	NA
Christopher Morgan, Acting Chief Operating Officer from 18.5.13	NA	NA	5-10	15-20	92	NA	NA

As Nicholas Chapman left on 22.12.13, his pension has started and therefore has no transfer value

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

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 2013-14 was £120,000-£125,000 (2012-13, £150,000-155,000).
This was 4.26 times (2012-13 - 5.15) the median remuneration of the workforce, which was £25,000-£30,000 (2012-13 £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.

The median calculation is based on the annualised earnings of those in post at the year end.
Despite the reduction in total number of staff included in this calculation - 672 at 31.3.14, 2,434 at 31.3.13, the median earnings remains similar for the 2 years. The earnings of the higest paid director still employed at 31.3.14 is lower than last year, hence the reduced ratio given above.

Cash Equivalent Transfer Value (CETV)

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.

Summary of Off Payroll Contracts

For all off-payroll engagements as of 31 March 2014, for more than £220 per day and that last longer than six months:	
The total number of existing engagements as of 31 March 2014	17
• The number that have existed for less than one year at time of reporting.	11
• The number that have existed for between one and two years at time of reporting.	2
• The number that have existed for between two and three years at time of reporting.	4
• The number that have existed for between three and four years at time of reporting.	0
• The number that have existed for four or more years at time of reporting.	0
Existing off-payroll engagements have at some point been subject to a risk based assessment as to whether assurance needs to be sought that the individual is paying the right amount of tax and, where necessary	

For all new off-payroll engagements between 1 April 2013 and 31 March 2014, for more than £220 per day and that last longer than six months:	
Number of new engagements which include contractual clauses giving NHS Direct the right to request assurance in relation to income tax and National Insurance obligations	13
Number for whom assurance has been requested	13
Of which:	
Assurance has been received	13
Assurance has not been received	0
Engagements terminated as a result of assurance not being received, or ended before assurance received.	0

Accountable Officer: Roger Rawlinson, Acting Chief Executive

Date: 9 June 2014

NHS Direct National Health Service Trust

Accounts 2013/14

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

Under the National Health Service Act 2006 and directions made thereunder by 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 NHS Trust Development Authority has appointed the Acting Chief Executive of the NHS Direct National Health Service Trust as the Accounting Officer, with the responsibility for preparing the Authority's accounts for transmitting them to the Comptroller and Auditor General.

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

- observe the accounts direction issued by the Secretary of State, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable and consistent 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 Acting 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 Officer's Memorandum issued by the NHS Trust Development Authority.

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

Introduction

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.

- This statement provides an overview of the governance of the trust; its management of risk, the state of its internal controls and an overview of risks managed over the past year. As the trust closed at the end of 2013/14, there are no future risks to describe.
- The trust complied with The UK Corporate Governance Code as it applies to the organisational type, and had an effective system of integrated governance.
- From 23 December 2013, the Accountable Officer role was assumed by Roger Rawlinson, Acting Chief Executive, following the departure of Nick Chapman, the former Chief Executive Officer. This was formally confirmed in a letter from the Chief Executive of the NHS Trust Development Agency on 17 March 2014.

Context

At the start of 2013/14 the trust was responding to the significant operational difficulties arising from implementation in March 2013 of the new NHS 111 services for local commissioners, covering approximately one third of the England population. The NHS 111 service was expected to be the major service offering for the trust, supported by an expanding range and development of digital services. As a consequence of the decommissioning of the national 0845 46 47 service, the trust had reviewed and fundamentally changed it's senior and operational management structures and governance arrangements, in order to be fit for purpose in a new competitive market environment. The trust's turnover was forecast to reduce by over 30% compared to 2012/13, and the strategic objective was to increase the income base to it's previous level, particularly through growth in digital services.

Following intense activity in April 2013, associated with improving the operational delivery of it's NHS 111 services, the Trust Board jointly commissioned, with NHS England and the NHS Trust Development Authority, an independent review to establish the reasons for the failure to successfully implement NHS 111 services to effectively meet contracted volumes and operational performance levels. The Board accepted the conclusions of the review, and noted that commissioners had rejected recovery plans prepared by the trust which had identified the need for significant price increases, in order to meet contract requirements. The price increases were required because call times and patient referral rates to clinical advisers continued to significantly exceed the values built into the trust's operating and financial models.

In the absence of commissioner support for the recovery plans, it was clear that if the trust continued to provide NHS 111 services, it would incur a substantial financial operating deficit, and be in breach of its break-even duty. It was therefore agreed with NHS England, local Clinical Commissioning Groups and the NHS Trust Development Authority, that the trust's NHS 111 services should be transferred to 'step-in' providers. The transfers were co-ordinated by NHS England, and following detailed due diligence activities and assessment of the capabilities of new providers, all of the trust's NHS 111 services were successfully transferred to a number of Ambulance Service Trusts by November 2013.

With the cessation of provision of NHS 111 services, and the imminent closure of the 0845 46 47 contingency service in February 2014, the Trust Board reviewed the future financial viability of the organisation and concluded that the trust would not be sustainable in the future given that:

- Operating income in 2014/15 was expected to be only £17million
- The trust would have no guaranteed income from April 2015
- The trust would be in recurrent breach of it's break even duty
- The trust would fail the 'going concern' test

In October 2013 the Trust Board agreed, with support from the NHS Trust Development Authority, that it should plan to cease to provide any services beyond March 2014, and formally consult with the public and staff interests on the dissolution of the trust.

From October 2013, the trust adopted a Programme Management approach to its preparations for dissolution, with five primary workstreams covering:

- Service transfers to other providers
- Sites and services decommissioning
- Staff support programme
- Dissolution process and governance
- Financial issues

The NHS Trust Development Authority established and led a Closure Board comprising membership of key stakeholder organisations, to oversee the delivery of the work programme.

The dramatic contrast in the trust's primary objectives over the last year, from a strategy to achieve income growth at the start of the year, to planned organisational closure by the year end, presented unique challenges for the entire workforce, and required strong leadership from the Board. Governance processes were reviewed and strengthened in response to the changing emphases over the year, particularly in relation to risk management. Continuous reviews of risks and mitigating actions were overseen by the Audit Committee and Trust Board and this approach was a key factor in the successful delivery of major organisational change.

By the end of the year the outcomes of the five workstreams had delivered:

- The safe transfer of all NHS Direct services to new providers by 31March 2014
- The transfer of closed operational sites to the Secretary of State
- The transfer of NHS Direct staff to new provider organisations, wherever possible, minimising the number of redundancies
- A successful application to the Secretary of State to dissolve the trust, with assurance that all residual assets and liabilities had been or will be transferred to successor organisations
- Assurance that all these activities were completed at the lowest possible expense to the public purse

Governance Structure

The Trust Board

The Trust Board was collectively responsible for the long-term success of the organisation and set the overall strategic aims and objectives. The Board membership, defined by the trust's Establishment Order comprised a Non-Executive Chairman, seven Non-Executive Directors (NEDs), the Chief Executive and seven Executive Directors of whom three were non-voting members. Following the departure of one Non-Executive Director in June 2013 and the Chairman and Chief Executive in December 2013, the Board comprised a Non-Executive Chairman, five Non-Executive Directors, the Chief Executive and six Executive Directors, of whom two were non-voting.

The Trust Board received regular performance and compliance reports from across key areas of the organisation, allowing it to make an assessment of its own effectiveness. It monitored 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 provided to patients and the wider NHS. All data submitted for inclusion in the Scorecard was quality-checked and approved by the relevant Executive from the business area that provided it. Data was extracted from reports and cross-checked against outputs to help to ensure accuracy and consistency. The NEDs constructively challenged these performance reports and held the Executive Directors to account. They also helped the Executive Directors to develop proposals on strategy.

As part of its original preparations to seek Foundation Trust status, the trust had developed a public membership base of over 16,000 that broadly represented the population of England and NHS Direct service-users. Members received newsletters by post or email (according to their preference) to keep them informed about new developments. Members were also invited to participate in specific working groups regarding the trust's services and strategic direction. Following the decision to dissolve the trust, all members were informed, and thanked for their past support. The membership was stood down with effect from October 2013.

The Trust Board regularly met in public and met in regular session 12 times during 2013/14. Until February 2014 its proceedings were streamed live on the web and posted on YouTube, promoting openness and transparency within the organisation. It also communicated through Twitter. In addition, the Board was convened for three 'extraordinary meetings' to approve the Annual Report and Accounts 2012/13 and to approve the draft trust dissolution business case for submission to the Secretary of State. It held a seminar event in December 2013 to consider the formal response and submissions from the staff side, following conclusion of the staff consultation on the consequences for the trust's workforce of service commissioning decisions.

The Non-Executive Directors actively participated in engagement activities with staff and external stakeholders, on which they reported their findings and observations in the public section of the Trust Board. These events were welcomed by staff, and provided the Non-Executive Directors with clear insight into the operational challenges faced by staff, which was particularly valuable during a year of significant uncertainty regarding the trust's future.

Patient safety and experience were key elements of every Trust Board meeting agenda. As described above, all Board members visited Contact Centres regularly to experience services first hand and to speak to frontline, supervisory and support staff. Members also listened to randomly selected voice recordings of calls to the services delivered by the trust's staff, and discussed their assessment of the calls in all of the open Board meetings. Learning from the call reviews was fed back to staff in order to enable service improvements and share best practice. Non-Executive Directors were also invited to observe internal reviews of serious incident investigations and outcomes.

During 2013/14 changes were made to the Trust Board executive membership to meet the changing needs of the organisation. Following the departure of Managing Director, Trevor Smith from the trust, the Acting Director of Finance and Performance, Jackie Dunn, was appointed substantively. Dr. Katherine Noble was appointed as Medical Director and, as former National Clinical Governance Lead for NHS 111 at the Department of Health, was able to augment and support the work of the Clinical Director/Chief Nurse, Patricia Hamilton. During the period January to March 2014 Kat was seconded to the Health and Social Care Information Centre, in the role of Acting Clinical Director for NHS Pathways, where she was leading Pathways in external relations, strategic, clinical and corporate development and supporting the authoring team. During this time, Kat retained her responsibilities as Medical Director for the trust, and continued to attend Trust Board meetings. For the same period, January to March, Ruth Rankine, Director of Strategy and Planning, was seconded to the NHS Trust Development Authority as Programme Director – NHS Direct Closure. In this role Ruth led, on the NHS Trust Development Authority's behalf, the programme of work to oversee the safe transfer of NHS Direct services to other providers, and the trust dissolution process, including appointment of successor bodies to take responsibility for the trust's residual assets and liabilities. During this period, Ruth relinquished her Board responsibilities at NHS Direct to avoid a conflict of interests.

The posts of Corporate Governance Consultant and Company Secretary were established from April in order to strengthen corporate governance management and systems at the trust during the final year of its existence, and provide support to the Board

The Chairmen of the Board's Sub-Committees changed during the year following the departure of Trevor Jones, Non-Executive Director in June 2013, and Joanne Shaw, Chairman in December 2013. Sue Hunt was appointed as Deputy

Chairman of the Board from July 2013 and Chairman of the Board from January 2014. Tim Heymann, Non-Executive Director, took over her responsibilities as Chairman of the Clinical Governance Committee from January 2014. Trevor Jones was succeeded as Chairman of the Remuneration Committee by Peter Catchpole, Non-Executive Director, from July 2013. All Trust Board *members* had good attendance records at the committees of which they were members. This is demonstrated in the following table:

	Trust Board (15 meetings)	Audit (4 meetings)	Finance (7 meetings)	Remuneration (2 meetings)	Clinical Governance (6 meetings)
Alan Bentall*	14 of 15		5 of 7		
Chris Morgan*	10 of 15				
Jackie Dunn	15 of 15	4 of 4 (N)	7 of 7		
Joanne Shaw	11 of 11				
Katherine Noble	9 of 13				0 of 5 (N)
Luisa Dillner	10 of 15		3 of 7		5 of 6
Nick Chapman	11 of 11	2 of 2 (N)	5 of 5	2 of 2 (N)	4 of 4 (N)
Peter Catchpole	12 of 15	4 of 4 (C)		2 of 2 (C)	
Roger Rawlinson**	15 of 15	2 of 2 (N)	2 of 2	2 of 2 (N)	2 of 2 (N)
Ruth Rankine*	10 of 11		3 of 5		
Steve Duncan	13 of 15		7 of 7	1 of 1	3 of 6
Sue Hunt	13 of 15	2 of 2	7 of 7		6 of 6 (C)
Tim Heymann	13 of 15	3 of 3			6 of 6 (C)
Tim Walton	14 of 15	2 of 2	7 of 7 (C)	2 of 2	
Trevor Jones	5 of 5	1 of 1		1 of 1 (C)	1 of 1
Tricia Hamilton	13 of 15				6 of 6

(C) Chair for the meeting
(N) Non-member in attendance
* Non-voting member
**Non-voting member, became a voting member from January 2014

The Trust Board had the appropriate balance of skills, experience and knowledge to discharge its responsibilities effectively. This included a Registered Nurse as Clinical Director / Chief Nurse, a Registered Doctor as Medical Director and a qualified Finance Director. In addition, the NEDs included two medical practitioners alongside colleagues with extensive experience in the private, not-for-profit and public sectors.

The Trust Board maintained an up-to-date Register of Interests, which formally recorded the declarations of interests made by its members. Any interest that arose during the course of a meeting was declared immediately and recorded in the minutes of the meeting. This ensured that the Board acted in the best interests of the organisation and avoided situations where there may have been a potential conflict of interest.

Trust Board sub-committees

The Trust Board had five sub-committees. During April 2013, the two sub-committees that had been established in 2012 on a time-limited basis - to oversee the creation of the new organisational model for NHS 111 services and to de-commission the 0845 46 47 service - were stood down, and their work was subsumed within the remaining committee structure on a business as usual basis.

Audit Committee

The Audit Committee was a Sub-Committee of the Trust Board. Its membership was made-up of Non-Executive Directors. This allowed the Trust Board to be independently assured about the effectiveness of the organisation's system of internal control. The Committee was assisted in this process by the trust's internal audit team, which delivered an annual programme of risk-related system reviews and investigations. The internal audit plan was signed off by the Audit Committee, which received progress reports at every meeting on the delivery of the plan, and outcomes of internal audit reviews. The Internal Audit Plan enabled the Board to be assured that key internal controls and other matters relating to risk were regularly reviewed.

This Committee's work was 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 corporate risk registers, ensuring that any highlighted risk areas were mitigated through appropriate management actions
- considering the assurances on risk and control set out in Internal Audit's annual report and opinion, together with key assurance assessments described in individual reports.

The Committee Chairman ensured that any areas of particular concern were brought to the Trust Board's attention, through the formal presentation of the minutes of each meeting to the Board. The committee also submitted an annual report on its work, including an assessment of its effectiveness, to the final Trust Board meeting in March 2014.

Finance Committee

The Finance Committee was also a sub-committee of the Trust Board and was responsible for providing additional assurance to the Board on financial management matters. It provided effective governance and controls over spending and investment decisions, benefits realisation and it also scrutinised financial planning, financial management, and performance reporting. It considered investment proposals and responses to invitations to tender from NHS Commissioners and where appropriate made recommendations for approval to the Trust Board. In addition, during 2013/14 the Committee undertook frequent detailed reviews of the complex financial issues related to the trust's dissolution, including plans for the transfer, sale or disposal of fixed assets, staff redundancy costs and contract termination arrangements. The committee also took particular interest in the trust's cash flow management arrangements, which were more challenging during the year as a consequence of service transfers and related credit control issues.

Remuneration Committee

The Remuneration Committee was also a sub-committee of the Trust Board. Its remit was to make nominations, ensuring there was a formal, rigorous and transparent procedure for the appointment of new Executive Directors to the Trust Board. It set the remuneration and terms-of-service for the Chief Executive and other Executive Directors, including salary uplifts and performance bonus payments where they applied. The Committee maintained an overview of all remuneration matters for staff in the trust and reported to the Non-Executive Directors.

Clinical Governance Committee

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

- ensuring that clinical governance mechanisms were 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 specifically reporting on it's assessment of clinical risk management to the Audit Committee.

Trust Performance

The Trust Board reviewed performance on a regular monthly cycle, using a Board 'Scorecard', which covered all significant aspects of the trust's performance. Actual performance is noted in the Operational Review in this report.

Risk Management

The Chief Executive reported to the Trust Board on risks and risk management. The organisation took an integrated approach to risk management ensuring that clinical and non-clinical risks were considered together. All staff members had responsibility for risk management in the context of their role and the trust continued to work to develop a culture where all staff understood their responsibilities and appreciated the important role they played in managing risk to a reasonable level.

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

- the Chief Executive had ultimate responsibility for implementation of the Board's Risk Management policy and reporting requirements
- all Executive Directors were responsible for implementing the trust risk policy at Directorate level and developing mitigation actions to manage the risks identified
- the Clinical Director / Chief Nurse led on the management of clinical risk in the trust, supported by the Medical Director.
- the Chief Information Officer (CIO) was appointed by the Trust Board as the Senior Information Risk Owner and led the management of information risk in the trust through the Information Asset Owners
- the Corporate Governance Consultant was responsible for maintaining the Board Assurance Framework and liaison with individual Directorate risk leads.

Directorate Risk Leads and Project Management Officers were responsible for identifying and reporting risks at Directorate and project level.

NHS Direct managed the risks to its principal objectives through its Board Assurance Framework (BAF). This identified the assurance available to the Trust Board in relation to the delivery and achievement of its key priorities and strategic objectives and the effectiveness of the operation of key control processes. The Board was apprised on a monthly basis of the gaps in control and assurance and the action being taken to address such gaps.

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

Frontline staff members were supported by specialist back-office staff, such as Clinical Governance Leads, who had substantial experience and training in investigation management, including root cause analysis, and experience in conducting investigations across multiple partners and collaborating with commissioners and delivery partners.

Emergency Preparedness

The trust had a Major Incident Plan which was last reviewed in July 2012 and was written in accordance with the Department of Health's (DH) Emergency Planning Guidance 2005 and the Civil Contingencies Act (CCA) 2004.

The key elements within the plan, when dealing with major service disruption were complied with during the service recovery period immediately following implementation of NHS 111 services in March/April 2013.

The plan was also utilised during routine resilience testing for standing up the dormant National Flu Pandemic Service during 2013.

State of Internal Controls

The trust's risk management systems and processes were subject to detailed Internal Audit review during the year, and the report to the Audit Committee provided substantial assurance as to the suitability and effectiveness of the trust's arrangements.

NHS Litigation Authority

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, and was not subject to further assessment during 2013/14.

Care Quality Commission

The Care Quality Commission is the independent regulator of all health and social care service providers in England. Its role is to ensure that care provided meets national standards of quality and safety.

NHS Direct was not subject to any inspection by the Commission during 2013/14. It continued to achieve compliance with the standards required by registration throughout the year, maintaining consistently high levels of satisfaction and trust from patients. Evidence of the trust's continued registration is publicly available on the CQC website - www.cqc.org.uk – including reports of past routine unannounced inspections.

Information Governance Toolkit

The Information Governance Toolkit was a performance tool produced by the Department of Health. Complying with these standards helped to ensure the trust met its statutory obligations to manage data. The trust successfully achieved compliance with all 36 applicable standards in version 11 of the Toolkit, achieving an overall attainment of 88%.

Information Risk Management

NHS Direct did not formally report any action on protected personal data related incidents to the Information Commissioner's Office in 2013/14.

Auditors

The Internal Audit services for the trust were provided by Parkhill Internal Audit Services (recently taken over by TIAA Ltd) and External Audit by the National Audit Office. Both the Internal and External Auditors reported independently to the Audit Committee.

The Head of Internal Audit Opinion 2013/14

During the year, Parkhill merged with TIAA Limited. This opinion covers the whole of the year, and has therefore relied on work carried out by Parkhill prior to its transfer to TIAA Limited on 1st October 2013.

The purpose of the annual Head of Internal Audit Opinion is to contribute to the assurances available to the Accounting Officer and the Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control. Overall, significant assurance can be given that there was a generally sound system of internal control, designed to meet the organisation's objectives, and that controls were generally being applied consistently.

The basis for forming the Opinion is as follows:

- An assessment of the design and operation of the underpinning Assurance Framework and supporting processes
- An assessment of the range of individual opinions arising from risk-based audit assignments that were reported throughout the year

External Audit

The National Audit Office opinion for 2013/14 is an unqualified opinion but with an emphasis of matter highlighting that the accounts have not been prepared on a going concern basis as a result of the dissolution of the Trust on 1 April 2014.

Clinical Audit, Service Evaluation and Quality Review

The trust completed a full programme of clinical audit, service evaluation and quality reviews during 2013/14. The results of these audits, evaluations and reviews, together with the relevant follow-up management actions were presented to the Clinical Governance Committee. The overall results demonstrated that whilst there was the potential for improvement, the services provided by the trust were safe and continued to operate within established professional and NHS standards.

Key Risks

The key strategic risks the trust faced in 2013/14 are identified below. The trust maintained close review of these areas throughout the year including the effectiveness of mitigating actions taken.

Key risk	Mitigation
NHS 111 Service Delivery	Following the intense operational service recovery measures undertaken during April and May 2013, service standards consistently met or exceeded KPI targets until the services were transferred to step-in providers during October and November 2013.
Digital and Other Services delivery	Service developments were completed in accordance with commissioner requirements
Financial Plan	The trust operated within the revised financial plan approved by the Board in July 2013, and subsequently agreed with the NHS Trust Development Authority.
Safe, Quality Services	Call review procedures, complaints and feedback mechanisms and incident investigations were undertaken throughout the year and reported to the Trust Board each month.
Engaging with the Public, Commissioners and Stakeholders	The trust continued to hold regular engagement meetings with a wide range of stakeholders
Staff Morale	There was significant regular communication with staff and a comprehensive colleague support programme accessible by all staff to assist preparations for the impact of the trust's dissolution.
Loss of key staff	A programme to support and retain staff ensured that there was minimal impact of the trust's dissolution on patient services, and effective mitigating action when necessary.
Retain Critical ICT Infrastructure	ICT managed service procurement was completed and implemented during the year, leading to service stability and substantial revenue savings.
Unfunded Decommissioning Costs	The Department of Health agreed to fund all decommissioning costs associated with the closure of the trust.

As noted in the Annual Report, the winding up of the Trust was passed to a legacy management team, containing key members of NHS Direct's staff. I am satisfied that these arrangements contributed to assurance over the management of legacy issues until the date of this report.

Accountable Officer: Roger Rawlinson, Acting Chief Executive

Date: 9 June 2014

Certificate and report of the Comptroller and Auditor General to the Houses of Parliament

THE CERTIFICATE AND REPORT OF THE COMPTROLLER AND AUDITOR GENERAL TO THE HOUSES OF PARLIAMENT

I certify that I have audited the financial statements of NHS Direct NHS Trust for the year ended 31 March 2014 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 the Board's and Chief Executive's responsibilities , the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit, certify and report on the financial statements in accordance with the National Health Service Act 2006. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the NHS Direct NHS Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by NHS Direct NHS Trust; 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 and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. 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 NHS Trust's affairs as at 31 March 2014 and of the deficit 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.

Emphasis of matter

Without qualifying my opinion, I draw attention to the disclosures made in note 1.3 to the financial statements relating to going concern. NHS Direct NHS Trust was dissolved on 1 April 2014. As a consequence the financial statements have been prepared on a basis other than going concern. Details of the impact of this on the financial statements are provided in Notes 1.3, 1.4 and 27 to the financial statements.

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 sections entitled "Director's Report" and "Public Interest and Governance", for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

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

- adequate accounting records have not been kept or 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.

Sir Amyas C E Morse

Date 17th June 2014

Comptroller and Auditor General

National Audit Office

157-197 Buckingham Palace Road

Victoria

London

SW1W 9SP

Annual Accounts 2013/14

Statement of Comprehensive Income for year ended 31 March 2014

	NOTE	2013-14 Total £000	2013-14 Decommissioning £000	2013-14 BAU £000	2012-13 Total £000
Gross employee benefits	9.1	**(68,977)**	**(7,861)**	**(61,116)**	(130,054)
Other costs	7	**(40,569)**	**(11,380)**	**(29,189)**	(77,493)
Revenue from patient care activities	4	**78,550**	**1,627**	**76,923**	138,574
Other Operating revenue	5	**327**		**327**	632
Operating surplus/(deficit)		**(30,669)**	**(17,614)**	**(13,055)**	(68,341)
Investment revenue	12	**26**		**26**	59
Other gains and (losses)	13	**(70)**		**(70)**	0
Finance costs	14	**0**		**0**	0
Surplus/(deficit) for the financial year		**(30,713)**	**(17,614)**	**(13,099)**	(68,282)
Public dividend capital dividends payable		**0**	**0**		0
Retained surplus/(deficit) for the year		**(30,713)**	**(17,614)**	**(13,099)**	(68,282)
Other Comprehensive Income					
Impairments and reversals	17	**(293)**			(168)
Total comprehensive income for the year		**(31,006)**			(68,450)

Financial Performance for the year ended 31 March 2014

Retained surplus/(deficit) for the year	**(30,713)**	(68,282)
Impairments	**5,605**	19,076
Adjusted retained surplus/(deficit)	**(25,108)**	(49,206)
PDC dividend balance receivable/(payable) at 31 March 2014	**0**	548
PDC dividend balance receivable/(payable) at 1 April 2013	**548**	70

The decommissioning costs relate to activities underpinning closure of the trust. The costs are detailed on Note 7.

The notes on pages 41 to 68 form part of this account.

Statement of Financial Position as at 31 March 2014

	NOTE	31 March 2014 £000s	31 March 2013 £000s
Non-current assets:			
Property, plant and equipment	15	**1,816**	8,030
Intangible assets	16	**1,133**	4,175
Trade and other receivables		**0**	0
Total non-current assets		**2,949**	12,205
Current assets:			
Trade and other receivables	20.1	**2,988**	5,295
Other current assets		**0**	0
Cash and cash equivalents	21	**36,004**	21,834
Total current assets		**38,992**	27,129
Non-current assets held for sale	22	**0**	0
Total current assets		**38,992**	27,129
Total assets		**41,941**	39,334
Current liabilities			
Trade and other payables	23	**(28,962)**	(40,852)
Other liabilities		**0**	0
Provisions	25	**(4,762)**	(21,708)
Borrowings		**0**	0
Other financial liabilities		**0**	0
Total current liabilities		**(33,724)**	(62,560)
Non-current assets plus/less net current assets/liabilities		**8,217**	(23,226)
Non-current liabilities			
Trade and other payables	23	**0**	(2,456)
Other Liabilities		**0**	0
Provisions	25	**(6,295)**	(4,608)
Borrowings		**0**	0
Total non-current liabilities		**(6,295)**	(7,064)
Total Assets Employed:		**1,922**	(30,290)
Financed by Taxpayers' Equity			
Public Dividend Capital		**90,929**	24,511
Retained earnings		**(89,007)**	(58,294)
Revaluation reserve		**0**	293
Other reserves		**0**	3,200
Total Taxpayers' Equity:		**1,922**	(30,290)

The assets and liabilities of the Trust were transferred to other NHS organisations as from 1 April, as shown on note 27.
The notes on pages 41 to 68 form part of this account.
The financial statements on pages 37 to 40 were approved on the advice of the Audit Panel convened on 9 June 2014 and signed by:

Signature:
Accountable Officer: Roger Rawlinson, Acting Chief Executive

Date: 9 June 2014

Statement of Changes in Taxpayers Equity for the year ended 31 March 2014

	Public Dividend capital £000s	Retained earnings £000s	Revaluation reserve £000s	Other reserves £000s	Total reserves £000s
Balance at 1 April 2013	**24,511**	**(58,294)**	**293**	**3,200**	**(30,290)**
Changes in taxpayers' equity for 2013-14					
Retained surplus/(deficit) for the year	0	(30,713)	0	0	**(30,713)**
Impairments and reversals	0	0	(293)	0	**(293)**
Transfers between reserves	3,200	0	0	(3,200)	**0**
Reclassification Adjustments					
New PDC Received	63,218	0	0	0	**63,218**
Net recognised revenue/(expense) for the year	**66,418**	**(30,713)**	**(293)**	**(3,200)**	**32,212**
Balance at 31 March 2014	**90,929**	**(89,007)**	**0**	**0**	**1,922**

Balance at 1 April 2012	**24,511**	**9,988**	**461**	**0**	**34,960**
Changes in taxpayers' equity for the year ended 31 March 2013					
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)**

Statement of cashflows for the year ended 31 March 2014

	NOTE	2013-14 £000s	2012-13 £000s
Cash Flows from Operating Activities			
Operating Surplus/(Deficit)		**(13,055)**	847
Decommissioning / Closure costs	7	**(17,614)**	(69,188)
Depreciation and Amortisation	7	**3,103**	4,276
Impairments and Reversals	7	**5,605**	19,076
Interest Paid		**0**	0
Dividend (Paid) / Refunded		**548**	(478)
(Increase)/Decrease in Trade and Other Receivables		**1,759**	308
Increase/(Decrease) in Trade and Other Payables		**(11,596)**	25,911
Provisions Utilised	25	**(9,360)**	(989)
Increase/(Decrease) in Provisions	25	**(5,898)**	21,991
Net Cash Inflow/(Outflow) from Operating Activities		**(46,508)**	1,754
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest Received		**26**	59
(Payments) for Property, Plant and Equipment	15	**(129)**	(2,405)
(Payments) for Intangible Assets	16	**(7)**	(1,287)
Proceeds of disposal of assets held for sale (PPE)		**26**	143
Proceeds of disposal of assets held for sale (Intangible)		**0**	127
Net Cash Inflow/(Outflow) from Investing Activities		**(84)**	(3,363)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING		**(46,592)**	(1,609)
CASH FLOWS FROM FINANCING ACTIVITIES			
Public Dividend Capital Received		**63,218**	3,200
Other Loans Repaid		**(2,456)**	(1,632)
Net Cash Inflow/(Outflow) from Financing Activities		**60,762**	1,568
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**14,170**	(41)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**21,834**	21,875
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		**36,004**	21,834

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 2013-14 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 Going concern

In the 2012-13 accounts the trust reported it would be a major provider of the new NHS 111 service and the NHS Direct 0845 46 47 telephony service was being phased out. Following rollout of the trust's NHS 111 services it became apparent that it could not be delivered to the standards the trust and commissioners required at the contracted price. Proposals were made to commissioners for increased funding to facilitate the service required but these were not accepted and the trust's 111 services were transferred to step-in providers. This left the trust with a much reduced income for this and future years for the remaining services it provided and after careful consideration the Board concluded the trust would not be financially viable and agreed with NHS TDA that all operational services should cease by 31 March 2014 and the trust be dissolved.

After appropriate consultation with staff and the public, the Minister of State signed the dissolution order for the trust on 16 March 2014 to be effective at 1 April 2014 with services that would have been performed by NHS Direct in future being transferred to other providers. This decision has resulted in additional decommissioning cost to those incurred in 2012-13 in respect of staff redundancies, impairment of assets, changing arrangements with suppliers including transferring relevant contracts to the new service providers and additional estates closure costs.

Note 7 gives the detail of the net additional amounts included in these accounts for the decommissioning costs under the headings detailed in the following paragraphs and totals £17m. This figure is additional to provisions and accruals made in 2012-13 of £18m which remained unused at 31 March 2014 for the purposes originally envisaged through the changes in the trust's services during the current year, but will be used as part of the closure costs. The total net additional cost of decommissioning will be met by the Department of Health.

As the trust has been dissolved it was not appropriate to prepare these accounts on a going concern basis and this has been recognised in the accounts preparation.

1.4 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.

1.4.1 Critical judgements in applying accounting policies

It is not considered that judgements made will have any significant impact under this requirement, as with the dissolution of the trust, trust costs involved are mainly identified but there have been some estimations as set out below, that management has made particularly in the process of applying the trust's accounting policies in relation to decommissioning.

1.4.2 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 but more particularly liabilities at the year end. As noted these are due in the main to accounting for decommissioning costs.

Sites: All sites, except for four being used by the step-in 111 service providers on a sublease basis have closed 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. However the subleases to the 111 providers only run until 31 March 2015 so there remain lease and dilapidation liabilities beyond this date which have been provided for. As some of these leases continue for some time, the precise amounts involved for dilapidations cannot be accurately determined at 31 March 2014 and there is the possibility of subletting in some cases.

Supplier Contracts: The majority of contracts have either been or are in the process of being terminated. A number have been novated to other organizations as part of the NHS service they are providing following the decision to close the trust. These include contracts necessary to ensure the closure of the trust can be completed successfully. Indeed it has proved necessary to enter into some new contracts to facilitate this such as for records which have to be retained, particularly those of a clinical nature and the period of retention involved results in a considerable future cost. A major contract to be terminated is the IT Managed Service, notice had been given to terminate this contract at 30 November 2013, to facilitate a tender process to reduce costs appropriate to the 111 service. This resulted in the existing contractor continuing to provide service at reduced cost until closure including revised termination charges lower than previously estimated in the 2012-13 accounts.

Assets: Assets used specifically in sites closing were treated as fully impaired Some assets particularly those used in telephony have been reviewed for the number of seats and licences being used following closure/transfer of the 111 contracts, and impaired to reflect these changes. These and other unimpaired assets are then transferred at the resultant net book value at 31 March 2014 under absorption accounting effective at 1 April 2014, in accordance with Treasury FREM.

Project and Legacy Costs: There have been significant costs associated with the above activities and ensuring all aspects concerned with the closure of the trust were dealt with fully and correctly. As the trust was dissolved at 1 April 2014, activities which need to continue until final closure were hosted by South Central Ambulance Trust. Where appropriate these costs are recognised in these financial statements.

Staff: Whilst most of the redundancy costs are certain either because arrangements have been made to transfer staff under TUPE arrangements to other providers or staff have left the organisation after being made redundant on 31 March, there is some element of uncertainty in relation to staff remaining to run Legacy Management Office as they may secure alternative employment within the NHS.

Contract Reprocurement Costs: Although the 111 contracts do have clauses entitling the commissioners to seek reimbursement of reprocurement and additional operational costs, no claims have been formally notified at the date of these accounts and this position is supported by both the NHS TDA and NHS England.

To the extent that significant decommissioning costs impact on cash requirements they have been funded by increasing the trust's Public Dividend Capital. This funding has been drawn down to meet costs as they arise. This funding was transferred to South Central Ambulance Trust on 1 April 2014 to facilitate settlement of all liabilities. Once all costs have been finalised any excess will be returned to the Department of Health (DH) and any shortfall will be funded by DH.

1.5 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 was from its prime commissioner, NHS England, for the continuing requirements around the 0845 service including some now transferred to other providers. 111 income has also been recognised on this basis following negotiated agreement with the CCGs involved in commissioning these services, on the basis of calls answered.

1.6 Employee Benefits

Short-term 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.

1.7 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.

1.8 Property, plant and equipment

1.8.1 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.

1.8.2 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 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.

18.3 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.

1.9 Intangible assets

1.9.1 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

1.9.2 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.

1.10 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.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set. AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.11 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.

1.12 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.

1.12.1 The trust as lessee

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

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

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

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

1.12.2 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.

1.13 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.

1.14 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 which varies in accordance with the period over of the cash flows.

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.

1.15 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.

1.16 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.

1.17 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.

1.18 Financial Instruments

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 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.

1.19 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.

1.20 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.

1.21 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.

1.22 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).

1.23 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 2013-14. The application of the Standards as revised would not have a material impact on the accounts for 2013-14, 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

NHS Direct NHS Trust only has one business segment, which is patient healthcare. None of the customers referred to in note 4 account for more than 10% of income, other than the services commissioned by NHS England Commissioning Board being the 0845 46 47 and Digital Health and Advisory services.

	2013/14	2012/13
	£000	£000
0845 46 47 Service	32,294	110,162
Choose & Book Appointments Line	7,598	6,373
Out of Hours Services	0	570
Dental Services	0	1,301
Long Term Conditions	883	1,568
Single Point of Access to NHS Services	0	5,103
Pandemic Flu & Fluline Service	4,199	4,385
Other Contestable Income	699	183
NHS 111 Income	8,400	8,929
Digital Health Advisory Services	24,476	0
	78,550	138,574

In 2013-14 there was a change in how some services were commissioned. Dental services were not commissioned locally and are therefore included within Digital Health Advisory Services commissioned by NHS England. Similarly, Out of Hours services were commissioned as part of the 111 service.

3 Income generation activities

The trust undertook income generation activities with an aim of achieving profit, which was then used in patient care.
The following provides details of income generation activities whose full cost exceeded £1m or was otherwise material. Income initially commissioned for some services but not fully utilised was used to cover the costs involved in decommissioning those services, with the agreement of the commissioners.

3.1 Pandemic Flu and Flu-line 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 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. This service was extended for a further one year to 31 March 2014 and then transferred to South Central Ambulance Service Trust.

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

Income from Department of Health in 2013/14 includes £3,654,063 (2013/14 £3,793,914) for reimbursement of costs incurred on the Pandemic Flu project, summarised below.

	2013-14	**2012-13**
	£000	£000
Income from Department of Health for System Build and Maintenance	**3,429**	3,684
Income from the Devolved Authorities for Scotland, Wales and Northern Ireland	**545**	591
Costs		
Directly attributable costs	**0**	0
System Build costs	**0**	0
Dormancy Fees	**(3,967)**	(4,275)
External charges	**0**	0
Contribution to specified overheads including staff working on the project	**7**	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	**225**	110
External charges	**0**	1
Internal recharges	**(171)**	(85)
Contribution to specified overheads including staff working on the project	**54**	26

3.2 Dental Services

	2013-14	2012-13
	£000	£000
Income	**0**	1,301
Full cost	**0**	**(1,520)**
Surplus/(deficit)	**0**	**(219)**
Contribution	**0**	**339**

Dental services were commissioned nationally in 2013-14 by NHS England and therefore included within the Digital Health Advisory category. In 2012-13, they were delivered via locally commissioned contracts.

3.3 Digital Health Advisory Services

	2013-14	2012-13
	£000	£000
Income	**24,476**	0
Full cost	**(21,590)**	0
Surplus/(deficit)	**2,886**	0
Contribution	**12,096**	0

Digital Health and Advisory services were previously reported within the core 0845 service as they were not separately commissioned services. This changed from 1 April 2013 as part of the decommissioning of 0845 service.

3.4 Long-term Conditions

	2013-14	2012-13
	£000	£000
Income	**883**	1,803
Full cost	**(721)**	(1,758)
Surplus/(deficit)	**163**	45
Contribution	**163**	284

3.5 Single Point of Access to NHS Services

	2013-14	2012-13
	£000	£000
Income	**0**	5,103
Full cost	**0**	(6,247)
Surplus/(deficit)	**0**	(1,144)
Contribution	**0**	(325)

This service was not commissioned in 2013-14

3.6 Choose and Book Appointments Line

	2013-14	2012-13
	£000	£000
Income	**7,598**	6,373
Full cost	**(6,955)**	(6,199)
Surplus/(deficit)	**643**	174
Contribution	**2,360**	1,944

3.7 111 Income

	2013-14	2012-13
	£000	£000
Income	**8,400**	8,929
Full cost	**(18,639)**	(12,226)
Surplus/(deficit)	**(10,239)**	(3,297)
Contribution	**(10,162)**	951

In March 2013 NHS Direct launched the majority of its NHS 111 services, however following performance issues it was subsequently agreed with commissioners that these contracts were financially unsustainable. This is reflected in the 2013-14 operational deficit.

3.8 0845 Service

	2013-14	2012-13
	£000	£000
Income	**32,294**	110,704
Full cost	**(32,294)**	(105,884)
Surplus/(deficit)	**0**	**4,820**
Contribution	**1,865**	951

The 0845 service continued to be delivered throughout 2013-14 as support for the implementation of 111 services and winter pressures, but in a reduced capacity compared to 2012-13.

4 Revenue from patient care activities

	2013-14 £000s	2012-13 £000s
Strategic Health Authorities	**0**	116,626
NHS England	**57,360**	0
Primary Care Trusts - non-tariff	**0**	16,770
Clinical Commissioning Group	**14,364**	0
NHS Trusts	**637**	0
NHS Foundation Trusts	**551**	199
Department of Health	**380**	4,332
NHS Other (including Public Health England and NHS Property Services Ltd)	**3,681**	0
Non-NHS		
Local Authorities	**455**	0
Other	**1,122**	647
Total Revenue from patient care activities	**78,550**	138,574

NHS England and Clinical Commissioning Groups took over from Strategic Health Authorities and Primary Care Trusts respectively as Commissioners in 2013-14.

5 Other operating revenue

	2013-14 £000s	2012-13 £000s
Education, training and research	**149**	232
Rental revenue from operating leases	**177**	205
Other revenue	**1**	195
Total Other Operating Revenue	**327**	632
Total operating revenue	**78,877**	139,206

6 Revenue

	2013-14 £000	2012-13 £000
From rendering of services	**78,877**	139,206
From sale of goods	**0**	0

7 Operating Expenses

	2013-14 £000s	2012-13 £000s
Services from CCGs/NHS England	**371**	0
Trust Chair and Non-Executive Directors	**86**	102
Supplies and Services - general	**67**	83
Consultancy services	**1,245**	1,961
Establishment	**1,511**	2,209
Transport	**738**	1,375
Premises	**4,923**	6,999
Depreciation	**1,737**	1,902
Amortisation	**1,366**	2,374
Audit fees	**66**	83
Other auditor's remuneration (Internal Audit fees)	**65**	87
Clinical negligence	**664**	292
Education and Training	**149**	160
Telecommunications	**2,570**	4,618
Health Information	**1,020**	5,443
IT Contracts (a)	**12,091**	16,925
Other	**520**	1,273
Total Operating expenses (excluding employee benefits and decommissioning costs)	**29,189**	45,886
Decommissioning Costs (b)	**11,380**	31,607
Total Operating expenses (excluding employee benefits)	**40,569**	77,493
Employee benefits		
Employee benefits excluding Board members	**60,214**	91,395
Termination Benefits	**0**	0
Board members	**902**	1,078
	61,116	92,473
Decommissioning Costs (b)	**7,861**	37,581
Total employee benefits	**68,977**	130,054
Total operating expenses	**109,546**	207,547

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

(a) IT contracts costs include £3,936,940 (2012/13 £4,275,915) in respect of Pandemic Flu and Fluline dormancy fees. CS computer contract included is £5,716,850 (2012/13 £9,814,358)

(b) Decommissioning costs were funded by the Department of Health through an increase in Public Dividend Capital. In 2012/13 an estimate of £69m costs was included in the accounts as provisions and accruals. However only £51m of the costs materialised due to the fact that the 0845 service was not decommissioned until February 2014. The underspend portion has been reversed and new costs associated with the Trusts's closure have been calculated. This is analysed below:

Decommissioning Costs

	I&E Charge		
	2013-14	2012-13	Total Decommissioning
	£000s	£000s	£000s
Redundancy and Other Termination costs	**7,391**	**33,579**	**40,970**
Impairments of Non-Current Assets	**5,605**	**19,076**	**24,681**
Supplier Contracts - Exit Costs	**421**	**7,724**	**8,145**
Sites Decommissioning	**3,949**	**1,709**	**5,658**
Project Costs	**1,876**	**7,100**	**8,976**
Exit costs funded by commissioners	**(1,627)**	**0**	**(1,627)**
	17,614	**69,188**	**86,803**

Analysis of 2013-14 decommissioning costs/charge

	Gross Cost 2013-14 £000s	Unutilised provision £000s	2012-13 Revised Unutilised Accrual £000s	Impairment £000s	Net I&E Charge £000s
Asset Impairment	6,218	0	0	(613)	**5,605**
Supplier Contracts - Exit Costs	6,563	(2,345)	(3,797)	0	**421**
Sites Decommissioning	5,962	(2,013)	0	0	**3,949**
Project Costs (excluding pay costs)	2,060	(655)	0	0	**1,406**
	20,803	(5,012)	(3,797)	(613)	**11,380**
Included within Employee benefits:					
Redundancy costs	15,699	(8,309)	0	0	**7,391**
Project pay costs	900	(430)	0	0	**470**
	16,599	(8,739)	0	0	**7,861**
	37,402	**(13,751)**	**(3,797)**	**(613)**	**19,241**
Exit costs funded by commissioners					**(1,627)**
Funded by Department of Health					**17,614**

8 Operating Leases

The trust had 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

	2013-14			2012-13
	Buildings £000s	Other £000s	Total £000s	Total £000s
Payments recognised as an expense				
Minimum lease payments	2,577	146	**2,723**	3,821
Contingent rents	0	0	**0**	0
Sub-lease payments	0	0	**0**	0
Total	**2,577**	**146**	**2,723**	3,821
Payable:				
No later than one year	578	0	**578**	2,920
Between one and five years	391	0	**391**	3,366
After five years	0	0	**0**	70
Total	**969**	**0**	**969**	6,356
Total future sublease payments expected to be received:			0	136

8.2 Trust as lessor

The trust sublets four of its occupied premises.

	2013-14 £000	2012-13 £000s
Recognised as income		
Rental revenue	162	205
Contingent rents	0	0
Total	**162**	205
Receivable:		
No later than one year	10	136
Between one and five years	0	0
After five years	0	0
Total	**10**	136

9 Employee benefits and staff numbers

9.1 Employee benefits

	2013-14		
	Total £000s	**Permanently employed £000s**	**Other £000s**
Employee Benefits – Gross Expenditure			
Salaries and wages	**54,656**	29,832	24,824
Social security costs	**2,541**	2,525	16
Employer Contributions to NHS BSA – Pensions Division	**3,919**	3,895	24
Other employment benefits	**0**	0	0
Termination benefits	**7,861**	7,861	0
Total employee benefits	**68,977**	**44,113**	**24,864**
Decommissioning costs (see note 7)	**7,861**		

	2012-13		
	Total £000s	**Permanently employed £000s**	**Other £000s**
Employee Benefits – Gross Expenditure			
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**
Decommissioning costs (see note 7)	**37,581**		

9.2 Staff Numbers

	2013-14			2012-13
	Total Number	**Permanently employed Number**	**Other Number**	Total Number
Average Staff Numbers				
Medical and dental	**1**	1	0	1
Ambulance staff	**0**	0	0	0
Administration and estates	**1,211**	744	467	1,486
Healthcare assistants and other support staff	**0**	0	0	0
Nursing, midwifery and health visiting staff	**191**	135	56	646
Nursing, midwifery and health visiting learners	**0**	0	0	0
Scientific, therapeutic and technical staff	**30**	30	0	43
Social Care Staff	**0**	0	0	0
Other	**0**	0	0	0
TOTAL	**1,433**	**910**	**523**	2,176
Of the above – staff engaged on capital projects	**0**	0	0	5

9.3 Staff Sickness absence and ill health retirements

	2013-14	2012-13
	Number	Number
Total Days Lost	14,028	21,607
Total Staff Years	1,177	1,703
Average working Days Lost	11.92	12.69

The statistics shown above for sickness absence are for the calendar year 1 January to 31 December 2013, rather than financial year, in accordance with instructions issued by the Department of Health.

	2013-14	2012-13
	Number	Number
Number of persons retired early on ill health grounds	**7**	11
	£000s	£000s
Total additional pensions liabilities accrued in the year	**613**	798

9.4 Exit Packages agreed in 2013-14

	2013-14			2012-13		
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	143		143	674	0	674
£10,001-£25,000	183		183	253	0	253
£25,001-£50,000	100		100	148	0	148
£50,001-£100,000	81		81	132	0	132
£100,001 - £150,000	5		5	10	0	10
£150,001 - £200,000	3		3	9	0	9
>£200,000	2		2	1	0	1
Total number of exit packages by type (total cost)	**517**	**0**	**517**	1,227	0	1,227
Total resource cost (£000s)	**14,343**		**14,343**	26,570	0	26,570

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 it is agreed. 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.

9.5 Exit Packages – Other Departures analysis

	Agreements	**Total value of agreements**
	Number	**£000s**
Contractual payments in lieu of notice	72	142
Exit payments following Employment Tribunals or court orders	0	0
Total	**72**	**142**

This disclosure reports the number and value of exit packages agreed in the year.

Contractual payments in lieu of notice related to Care Connect and Choose and Book service staff who were transferred under TUPE regulations to alternative providers on 31 March. The costs were met by the Commissioners of these services as contract exit costs.

The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report.

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:

10.1 Full actuarial (funding) valuation

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

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

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

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

10.2 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 was 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.

10.3 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 AVCs run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

11 Better Payment Practice Code

This is included on page 25 of the Annual Report.

12 Investment Income

	2013-14 £000s	2012-13 £000s
Interest Income		
Bank interest	**26**	56
Other loans and receivables	**0**	3
Total investment income	**26**	59

13 Other Gains and Losses

	2013-14 £000s	2012-13 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**(70)**	0
Gain/(Loss) on disposal of assets other than by sale (intangibles)	**0**	0
Total	**(70)**	0

14 Finance Costs

	2013-14 £000s	2012-13 £000s
Interest expense	**0**	0
	0	0
Total	**0**	0

15 Property, plant and equipment

15.1 Property, plant and equipment current year

2013-14	Land	Buildings excluding dwellings	Assets under construction & payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:							
At 1 April 2013	**556**	**11,460**	**634**	**1,985**	**10,176**	**2,290**	**27,101**
Additions of Assets Under Construction	**0**	**0**	**129**	**0**	**0**	**0**	**129**
Reclassifications	0	156	(212)	13	0	43	**0**
Disposals other than for sale	0	0	0	0	(19)	(357)	**(376)**
Impairments/negative indexation	0	(238)	0	(21)	0	(34)	**(293)**
At 31 March 2014	**556**	**11,378**	**551**	**1,977**	**10,157**	**1,942**	**26,561**
Depreciation							
At 1 April 2013	**8**	**7,451**	**241**	**1,599**	**7,913**	**1,859**	**19,071**
Disposals other than for sale	0	0	0	0	(15)	(265)	**(280)**
Impairments	0	2,569	310	211	1,379	167	**4,635**
Reversal of Impairments	0	(82)	0	(29)	(285)	(22)	**(418)**
Charged During the Year	1	637	0	196	700	203	**1,737**
At 31 March 2014	**9**	**10,575**	**551**	**1,977**	**9,691**	**1,942**	**24,745**
Net Book Value at 31 March 2014	**547**	**803**	**0**	**(0)**	**466**	**0**	**1,816**
Purchased	547	803	0	(0)	466	0	**1,816**
Total at 31 March 2014	**547**	**803**	**0**	**(0)**	**466**	**0**	**1,816**
Asset financing:							
Owned	547	803	0	(0)	466	0	**1,816**
Total at 31 March 2014	**547**	**803**	**0**	**(0)**	**466**	**0**	**1,816**

Net Impairment charge of £4,217k relates to costs of closing the trust as shown on Note 7

Revaluation Reserve Balance for Property, Plant & Equipment

	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2013	0	238	0	21	0	34	**293**
Movements (specify)	0	(238)	0	(21)	0	(34)	**(293)**
At 31 March 2014	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Additions to assets under construction in 2013/14

	£000's
Land	
Buildings excl Dwellings	129
Dwellings	
Plant & Machinery	
Balance as at YTD	**129**

15.2 Property, plant and equipment prior year

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

Impairment charge of £1,819k relates to 0845 46 47 service decommissioning as shown on Note 7
Disposals other than for sale relate to release of accruals re non current assets no longer required.

15.3 Property, plant and equipment depreciation

The long lease for the Nottingham site 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 2014 by DVS on an existing use basis and this is also deemed its market value for arriving at the impairment included in these accounts. This property has been transferred to the Secretary of State on 1 April 2014 and is managed by NHS Property Services Limited.

15.3.1 Economic lives of fixed assets still subject to depreciation, current year

	Min Life (years)	Max Life (years)
Long Leasehold Land	990	990
Buildings excluding dwellings - all leasehold	1	66
Plant & Machinery	0	0
Information Technology	1	5
Furniture & Fittings	0	0

15.3.2 Economic lives of fixed assets still subject to depreciation, previous year

	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 Intangible non-current assets

16.1 Intangible non-current assets 2013/14

2013-14	Software purchased £000's	Licences & trademarks £000's	Asset under construction £000's	Development expenditure £000's	Total £000's
Cost or valuation:					
At 1 April 2013	**5,791**	**19,430**	**3,076**	**351**	**28,648**
Additions - purchased	0	0	7	0	**7**
Reclassifications	924	0	(924)	0	**0**
Disposals other than by sale	(293)	0	(22)	0	**(315)**
At 31 March 2014	**6,422**	**19,430**	**2,137**	**351**	**28,340**
Amortisation					
At 1 April 2013	**4,255**	**18,418**	**1,557**	**243**	**24,473**
Impairments charged to operating expenses	393	570	580	20	**1,563**
Reversal of impairments charged to operating expenses	(163)	(32)	0	0	**(195)**
Charged during the year	861	474	0	31	**1,366**
At 31 March 2014	**5,346**	**19,430**	**2,137**	**294**	**27,207**

Net Book Value at 31 March 2014	Software purchased £000's	Licences & trademarks £000's	Asset under construction £000's	Development expenditure £000's	Total £000's
Purchased	1,077	0	0	57	**1,133**
Total at 31 March 2014	**1,077**	**0**	**0**	**57**	**1,133**

Net impairment charge of £1,386k relates to costs of closing the Trust as analysed on Note 7.

Disposals other than for sale relates to release of accruals re non current assets no longer required and adjustment of NBV to match creditor balance owing.

Additions to Assets Under Construction	£000's
Software developed	7
Software purchased	0
Balance as at YTD	**7**

16.2 Intangible non-current assets prior year

2012-13	Software purchased £000's	Licences & trademarks £000's	Asset under construction £000's	Development expenditure £000's	Total £000's
Cost or Valuation					
At 1 April 2012	**5,718**	**19,445**	**2,002**	**323**	**27,488**
Additions - purchased	0	0	1,287	0	**1,287**
Reclassifications	185	0	(213)	28	**0**
Disposals other than by sale	(112)	(15)	0	0	**(127)**
At 31 March 2013	**5,791**	**19,430**	**3,076**	**351**	**28,648**
Amortisation					
At 1 April 2012	**2,426**	**2,205**	**0**	**211**	**4,842**
Impairments charged to operating expenses	789	14,911	1,557	0	**17,257**
Charged during the year	1,040	1,302	0	32	**2,374**
At 31 March 2013	**4,255**	**18,418**	**1,557**	**243**	**24,473**
Net Book Value at 31 March 2013	**1,536**	**1,012**	**1,519**	**108**	**4,175**
Purchased	1,536	1,012	1,519	108	**4,175**
Total at 31 March 2013	**1,536**	**1,012**	**1,519**	**108**	**4,175**

16.3 Intangible non-current assets depreciation

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:

16.3.1 Intangible non-current assets depreciation 2013/14

	Min Life (years)	Max Life (years)
Computer Software purchased	3	5
Development expenditure (Computer Software) internally generated	1	4
Licensed Content	1	1

16.3.2 Intangible non-current assets depreciation 2012/13

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

17 Analysis of impairments and reversals recognised in 2013/14

	2013-14 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	
Loss resulting from decommissioning activities	1,750
Total charged to Departmental Expenditure Limit	**1,750**
Changes in market price	2,487
Total charged to Annually Managed Expenditure	**2,487**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve	
Loss resulting from decommissioning activities	55
Changes in market price	238
Total impairments for PPE charged to reserves	**293**
Total Impairments of Property, Plant and Equipment	**4,530**
Intangible assets impairments and reversals charged to SoCI	
Loss resulting from decommissioning activities	1,368
Total charged to Departmental Expenditure Limit	**1,368**
Total Impairments of Intangibles	**1,368**
Total Impairments charged to Revaluation Reserve	293
Total Impairments charged to SoCI - DEL	3,118
Total Impairments charged to SoCI - AME	2,487
Overall Total Impairments	**5,898**

	Total £000's	Property Plant and Equipment £000's	Intangible Assets £000's
Impairments and reversals taken to SoCI			
Loss or damage resulting from normal operations	**3,118**	1,750	1,368
Over Specification of assets	0	0	0
Abandonment of assets in the course of construction	0	0	0
Total charged to Departmental Expenditure Limit	**3,118**	**1,750**	**1,368**
Other	0	0	0
Changes in market price	**2,487**	2,487	0
Total charged to Annually Managed Expenditure	**5,605**	**4,237**	**1,368**
Property, Plant and equipment impairments and reversals charged to the revaluation reserve			
Loss of damage resulting from normal operations	**55**	55	0
Changes in the market price	**238**	238	0
Total impairments for PPE charged to reserves	**293**	**293**	**0**
Total Impairments of Property, Plant and Equipment changed to SoCI	**5,898**	**4,530**	**1,368**

18 Capital Commitments

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

	31 March 2014	31 March 2013
	£000s	£000s
Property, plant and equipment	**0**	103
Intangible assets	**0**	28
Total	**0**	131

19 Intra-Government and other balances

	Current receivables	Non-current receivables	Current payables	Non-current payables
	£000s	£000s	£000s	£000s
Balances with other Central Government Bodies	1,074	0	1,155	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	418	0	0	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	1,496	0	27,807	0
At 31 March 2014	**2,988**	**0**	**28,962**	**0**
Prior period:				
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**

20 Trade and other receivables

20.1 Trade and other receivables

	Current		Non-current	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000s	£000s	**£000s**	£000s
NHS receivables - revenue	**1,492**	1,361	**0**	0
NHS receivables - capital		0	**0**	0
NHS prepayments and accrued income	**16**	94	**0**	0
Non-NHS receivables - revenue	**25**	277	**0**	0
Non-NHS receivables - capital		0	**0**	0
Non-NHS prepayments and accrued income	**585**	1,727	**0**	0
Provision for the impairment of receivables	**(125)**	(158)	**0**	0
VAT	**869**	1,806	**0**	0
Other receivables	**126**	188	**0**	0
Total	**2,988**	5,295	**0**	0
Total current and non current	**2,988**	5,295		
Included in NHS receivables are prepaid pension contributions:	**0**	0		

The majority of trade is with other NHS organisations such as NHS Commissioning Board and as these are funded by Government to commission NHS patient care services, no credit scoring of them is considered necessary. Other trade of significance is with large pharmaceutical companies, which have satisfactory credit ratings.

20.2 Receivables past their due date but not impaired

	31 March 2014	31 March 2013
	£000s	£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

	2013-14 £000s	2012-13 £000s
Balance at 1 April 2013	**(158)**	(160)
Amount written off during the year	**9**	2
Amount recovered during the year	**24**	0
(Increase)/decrease in receivables impaired	**0**	0
Balance at 31 March 2014	**(125)**	(158)

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

21 Cash and Cash Equivalents

	31 March 2014 £000s	31 March 2013 £000s
Opening balance	**21,834**	21,875
Net change in year	**14,170**	(41)
Closing balance	**36,004**	21,834
Made up of		
Cash with Government Banking Service	**36,004**	21,834
Commercial banks	0	0
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	**36,004**	21,834
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**36,004**	21,834

22 Non-current assets held for sale

There were no non-current assets held for sale at 31 March 2014.

23 Trade and other payables

	Current		Non-current	
	31 March 2014 £000s	31 March 2013 £000s	31 March 2014 £000s	31 March 2013 £000s
Interest payable	**0**	0	**0**	0
NHS payables - revenue	**829**	434	**0**	0
NHS accruals and deferred income	**326**	1,086	**0**	0
Non-NHS payables - revenue	**983**	1,968	**0**	0
Non-NHS payables - capital	**2,236**	2,007	**0**	2,456
Non-NHS accruals and deferred income	**24,048**	34,144	**0**	0
Social security costs	**241**	590	**0**	0
Tax	**297**	611	**0**	0
Other	**2**	12	**0**	0
Total	**28,962**	40,852	**0**	2,456
Total payables (current and non-current)	**28,962**	**43,308**		
Included above:				
Outstanding Pension Contributions at the year end	326	798		

24 Deferred Income

	Current		Non-current	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000s	£000s	**£000s**	£000s
Opening balance at 1 April 2013	1,071	1,060	0	0
Deferred income addition	0	710	0	0
Transfer of deferred income	(759)	(699)	**0**	0
Current deferred Income at 31 March 2014	**313**	1,071	**0**	0
Total deferred income (current and non-current)	**313**	**1,071**		

25 Provisions

	Total	Pensions to Former Directors	Pensions Relating to Other Staff	Restructuring	Other	Redundancy
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Balance at 1 April 2013	**26,316**	0	763	9,564	2,687	13,302
Arising During the Year	**8,756**	0	34	8,722	0	0
Utilised During the Year	**(9,360)**	0	(31)	(4,121)	(215)	(4,993)
Reversed to Accruals*	**(13,751)**	0	0	(5,442)		(8,309)
Reversed Unused	**(983)**	0	0	0	(983)	0
Unwinding of Discount	**0**	0	0	0	0	0
Change in Discount Rate	**80**	0	80	0	0	0
Balance at 31 March 2014	**11,057**	**0**	**846**	**8,723**	**1,489**	**0**
Expected Timing of Cash Flows:						
No Later than One Year	**4,762**		31	3,242	1,489	
Later than One Year and not later than Five Years	**5,605**		124	5,481	0	
Later than Five Years	**691**		691	0	0	

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at 31 March 2014	11,192
As at 31 March 2013	14,919

Reversed to Accruals*- This relates to unused provisions re the closure of the 0845 46 47 service which have now been reversed and utilised in accruing for the close down costs included in these accounts. Details on Note 7.

Pensions relating to other staff relate 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 1.8% in line with Treasury guidance.

Restructuring provision relates to costs associated with dissolution of the trust as explained in note 1.3.2.

Other provisions include brought forward 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 and Employers liability insurance.

26 Contingencies

	31 March 2014	31 March 2013
	£000s	£000s
Contingent liabilities		
Equal Pay	**0**	0
Other - Employment Liability	**27**	25
Contingent liabilities associated with decommissioning the 0845 service		9,812
Amounts Recoverable Against Contingent Liabilities	**0**	0
	27	9,837

All costs considered to arise as a result of the trust's dissolution have been estimated and included in these accounts; the exception being possible claims from CCG commissioners for additional operating and reprocurement costs. There were no formal disputed claims made to the date of these accounts and this position is supported by both NHS England and the NHS TDA.

The total decommissioning costs incurred by the trust in both 2012-13 and the current year are estimated to total £86m.

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.

The accounts reflect items arising on closure of the trust at 31 March 2014 and estimates adopted have been arrived at using best information available in accordance with the above. This includes transfer of assets to other service providers and sale proceeds of those no longer required.

The assets and liabilities of the Trust transferred to legacy bodies effective 1 April 2014 are shown below:

	31 March 2014	HSCIC	Department of Health	Ambulance Service Trusts*	South Central Ambulance Service Trust
	£000s	£000s	£000s	£000s	£000s
Non-current assets:					
Property, plant and equipment	**1,816**	466	1,350		
Intangible assets	**1,133**	781		352	
	2,949	**1,247**	**1,350**	**352**	**0**
Current assets:					
Trade and other receivables	**2,988**				2,988
Cash and cash equivalents	**36,004**				36,004
	38,992	**0**	**0**	**0**	**38,992**
Current liabilities					
Trade and other payables	**(28,962)**				(28,962)
Provisions	**(4,762)**		(1,863)		(2899)
	(33,724)		**(1,863)**		**(31,861)**
Non-current liabilities					
Provisions	**(6,295)**		(5,481)		(814)
	(6,295)	**0**	**(5,481)**	**0**	**(814)**
Net Assets/(Liabilities)	**1,922**	**1,247**	**(5,994)**	**352**	**6,316**

Allocation to Ambulance Service Trusts		West Midlands Ambulance Service Trust	North West Ambulance Service Trust	London Ambulance Service Trust	South West Ambulance Service Trust
	£000s	£000s	£000s	£000s	£000s
Intangible assets	**352**	153	118	46	35

28 Financial risk management

28.1 Overview

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 had with Clinical Commissioning Groups and the way those Clinical Commissioning Groups 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.

28.2 Currency Risk

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

28.3 Interest Rate Risk

The trust had no borrowings and therefore no exposure to interest rate fluctuations.

28.4 Credit Risk

Because the majority of the trust's income was from contracts with other public sector bodies, the trust had low exposure to credit risk. The maximum exposures as at 31 March 2014 are in receivables from customers, as disclosed in the trade and other receivables note.

28.5 Liquidity Risk

The trust's operating costs were incurred under contracts with NHS England and CCGs, which are financed from resources voted annually by Parliament. The trust funded its capital expenditure from funds obtained within its prudential borrowing limit. The cash costs of decommissioning the trust 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 NHS Direct Trust, except as disclosed in the Remuneration report.

The Department of Health is regarded as a related party. During the year 2013/14, the trust 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:

- NHS England Commissioning Board
- NHS Clinical Commissioning Groups
- NHS Foundation Trusts
- NHS Trusts
- NHS Litigation Authority

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

	2013/14			2012/13		
	Income	Debtor	Creditor	Income	Debtor	Creditor
Income	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
NHS Midlands and East (formerly East of England) SHA				116,989	649	0
Department of Health	508		313	4,514	16	431
Public Health England	3,681	27				
Blackpool PCT				3,621	12	3
Calderdale PCT				5,103	0	429
Lincolnshire Teaching PCT				2355	4	0
Luton Teaching PCT				513	0	0
Manchester PCT				259	28	7
Nottingham City PCT				1,635	18	0

Stockport PCT				369	43	5
Warwickshire PCT				605	0	0
NHS England Commissioning Board	57,360	1,039		0	0	0
Bedfordshire CCG	638			0	0	0
Bromley CCG	995			0	0	0
Cambridge And Peterborough CCG	615			0	0	0
Chiltern CCG	330			0	0	0
Cumbria CCG	301			0	0	0
Kernow CCG	644			0	0	0
Leicester City CCG	431			0	0	0
Liverpool CCG	432			0	0	0
Luton CCG	759			0	0	0
North, East, West Devon CCG	335			0	0	0
Sandwell And West Birmingham CCG	3,468			0	0	0
Somerset CCG	537			0	0	0
Sutton CCG	326			0	0	0
West Essex CCG	423			0	0	0
West Midlands Ambulance Service NHS FT	449	241		0	0	0
Nottingham City Council	455			0	0	0

	2013/14			2012/13		
	Expenditure	Debtor	Creditor	Expenditure	Debtor	Creditor
Expenditure	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Imperial College Healthcare NHS Trust	112			208	0	44
NHS Litigation Authority	783			399	0	0
North West Ambulance Service NHS Trust	0			795	0	42
University Hospitals Of Leicester NHS Trust	293			352	0	0
Yorkshire Ambulance Service NHS Trust	127			447	9	0
Department of Work and Pension	6,420		1,155	6,476	0	794

30 Losses and special payments

The total number of losses cases in 2013-14 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	0	0
Special payments	183,701	39
Total losses and special payments	183,701	39

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

31 Financial performance targets

31.1 Breakeven performance

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.

	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s
Turnover	144,381	161,566	191,036	149,606	143,801	139,206	**78,877**
Retained surplus/(deficit) for the year	5,062	467	949	2,733	488	(68,282)	**(30,713)**
Adjustment for:							
Timing/non-cash impacting distortions:							
Adjustments for Impairments	0	0	0	0	0	19,076	**5,605**
Break-even in-year position	5,062	467	949	2,733	488	(49,206)	**(25,108)**
Break-even cumulative position	5,062	5,529	6,478	9,211	9,699	(39,507)	**(64,615)**

	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %
Materiality test (I.e. is it equal to or less than 0.5%):	0	0	0	0	0	0	0
Break-even in-year position as a percentage of turnover	3.5%	0.3%	0.5%	1.8%	0.3%	-49.1%	**-38.9%**
Break-even cumulative position as a percentage of turnover	3.5%	3.4%	3.4%	6.2%	6.7%	-28.4%	**-81.9%**

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 did not meet its break-even duty. However this is due to costs associated with decommissioning the 0845 46 47 service, the difficulties experienced operating NHS 111 services and the closure of the trust, which will be separately funded by the Department of Health.
The operating deficit amounted to £13.1m, after adjusting for decommissioning costs of £17.6m, 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 in no dividend being payable for 2013-14 or 2012-13.

31.3 External financing

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

	£000s	**2013-14 £000s**	2012-13 £000s
External financing limit		**52,667**	6,988
Cash flow financing	**46,592**		(1,609)
Finance leases taken out in the year			
Other capital receipts			3,200
External financing requirement		**(46,592)**	
Undershoot/(overshoot)		**6,075**	**8,579**

31.4 Capital resource limit

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

	2013-14 £000s	2012-13 £000s
Gross capital expenditure	**136**	3,692
Less: book value of assets disposed of	**(389)**	(270)
Charge against the capital resource limit	**(253)**	3,422
Capital resource limit	**449**	5,985
(Over)/underspend against the capital resource limit	**702**	2,563

NHS Direct National Health Service Trust

Appendices

Appendix A: Indicators of Quality

During 2013/14, NHS Direct ran three major service streams: a range of NHS 111 services, the DHAS group and the contingency 0845 46 47 service. The table below contains an annualised summary of performance against the main service indicators from the monthly corporate scorecard.

Access

The following metrics monitored the likelihood and speed of patients reaching an advisor when calling the service:

Service	Metric	Calculation	Target	Actual
0845 46 47	Answered within 60 seconds	Calls answered within 60 seconds / all calls answered	≥95%	98%
111	Answered within 60 seconds	Calls answered within 60 seconds / all calls answered	≥90%	99%
0845 46 47	Abandoned after 30 seconds	Calls abandoned after 30 seconds / all calls answered + calls abandoned after 30 seconds	≤5%	0.4%
111	Abandoned after 30 seconds	Calls abandoned after 30 seconds / all calls offered	≤5%	0.3%

Effectiveness

The following metrics monitored adherence to standard processes, communicative quality and appropriateness of outcome

Service	Metric	Calculation	Target	Actual
0845 46 47	Call Quality	Call reviews rated good or excellent/all call reviews	≥80%	87%
111	Call Quality	Call reviews rated good or excellent/all call reviews	≥80%	86%
DHAS	Call Quality	Call reviews rated good or excellent/all call reviews	≥80%	91%
0845 46 47	Calls not requiring onward referral	Calls not requiring onward referral /all calls	*	49%
111	Referrals to 999	Calls referred to 999 / all calls answered	≤10%	10%

* no formal target due to 0845 46 47 operating as a contingency

Patient experience

These metrics monitored patient feedback and satisfaction with the service they had received

Service	Metric	Calculation	Target	Actual
0845 46 47	Complaints per 10,000 calls	Complaints / (all calls/10,000)	≤1	0.30
111	Complaints per 10,000 calls	Complaints / (all calls/10,000)	≤1	0.43
DHAS	Complaints per 10,000 calls	Complaints / (all calls/10,000)	≤1	0.30
0845 46 47	Patient Satisfaction	Average reported experience of service provided	*	95%
111	Patient Satisfaction	Average reported experience of service provided	≥90%	86%

* no formal target due to 0845 46 47 operating as a contingency

Safety

These metrics scored clinical safety through incident management and review and access to clinicians for secondary triage

Service	Metric	Calculation	Target	Actual
All	Service-wide incidents leading to harm	Serious incidents investigated found to result in serious harm or death to action or inaction / serious incidents	≤10%	2.4%
0845 46 47	Urgent started within 20 minutes	Calls where clinical assessment was started within the time shown, relative to its urgency	≥95%	94%
0845 46 47	Less Urgent started within 60 minutes		≥95%	97%
0845 46 47	Non urgent started within 120 minutes		≥95%	99%

111	Call backs within 10 minutes	Queued calls reaching a clinician within 10 minutes/all queued calls	≥98%	62%
111	Referrals to clinician that were warm transferred	Calls requiring a clinician that were transferred while the patient was on the phone / all calls requiring a clinician	≥95%	84%

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