NHS
Direct
NHS Direct Business Plan
2011/12–2015/16
We're here

Foreword

Remote and virtual health care has a great deal to offer to patients and the public, to the NHS and the wider social care system. We share a vision that patient empowerment supported by self-service and self-care is critical for the future of a sustainable NHS, as well as being what patients themselves increasingly want. Keeping our eyes on this longer term goal will be key to success in a uniquely demanding and testing period ahead.

The challenge for the NHS is clear: to find innovative and cost-effective ways of providing healthcare, which respond to the specific needs and choices of patients and the public, whilst maintaining safety and improving health outcomes. This challenge comes at a time when fundamental changes are taking place to the structure of health service commissioning and provision.

The period of this five-year business plan will see radical changes to NHS Direct's core business. Our stakeholders agree that we have an important role in the changing NHS and we have ambitious plans to fulfil their expectations and to support them in meeting their own challenges going forward. We recognise that this will require us to make very significant changes to our own services and operations.

Our core business will shift from delivering the 0845 4647 health advice and information line and associated web services under a single contract on behalf of the whole NHS, to being a competitive provider of the new, nationally specified but locally commissioned NHS 111 urgent care service. Around this we intend to offer a range of value added service enhancements and additional remote and virtual offerings to meet local commissioner needs, building on our unparalleled experience of digital and remote healthcare.

Remotely-delivered clinical services help manage the pressures on stretched primary and secondary healthcare by reducing avoidable demand on face-to-face services and by steering people to the right setting at the right time. They support patients to take more control and exercise greater choice over their health and how they access care. They protect high cost face-to-face services for the people and situations that need them, whilst for the growing numbers of people who already turn first to the internet for everyday needs, they provide a more convenient and responsive service at lower cost. They do so while safeguarding patient safety and supporting the achievement of high quality health outcomes.

Our vision is consistent with wider government policy to make public services accessible online. Over seven million uses of our online health and symptom checkers compared to five million contacts to the 0845 4647 core telephone service demonstrates the importance of online channels in health and underlines the need for the new NHS 111 urgent care service to include online and mobile access alongside the telephone.

NHS Direct aims to play a leading role in supporting the NHS to exploit the full potential of multi-channel, remotely-delivered clinical care, for the mutual benefit of local and national health economies and of patients. We are excited about our new role in supporting NHS 111 and about creating new remote and digital services to meet the growing and changing demands for healthcare, helping the NHS to catch up with other sectors of the economy. We look forward to working with the new commissioning and competitive provider regime to clearly demonstrate the value offered by these services.

These significant, demanding and important challenges will fundamentally reshape our organisation. We are determined to build on our expertise and experience in order to develop and deliver world–class services that meet the requirements and expectations of commissioners, patients and the wider public.

Joanne Shaw
Chair

Nick Chapman
Chief Executive

Contents

Foreword 3

Introduction 7

Section 1: Executive summary 8
- Profile 8
- Market assessment 8
- Our strategy 8
  - Vision and strategic objectives 8
  - Our stakeholders and members 8
  - NHS Foundation Trust status 9
- Our service development plans 9
- Our organisational development plans 9
- Financial analysis 10
- Risk 11
- Leadership and workforce 11
- Governance 12

Section 2: Profile 13
- Overview 13
- Supporting patients and the NHS 13
- Performance 13

Section 3: Strategy 15
- Corporate vision and objectives 15
- Service developments 15
- Organisational development 15
- NHS Foundation Trust status 16
- Stakeholders and consultation 16
  - Our local and national stakeholders 17
  - Members 18
  - Engagement in developing the strategy 18
  - Annual stakeholder survey 18

Section 4: Market assessment 19
- Overview 19
- Patients 19
- Urgent care 20
- Commissioning 20
- The financial and competitive environment 21
- PESTLE analysis 21
- A role for NHS Direct 22

Section 5: Service development plans 23
- Introduction 23
- A major provider of the national specification for NHS 111 24
  - Introduction 24
  - The NHS 111 market 24
  - Commissioners 24
  - The specification 24
  - NHS 111 – benefits of NHS Direct 24
- Developing additional NHS 111 services as an option for commissioners 25
- Patients with long-term conditions 25
  - Introduction 25
  - The market for services for patients with long-term conditions 25
  - Commissioners 26
  - The specification 26
  - Long-term conditions – benefits of NHS Direct 26

Supporting patient choice – patient decision aids 26
Introduction 26
The market for patient decision aids 26
Commissioners 27
The specification 27
Patient decision aids – benefits of NHS Direct 27
Maintaining existing services 27
Our organisational development plan 27

Section 6 overview **29**
Income and expenditure 29
Income 30
Expenditure 31
Recurrent run rate 32
Cost improvement programme 32
Service lines 32
Management costs 32
Cash 32
Capital investment programme 33
Financial performance rating 33
Financial risks 33
Conclusion 34

Section 7: Risk **35**
Key risks and mitigations 35

Section 8: Leadership and workforce **36**
Overview 36
The Trust Board 36
Staff survey 2010 37
HR function 37
Union recognition 37
Workforce strategy 37
Our values 38
Internal communications 38
Equality and diversity 38
Learning and development strategy 38
Front line skills development 39
Management and board development 39

Section 9: Governance arrangements **40**
Corporate governance and management 40
Clinical governance 40
Information governance 40
Risk management 41
Finance controls and reporting 41
Audit arrangements 41
Performance management framework 41
Objectives and KPIs for 2011/12 41
Information systems 43

Section 10: Appendices **44**

Introduction

The purpose of this business plan is to set out NHS Direct's strategy and plans for the next five years, 2011/12 to 2015/16.

We have set out our plans so that our commissioners, staff and other stakeholders can see how we intend to meet the challenges ahead. As the leading provider of remote health advice and information, NHS Direct has a great deal to offer patients and the public, the NHS and the wider social care system. Our stakeholders agree that we have an important role in the changing NHS and we have ambitious plans to fulfil their expectations and to support them in meeting their own challenges going forward. We recognise that this will require us to make very significant changes to our own services and operations. We will be operating in a new competitive environment, open to a range of private and public sector providers. We are confident in our ability to provide high quality, efficient services that clearly meet the needs of patients and commissioners. We will compete strongly in market areas where we believe our services can deliver value. This plan sets out how we will do this, to develop our services into what the NHS and the public will need from us in the years to come.

During the coming months we will be developing a further document - our integrated business plan (IBP) - as part of our application to become an NHS Foundation Trust. While this current plan is not intended to cover either the range or the detail of the IBP, our intentions and objectives captured here will form the cornerstone of our IBP.

Section 1: Executive summary

Profile

NHS Direct provides clinical care and services delivered across a number of channels using its virtual national network of call centres and home-workers.

We provide a key element of the urgent care pathway, helping patients achieve the best health outcomes, through a number of our services. Over 50% of all calls to NHS Direct are resolved in house without the need for onward referral to another health service.

In addition, we support:

- Over 11,000 patients to manage their long-term conditions at home, reducing their need for face-to-face care, as part of our care management programmes
- Patient choice and the government policy of "no decision about me without me" through providing patient decision aids, designed to help patients make difficult decisions about tests and treatments. We handle 3.8 million calls to The Appointments Line services for NHS Choose and Book advice
- National resilience through the operation of the National Pandemic Flu Service, which completed 2.7 million phone and web assessments during the flu pandemic of 2009/10. This won, with Ernst and Young, the Management Consultancies Association (MCA) award for work on Change Management in the Public Sector.

We develop and maintain high-quality evidence-based clinical content, suitable for remotely-delivered services and providing high standards of clinical safety. Our digital services have been recognised by a number of awards.

We have been rated excellent by the Care Quality Commission (CQC) and have maintained our clinical safety and effectiveness. 93% of our patients in urgent care services and 99% in The Appointments Line say they are very satisfied with the service they receive. We have achieved steady annual performance in a period of challenge and change.

Market assessment

There will be significant and rapid change in NHS Direct's external environment. Longer term demographic changes and trends will continue to affect public expectations and demand for health services, and national and local health economies will be stretched by this changing and growing demand. The new nationally specified NHS 111 urgent care service is being launched to provide free telephone access to integrated non-emergency urgent care. This will replace our current core business, with far reaching implications for our operations and organisation. We will face greater competition to provide services as the Government seeks to open the market to "any willing provider". At the same time the commissioning regime will undergo radical change, as the majority of NHS services will be commissioned by GP commissioning consortia, or clusters of consortia, replacing Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs). This will require us to transform the way we engage with commissioners and how we market and manage our services.

NHS Direct's expertise in clinical patient care which is remotely-delivered means we are well placed to play a key role in the transformation of health care in England. We will continue to support patients and make a substantial contribution to NHS productivity and quality improvement through delivering clinically safe, cost-effective, multi-channel remote care.

Our strategy

Vision and strategic objectives

Our market assessments, and our engagement with our stakeholders, members and staff, have confirmed to the NHS Direct Board that the high level vision we set last year remains appropriate.

Our vision is to: "provide remotely-delivered care that is increasingly valued by patients and the wider health and social care system". Underpinning this vision, our six strategic objectives remain to:

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

Our stakeholders and members

Our commissioners, clinical professional bodies, staff, and over 18,000 public members are important to us in providing insight into what services to develop and supporting us in delivering them. In our consultation with our stakeholders and staff between December 2010 and February 2011 they gave positive support for our five year strategy.

NHS Foundation Trust status

To deliver our strategy and play our part in meeting the NHS challenges, we will need to:

- raise start-up funding to develop and pilot innovative services
- respond quickly and flexibly to service demands
- have greater insight into patient and health economy requirements
- be able to shape the organisation to respond to the changing health economy.

NHS Foundation Trust status will provide opportunities and potential benefits that will support us in meeting these challenges and achieving our objectives:

- a strengthened membership and governance structure, giving greater insight to patient and health economy requirements and enhanced focus on quality and choice
- increased freedoms to restructure and adapt, providing greater flexibility and responsiveness to service demands
- increased ability to use our capital, and increased access to external capital to help us to develop opportunities.

We are undertaking a thorough review and assessment of the organisational features that will be the best fit for our future requirements and intend to achieve NHS Foundation Trust status from April 2013.

Our service development plans

To achieve our strategy in the context of our market analysis and our strengths, weaknesses, opportunities and threats, we will undertake the following service developments:

- we will focus on delivering the national specification for the new NHS 111 urgent care telephone service, aiming to be a major provider
- we will continue to develop clinical services (including a web service) as complementary options to the NHS 111 service, in response to demand from commissioners
- we will continue to develop clinical services to support patients with long-term conditions; to support patient choice; and to support national resilience
- we will continue to provide the 0845 4647 urgent care service until NHS 111 is nationally available, ensuring it continues to provide a clinically safe and effective service for patients and commissioners.

At the same time we will continue to provide those services commissioned locally, such as call handling and nurse assessment for GP and dental out of hours services and The Appointments Line.

Our organisational development plans

A flexible and motivated workforce and outstanding leadership are essential to our being a thriving NHS Foundation Trust in the era of the NHS 111 service. We have excellent staff, managers, infrastructure, skills, experience and resources within our organisation. At the same time, we need to develop new skills and new ways of working.

We will create a delivery model for high quality and cost-competitive NHS 111 and other services. We will listen carefully to our commissioners and create services that meet their needs, demonstrating our value. We will continue to improve staff time with patients and to reduce support and overhead costs. We will have a project in place to achieve NHS Foundation Trust status from April 2013.

Our previous change programmes have resulted in a more streamlined organisation as a single national employer with strong local management. The programme to achieve the next stage of our development will continue this work, with four workstreams, each led by an executive director:

- operational delivery model: design, build and deliver an organisation that operates NHS 111 services that meet the national specification; offers complementary services, and provides services for patients with long-term conditions and to support patient choice, which are competitive on price and quality
- marketing and service development: build our capability, knowledge and experience to ensure we provide commissioners with the support and services they need
- corporate development: design, build and deliver the appropriate supporting functions and undertake the programme of work required to be successful in an application for NHS Foundation Trust status
- existing services: ensure we continue to focus on consistently meeting our clinical, corporate and financial standards on all existing contracts, whilst improving efficiencies and supporting the transition.

To support the executive in delivering the objectives for each workstream, a central team will:

- ensure the programme has sufficient management capability and capacity to deliver
- ensure people are supported through the transition so that changes are effective
- manage inter-dependencies and co-ordinate work that spans workstreams
- oversee programme risks to ensure they are mitigated or managed effectively
- ensure that engagement with external stakeholders is proactive and supportive
- ensure our staff are informed and can contribute effectively to our future development.

Financial analysis

We have agreed a settlement with our main national commissioner, the East of England SHA to deliver the core 0845 4647 contract in 2011/12, including additional support to meet the costs of peak periods such as Christmas and Easter.

We are committed to improving our performance and in 2011/12 will measure most of our core contract key performance indicators (KPIs) on a daily basis. We are, in line with all NHS organisations, taking actions to deliver real cash releasing efficiencies of at least 4% as the NHS addresses the challenges of increasing demands for constrained resources. We will be doing this at the same time as we make the transition from the current service to NHS 111 and seek further opportunities to provide locally commissioned services, as well as working towards becoming an NHS Foundation Trust.

The key elements of our financial plan for 2011-12 are set out in Figure 1-1 below and include:

- a revenue surplus of £0.3 million
- EBITDA[1] of £6.6 million (4.5% of turnover)
- a total turnover projection of £146.7 million
- a capital programme of £9.2 million
- a cost improvement programme of £14.6 million
- strategic development funding of £3 million.

2011-12 will be a financially challenging year. Our key financial risks include:

- the need to extract the costs associated with activity reductions and lost contracts
- a more challenging regime of performance indicators
- successful delivery of the organisation development programme
- satisfying the conditions for the additional peak period support funding
- internal generation of funding for the significant organisational change programme.

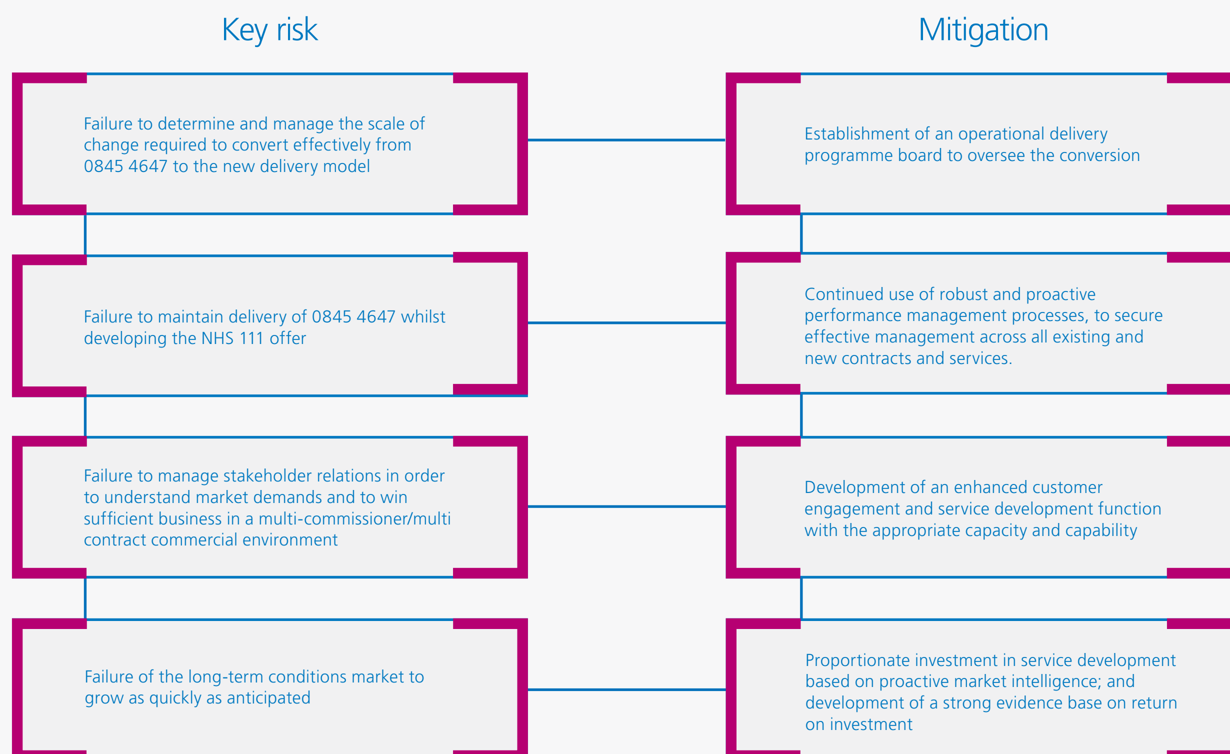
Figure 1-1 Summary income and expenditure

Summary I&E	Budget 2010/11 £m	Forecast Outturn 2010/11 £m	Budget 2011/2012 £m
Total Income	159.6	147.8	146.7
Total Operating Costs	154.0	142.0	140.1
EBITDA[1]	**5.6**	**5.8**	**6.6**
Capital Charges	5.4	5.3	6.3
Net Surplus	**0.2**	**0.5**	**0.3**

[1] Earnings before interest, taxes, depreciation, and amortization

Risk

We have identified our key strategic risks.



Underpinning these strategic risks will be a comprehensive regime identifying the key risks for service developments and operational delivery, their mitigations, and the process for monitoring and managing them successfully.

Leadership and workforce

Our approach to leadership, our workforce strategy and our learning and development strategy have been developed in consultation with a wide range of NHS Direct colleagues, members and stakeholders. They are in line with the corporate vision and our development plans and draw on the results of the 2010 staff survey.

NHS Direct employs 2,851 substantive employees (2,130 whole time equivalents). Staff are predominantly nurse advisors, dental nurse advisors, health advisors and health information advisors, all of whom are skilled in the specialist area of remote clinical assessment.

The workforce strategy is to:

- develop an appropriate organisation for the NHS 111 service
- develop our capacity to win and operationalise contracts
- develop our market and service capability knowledge and experience
- be a great place to work and continue to develop our values
- improve the time front line staff spend with patients and reduce sickness absence
- develop robust and equitable workforce planning and rostering
- ensure NHS Direct is well prepared for becoming an NHS Foundation Trust.

Continued skills development for front line staff is important for achieving high standards of patient care. Effective leadership and management are necessary to operate an NHS Foundation Trust in a competitive market environment as NHS 111 is introduced. Our learning and development strategy includes:

- front line skills development to provide safe and effective care and to develop staff professionally
- management and board development that prepares for NHS Foundation Trust, supports managers in good performance management and identifies and develops our future talent.

Governance

The NHS Direct Board, supported by its six sub-committees, oversees NHS Direct's performance, strategy, governance and compliance and stakeholder engagement. It takes an active role in reviewing user experience, listening to patient calls and visiting contact centres to meet with front line staff.

Risk management is an integral part of day-to-day management and quality improvement at all levels within the Trust. Our clinical governance procedures, overseen by the clinical governance committee, help us to ensure we deliver a high quality, safe, and effective service to our patients. We are assessed on these every year by the Care Quality Commission and have consistently been rated as excellent. The finance committee provides board assurance on financial performance and investment. The audit committee provides assurance on controls and risk management. The information governance steering group provides strategic direction on information governance and oversees our compliance with the standards requirements of the NHS information governance toolkit.

Performance management is in place throughout the organisation, supported by a set of corporate performance indicators monitored by the Board, together with balanced scorecards, bringing together a range of activity and quality measures at an individual and team level, within operations. The Board scorecards will continue to be used to measure performance against objectives for our existing services. There will be further work to develop objectives and measures for new service developments, as a clearer picture emerges of our potential activity in these service areas. The central programme team will monitor progress in implementing the organisational development programme.

The information technology infrastructure is designed to have multiple levels of resilience and to be secure. The N3 wide area network connects the NHS Direct sites and data centres. The system is intuitive and easy to operate, prompting staff and allowing data entry while talking to the patient. During 2011/12 the focus of our information technology development programme will be on developing interconnectivity between systems; in particular ambulance service systems, the Personal Demographic Service and other providers of NHS 111 services. We will also improve links between our telephony system and clinical application to improve efficiency and streamline our processes.

Section 2: Profile

Overview

NHS Direct provides clinical care and services across a range of channels using its virtual national network of call centres and home-workers. We use online and telephone-based care management and telehealth technology to assess patients' symptoms, provide self-care advice, help patients to access appropriate urgent care, manage their long-term conditions and make choices about their care. We reduce demand for face-to-face services by supporting self care. We provide the Department of Health and the wider NHS with a source of resilience in the face of national health emergencies.

Supporting patients and the NHS

We provide a key element of the urgent care pathway, helping patients achieve the best health outcomes, through a number of our services. Over 50% of all calls to NHS Direct are resolved in-house through self care advice and information, without the need for onward referral to another health service.

We currently operate our core 0845 4647 and online service under a single contract with the East of England SHA, acting on behalf of the 10 SHAs in England. We take nearly 5 million calls to our 0845 4647 service per year and forecast over 8 million annual uses of our online health and symptom checkers, demonstrating that our services are popular, convenient and relevant to the general public. Eight ambulance trusts connect with our nurses who provide support and advice to their Category C 999 calls. Over 15% of these calls resulted in home care advice and over 30% are directed to appropriate primary care services, providing callers with a more appropriate service and reducing the number of ambulances dispatched unnecessarily.

We provide a single point of access for over a million patients in a group of PCTs in Yorkshire, and for the NHS 111 pilots. We offer call handling and clinical assessment for out of hours GP services and have dental nurses who provide pain management advice and emergency dental referral for dental practices.

NHS Direct supports over 11,000 patients to manage their long-term conditions at home, reducing their need for face-to-face care, as part of our care management programmes.

We support patient choice and the government policy of "no decision about me without me" through online patient decision aids (PDAs), designed to help people make better informed decisions, in consultation with their health professional, about difficult choices between different tests and treatments. We handle 3.8 million calls to The Appointments Line service for NHS Choose and Book advice.

NHS Direct supports national resilience through the operation of the National Pandemic Flu Service, which completed 2.7 million phone and web assessments during the flu pandemic of 2009/10. We won a 2011 Management Consultancies Association (MCA) award for our work with Ernst and Young to develop the National Pandemic Flu Service. The award recognised work on Change Management in the Public Sector.

We develop and maintain high-quality evidence-based clinical content suitable for remotely-delivered services and provide high standards of clinical safety.

NHS Direct has a national infrastructure, supported by a state of the art telephony system, with a local presence through our network of 31 contact centres across England, and our home workers. This enables us to operate as a virtual contact centre, offering scalability and resilience.

Our digital services have been recognised by a number of awards including winner of the e-Government excellence award for innovation in strategy on a national level and winner of 'Best Healthcare and Medical Site' from SiteCore 'Site of the Year' awards.

Performance

We have achieved steady annual performance in a period of challenge and change. We have been rated excellent by the CQC and have maintained our clinical safety and effectiveness. The overwhelming majority of our patients say they are very satisfied with the service they receive from us, reporting 93% satisfaction with urgent care services and 99% with The Appointments Line. When asking users if they would recommend our service to their families or friends, our loyalty (net promoter) score is, at 77, within the range identified as "excellent".

Within this is a more complex story where periods of high demand, such as at Christmas or Easter bank holidays, have resulted in under-performance against access targets. We have addressed this problem through changes to our mechanisms for rostering staff to meet demand, but further work is required on forecasting and developing a more flexible response to meet changing demand. As for any organisation, any changes to staff working patterns are sensitive and require careful implementation.

During the flu pandemic NHS Direct ran parallel services for the core 0845 4647 service, and for assessing flu symptoms and issuing antivirals. Through extensive preparatory work with partners in the Department of Health and the wider NHS, we were well prepared for our role in operating the National Pandemic Flu Service, and we were able to deliver an end-to-end solution in a matter of weeks.

Call centre
Call centre (nurse only)
National headquarters
Newcastle
Carlisle
Stockton
Kencal
NORTH DIVISION
Hull
Blackburn
Wakefield
Middlebrook
Liverpool
Sheffield
Chesterfield
Mansfield
Nantwich
Derby
Nottingham
Stafford
Norwich
Dudley
MIDLANDS & SOUTH WEST DIVISION
Bedford
Ipswich
Milton Keynes
Chelmsford
SOUTH DIVISION
Leman Street
Ilford
Bristol
Beckenham
Chatham
Hedge End
Ferndown
Exeter
Truro

Section 3: Strategy

Our strategy sets out how we will target our expertise and resources on activities where we can deliver maximum benefit to patients, commissioners and the health system.

Corporate vision and objectives

Our market assessments, and our engagement with our stakeholders, members and staff, have confirmed to the NHS Direct Board that the high level vision we set last year remains appropriate.

Our vision is to:

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

Underpinning this vision, our six strategic objectives remain equally important. Over the next five years our objectives will remain to:

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

Service developments

Through engagement with our stakeholders, we have identified the specific areas where we should target our resources and expertise to provide the maximum benefit to patients and the NHS:

- we will focus on delivering the national specification for the new NHS 111 urgent care telephone service, aiming to be a major provider
- we will continue to develop clinical services (including a web service) as complementary options to the NHS 111 service, in response to demand from commissioners
- we will continue to develop clinical services to support patients with long-term conditions; to support patient choice; and to support national resilience
- we will continue to provide the 0845 4647 urgent care service until NHS 111 is nationally available, ensuring it continues to provide a clinically safe and effective service for patients and commissioners.

At the same time we will continue to provide our other services including The Appointments Line and locally commissioned services such as call handling and nurse assessment for GP and dental out of hours services.

Organisational development

To provide these services, we will continue to build on our existing improvement programmes and increase our focus on the particular organisational areas which will prime us for delivery of this strategy.

Our organisational development will help us to:

- create a delivery model for NHS 111 and other service lines which provide high quality services that are cost competitive and attractive to commissioners
- focus on listening carefully to our commissioners to create services that meet their needs, engage them and demonstrate the value of our services in the developing marketplace
- continue to improve the proportion of the time that staff spend with patients and to reduce our support and overhead costs to provide best value for money for our commissioners
- establish a delivery programme to build our new capabilities and the new organisation
- engage with our staff, seeking and valuing their input and supporting them as we move to the new organisation
- embed our values in our organisational behaviours with patients, staff and stakeholders
- pursue NHS Foundation Trust status.

NHS Foundation Trust status

Developing and delivering new services and operating in a more competitive and locally driven commissioning regime will be challenging for NHS Direct. We need to adopt the most appropriate organisational form to meet these challenges. The government has made it clear that it will repel the current legislative model for NHS trusts with the expectation that all current trusts will become, or be part of an NHS Foundation Trust from April 2014.

To successfully support the NHS to meet the demands that will be placed on it, we will need:

- to become a high quality, cost effective provider of the new NHS 111 urgent care service as currently specified; and beyond that
- to develop and roll out our services quickly, be able to flex them in line with local needs, and to win and manage a rolling programme of multiple contracts
- to generate start-up funding for the development and piloting of innovative services before offering them to local health economies.

NHS Foundation Trust status will provide opportunities and potential benefits that will support us in meeting these challenges and achieving our objectives:

- a strengthened membership and governance structure. This will give greater insight into patient and health economy requirements, enhance our focus on quality and choice, and improve our ability to respond to our patients and commissioners
- increased freedoms to restructure and adapt. This will give us greater flexibility and speed to respond to service demands
- increased ability to use our capital, and increased access to external capital. This will help us to develop opportunities and to bring higher rates of return, qualitative and financial, on investments in service provision to the benefits of patients and commissioners.

We are undertaking a thorough review and assessment of the organisational features that will be the best fit for our future requirements, with the intention of achieving NHS Foundation Trust status from April 2013.

Stakeholders and consultation

Our commissioners, clinical professional bodies, staff, and over 18,000 public members are important to us in providing insight into what services to develop and supporting us in delivering them. In our consultation with our stakeholders and staff between December 2010 and February 2011 they gave positive support for our five year strategy.

Our local and national stakeholders

NHS Direct has a number of stakeholders, both local and national, which are outlined in the table below:

Local stakeholders	National stakeholders
Providers and commissioners of local NHS services	Westminster and Whitehall
GP commissioning consortia	**Department of Health – ministers, special advisors and civil servants**
GP out of hours providers	**Cabinet Office – ministers and civil servants**
Ambulance trusts	**Members of Parliament with a national health remit**
Strategic Health Authorities	**Professional and trade bodies**
Primary Care Trusts	**Royal College of Nursing**
Acute trusts	**Royal College of General Practitioners**
Mental health trusts	**Other Royal Colleges**
Pharmacists	**British Medical Association**
	UNISON
	NHS Alliance
Local decision makers and influencers	**NHS Confederation and NHS Employers**
Local medical committees	**Contact Centre Association**
Local patient groups and voluntary organisations	
Local authorities including health overview and scrutiny committees	Regulators, advisory and statutory bodies
Regional government resilience forums	**Monitor and Care Quality Commission**
Local members of Parliament	**National Audit Office**
Patients	**Health Protection Agency and NICE**
Members of the public	
	National providers of NHS services
Internal - locally based stakeholders	**NHS 24 and NHS Direct Wales**
Local staff	**NHS Choices**
Local members	**External suppliers and partners**
	Connecting for Health
	Suppliers of resources and technical infrastructure
	Patient groups and charities
	The Patients Association
	Condition-based charities
	Internal – stakeholders with a national remit
	Staff who represent other staff
	Members who represent members on groups and committees

Members

Over 18,000 public members have joined NHS Direct since December 2007. We communicate with most of our members via e-mail and online surveys, but a significant number receive regular information from us by post, in the form of our quarterly newsletter 'Together', a summary of our annual report and other relevant communications.

Members are invited to all board meetings. As we are a national organisation, many choose to observe the Board meeting via live web-streaming rather than attending in person. Members are also engaged directly in internal working groups and committees overseeing some of our organisational activities including:

- patient and public involvement working group
- research committee
- newsletter editorial group
- specific working groups for individual research and clinical audit projects including the Healthlines research programme and the dignity and respect audit.

Engagement in developing the strategy

NHS Direct consulted members, staff and regional stakeholders on our proposed strategy between December 2010 and February 2011.

Stakeholder group	Responses	Communication channel
Members	955	Article and survey in our members' newsletter 'Together'
Staff	200	Online discussion boards and dedicated team meetings. These were supported by a video from the Chief Executive outlining our proposed direction.
Regional stakeholders (SHAs, PCTs, GP commissioners, ambulance trusts and local authorities)	40	Face-to-face discussions with NHS Direct regional directors and regional heads of service development

Our stakeholders were positive about our five year strategy, but expressed some concerns that we may have been too broad with our proposed service offerings. As a result, we will focus new developments in those areas which offer greatest value in terms of patient outcomes and contribution to the NHS.

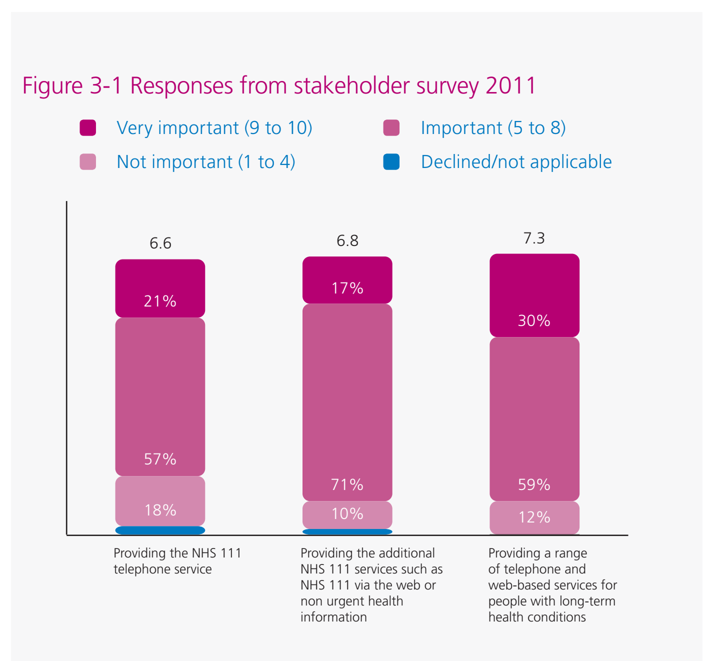
During this period we also undertook more general engagement about our organisation through annual staff and stakeholder surveys and a range of external engagement events. We have reflected the outcomes of this engagement in our proposed strategy.

The engagement exercises also gave us further feedback on how stakeholders experience our services, and, where appropriate, we will reflect this in the way we implement our strategy. We will continue to engage with stakeholders throughout the lifetime of the business plan to test the strategy's continuing relevance and as part of our consultation on becoming an NHS Foundation Trust.

Annual stakeholder survey

NHS Direct commissioned independent research during February and March 2011, into regional stakeholders' opinions of the Trust and its services. 206 external stakeholders participated in an extended telephone-based survey. Participants were asked for their opinions on our proposed strategy. The survey results provided strong support for our future direction. See Figure 3-1 below.

Figure 3-1 Responses from stakeholder survey 2011



Section 4: Market assessment

Overview

There will be significant and rapid change in NHS Direct's external environment. Changes to our market fall into four specific areas:

- **Patients**: longer term demographic changes and trends in consumer behaviour will continue to affect public expectations and demand for health services. Patients know more, expect more and want to use technology to receive clinical services where and when they want. They want to be supported in caring for themselves wherever possible and will want to be assured that this care is of the highest clinical standard. Population numbers are increasing and people are living longer. More people will have multiple long-term conditions.

- **Urgent care**: the new nationally specified and locally commissioned NHS 111 urgent care service will replace our current core business, with far-reaching implications for our operations and organisation. The market for the NHS 111 service is at a very early stage of development, with significant uncertainties about how it will evolve.

- **Commissioning**: the commissioning regime will undergo radical change, as the majority of NHS services will be commissioned by GP consortia, or clusters of consortia, replacing SHAs and PCTs, and requiring us to transform the way we engage with commissioners and how we market and manage our services.

- **The financial and competitive environment**: the health economy will be stretched by growing and changing demand. Commissioners and providers will be under great pressure to contain costs to within the modest increase set by the government for the whole NHS. There will be a more competitive environment with existing and new organisations entering the market.

Remotely-delivered clinical services which signpost patients and reduce inappropriate demand; which enable better use of expensive hospital and related resources; and are delivered in a high quality way, will become increasingly attractive to commissioners. The increased availability and affordability of remote technologies will make their use more attractive to individuals and will support this delivery of healthcare.

NHS Direct's expertise in providing remotely-delivered, multi-channel patient care means we are well positioned to meet these challenges and to support the NHS to exploit the potential of remote care.

Patients

Patients want to be informed of treatment alternatives and consulted during their medical encounter. More people want to use technology to receive health services where and when they want: 53% of people use the internet every day, and 69% use the internet at least once per week[2].

After relatively slow growth in the preceding 30 years, the population is projected to increase by 8 million between 2011 and 2033, an increase over that period of 15% as births continue to outnumber deaths, and people live longer[3] (see Figure 4-1).

The age demographic of the population is also changing significantly – people are living longer, and older people comprise an increasing proportion of the population. By 2033 the proportion of the population of England who are aged 60 or over will have risen from 22.6% in 2011 to 28.2%, and will number 17.1 million[4] (see Figure 4-2).

Figure 4-1 Actual and projected total population, United Kingdom, 1971-2083

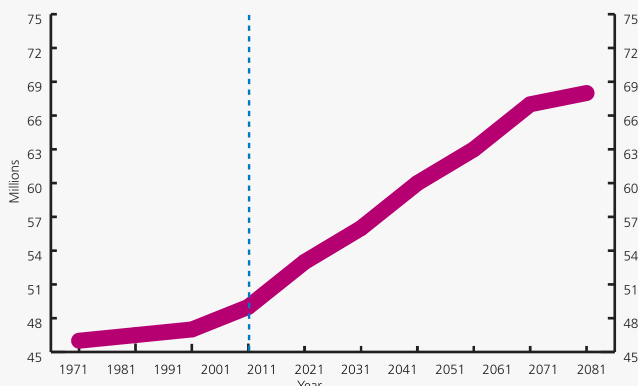
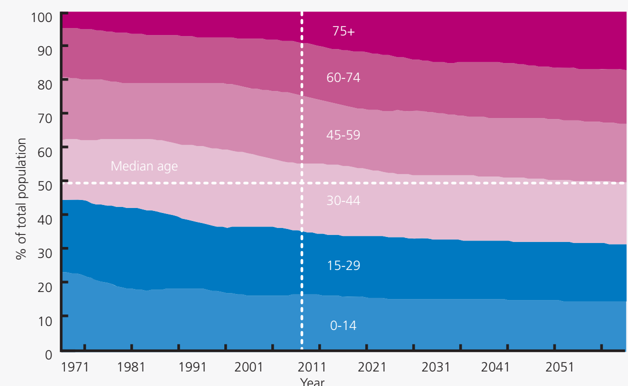


Figure 4-2 Percentage age distribution, England, 1971–2058



More people are living with long-term conditions, and living longer with those conditions. 15.4 million patients are registered with GP practices in England as having a long-term condition and the Department of Health estimate this will increase to over 18 million by 2025[5] (Figure 4-3), with the prevalence of long-term conditions increasing with age[6] (Figure 4-4).

The health economy will continue to be stretched by this growth in demand at the same time as the total NHS budget will have very limited growth.

Urgent care

The vision for urgent and emergency care is of universal access to high quality urgent and emergency care services 24/7, that ensures people receive the right care, from the right person, in the right place, at the right time.

As part of this, NHS 111 is being launched to provide free telephone access to integrated non-emergency urgent care. The first pilots of this new service were launched in August 2010 in County Durham and Darlington and in November 2010 in Luton, Nottingham City and Lincolnshire.

NHS 111 will replace NHS Direct's 0845 4647 telephone service by April 2013. It is specified nationally but will be commissioned and delivered locally on a competitive basis. This will have a greater impact on NHS Direct than any change since the creation of our service as a single organisation in 2004.

NHS commissioners are being asked to take on this new responsibility for implementing the NHS 111 urgent care service whilst broader commissioning arrangements are going through a period of unprecedented change.

Commissioning

The commissioning regime will undergo radical change, as the majority of NHS services will be commissioned by GP commissioning consortia, or clusters of consortia, replacing SHAs and PCTs. This will require us to transform the way we engage with commissioners and how we market and manage our services.

A new NHS Commissioning Board, accountable to the Secretary of State, will manage the overall commissioning revenue limit and delivery of improvements against health outcome measures. It will commission primary medical services, family health services (dentistry, community pharmacy, and primary ophthalmic services), national and regional specialised services, and prison health services. The board will hold the GP commissioning consortia to account for their performance.

GP commissioning consortia will be fully operational from April 2013. They will commission a range of services including urgent and emergency care including accident and emergency, ambulance and out-of-hours services; elective hospital care; continuing healthcare; community health; maternity; healthcare services for children, older people, people with mental health conditions and people with learning disabilities. They may also commission some health improvement services jointly with local authorities such as obesity, smoking cessation and drug/alcohol services.

Public Health England will formally come into effect in April 2012, subject to Parliamentary approval, and will incorporate functions from the Health Protection Agency, National Treatment Agency and the Public Health

Figure 4-3 Projection of number of patients with long-term conditions

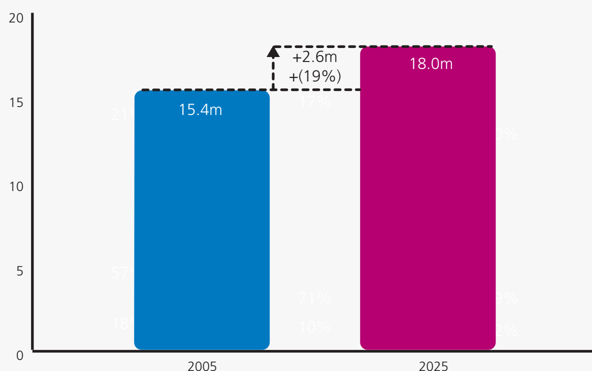
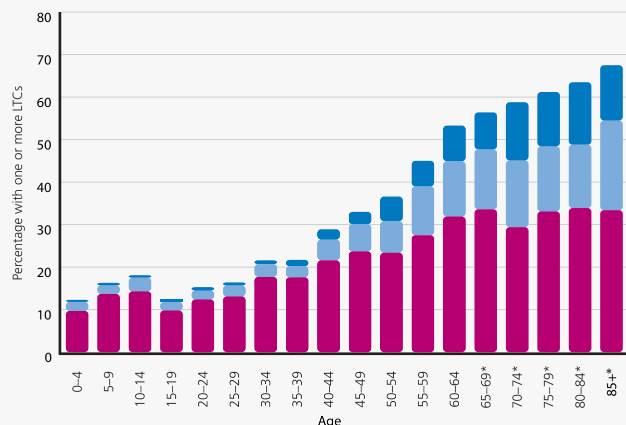


Figure 4-4 Percentage of people with one or more long-term condition by age



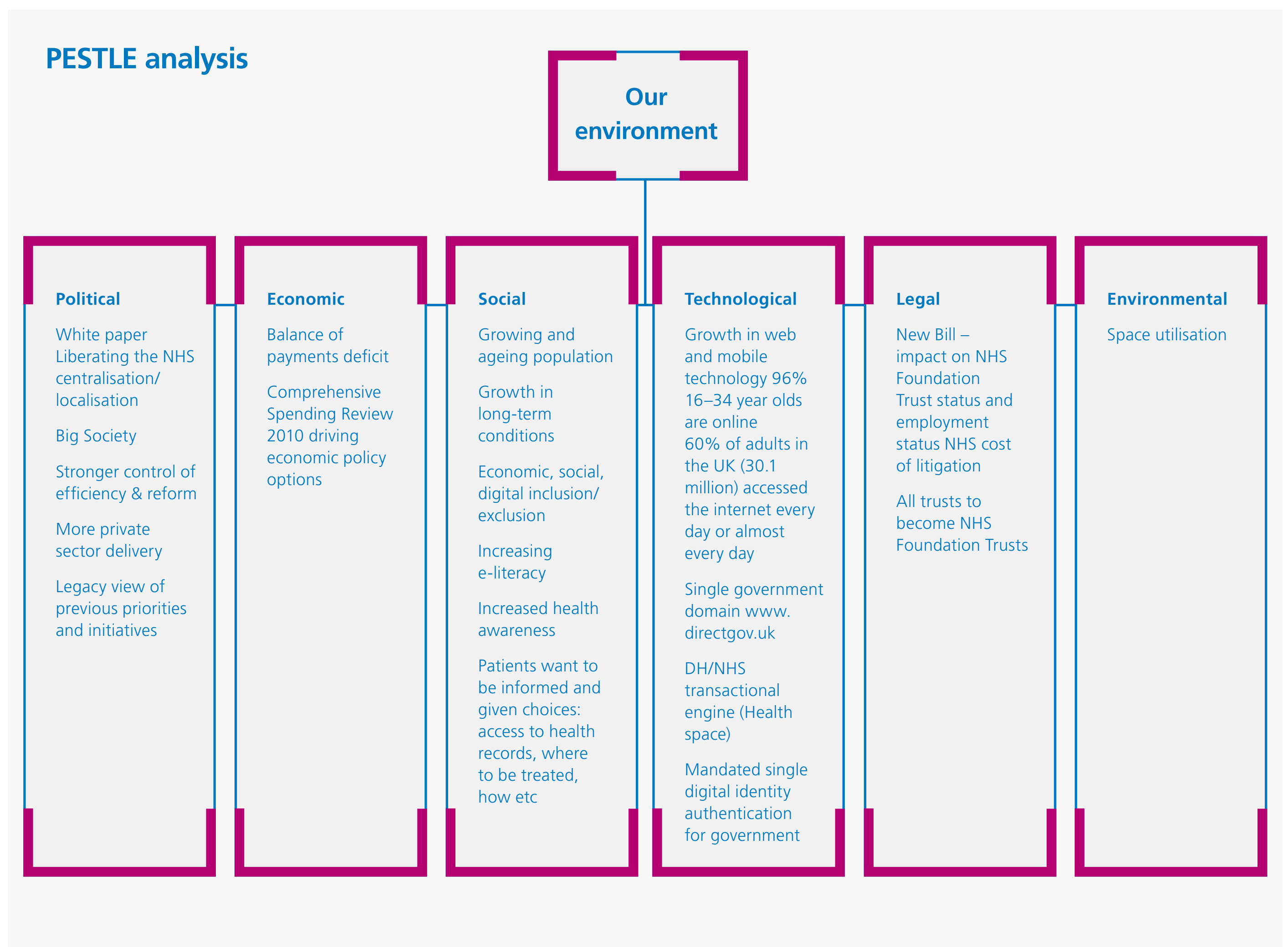
Observatory. Directors of public health will be situated in Local Authorities. Local, statutory health and wellbeing boards are being proposed to support collaboration across the NHS and local authorities, operating in shadow form from 2012 and established from 2013.

The financial and competitive environment

At the same time as these far-reaching changes in commissioning are taking place, £20 billion is being sought in efficiency savings to reinvest in front-line care.

The competition for the provision of health services will also change. The concept of "any willing provider" is a clear part of government strategy on health, based on the principle that where there is effective competition, all producers are driven to raise standards and quality. A number of organisations are poised to enter the markets in which we are planning to develop and deliver our services.

Initially, commissioners will be looking for lean, cost-effective and reliable suppliers who are capable of delivering the national specification of the NHS 111 service at a highly competitive price. Over time they will increasingly be looking for delivery partners who can work effectively with other providers to integrate non-emergency care, and to help meet local priorities in terms of reducing unscheduled care needs, making best use of other NHS resources and promoting self-care.



A role for NHS Direct

NHS Direct's expertise in clinical patient care which is remotely-delivered means we are well placed to play a key role in the transformation of health care in England. We will continue to support patients and make a substantial contribution to NHS productivity and quality improvement through delivering clinically safe, cost-effective, multi-channel remote care.

In urgent care, the 0845 4647 service reduces demand for other NHS services and provides advice, information and signposting for patients to the most appropriate care. We are involved in all of the current NHS 111 pilots.

We provide services in the management of long-term conditions, helping patients to manage their own health and live safely in their own homes.

We support patient choice, providing decision aids to support patients to choose the most appropriate treatment for them and providing the Telephone Appointments Line for the NHS Choose and Book service.

We are a key provider of national resilience, maintaining the National Pandemic Flu Service and working closely with the Health Protection Agency to provide early warning signs of potential outbreaks.

[2] Experian Ltd 2009 Experian Future Foundation /nVision Research | Base: 1,200 respondents aged 15+, GB

[3] Office for National Statistics National population Projections, 2008-based (statistical bulletin, published 21 October 2009)

[4] as above

[5] Department of Health (2010) Improving the health and well being of people with long term conditions

[6] Department of Health (2008) Raising the profile of long-term conditions care

Section 5: Service development plans

Introduction

We will provide remotely-delivered care that is increasingly valued by patients and the wider health and social care system. We will build on our expertise in providing remote, multi-channel patient care to be a key player in the transformation of the provision of health care in England. To achieve our strategy in the context of our market analysis and our strengths, weaknesses, opportunities and threats, we will undertake the following service developments:

- we will focus on delivering the national specification for the new NHS 111 urgent care telephone service, aiming to be a major provider
- we will continue to develop clinical services (including a web service) as complementary options to the NHS 111 service, in response to demand from commissioners
- we will continue to develop clinical services to support patients with long-term conditions; to support patient choice; and to support national resilience
- we will continue to provide the 0845 4647 urgent care service, ensuring it continues to provide a clinically safe and effective service for patients and commissioners, whilst managing its orderly wind-down until NHS 111 is nationally available.

The rest of this section takes each of our service developments in turn and sets out the rationale and our plans for each.

SWOT analysis

Strengths

Rated "excellent" by the Care Quality Commission

Only large scale public provider of remotely-delivered multi-channel healthcare providing; clinical excellence; resilience and; scalability; through an integrated web and telephony platform

Capability and experience in developing clinical content, tools and processes

National and local infrastructure and staffing in place

Experience of establishing and delivering NHS 111

Part of NHS family

Track record in delivering self-care and handling emergencies

First UK public sector organisation to develop and manage online patient decision aids

Opportunities

New market for NHS 111 provision

Ability to offer additional services to complement NHS 111 including capability and expertise

Integration of NHS 111 with other service offerings e.g. telehealth, patient decision aids and The Appointments Line

Market for long-term conditions ready for development

Role of shared decision making in empowering patients and delivering savings

New partnerships with public and private sector organisations to deliver services

Weaknesses

Overhead costs

Hampered by history of the organisation

As a national organisation, ability to 'feel' local and capacity to engage locally

Threats

Uncertainty of future commissioning arrangements

Introduction of "any willing provider" and competition for NHS 111

Ability to mitigate liabilities

Managing the transition between 0845 4647, commissioned services and NHS 111

A major provider of the national specification for NHS 111

Introduction

NHS 111 will make it easier for the public to access local health services when they need help quickly, but it isn't life-threatening, or when they don't know who to call. The introduction of the NHS 111 service is part of the wider developments to deliver a 24/7 urgent care service that ensures people receive the right care, from the right person, in the right place, at the right time.

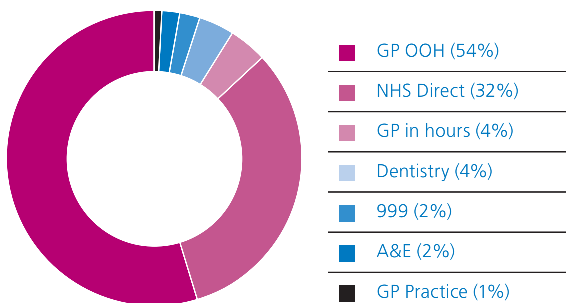
This new free to call, easy to remember three-digit number will be available 24 hours a day, 365 days a year and will provide a clinical assessment at the first point of contact, without the need to call patients back. It will direct people to the right NHS service, first time, without the need for them to be re-triaged. It will be able to transfer clinical assessment data to other providers and book appointments for patients when appropriate.

NHS 111 will work alongside the 999 emergency service and will be able to dispatch an ambulance without delay and without the need for the patient to repeat any information.

The NHS 111 market

86% of the NHS 111 call volume is expected to come from NHS Direct and GP out of hours services and we have based our assumptions on the Department of Health estimates for NHS 111 call volumes. (See Figure 5-1).

Figure 5-1 % each group will contribute to estimated NHS 111 call volumes



This service will be contestable and open to any willing provider who can meet the requirements. The market will be competitive with a number of new entrants as well as incumbents. We expect that competitors will include commercial contact centres, systems integrators, GP out of hours providers and ambulance trusts. Our size, track record, risk management and clinical governance and safety complement our price competitiveness and will position us to be an attractive provider and partner.

Commissioners

In the short term SHAs and PCTs will commission NHS 111 services with contracts increasingly moving to GP commissioning consortia as SHAs and PCTs cease to exist. We may see some primary or secondary contracting by lead providers.

The specification

NHS 111 operates according to the following core principles:

- ability to dispatch an ambulance without delay
- completion of a clinical assessment on the first call without the need for a call back
- ability to refer calls to other providers without the caller being re-triaged
- ability to transfer clinical assessment data to other providers and book appointments where appropriate.

These are the fundamental requirements that underpin the NHS 111 service. NHS Direct will focus on delivering the national specification, to a high standard, driving down our delivery costs to be competitive at the prevailing market price.

NHS 111 – benefits of NHS Direct

NHS Direct's NHS 111 service offer will provide a range of specific benefits to patients and commissioners, including:

- safe and appropriate health outcomes based on our proven experience in remotely-delivered urgent care
- assurance on safety through high-quality, validated clinical governance
- expertise in reducing avoidable referrals to face-to-face services
- experience in providing high quality information
- reassurance for patients from access to advisors who give valued clinical assessment and advice
- track record in providing excellent customer service and responsiveness

- confidence in a fully compliant and signed-off provider of NHS 111 national service specification.
- assurance on data security from robust and validated information governance processes
- proven ability to manage effective and safe roll-out of local NHS 111 projects
- capacity to expand as the NHS 111 service rolls out more widely
- demonstrated service resilience, through experience and infrastructure, in times of emergency (e.g. National Pandemic Flu Service).

Developing additional NHS 111 services as an option for commissioners

While we will focus on delivering a competitive NHS 111 national specification, we will also innovate and develop additional options for commissioners, which would help to manage demand and further reduce cost. Where we see a potential demand we will work with commissioners to identify the potential benefits of complementary NHS 111 services. We will be flexible in our delivery of the national specification to ensure we are able to anticipate and respond to changes.

As part of these additional options, we believe that an on-line service is a critical success factor for the NHS 111 operation. Our vision is consistent with wider government policy to make public services accessible online. Over 7 million uses of our online health and symptom checkers compared to 5 million contacts to the 0845 4647 core telephone service, show the importance of on-line channels in health, and underline the need for the NHS 111 service to include online and mobile access alongside the telephone.

The online service allows more people to make greater use of the service and so get the help they need. Commissioners will see a reduced cost per contact and the health system will provide better access to some of the traditionally hard to reach groups.

We believe that there is also significant potential benefit for patients and commissioners from the provision of a health information service to address complex needs. We have extensive experience in the provision of such a service and we will work proactively with commissioners to explore and test the value of such a service to complement NHS 111 and respond to their requirements.

Patients with long-term conditions

Introduction

The pressure to reduce costs and improve patient outcomes means moving from a system of "diagnose and treat" to one of "predict and prevent" and managing long-term conditions is seen as being ripe for this transformation.

Telecare uses a combination of alarms, sensors and other equipment to monitor activity changes over time and will raise a call for help in emergency situations, such as a fall, a fire or a flood. For example, a bed occupancy sensor can be used to monitor when a person gets out of bed at night and if they do not return within a certain period, an alarm would be raised as they may have fallen.

Telecoaching provides remote support for patients in their chosen areas for lifestyle development or change, using motivational counselling and other forms of coaching to facilitate behavioural change. For example, it can be used to support self care, by helping patients understand and adhere to their medication regimes.

Telehealth uses equipment to monitor people's health in their own home, for example blood pressure, blood oxygen levels, blood glucose monitoring, cardiac arrhythmia monitoring and medication reminder systems. These measures are automatically transmitted using phone lines or wireless technology and readings that are out of the range expected are flagged to a clinician who can monitor the user's condition without the patient leaving home.

The market for services for patients with long-term conditions

Remotely-delivered care for patients with long-term conditions is already being provided but the numbers are relatively low. While this has been a potential market for growth for some time, we believe the opportunities will develop faster over this coming business plan period. Service trials are underway and analysis of the benefits from these will start to be available. Where this evidence demonstrates benefits from using telehealth and telecare services, the growth in numbers of people to treat, combined with the necessity to reduce costs, will lead providers and commissioners to use them. The plan to release £20 billion per year to the front line for treatment and care of patients means funding will become available to invest in such schemes.

Competition will come from other established telehealth suppliers, care management organisations and local authority call centres. We have also identified a number of potential partners.

Commissioners

There is likely to be a range of commissioners and providers interested in the potential of remotely-delivered services for patients with long-term conditions, as more robust evidence emerges and the market develops with different needs. They will include PCTs and GP commissioning consortia; acute trusts and community providers; local authorities; technology and device suppliers.

The specification

We will provide telehealth and telecoaching services designed to meet the needs of patients at whatever level of care they need. This will range from preventative measures for at-risk patients to proactive management of patients with multiple and severe symptoms. In the medium term, we will seek to identify opportunities to integrate telehealth and telecoaching services with NHS 111 services to deliver a more coherent service across the patient pathway.

Long-term conditions – benefits of NHS Direct

NHS Direct's service offer to support the management of long-term conditions will provide a range of specific benefits to patients and commissioners, including:

- improved patient experience through access to safe and high quality support helping patients (and carers) to manage their condition(s) more effectively with less disruption to their lives
- experience in developing services, with commissioner and provider partners, to address specific local needs
- assurance on safety through high-quality, validated clinical governance
- proven expertise in reducing avoidable use of front line services
- track record in providing excellent customer service and responsiveness
- more efficient delivery of, and improved patient accessibility to, services from use of a range of channels
- confidence in capacity to manage end to end delivery, and to source appropriate technology, through partnerships with experienced equipment suppliers.

Supporting patient choice – patient decision aids

Introduction

Shared decision making is about creating the right culture and environment for patients to be actively engaged in the process of decision making about their own health care. It seeks to shift the culture from medical opinion to patient choice. It requires the use of decision aids, embedded in the consultation process, that allow an honest and informed conversation between patient and clinician. The outcome should lead to an agreed decision on the "highest value" option, in that situation and at that time for that individual.

Decision aids are self administered information tools that prepare patients for making informed decisions about options for medical tests or treatments. They are designed to increase a patient's awareness of expected outcomes and to facilitate communication with their healthcare professionals.

In situations where there is more than one viable treatment or intervention, using online patient decision aids (PDAs) will promote informed choice and autonomy and increase patient satisfaction. It does so by helping patients, in conjunction with their health professionals, to review the potential pros and cons of alternative treatments and to consider them in the context of their health needs and their values and lifestyle.

The market for patient decision aids

The QIPP (Quality Innovation, Preventions and Productivity) Right Care workstream, supported by NHS East of England, is leading on the development of a shared decision making programme for the NHS. Its objectives for 2011/12 include a suite of decision aids available on a national platform from NHS Direct with a national Patient Decision Support service. It is also planning a national "Shared Decision Making" engagement programme for the public, patients, carers, managers and clinicians and aims to embed shared decision making into commissioning[8].

NHS commissioners are being encouraged to take the lead in empowering patients by expanding access to information, extending the range and nature of patient choice: "no decision about me without me".

Studies have been done which found that 47% of treatment decisions were based on insufficient evidence and 8% of treatment decisions as having been tradeoffs between benefits and harms (Godlee 2005)[9]. By reducing the uptake of major elective surgeries, costs are reduced, without related adverse effects on health outcomes (Whelan 2004)[10], (Auvinen 2004)[11]. The Foundation for

Informed Medical Decision Making and the University of Cardiff recently calculated that savings of around £150 million per year could be achieved if an effective system of decision support was available for 11 elective surgical procedures.

Competition will primarily come from other organisations who deliver patient decision aids, mainly in the USA.

Commissioners

The East of England SHA, working with the Institute of Improvement and Innovation, approved funds in 2010/11 for the development of nine patient decision aids in three phases. Six patient decision aids, with telephony back-up, are currently available on the NHS Direct website. We have since been commissioned to develop additional patient decision aids over the next 18 months.

We are working with clinicians and the Royal Colleges to produce supporting materials such as factsheets and DVDs. We will develop and use relevant patient outcome data and build an evaluation/reporting framework to demonstrate the benefits of patient decision aids. We will work with medical, national and consumer press as well as key patient groups, third sector organisations and community services.

The specification

The NHS Direct patient decision aids provide information to patients about the decision at stake and options available, using evidence-based information e.g. images, diagrams, questionnaires, and films of patient experiences and health professionals. The patient decision aids are web-based and generate a decision summary to share with health professionals. A telephone support service will be provided by health information advisors with nurse support for symptomatic patients and language line access where required.

Patient decision aids – benefits of NHS Direct

NHS Direct's patient decision aids service offer will provide a range of specific benefits to patients and commissioners, including:

- enhanced patient experience from guidance to support them in making better-informed decisions about potential treatments

- safe and appropriate health outcomes based on proven experience in development of, and support for, evidence-based decision aids which are regularly updated

- assurance on safety through high-quality, validated clinical governance

- track record in providing excellent customer service and responsiveness

- potential to achieve efficiencies through reductions in unnecessary procedures

- more efficient delivery of, and improved patient accessibility to, services through use of a range of channels

- responsiveness from telephone support and in the longer term the potential to link patient decision aids with our NHS 111 and long-term conditions services

- ethical demand management of patients, achieving the right intervention rate, reducing the potential for litigations and complaints.

Maintaining existing services

We will continue to focus on consistently meeting our clinical, corporate and financial standards on all existing contracts, whilst improving efficiencies and supporting the transition. These include:

- our core 0845 4647 service, commissioned by the East of England SHA on behalf of all SHAs, until it is replaced nationally by the NHS 111 service in April 2013

- The Appointments Line, also commissioned by the East of England SHA, to provide patients with the information and support to choose their consultant and hospital and to manage their initial appointment.

- other locally commissioned services, while they are required

- the national resilience service commissioned by the Department of Health to support the country in a time of national emergency, including the National Pandemic Flu Service.

Our organisational development plan

A flexible and motivated workforce and outstanding leadership are essential to our being a thriving NHS Foundation Trust in the era of the NHS 111 service. We have excellent staff, managers, infrastructure, skills, experience and resources within our organisation. At the same time, we need to develop new skills and new ways of working.

Our previous change programmes have resulted in a more streamlined organisation as a single national employer with strong local management. The programme to achieve the next stage of our development will continue this work, with four workstreams, each led by an executive director:

- operational delivery model: design, build and deliver an organisation that operates NHS 111 services that meet the national specification, offers complementary services and services for patients with long-term conditions and to support patient choice, which are competitive on price and quality

- marketing and service development: build our capability, knowledge and experience to ensure we provide commissioners with the support and services they need

- corporate development: design, build and deliver the appropriate supporting functions and undertake the programme of work required to be successful in an application for NHS Foundation Trust status

- existing services: ensure we continue to focus on consistently meeting our clinical, corporate and financial standards on all existing contracts, whilst improving efficiencies and supporting the transition.

To support the executive in delivering the objectives of each workstream, a central team will:

- ensure the programme has sufficient management capability and capacity to deliver

- ensure people are supported through the transition so that changes are effective

- manage inter-dependencies and co-ordinate work that spans workstreams

- oversee programme risks to ensure they are mitigated or managed effectively

- ensure that engagement with external stakeholders is proactive and supportive

- ensure our staff are informed and can contribute effectively to our future development.

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[8] Department of Health (2011) Right Care Commissioning for Value Outline programme for 2011/12

[9] Godlee F., Clinical Evidence. BMJ Publishing Group, 2005

[10] Whelan T., et al. Effect of a decision aid on knowledge and treatment decision making for breast cancer surgery: a randomized trial. JAMA 2004;292:435-41.

[11] Auvinen A., et al. A randomized trial of choice of treatment in prostate cancer: the effect of intervention on the treatment chosen. BJU International 2004;93:52–6.

Section 6: Financial overview

We have agreed a settlement with our main national commissioner, the East of England SHA, to deliver the core 0845 4647 contract in 2011/12, including additional support to meet the costs of peak periods such as Christmas and Easter.

We are committed to improving our performance and in 2011/12 will measure most of our core contract key performance indicators (KPIs) on a daily basis. We are, in line with all NHS organisations, taking actions to deliver real cash releasing efficiencies of at least 4% as the NHS addresses the challenges of increasing demands for constrained resources. We will be doing this at the same time as we make the transition from the current service to NHS 111 and seek further opportunities to provide locally commissioned services, as well as working towards becoming an NHS Foundation Trust.

We have prepared a financial plan which is described in detail in this section. Key elements include:

- an overall revenue surplus of £0.3 million
- planned EBITDA[12] of £6.6 million (4.5% of turnover)
- a total turnover projection of £146.7 million
- estimated core contract income of £123 million
- estimated income from other commissioned services of £18.1 million
- a capital programme of £9.2 million
- a cost improvement programme of £14.6 million
- strategic development funding of £3 million
- discretionary business case funding of £1 million
- a downside provision of £2 million
- a capacity plan to deliver 4.7 million call contacts for the core contract.

The key risks and opportunities in delivering this plan are included later in this section. We are now developing financial forecasts for the period 2012/13 to 2015/16, underpinned by the Department of Health agreement to cover fixed costs for the next two financial years with planned expansion of NHS 111 volumes and contractions in core services at marginal rates during that time.

Income and expenditure

A detailed income and expenditure statement is attached at Appendix 1. It shows a planned surplus of £0.3 million compared to the 2010/11 planned surplus of £0.2 million and forecast outturn surplus of £0.5 million. Table 6-1 below shows a summary position:

Figure 6-1 Summary income and expenditure position

Summary I&E	Budget 2010/11 £m	Forecast Outturn 2010/11 £m	Budget 2011/2012 £m
Total Income	159.6	147.8	146.7
Total Operating Costs	154.0	142.0	140.1
EBITDA	**5.6**	**5.8**	**6.6**
Capital Charges	5.4	5.3	6.3
Net Surplus	**0.2**	**0.5**	**0.3**

[12] Earnings before interest, taxes, depreciation and amortization

Income

Total NHS Direct income is forecast to be £146.7 million in 2011/12. This is a reduction of £1.2 million from the forecast outturn of £147.9 million in 2010/11. Table 6-2 provides a breakdown by service type.

Table 6-2 Income by service type

	Forecast Outturn 2010/11 £m	Budget 2011/12 £m	Increase/ (decrease) £m
Core Income	119.9	123.0	3.1
The Appointment Line	7.4	6.8	(0.6)
Locally Commissioned Services	14.7	11.3	(3.4)
Fluline	4.8	4.8	0.0
Other	1.1	0.8	(0.3)
Total	**147.9**	**146.7**	**(1.2)**

Core contract

Core call volumes of 4.7 million with associated income of £113.8 million have been agreed with the commissioners for 2011/12. NHS Direct has negotiated that the baseline income will be on the basis of a 'minimum take'. A marginal payment of £8.61 will be payable to NHS Direct for any additional activity. Table 6-3 below provides a breakdown of the core income component in 2011/12.

On top of the baseline, NHS Direct and the commissioners are currently finalising details on the provision of additional capacity funds, expected to be around £5.0 million. The additional monies will enable NHS Direct to recruit, train and deploy sufficient frontline staff to enable all KPI targets to be met during high demand periods (e.g. Christmas). This is included within the budget.

Despite NHS Direct agreeing a minimum take there are risks associated with failure to achieve the KPI targets. The maximum KPI penalty exposure is expected to be £7.0 million in 2011/12. This comprises £5.7 million against the core contract (5%) and £1.3 million against the additional funding (25%).

The commissioners have agreed that NHS Direct can defer £0.4 million of innovations funding into 2011/12. Additionally it has been agreed that the commissioners will return the £2 million non-recurrent monies being given back by NHS Direct in 2010/11.

The Trust has budgeted for the NHS 111 pilot income as agreed with the SHA in 2010/11 within the core contract and detailed in Table 6-3. No provision has been made for income assumptions beyond these pilots.

Table 6-3 Core income 2010/11 to 2011/12

	Forecast Outturn 2010/11		Budget 2011/12	
	£m	Activity (m)	£m	Activity (m)
Baseline	115.2	4.8	113.8	4.7
Additional Capacity*	–	–	5.0	–
111 Pilots	2.8	0.1	1.8	0.1
Innovations	1.1	–	0.4	–
Non-recurrent support	0.7	–	2.0	–
Total	**119.9**	**–**	**123.0**	**4.8**

*Awaiting confirmation

Other service lines

The Appointments Line continues to see a reduction in overall volumes from 3.7 million in 2010/11 to 3.4 million in 2011/12 with a consequential reduction in income from £7.4 million to £6.8 million.

Other locally commissioned service income is forecast to fall to £11.3 million in 2011/12 from the £14.7 million received in 2010/11. The biggest elements in this reduction are out of hours and dental with falls of £1.2 million and £1.0 million respectively. Table 6-4 contains a breakdown.

Table 6-4 Locally commissioned service income 2010/11 to 2011/12

	Forecast Outturn 2010/11 £m	Budget 2011/12 £m	Increase/ (Decrease) £m
Dental	2.0	1.0	(1.0)
Out of hours (OOH)	2.3	1.1	(1.2)
Long-Term Conditions (LTC)	3.9	3.3	(0.5)
Single Point of Access	5.6	5.5	(0.1)
Other	0.8	0.3	(0.5)
Total	**14.6**	**11.3**	**(3.3)**

Expenditure

The financial plan provides for total operating costs of £140.1 million. This compares to a forecast 2010/11 outturn of £142 million, the main reasons for the variance being:

- front line staff - net reduction in budget from forecast outturn 2010/11 of £2.2 million. The front line staff budget has been reduced by £7.9 million for the full year effect of savings from the strategic development programme change projects, offset by additional budget provision of £1 million for pay award and incremental drift. In addition, the 2011/12 budget includes £5 million for the additional funding available to meet targets at peak periods. As previously noted this is subject to final agreement with the SHA.

- other divisional and directorate costs – the 2011/12 budget has been uplifted for pay and non-pay inflation and the full year impact of the implementation of health and symptom checkers.

- strategic developments fund - the expenditure plan includes £3 million of funding to support the development of NHS 111, long-term conditions services and our NHS Foundation Trust application.

- a discretionary fund of £1 million has been set aside within the plan for business cases.

- a £2 million contingency reserve is included within the plan.

- capital charges for 2011/12 are £1 million higher than forecast outturn for 2010/11, reflecting the additional cost of the capital programme.

The 2011/12 total operating costs of £140.1 million include a target reduction of £5.4 million for reduced core contract call volumes and loss of locally commissioned services income. A detailed plan of how this £5.4 million is to be achieved is still to be finalised, however an initial review of the costs associated with the loss of income indicates that between £2 million and £4 million will need to be identified from front line staffing, with the remainder to be identified from other support costs and overheads. In 2011/12 there is a gross pay budget of £92.6 million.

Recurrent run rate

The planned recurrent run rate for income is £141.7 million, which is all income excluding the National Pandemic Flu Service and innovations and non recurrent SHA funding of £2 million. At this stage the NHS 111 running costs funding has been treated as recurrent in both income and expenditure on the assumption that the pilots will continue.

The planned recurrent run rate for expenditure is £138.4 million. This excludes the National Pandemic Flu Service, the innovation expenditure and identified strategic investment funds.

The monthly run rate plan will be based on agreement of expenditure and income profiles with budget holders.

Table 6-5 Recurrent run rate compared with total budget

	2010/11 Total Budget £m	2011/12 Recurrent Budget £m
Income	146.7	139.7
Expenditure	146.4	138.4
Surplus	**0.3**	**1.3**

Cost improvement programme

The cost improvement programme for 2011/12 totals £14.6 million. It includes £7.9 million for the full year effect of strategic development programme schemes implemented during 2010/11, £1.3 million of further efficiencies identified by budget holders to offset cost pressures and a £5.4 million cost reduction target to match reduced call activity and the loss of locally commissioned contracts. Appendix 5 provides further details.

Service lines

In 2011/12, there will continue to be a focus on the financial performance of the NHS Direct service lines. Further developments include introducing three new service lines (for innovations, online health and symptom checkers, new NHS 111 contracts and contract level information to underpin the locally commissioned services.

Management costs

During 2010/11, our targeted 30% reduction in management and overhead costs was monitored each month based on the planned income for 2010/11. Performance will continue to be tracked on an equivalent basis throughout 2011/12.

Cash

The cash balance is expected to reduce by £10 million over the financial year primarily through:

- the capital expenditure programme exceeding depreciation in the year (£3 million)
- repayment instalments due on the long-term financing arrangements for the licensed content
- online health and symptom checkers capital expenditure in 2010/11 (£2 million) release of deferred income in relation to innovation and NHS 111 funding (£4 million).

Capital investment programme

The capital investment programme for 2011/12 is £9.2 million. The key components of the programme are:

- £3 million of pre-commitments for schemes started or approved in 2010/11
- £3.5 million for the telephony refresh project
- £0.4 million earmarked for NHS 111 initiatives
- £0.2 million for long-term care initiatives
- £2.1 million for other service developments.

Some outline business cases have been prepared and are awaiting fi nal approval as part of the Trust business plan. Further detail is provided in Appendix 4.

Financial performance rating

We will continue to assess our performance against the Department of Health performance criteria for non NHS Foundation Trusts. An assessment of the plans and performance will also be undertaken using Monitor metrics for internal review.

Financial risks

A number of risks to delivering 2011/12 activity within the plan have been identified along with the opportunities which exist to mitigate these risks. A summary of the risks and opportunities is detailed in Table 6-6 below.

Table 6-6 Financial risk and mitigation

	Potential Impact 2011/12 £m
Capacity Plan	3.0
KPI Penalties	1.4
Set-up Costs	1.3
Other Efficiences	1.4
LCS Income	0.3
Fluline	0.1
Total Risks	**7.5**
Qipp	(1.2)
Other Income Streams	TBD
Further Cost Efficiency	TBD
Application of Contingency	(2.0)
Total Mitigation and Opportunity	**(3.2)**
Net Risk	**4.3**

Conclusion

2011/12 will clearly be a financially challenging year. This includes:

- the need to extract the costs associated with activity reductions and lost contracts
- a more challenging KPI regime
- successful delivery of strategic development programme schemes
- satisfying the conditions for the additional peak period support funding
- internal generation of funding for the significant organisational change programme.

Despite these challenges, we aim to achieve another successful year of close and effective financial management.

The following financial reports can be found in the appendices

1: Income and Expenditure statement

2: Balance sheet

3: Cash flow statement

4: Capital investment programme

5: Cost improvement programme

6: Risks and opportunities

Section 7: Risk

This five year business plan will see a number of changes to NHS Direct and to the wider NHS environment within which it operates. The most significant will see NHS Direct converting from being a monopoly provider, via one commissioner and one contract, of the 0845 4647 service generating over 80% of its total income, to a position where it will be one of a number of providers competing to provide the new NHS 111 service, procured and contracted by a number of local commissioners.

We will need to implement a comprehensive and focused engagement programme across a wide group of commissioners, many of whom we will not have engaged with previously, in order to understand and respond to their requirements and to enhance their recognition of the role that remotely-delivered services can play in meeting patient and health economy needs. This will include not just those with responsibility for the NHS 111 service within their locality but those who may be interested in services to support patients with long-term conditions, and other services to support patient choice.

The NHS 111 service specification will require a different operational delivery model to that currently in place for providing 0845 4647, and we will need to move to this new model whilst continuing to deliver the 0845 4647 service, meeting its safety and quality requirements, and whilst developing and rolling out our service offers in long-term conditions and patient choice.

These are all significant challenges that will require a strong performance management culture and effective programme management skills. There are a number of strategic risks that we will need to manage.

Underpinning these strategic risks will be a comprehensive regime identifying the key risks for service developments and operational delivery, their mitigations, and the process for monitoring and managing them successfully.

Key risks and mitigations

Key risk	Mitigation
Failure to determine and manage the scale of change required to convert effectively from 0845 4647 to the new delivery model	Establishment of an operational delivery programme board to oversee the conversion
Failure to maintain delivery of 0845 4647 whilst developing the NHS 111 offer	Continued use of robust and proactive performance management processes, to secure effective management across all existing and new contracts and services.
Failure to manage stakeholder relations in order to understand market demands and to win sufficient business in a multi-commissioner/multi contract commercial environment	Development of an enhanced customer engagement and service development function with the appropriate capacity and capability
Failure of the long-term conditions market to grow as quickly as anticipated	Proportionate investment in service development based on proactive market intelligence; and development of a strong evidence base on return on investment

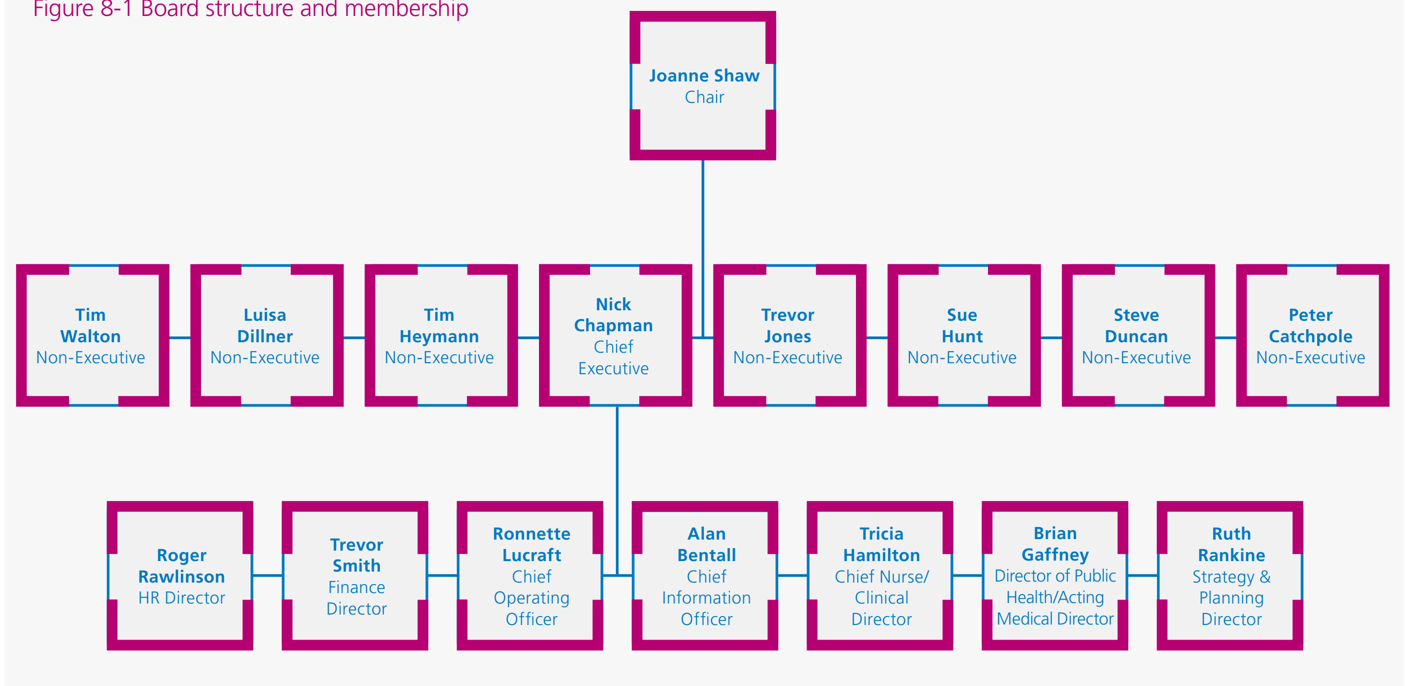
Section 8: Leadership and workforce

Overview

Our approach to leadership, our workforce strategy and our learning and development strategy have been developed in consultation with a wide range of NHS Direct colleagues, members and stakeholders. They are in line with the corporate vision and our development plans set out previously and draw on the results of the 2010 staff survey. They have been discussed with the National Joint Partnership Forum and agreed with the NHS Direct Board.

Management and clinical standards and behaviour in NHS Direct are informed by the NHS Code of Conduct, the Care Quality Commission and Monitor. We also benchmark ourselves through the Contact Centre Association, whose Global Standard Accreditation we achieved in 2009 and retained in 2010.

Figure 8-1 Board structure and membership



The Trust Board

The Trust Board oversees the activity and approves the key decisions of the Trust, through formal monthly board meetings held in public and streamed online, and through chairing and membership of the formal Board sub-committees. The Board includes an executive medical director and two experienced medical practitioners as non-executives along with senior experts from the NHS, medical, technology, finance, not-for-profit, business and local government backgrounds.

Our strong and stable executive team includes an executive medical director, in addition to the clinical director whose background reflects the significance of nursing skills to our business. Together the Board is able to bring to the leadership of the Trust exceptional breadth and depth of experience across both the public, not-for-profit and private sectors.

The Board is committed to transparency and accountability to its stakeholders. Recognising that it is a national, multi-channel organisation, papers for monthly public board meetings are published online and meetings themselves are streamed live on the web and posted on YouTube. We believe that we are the only NHS organisation to do this. The Board also communicates with stakeholders via Twitter, where we have over 8,000 followers. The Board meets for a board development event every six months, and holds single subject workshops and seminars every month to look in detail at important topics such as risk management and staff survey results.

Patient safety and experience form a key part of every board agenda. Patient consent is sought for board discussion of a selection of live calls to and from our service. The call recordings are securely

distributed to board members in advance of each meeting and discussion of patient experience, quality and safety issues arising from the recordings is led by the Clinical Director. Calls are selected according to a pre-agreed programme of topics covering all our services and including critical incidents.

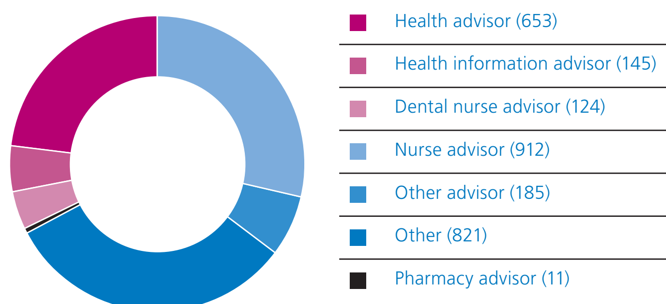
Executive and non-executive board members visit contact centres regularly to experience the service first hand and to speak to front line, supervisory and support staff. Feedback from visits is discussed at board meetings so that decisions are informed by robust understanding of staff views and the reality of the service on the ground.

The Board reviews its own performance regularly. Each board meeting ends with structured feedback on the meeting from a nominated board member or observer.

The Board programme for 2011/12 will include an assessment of board capability to lead an NHS Foundation Trust, a specific development plan, and close scrutiny of our plans to become an NHS 111 provider.

NHS Direct employs 2,851 substantive employees (2,130 whole time equivalents) of whom 40% are registered with the Nursing and Midwifery Council (NMC), and 124 are registered with the General Dental Council (GDC). 5 employees are registered with the General Medical Council (GMC) and 11 are pharmacy advisors. Staff are predominantly nurse advisors, dental nurse advisors, health advisors and health information advisors, all of whom are skilled in the specialist area of remote clinical assessment (see Figure 8-2). The overall gender split is 83% female - 17% male. 59% of staff are part-time and 93% of these part-time staff are female. 59% of NHS Direct staff are aged 41 or over and the ethnic mix broadly reflects the communities where we are based.

Figure 8-2 Staffing by headcount



The high proportion of part-time staff means that we can schedule more people to meet peaks of high demand, can provide flexibility for staff and can employ a broader demographic range of staff. On the other hand, the high proportion of women in front line posts, many of whom are statistically more likely to have caring responsibilities, gives the organisation challenges in staffing a 24/7 365 day a year contact centre service. 98% of the substantive staff in the Trust are contracted under the NHS Terms and Conditions of Service.

Staff survey 2010

NHS Direct participated in the NHS Staff Survey for the first time in 2010. Over half of our employees (56%) took part in the survey, and 58% were clinically qualified. A large majority responded that their role makes a difference to patients, and they are well trained and competent in their roles. However, they do not feel involved in important decisions in the Trust, nor well supported by colleagues, and feel they have a more stressful working life than equivalent NHS roles elsewhere. The workforce strategy incorporates our action plan to address issues raised in the survey.

HR function

The HR function in NHS Direct was restructured in 2010. Business partners work as part of divisional management teams, supported by an HR service centre which manages external contracts, ensures high quality HR and payroll services, and provides specialists in employee relations, workforce planning, workforce information and policy development.

Union recognition

NHS Direct has a formal trade union recognition agreement in place with UNITE, UNISON and the Royal College of Nursing, and effective partnership arrangements in place for information, consultation and negotiations with staff side representatives. Each division has a Joint Partnership Forum, which sends a representative to the monthly National Joint Partnership Forum. There is excellent engagement from the designated full-time officers from UNISON and the Royal College of Nursing, who have been closely involved in helping to shape the reconfigurations that NHS Direct has undertaken in the last year.

Workforce strategy

The principal objectives of the 2011/12 workforce strategy are to:

- develop an appropriate organisation for the NHS 111 service, reducing overheads through efficiencies where possible
- develop our capacity and capability to compete for, win and successfully operationalise contracts, including managing TUPE implications

- develop our market and service capability, knowledge and experience
- continue to develop the practical manifestation of "Our Values"
- be a great place to work and an employer of choice by developing effective approaches to communication and involvement, health and well being, reward and recognition, and employee-led efficiencies
- improve staff time with patients, manage team performance and reduce high rates of sickness absence across the organisation
- develop robust and equitable workforce planning and rostering systems, which support the efficiency of the organisation and the front line
- ensure that NHS Direct is well prepared for the challenges of NHS Foundation Trust status through developing the appropriate capability and capacity of its key employees.

Our values

We developed our values through extended consultation with our staff and stakeholders. We will continue to implement them through a multi-disciplinary group of values ambassadors who will develop the practices and processes, including a "Values Toolkit" for line managers, to ensure our values are part of our behaviours, recruitment, induction and review processes.

Internal communications

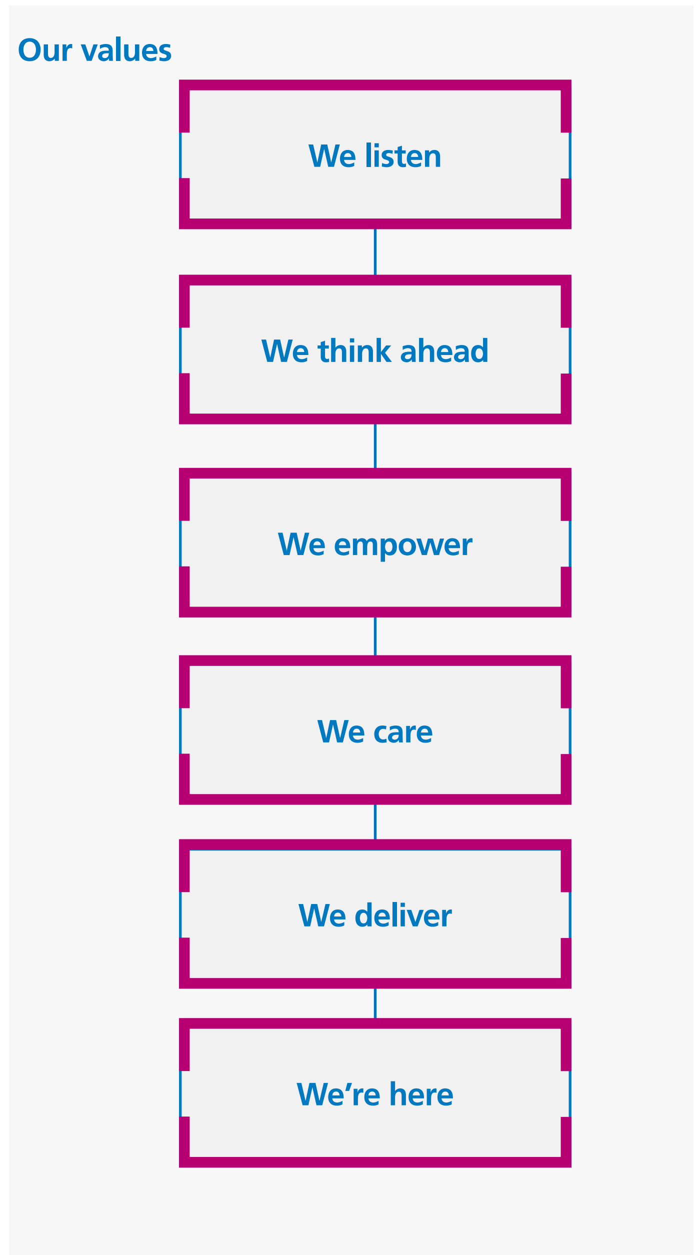
The continuing development of new, practical channels for communicating with our colleagues is central to the effective running of our business. We will work to improve employee engagement and involvement, and to provide an enhanced structure conducive to first rate line-management communication. Our intranet will be developed further to support cross-function and multi-location working and we will be providing enhanced areas to promote interaction within our staff community.

Equality and diversity

Our equality and diversity strategy has been ratified by the National Joint Partnership Forum and the executive management board. All staff are trained on equality and diversity as part of their induction. A single equality scheme will be in place by the end of 2011/12. Equality impact assessments will be embedded in internally and externally facing operations.

Learning and development strategy

Continued skills development of front line staff is important for achieving high standards of patient care. Effective leadership and management are necessary to operate an NHS Foundation Trust in a competitive market environment as NHS 111 is introduced.



Front line skills development

As a patient centred, clinical service, we will ensure that all front line staff have the knowledge and skills to provide patient care, information and advice that is safe, up to date and in accordance with best practice. All clinical staff will maintain a professional development portfolio to ensure that clinical education is focused on clinical governance and effectiveness is linked to our business objectives.

We will develop a presence on national NHS education bodies, links into the National Institute of Innovation and Improvement, and moves to influence nurse education bodies to include "telehealth" in pre- and post registration education.

We will provide a comprehensive corporate induction programme and ensure all our staff comply with statutory and mandatory training requirements.

Having nurse advisors at band 5 and assistant practitioners at band 4 means we can provide a genuine career ladder for front line staff in NHS Direct, which we will continue to develop.

Management and board development

We will hold six monthly board development events, focusing on preparation for NHS Foundation Trust status and conversion to an NHS 111 provider.

We will continue to run the Senior Leadership Programme to prepare senior managers in NHS Direct for leadership roles in a future commercial environment and the Competent Manager Programme for first line managers, focusing on getting the best out of teams through good performance management.

Using the Knowledge and Skills Framework (KSF), the NHS Leadership Qualities Framework and the Skills for Health Leadership National Occupational Standards, the organisation will develop a programme that supports aspiring managers, front line managers, middle managers and aspiring executives. Every member of our staff takes part in an annual performance review, linked to the annual business planning cycle. As part of the performance review process, line-managers and their staff develop and agree team and individual objectives, including personal development objectives, based on the organisation's strategic objectives, and review previous performance.

Section 9: Governance arrangements

Corporate governance and management

The NHS Direct Board oversees NHS Direct's performance, strategy, governance and compliance and stakeholder engagement. It takes an active role in reviewing user experience, listening to patient calls and visiting contact centres to meet with front line staff.

The Board has six sub-committees: the audit committee, finance committee, remuneration committee, clinical governance committee and innovation committee as well as the executive management board.

Clinical governance

Our clinical governance procedures help us to ensure we deliver a high quality, safe, and effective service to our patients. We are assessed on these every year by the Care Quality Commission and have consistently been rated as excellent.

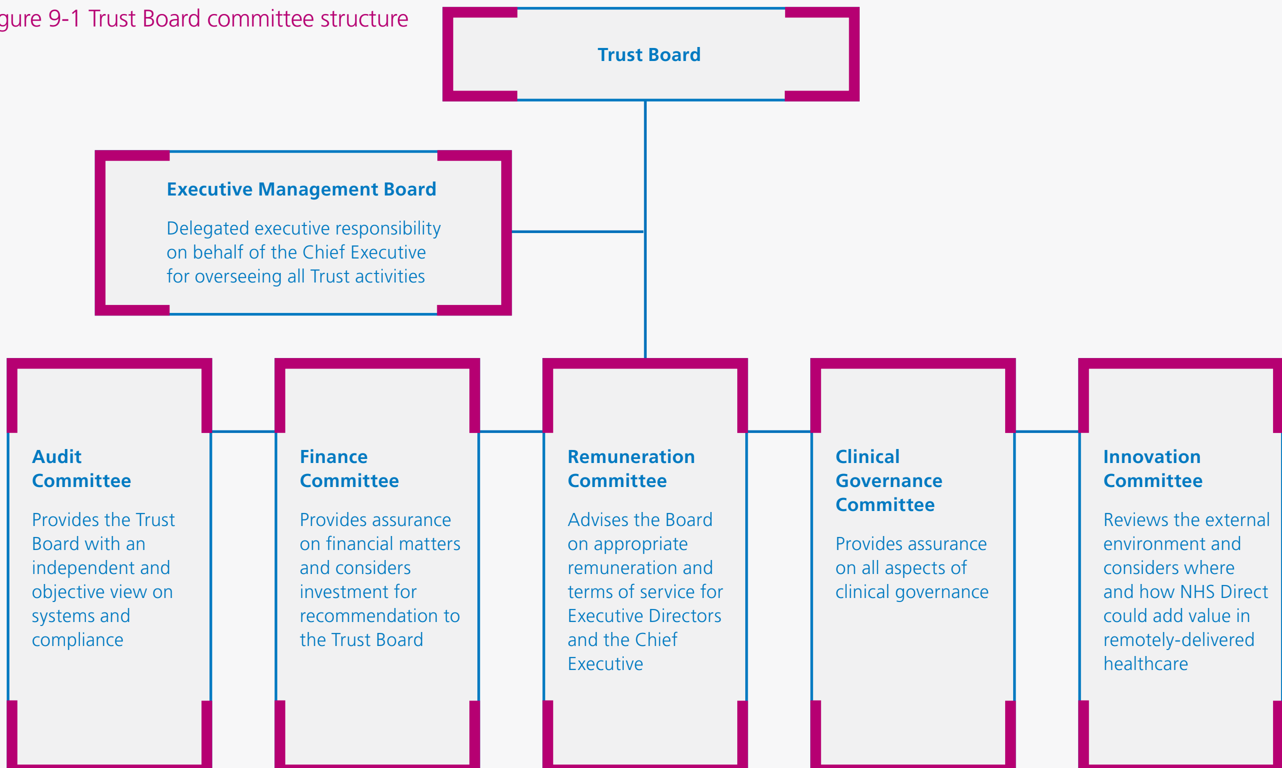
We have robust policies and procedures which are overseen by the Board through the clinical governance committee. All staff are trained in and use the principles of clinical governance. As part of clinical audit, any member of staff can confidentially raise a concern that will be considered by an independent governance team for national review. All learning from reviews and audits of our work and from feedback from patients and stakeholders is fed back to individuals where required. Learning is also shared with all staff and relevant amendments are made to procedures, systems and training materials.

Information governance

Information governance is managed by the senior information risk owner (SIRO) who is appointed by the Trust Board with overall responsibility for the implementation of information risk management. The SIRO chairs the information governance steering group (IGSG) which has representatives from each directorate and provides strategic direction on information governance to the executive management board, audit committee and 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 IGSG also oversees the management and reporting against the standards of the NHS information governance toolkit and ensures the terms and conditions of the information governance assurance statement are upheld. The toolkit draws together the legal rules and central Department of Health guidance on information governance

Figure 9-1 Trust Board committee structure



as a set of requirements. NHS Direct submits an annual self-assessment return of our compliance with these requirements.

Risk management

Risk management is an integral part of day-to-day management and quality improvement at all levels within the Trust. The Trust Board and the Chief Executive are ultimately responsible for risk, with the audit committee responsible for assurance that the systems and mechanisms in place are working to support the effective management of risk. The Board regularly reviews the board assurance framework which is the mechanism by which the achievement of organisational objectives is considered against the key risks facing the organisation. It also considers the controls and assurance against the risk. These risks are managed and monitored through risk registers.

Each directorate has a risk register and risks are escalated to the corporate risk register depending on the risk score, which is devised taking in to account the likelihood and impact of the risk materialising. Risks are also considered and evaluated across directorates to identify whether the impact of the risk might affect a number of directorates (compounded risks). The process is managed by the risk and emergency planning manager, supported organisationally through the risk management forum, where cross-functional risks are discussed and consistency checked. Quality assurance of reporting processes are also considered.

Finance controls and reporting

The finance committee provides additional assurance to the Board but does not replace or remove the requirement for the Board to monitor financial performance. Specific areas that the finance committee covers are:

- financial planning
- financial performance, to ensure the Board receives best practice financial management and reporting.
- financial reporting
- promotion of financial awareness amongst all staff especially management and budget holders
- business case assessment and scrutiny (including post project review and monitoring)
- commercial approach to contract pricing, delivery and performance including assessment of financial results through service line reporting
- investment and disinvestment, tracking progress against, and supporting the delivery of, efficiency and cost reduction programmes.

A monthly financial report and commentary is presented at the Trust Board and the finance committee. It covers all the key financial targets and indicators, including income and expenditure position, savings, capital, cash, activity, key assumptions and forecasts. Monthly management accounts are provided to all budget holders.

Audit arrangements

The audit committee reviews the adequacy of the underlying assurance processes which indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks. The internal audit plan, carried out by our internal auditors, enables the Board to be assured that key internal controls and other matters relating to risk are regularly reviewed. The committee receives internal and external audit reports and progress reports on risk-related issues, while also providing to the Board an overview of the effectiveness of the assurance arrangements based on the work of the clinical governance committee.

Performance management framework

The Board takes overall responsibility for performance management, and to enable this it reviews a board scorecard on a monthly basis. The executive management board has a separate, more detailed scorecard, which is also regularly scrutinised.

Performance management is in place throughout the organisation, with balanced scorecards in place at an individual and team level within operations. The balanced scorecard brings together a range of activity and quality measures which are used by performance managers to drive improvement.

Objectives and KPIs for 2011/12

The board scorecard monitors performance against objectives for our existing services. Further work will continue on developing objectives and measures for new service developments, as a clearer picture emerges of our potential activity in these service areas. The central programme team will monitor progress in implementing the organisational development programme. For 2011/12, the board scorecard will include the following measures:

Figure 9-2 Performance scorecard for 2011/12

Area	Sub-area	Key performance indicator (KPI)	Target
Quality and productivity	Patient	Patient satisfaction	≥90%
	Quality and safety	Number of complaints	1 per 10,000 calls
		Actions arising from complaints implemented to deadlines	≥95%
		Expert call review scoring good/excellent	≥80%
		% of incidents reported to National Review that have given rise to harm	≤10%
	Access	Time to answer - within 60 seconds	≥95%
		Abandonment rate	≤5%
		Time to clinical assessment urgent calls - within 20 minutes	≥95%
		Time to clinical assessment less urgent - within 60 minutes	≥95%
		Time to clinical assessment non-urgent calls - within 120 minutes	≥95%
	Productivity	Time with patients	≥50%
		Waiting for call time	≤15%
Value to patients and NHS	Total volumes	Number of uses of online health and symptom checkers	7.3 million contacts
		0845 4647, NHS 111 and urgent care services	5.5 million calls answered
		Long-term conditions	152,000 patients
		Patient choice	3.4 million calls answered*
	Outcome of 0845 4647 service	% telephone contacts not requiring onward referral	≥50%
		% urgent and emergency onward referrals	≤25%
Great place to work	Sickness	Total sickness	10 days per WTE per year
		Number of people on long-term sick leave	≤40 people by 31st March 2012
	Recruitment & retention	Proportion of staff recruited who complete a year	≥85%
		Staff engagement (quarterly surveys)	TBC
Corporate effectiveness & efficiency	Finance	Recurring financial balance (monthly run-rate)	10%
		Department of Health financial health index	2.5

*The Appointments Line call volume

Information systems

The information technology infrastructure is designed to have multiple levels of resilience and to be secure. The core service application (InteflеCS) is delivered from a primary data centre but can be switched to a secondary data centre to fulfil disaster recovery requirements. The N3 wide area network connects the NHS Direct sites and data centres.

The system is intuitive and easy to operate, prompting staff and allowing data entry while talking to the patient. All direct input has an inbuilt audit trail as part of our data audit process.

In the redesign of care services, with patients and service users as active participants in their care, the information systems should provide the supporting infrastructure rather than be an end in themselves. This business plan, the NHS information strategy and the government's information, communications and technology strategy will be key inputs into the development of our own information and technology strategies during 2011/12.

During 2011/12 the focus of our information technology development programme will be on developing interconnectivity between systems, in particular connecting with: ambulance service systems for despatching ambulances; the Personal Demographic Service to accurately identify service users; and other providers of NHS 111 Services. We will also improve links between our telephony system and clinical application to improve efficiency and streamline our processes.

Section 10: Appendices

Appendix 1: Income and expenditure 45

Appendix 2: Balance sheet 46

Appendix 3: Cash flow 47

Appendix 4: Capital investment programme 48

Appendix 5: Cost improvement programme 49

Appendix 6: Risks and opportunities 50

Appendix 1: Income & expenditure

	Approved Budget 2010/11 £m	Forecast Outturn 2010/11 £m	Base Budget 2011/12 £m
Core Income	125.5	119.9	123.0
The Appointment Line Income	8.1	7.4	6.8
Locally Commissioned Services Income	17.8	14.7	11.3
Fluline	6.6	4.8	4.8
Other Income	1.6	1.0	0.8
Total Income	**159.6**	**147.8**	**146.7**
Service Delivery Staff	72.0	71.6	69.4
Other Divisional Costs	16.6	15.6	16.7
Directorate Costs	45.8	43.6	46.3
Efficiency Target for Call Volume Reduction	0.0	0.0	(5.4)
Fluline	6.6	4.8	4.8
Strategic Development Funds	3.1	3.1	3.0
Innovation and 111 Set Up	2.2	2.3	0.4
Discretionary Business Case Fund	0.0	0.0	1.0
Allocated Reserves	2.6	1.0	1.9
Contingency	5.1	0.0	2.0
Total Operating Costs	**154.0**	**142.0**	**140.1**
EBITDA	**5.6**	**5.8**	**6.6**
Depreciation	5.0	4.6	5.7
Net Interest	(0.1)	0.0	(0.1)
Dividend	0.5	0.7	0.7
SURPLUS / (DEFICIT)	**0.2**	**0.5**	**0.3**

EBITDA: Earnings Before Interest Tax Deprecation and Amortisation
Budget and Forecast 2010/11 as per 28 February 2011

Appendix 2: Balance sheet

	Forecast March 2011 £m	Base Budget March 2012 £m
NON CURRENT ASSETS		
Property Plant and Equipment	13	15
Intangible Assets	22	23
Other Assets	0	0
Total Non Current Assets	**35**	**39**
CURRENT ASSETS		
Trade and Other Receivables	5	3
Other Current Assets	3	2
Cash and Cash Equivalents	20	10
Total Current Assets	**27**	**15**
TOTAL ASSETS	**63**	**54**
CURRENT LIABILITIES		
Trade and Other Payables	8	7
Borrowings	0	0
Other Financial Liabilities	13	9
Provisions	2	0
Other Liabilities	0	0
Net Current Assets/(Liabilities)	**4**	**(1)**
Total Assets less Current Liabilities	**40**	**38**
NON CURRENT LIABILITIES		
Trade and Other Payables	6	5
Borrowings	0	0
Provisions	1	1
Other Liabilities	0	0
Total Assets Employed	**32**	**33**
Financed by:		
Public Dividend Capital	25	25
Revaluation Reserve	0	0
Income and Expenditure Reserve	7	8
TOTAL TAXPAYERS EQUITY	**32**	**33**

Forecast 2010/11 based on position at 28 February 2011

Appendix 3: Cashflow

	Forecast March 2011 £m	Base Budget March 2012 £m
Operating Surplus / (Deficit) excl interest	1	1
Depreciation and Amortisation	4	6
Impairments and Reversals	1	0
Interest Paid	0	0
Dividend Paid	(1)	(1)
(Increase) / Decrease in Trade and Other Receivables	11	2
Increase / (Decrease) in Trade and Other Payables	5	(5)
Increase / (Decrease) in Provisions	0	(2)
Net Cash Inflow / (Outflow) from Operating Activities	**21**	**1**
Interest Received	0	0
(Payments) for Property, Plant and Equipment	(1)	(5)
Proceeds from Disposal of Propery, Plant and Equipment	0	0
(Payments) for Intangible Assets	(23)	(4)
Proceeds from Disposal of Intangible Assets	0	0
Net Cash Inflow / (Outflow) from Investing Activities	**(24)**	**(9)**
Net Cash Inflow / (Outflow) before Financing	**(3)**	**(8)**
Public Dividend Capital Received	0	0
Public Dividend Capital Repaid	0	0
Other Loans Received	0	0
Other Loans Repaid	0	0
Other Capital Receipts	0	0
Capital Expenditure Financing	9	(2)
Cash Transferred (to) / from Other NHS Bodies	0	0
Net Cash Inflow / (Outflow) from Financing Activities	**9**	**(2)**
Net Increase / (Decrease) in Cash and Equivalents	**5**	**(10)**
CASH / EQUIVALENTS / (BANK OVERDRAFTS) AT START OF FINANCIAL YEAR	**14**	**20**
CASH / EQUIVALENTS / (BANK OVERDRAFTS) AT END OF FINANCIAL YEAR	**20**	**10**

Appendix 4: Capital investment programme

	Budget Plan 2011/12 £m
Pre-Commitments from 2010/11 Capital Programme	
111 development costs phase 2 and 3	0.5
Video conferencing facilities extension	0.3
Executive Information System (Data Warehouse)	0.6
Health Information Directory	1.4
ESR/CCC Integration project	0.2
Sub Total Pre-Commitments	**3.0**
New schemes for 2011/12	
Telephony Refresh	3.5
111 Initiatives	
CSPT/teleguide for 111	
CTI for 111	
111 online	
Sub total 111 Initiatives	**0.4**
LTC Initiatives	
-Strategic Platform for Long Term Conditions management	
Sub Total LTC Initiatives	**0.2**
Service Developments	
Great Place to Work	
People Management toolkit	
Homeworking	
Disaster Recovery for CAS	
Lexicon Replacement project	
Real Time Reporting	
UAT tools	
Online membership and patient engagement service	
Online webchat and video chat re-procurement	
Sub Total Service Developments	**2.1**
TOTAL	**9.2**

Appendix 5: Cost improvement programme

	Savings 2011/12 £m
Full Year Effect of 2010/11 SDP schemes	
DT2a Rostering Revolution	1.2
DT2b Ops Restructure - Management	0.3
DT2b Ops Restructure - First Line Managers	3.9
DT3 Team Performance and Capability	1.2
DT5a Band 5 Nurses	1.3
Sub total FYE of SDP schemes	**7.9**
Additional CIP targets for 2011/12	
Directorates - savings identified	0.9
Operations - savings identified	0.4
Efficiencies to match call volume reductions to be identified	5.4
Sub-total CIP targets 2011/12	**6.7**
TOTAL	**14.6**

Appendix 6: Risks and opportunities

	£m	%	Potential 2011/12 £m
RISKS AND UNCERTAINTIES			
Capacity Plan	12.0	25.0	3.0
KPI Penalties	6.9	20.0	1.4
Other Efficiencies	5.4	25.0	1.4
Set up costs for 111 or LTC pilots	5.0	25.0	1.3
Locally Commissioned Services Income	1.0	25.0	0.3
Fluline	0.5	25.0	0.1
Total risks			**7.5**
Opportunities			
QIPP Funds Available			1.2
Other Income streams:			
Locally Commissioned services			TBD
Grants			TBD
Further Cost Efficiency			TBD
TOTAL OPPORTUNITIES			**1.2**
Mitigation			
Application of Risk Reserve			2.0
Total mitigation			**2.0**
Net risks			**4.3**