Department of Health

NHS

Northamptonshire Teaching Primary Care Trust

2012-13 Annual Report and Accounts

Published to gov.uk, in PDF format only.

www.gov.uk/dh

Northamptonshire Teaching Primary Care Trust

2012-13 Annual Report

NHS
Northamptonshire

Annual Report
2012-13

NHS Northamptonshire

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Welcome and Introduction

Welcome to the NHS Northamptonshire Annual Report for 2012/13.

This was a year of transition and change as we continued to prepare for the new commissioning arrangements and other reforms set out in the Health and Social Care Bill which passed into law in March 2012.

We have continued to support the development of our Clinical Commissioning Groups (CCGs), NHS Corby CCG and NHS Nene CCG, as well as the emerging National Commissioning Board. We also worked closely with our local authority in developing the new health and wellbeing board. Our public health team are now based within Northamptonshire County Council, ready for the transfer of functions and responsibilities in April 2013.

NHS Northamptonshire officially closed down on 31 March 2013 and we would particularly like to acknowledge the hard work and dedication of all our staff over the years especially during the transition period where their professionalism has ensured a smooth transfer of responsibility to the new receiver organisations, the CCGs, the National Commissioning Board and the Public Health team now based in Northamptonshire County Council.

We are proud of what NHS Northamptonshire has achieved, and believe we have built a strong legacy for our CCGs to take forward to ensure that the NHS continues to deliver the best healthcare possible for the residents of Northamptonshire.

Annual Report

All NHS organisations are required to publish an annual report and financial statements at the end of each financial year. This report provides an overview of the work of NHS Northamptonshire, the Primary Care Trust (PCT) for the county, between 1 April 2012 and 31 March 2013.

The report is made up of two parts. The first part includes information about the details of our performance as well as commentary on wider events which have shaped our business and priorities. The second part is a summary of the organisation's financial statements for the financial year 2012/13 including the remuneration report and governance statement.

Operating and Financial Review

About NHS Northamptonshire

Our history

NHS Northamptonshire was formed on 1 October 2006 when the three previous Primary Care Trusts (PCTs) merged – Daventry and South Northamptonshire, Northampton Teaching and Northamptonshire Heartlands.

In July 2011, NHS Northamptonshire completed the process of the separation of all its directly provided services from those commissioning functions as set out in the NHS Operating Framework for 2010/11. Through this transfer, NHS Northamptonshire became solely a commissioning organisation which contracts with community providers rather than providing these services directly.

Following the introduction of the government's NHS reforms, NHS Northamptonshire formed a PCT cluster with NHS Milton Keynes in June 2011.

The cluster supported local CCGs across Northamptonshire and Milton Keynes to enable a smooth handover of PCT functions to new commissioning arrangements.

The community we serve

Northamptonshire has a growing and ageing population - currently the resident population is 691,900, which is predicted to increase to 762,300 by 2019. Although the number of people in all age groups is likely to increase, the biggest increase is in the number of people aged 65 and above. It is predicted that almost one in five of Northamptonshire's population will be 65 or over by 2019. Similarly the number of people aged over 85 is expected to increase by around 5,000 in the next ten years.

These changes have predominantly been driven by the increase in life expectancy. In Northamptonshire the average life expectancy for men in the county is 78.3 years, and for women 82.2 years which is similar to the England average. However there are significant differences in life expectancy across the county. There is a difference of 9.1 years for men and 5.5 years for women between areas with the highest and lowest life expectancy.

Whilst more people in Northamptonshire are living longer there is a discrepancy between improvements in total life expectancy and healthy life expectancy. Across the county, disability-free life expectancy can vary from 52.78 to 68.43 years for men and 58.82 to 70.63 years for women.

As a result, people are living longer and they are likely to spend a greater proportion of their life living with disability and long term illness, therefore requiring health and social care support.

Currently approximately 1 in 4 people is aged under 20 in Northamptonshire. Over the next ten years the number of children and young people in the county is estimated to grow by around 18,000, but as a group they will decrease slightly as a proportion of the population. The most significant growth will be in amongst 5 to 9 year olds, a result of the recent increasing trend in fertility rates. In 2009 there were 67.1 live births per thousand women aged 15-44 in Northamptonshire, a peak after many years of decline and a higher rate than the general fertility rate for England. About 1 in 5 of these children were born to mothers who were born outside the United Kingdom.

The ethnic mix of the population is changing, with more ethnic diversity found in the younger age groups. Current estimates suggest that 89% of the under 16 population are white, compared to 92% of the adult population and 97% of the retirement age population.

The transition to local clinically-led commissioning

The government's Health and Social Care Bill includes plans to hand the annual NHS budget of around £80bn directly to family doctors who, it says, are better placed to decide which services are needed for their patients.

By 1 April 2013 all GP practices in England will join with colleagues to become part of a Clinical Commissioning Group (CCG), and the Primary Care Trusts has been abolished.

Northamptonshire has two Clinical Commissioning Groups (CCGs) within the county:

- NHS Nene CCG covers 70 GP practices in the county, and over 350 GPs. The Chair is Dr Darin Seiger.
- NHS Corby CCG includes all five GP practices in Corby covering around 67,000 patients. The Chair is Dr Peter Wilczynski.

The Oundle Surgery and the Wansford & Kings Cliffe practice have joined NHS Cambridgeshire and Peterborough CCG.

In 2011-12 partial commissioning budgets were delegated to the CCGs who have been developing their own governance structure underneath the overarching NHS Northamptonshire and Milton Keynes Board. For 2012-13 full commissioning budgets were devolved to the CCGs.

Authorisation
During 2012/13, both CCGs in Northamptonshire were successfully authorised by the National Commissioning Board to become standalone statutory NHS organisations on 1 April 2013. This means that they are deemed able to handle their local commissioning budgets and make clear decisions about how services will be designed and where they should be delivered.

The authorisation process assessed every CCG against a set of 119 criteria. CCGs had to submit evidence for each area and also host a panel day where questions were asked by an independent team of NHS experts. Although successful in authorisation Nene CCG still have 4 of the 119 criteria outstanding at this point in time but an action plan is in place to clear these outstanding items.

The cluster PCT objectives and strategy
NHS Northamptonshire and NHS Milton Keynes formed a cluster in June 2011, effectively pooling the resources of the two PCTs in order to maintain robust capacity and capability. This clustering arrangement continued in operation until 31 March 2013 when the PCTs were abolished and their responsibilities passed over to the new receiver organisations. Professor John Parkes and Professor William Pope were appointed as Chief Executive and Chair respectively of the cluster on its formation in June 2011 but, on 1 October 2012 Jane Halpin, Local Area Team Director took over as Chief Executive..

During 2012/13, the cluster continued to support the local CCGs in Northamptonshire to enable a smooth handover of PCT functions to the new commissioning arrangements.

The cluster's aims were to ensure:

- Delivery of the strategic plan
- Transformational changes to the local health economy
- Business continuity
- Financial stability

Through the transition, the cluster:

- Managed limited resources and reach financial control
- Provided high quality support to development of GP commissioning arrangements
- Continued to develop and improve healthcare services for the Northamptonshire population
- Jointly established the Health and Wellbeing Board with Northamptonshire County Council
- Worked with partners within and outside the health economy to ensure preparedness for new arrangements

This resulted in a legacy to be proud of and for the new CCGs to inherit and build upon as they strive to become leading CCGs nationally with the aim of delivering high quality healthcare services for the people of Northamptonshire.

QIPP (Quality, Innovation, Productivity and Prevention)
During the year, we have worked with our health and social care partners across Milton Keynes and Northamptonshire to improve quality and productivity across the health and social care system as part of the national QIPP (Quality, Innovation, Productivity and Prevention) programme to reinvest efficiency savings of up to £20 billion nationally in improving services and health outcomes .The aim is to do more with the funding we receive to meet the challenges of a growing and ageing population, rising patient expectations and the extra costs of medical advances and new treatments.

For 2012-13 QIPP plans have been fully developed by the CCGs and they have taken on devolved responsibility for delivering the QIPP programmes. The QIPP target for 2012-13 was set at £33m with additional schemes being developed as 'headroom'. In addition, providers had their own separate CIP (Cost Improvement Plan) to deliver for the year to cover the 4% efficiency reductions to their contract tariffs as required by commissioners with further savings to cover any additional cost pressures that they may face.

Greater East Midlands Commissioning Support Unit (GEM CSU)
During 2012/13, the PCT also supported the creation of the local office of the Greater East Midlands Commissioning Support Unit.

Commissioning Support Units have been created as the most efficient and cost-effective way of providing excellent 'at scale' commissioning support activities. This allows Clinical Commissioning Groups (CCGs) to maximise their investment in frontline healthcare services and to improve health outcomes.

GEM CSU is one of the biggest Commissioning Support Units in the country, serving 20 CCGs, with a population of around 5 million.

Healthier Together
NHS Northamptonshire has been a fully involved partner in 'Healthier Together', a commissioner-led review of local health services across the South East Midlands region, covering Bedfordshire, Luton, Milton Keynes and Northamptonshire.

In the year since its launch, the Healthier Together programme has carried out invaluable work;

- More than 200 clinicians have collaborated in six clinical working groups
- Through communications and engagement activities, Healthier Together has come into direct contact with more than 12,000 local patients and residents and indirect contact with many tens of thousands more.

The programme now has an extensive bank of clinical evidence and local knowledge about how to meet the health challenges of the present and future.

This current phase is now complete and the work of the Clinical Senate and the six clinical working groups has concluded with the publication of their reports.

From April 2013, the next phase of the programme will be taken forward more locally in the north and south of the region, with Clinical Commissioning Groups and hospitals working together to find the right solutions for their local populations. These will be based on the principles established by Healthier Together, including the commitment to providing more care closer to home.

This will enable each area to move at a pace that reflects their own local issues, including closer working partnerships between the hospitals in Northamptonshire and also between Milton Keynes Hospital and Bedford Hospital.

The challenges that face our healthcare system remain:

- The population is increasing and people are living longer.
- There are significant shortages of skilled and experienced clinicians in several key disciplines – including A&E and maternity services.
- The NHS – in common with all UK public services – is under financial constraint.

That is why all the partner organisations remain committed to continuing the work of Healthier Together.

Health and Wellbeing Board
The Health and Wellbeing Board in Northamptonshire will act as an advisory body to the Council's Cabinet, NHS Commissioning Board and Clinical Commissioning Groups in the context of relevant sections of the Health and Social Care Act.

The Shadow Health and Wellbeing Board continued to act as a Shadow until the formal constitution of the Health and Wellbeing Board in April 2013.

The Health and Wellbeing Board has the responsibility to ensure that the commissioning plans of CCGs, social care and public health reflect the priorities, objectives and actions set out in its Health and Wellbeing Strategy, promoting joint commissioning wherever it is sensible to do so. The Board can assume the lead role for commissioning specific services where the local authority and CCGs wish to delegate responsibility.

The philosophy for the Northamptonshire Health and Wellbeing Board can be described as "achieving more by doing things differently". For this reason, this strategy depends heavily on working closely and innovatively with employers, individual communities and community organisations, including existing locality health and wellbeing .

The suggested 8 key strategic outcomes are:

1. Every child is safe and has the best start in life
2. People choose healthier lifestyles and exert greater control over their health and wellbeing
3. Vulnerable adults and elderly people are safe and successfully access services and supports that maximise their independence
4. Health inequalities across different communities are reduced through improving the health and wellbeing of communities with the worst health
5. Health, social care and public health services collaborate in all areas and are integrated where people have health and social care needs
6. The numbers of people experiencing emergency, unscheduled care is reduced
7. Social enterprises focussed on improving health and wellbeing operate successfully in communities across Northamptonshire
8. Led by the NHS and local authorities, employers throughout the county promote the health and wellbeing of their employees

A countywide consultation on the Health and Wellbeing Strategy was held in Autumn 2012. Over 380 people or organisations responded to the consultation at events, or to the online survey. Feedback from members of the public will inform and strengthen the strategy.

The Board have made a commitment to bring the leadership, energy and focus necessary to make a positive difference and support the people of Northamptonshire to enjoy the best possible levels of health and wellbeing now and in the future.

Membership

Northamptonshire County Council:

- Portfolio Holders for Adult Social Services and for Children's Services
- Leader of the County Council
- Director for Adult Social Services
- Director for Children's Services
- Director for Public Health

NHS Nene Clinical Commissioning Group: two representatives

Clinical Commissioning Groups: one representative per CCG

HealthWatch (LINk until HealthWatch established): one representative

District and Borough Councils:

- one senior member representing the District and Borough Councils
- a director with responsibility for housing matters to represent housing officers

University of Northampton: one representative

Northamptonshire Police: one representative

Representatives of VCS or other public service officials

Professional and community organisations that can advise on and give a voice to the needs of vulnerable and less heard groups

Performance and quality

Our core purpose was the delivery of improved quality for our patients, by improving safety, effectiveness and patient experience.

The NHS Operating Framework set out the national priorities for 2012/13. In order to improve services for patients four key themes were identified:

- putting patients at the centre of decision making in preparing for an outcomes approach to service delivery, whilst improving dignity and service to patients and meeting essential standards of care;
- completion of the last year of transition to the new system, building the capacity of emerging clinical commissioning groups (CCGs) and supporting the establishment of Health and Wellbeing Boards so that they become key drivers of improvement across the NHS;
- increasing the pace on delivery of the quality, innovation, productivity and prevention (QIPP) challenge; and
- maintaining a strong grip on service and financial performance, including ensuring that the NHS Constitution right to treatment within 18 weeks is met which included maintaining performance on key waiting times, continuing to reduce healthcare associated infections and improving the overall patient experience.

The delivery of national performance standards is fundamental to NHS Northamptonshire's ability to deliver its strategic goals and ensure full implementation of its strategic plan.

Key Department of Health national targets were monitored throughout the year and were reported on at Board meetings through the performance dashboard. Overleaf are the main targets with explanatory commentary.

PERFORMANCE INDICATORS SUMMARY - COMMISSIONER VIEW

Performance Dashboard		Commissioner View	NHS Northamptonshire
National Quality Measures	Area	Indicator	Period
			YTD
	Cancer 2 week waits	Cancer 2WW	95.6%
		Cancer 2WW - Breast Cancer	98.4%
	Mixed Sex Accommodation	Unjustified breaches	7
	Referral to Treatment and diagnostic waits (including incomplete pathways)	Diagnostic Test waiting times - % waiting 6 weeks or more	0.8%
		RTT - admitted % within 18 weeks	95.4%
		RTT - incomplete % within 18 weeks	96.7%
		RTT - non-admitted % within 18 weeks	97.8%
Preventing people from dying prematurely	Ambulance Quality	Cat A response within 8 mins Red 1 - EMAS *	71.7%
		Cat A response within 8 mins Red 2 - EMAS	75.6%
		Cat A response within 19 mins - EMAS	91.9%
	Cancer 31 day, 62 day waits	31 Day Waits	98.0%
		31-day subsequent Surgery waits	98.0%
		31-days Anti-Cancer Drug Regime Waits	99.6%
		31-days Radiotherapy Treatment Course Waits	98.9%
		62-day Cancer Waits	84.9%
		62-days from Screening Service referral	97.3%
		62-days Waits from decision to upgrade	89.2%
Public Health	Tier 1	Quality stroke care (% of people who spend 90% of time on stroke unit)	86.1%
		Quality stroke care (% TIA cases who are scanned and treated within 24hrs)	80.6%
	Tier 2	Smoking quitters (4 weeks)	3,838
	Tier 3	Health checks	4.5%
Treating and caring for people in a safe environment and protect them from avoidable harm	Incidence of C. difficile	CDI	210
	Incidence of MRSA	MRSA	7

MRSA
The number of MRSA infections reported in 2012/13 was 7 and although this was below the planned ceiling of 9 the indicator remains red as it remained above the nationally set target. With a zero tolerance to MRSA in 2013/14, sustained efforts will be required to ensure this is achieved.

Clostridium difficile
The full year ceiling for C.Difficile infections in 2012-13 for Northants was 207, the end of year outturn was 210. This can be broken down as: Northampton General Hospital = 29/36; Kettering General Hospital FT = 41/36; Northamptonshire Healthcare FT (NHFT) = 48/40, the patient cohort for NHFT included all patients that had any contact with any NHFT service in the 6 months prior to the positive result. There were 92 cases from other sources such as Primary Care and other trusts.

Action plans from all main NHS providers have been submitted and are monitored at Trust Infection Prevention Committees. A sub group of the Whole Health Economy Infection Prevention Committee has been established to identify and implement measures to reduce the number of cases and impact of Clostridium difficile infection.

Referral to Treatment 18 week waiting
National maximum waiting time compliance was achieved for 2012/13. 95.4% of admitted patients and 97.8% of non-admitted patients started their treatment within 18 weeks of referral by their GP (against standards of 90% and 95% respectively). 96.7% of patients on incomplete pathways were waiting less than 18 weeks against the standard of 92%.

Continued focus will be required in 2013/14 to ensure that no 52+ week waits occur and that the RTT standards are delivered at speciality level.

Diagnostic waits
Both NGH and KGHFT achieved the standard of no more than 1% of patients waiting longer than 6 weeks for diagnostic tests in 2012/13.

A&E 4 hour wait
The A&E standard continues to be a challenge across the system with NGH and KGHFT both delivering performance of 91.4% against a standard of 95% in 2012/13.

Commissioner actions include:

- Urgent care strategy now developed.
- Improved operational processes to support timely discharges agreed with providers.
- Daily conference calls continue; providing challenge and support as required.
- Provider recovery plans agreed and closely monitored.

Cancer care
Please note due to access issues with the national cancer database it has not been possible to update cancer performance for the commissioner and the figures below are based on provisional provider level performance, which will also require validation.

KGHFT achieved all cancer standards in 2012/13.

In 2012/13 NGH achieved all cancer standards with the exception of the 62 days standard from urgent GP referral with 83.1% against a standard of 85%. Corrective action has been undertaken by the trust and performance will continue to be closely monitored.

Venous Thromboembolism (VTE) risk assessment:
VTE is a condition in which a blood clot forms in a vein and is a significant cause of mortality, long term disability and chronic ill health. All providers of acute services are required to ensure that a VTE risk assessment has been carried out on at least 90% of adult patients on admission to hospital. NGH achieved 91.8% and KGH achieved 93.6%, based on February 2013 data.

Smoking Quitters
The number of smoking quitters remains behind target with 3,838 smoking quitters at the end of quarter 3 against a trajectory of 3,943 (97.3% of plan) although every effort was made in the final quarter to achieve plan.

Health Checks
The health checks programme in Northants ramped up towards the end of 2012-13, but it was not enough to deliver the 2012-13 plan.

A total of 10,142 health checks were offered (25% of plan) and 6,268 delivered (42% of plan).

EMAS
EMAS achieved the 8 minute Cat A Red 2 standard in 2012-13 with performance of 76% performance against a standard of 75%.

However EMAS did not achieve the other 8 minute Cat A Red 1 standard with performance of 72% against the 75% standard. EMAS also did not achieve the 19 minute Cat A standard with performance of 92% against a standard of 95%.

Mental Health
Performance against all national mental health indicators remain on track within Northamptonshire.

NHS Northamptonshire

PERFORMANCE INDICATORS SUMMARY - PROVIDER VIEW

Performance Dashboard		All Northants Providers View	Northampton General Hospital NHS Trust		Kettering General Hospital NHS FT		Northamptonshire Healthcare NHS FT	
Domain	Area	National Quality Measures	Standard / Plan	Period	Standard/ Plan	Period	Standard/ Plan	Period
				YTD		YTD		YTD
Enhancing quality of life for people with long-term conditions	Mental Health Measures	Mental health measures - CR/HT						268
		Mental health measures - CPA					95%	97.3%
		Mental health measures - EI						73
		Mental Health Measures - IAPT						
Ensuring that people have a positive experience of care	A&E Total time	A&E <4hrs	95%	91.4%	95%	91.4%		
	Cancer 2 week waits	Cancer 2WW	93%	96.7%	93%	94.8%		
		Cancer 2WW - Breast Cancer	93%	99.3%	93%	98.4%		
	Mixed Sex Accommodation	Unjustified breaches	0	0	0	0		
	Referral to Treatment and diagnostic waits (including incomplete pathways)	Diagnostic Test waiting times - % waiting 6 weeks or more	1%	0.0%	1%	0.2%		
		RTT - admitted % within 18 weeks	90%	96.2%	90%	94.7%		
		RTT - incomplete % within 18 weeks	92%	96.8%	92%	96.8%		
		RTT - non-admitted % within 18 weeks	95%	98.4%	95%	97.1%		

PERFORMANCE INDICATORS SUMMARY - PROVIDER VIEW continued

Performance Dashboard		All Northants Providers View	Northampton General Hospital NHS Trust		Kettering General Hospital NHS FT		Northamptonshire Healthcare NHS FT	
Domain	Area	National Quality Measures	Standard / Plan	Period	Standard/ Plan	Period	Standard/ Plan	Period
				YTD		YTD		YTD
Preventing people from dying prematurely	Cancer 31 day, 62 day waits	31 Day Waits	96%	98.1%	96%	100.0%		
		31-day subsequent waits Surgery	94%	98.1%	94%	100.0%		
		31-days Anti-Cancer Drug Regime Waits	98%	98.0%	98%	100.0%		
		31-days Radiotherapy Treatment Course Waits	94%	99.0%	94%	100.0%		
		62-day Cancer Waits	85%	84.2%	85%	88.2%		
		62-days from Screening Service referral	90%	97.4%	90%	93.2%		
		62-days upgrade		90.0%	90%	87.2%		
Treating and caring for people in a safe environment and protect them from avoidable harm	Incidence of C. difficile	CDI	3	29	2	34		
	Incidence of MRSA	MRSA	0	2	0	1		
	VTE Assessments	VTE risk assessment	90%	91.8%	90%	92.8%		

			EMAS	
Domain	Area	Local Measures	Standard/Plan	Period
			Target	YTD
Ambulance Service	Ambulance Clinical Quality	CAT A response within 8 minutes - Red 1	75%	70.0%
		CAT A response within 8 minutes - Red 2	75%	74.0%
		CAT A response within 19 minutes	95%	93.6%

PUBLIC HEALTH INDICATORS SUMMARY

Public Health Dashboard — NHS Northamptonshire

Area	Indicator	Standard/Plan	Period
			YTD
Tier 1	Quality stroke care (% of people who spend 90% of time on stroke unit)	82%	86.1%
	Quality stroke care (% TIA cases who are scanned and treated within 24hrs)	80%	80.6%
Tier 2	All age all cause mortality rate per 100,000 population (males)	580.96	638.44
	All age all cause mortality rate per 100,000 population (females)	443.75	456.74
	< 75 CVD Mortality rate per 100,000 population	52.55	55.26
	< 75 Cancer Mortality rate per 100,000 population	96.57	104.49
	Smoking (4 wk quitters)	1331	3293
	Prevalence of Breast Feeding at 6-8 weeks	48.3%	42.2%
	Maternity 12 weeks access	95.4%	87.0%
	Teenage Pregnancy rate per 1000 population	38.83	34.2
	% Children in Reception with height and weight recorded who are obese	9.6%	9.4%
	% Children in Reception with height and weight recorded	91%	95.9%
	% Children in Year 6 with height and weight recorded who are obese	18.2%	17.6%
	% Children in Year 6 with height and weight recorded	88%	93.8%
	Immunisation DTaP/IPV/Hib Aged 1	97.2%	97.0%
	Immunisation PCV Aged 2	97.8%	95.5%
	Immunisation Hib/Men C Aged 2	97.0%	95.5%
	Immunisation MMR Aged 2	95.5%	95.3%
	Immunisation DTaP/IPV Aged 5	92.4%	93.8%
	Immunisation MMR 2nd Dose Aged 5	92.4%	90.7%
Tier 3	NHS Health Check – No. offered	20.0%	4.5%
	Hospital admissions for alcohol related harm per 100,000 population		1596.3

Advice and Information Service

The aim of NHS Milton Keynes and Northamptonshire's Advice and Information Service is to provide a seamless, accessible, flexible approach to capturing and responding to feedback, enquiries, comments, concerns, compliments and complaints from the local population. The service is accessible with a free phone telephone number and one leaflet with a paragraph translated into our top seven languages. We have also provided the information in easy read formats. All the information and feedback we receive helps us to improve NHS Northamptonshire's services.

The number of enquiries received for 2012/13 totalled 1161 mainly relating to GP and dental queries, GP registration, funding, CHC and the Orthotic Service. There were 10 written concerns handled in 2012/13 including provision of nappies for disabled children, the criteria relating to cataract treatment and Continuing Healthcare. In addition, 65 MP enquiries were handled by the team and responded to by the Chief Executive. MP enquiries mainly related to funding issues.

A total of 161 complaints were received in 2012/13. The majority of complaints reported were relating to Primary Care Services, in particular GP and dental practices.

NHS Milton Keynes and Northamptonshire's Complaints Policy and Procedures reflects the Health Service Ombudsman's Principles for Remedy. The Complaints Policy provides consistent arrangements for making complaints across health and social care.

Our workforce

The average number of whole time equivalent staff employed by NHS Northamptonshire in 2012-13 was 349. The table below shows the percentage of days lost through staff sickness in 2012/13.

	NHS Northamptonshire
Wte days lost	**4,340**
Staff sickness absence rate	**6.5%**

Involving staff

NHS Milton Keynes and Northamptonshire began communicating with staff about the transition in May 2012. This was by means of regular HR bulletins and via a dedicated page on the local staff intranet.

In May 2012 staff were communicated with via individual letter advising that they were 'affected by change'. Staff designated 'affected by change' in PCTs received 'restricted' access to vacant positions within the new 'Receiver' organisations.

People Transition arrangements

A consultation was launched in September which ran from 26 September 2012 – 25 October 2012. Staff were given the opportunity to comment on the consultation either through 1:1 conversations with their line managers or via an email inbox.

A number of Consultation Engagement Events took place during the following 30 days as the PCT worked together with the emerging 'Receiver' organisations to build a clearer picture of structures moving forward.

A national job matching exercise took place in line with the National Transition Framework (2011) with Function experts and unions accessing both Department of Health generic job descriptions together with local Role Content Specifications for individuals.

Partnership Forum

The PCT worked collaboratively during this period of change with their partnership unions - Unison, BMP, RCN and MiP. Regular meetings took place with discussions regarding terms and conditions of employment and the staff movements during the People Transition as we moved into the new NHS architecture.

The forum remains a positive step in strengthening the working relationship between management and the unions for the benefit of all staff employed by NHS Milton Keynes and Northamptonshire.

Support for staff

During the People Transition a full programme of outplacement support was offered to all staff regardless of the status of their employment. This included:

- Interview training
- CV building workshop
- Stress relief workshop
- Confidence Building workshop
- Pensions and retirement seminars
- Networking/job search workshop

These sessions were offered during September 2012 to March 2013 and were free of charge for all staff.

Training and Development

A programme of training was provided for staff in line with appraisal responses. These were ad hoc as well as group training. For example:

- Microsoft package training for MS Word/MS Excel and MS Powerpoint at beginners and intermediate levels;
- Telephone Technique training;
- Art of Amazing Service; and

- Minute Taking workshops.

In addition to the above, a programme of Customer Focus training was delivered to a cohort of 24 senior staff.

Mandatory Training
As an organisation we actively promote online mandatory training via the Electronic Staff Record (ESR). All new starters are provided with username and password and are required to complete a suite of training modules including; infection control, information governance, health and safety, diversity and inclusion, manual handling and fire safety. For those staff with direct contact with vulnerable adults or children they are required to complete additional appropriate modules.

In addition to the online method of learning we also offered classroom facilitated training in Information Governance.

Employee Wellbeing - thrive
In addition to the formal training we also continued to provide a more holistic approach to wellbeing of our staff through our health and wellbeing programme, *thrive*. The programme is in its fourth year and has continued to deliver a variety of activities, thus promoting physical, mental and emotional wellbeing.

Apprentices
The organisation has continued to support the Apprenticeship programme for young people (aged 16-24) and have seen a further five apprentices being enrolled onto NVQ level 2 in Business Administration - two into Continuing Healthcare, one each into Estates and Facilities, Nene CCG and Information Management and Technology.

This new cohort of apprentices were regularly supported as they work to achieve their relevant qualifications and gain essential work experience.

Human Resources policies
NHS Milton Keynes and Northamptonshire's Human Resources policies are available on request.

Equality and diversity
NHS Milton Keynes and Northamptonshire is committed to providing equal access to health services for all groups and communities as well as promoting equality, diversity and human rights. We will do this by identifying and overcoming barriers to access and inclusion across the range of health services commissioned.

We will promote and champion a culture of diversity, fairness and equality for all our employees, potential employees, service users, carers and members of the public. We will do this by valuing and celebrating individual difference and acknowledging potential

contribution to the continued development of the organization which will in turn improve the services we commission.

Single Equality Scheme (SES)
NHS Milton Keynes and Northamptonshire have an SES encompassing all six equality strands – race, disability, gender, age, sexual orientation and religion/belief. This scheme covers the whole local health economy of Milton Keynes and Northamptonshire.

Information Governance Serious Untoward Incidents (SUIs)
The PCT adheres to the Department of Health Policy, Checklist for reporting, managing and investigating information governance serious untoward incidents. Gateway ref:13177. There have been no incidents reported in year 2012/13 classified as serious incidents.

Information
As a public service, NHS Northamptonshire complies with the Treasury's guidance on setting charges for information.

Health and safety

A strong safety culture is important in order to protect the wellbeing of our patients and staff. A joint Health and Safety Committee oversees and monitors a full programme of fire, health and safety and security audits and reports on health and safety performance. A key role of the Committee is to ensure that the work of staff is underpinned by appropriate policies and guidelines and that up-to-date information is sent out to staff. Any significant risks are escalated to the Risk Group with a comprehensive action plan to mitigate and manage those risks.

Health and Safety training is mandatory for all staff, covering a range of areas including moving and handling, asbestos awareness, fire and infection control. We employ the services of a local security management specialist to provide advice and support on security and personal safety issues. All staff have access to occupational health and counselling services.

Protecting health through emergency planning
Emergencies take many forms, from severe weather conditions and flooding to transport crashes, local outbreaks of infectious diseases or pandemics. Planning for such incidents forms an important part of the work of NHS Northamptonshire.

Under the Civil Contingencies Act 2004 we are required to:

- Assess the risk of emergencies occurring and use this information to inform planning
- Put into place emergency plans
- Put into place business continuity arrangements
- Make arrangements for information to be made available to the public about civil protection matters, including warning, informing and advising the public in the event of an emergency
- Share information with other local responders
- Co-operate with other local responders to enhance co-ordination and efficiency

- We are also the local lead agency for assessing risks that have a direct impact on the health of the public (e.g. pandemic flu, heatwave and outbreaks of infectious disease).

The Trust has maintained a major incident plan, and lead on the development of a PCT Cluster major incident plan with supporting on-call procedures.

Our Public Health directorate also works closely with the HPA to ensure the safety of the public. The HPA aims to protect people from infectious diseases, to prevent harm when hazards involving chemicals, poisons or radiation occur and to help prepare for new and emerging threats, such as a bio-terrorist attack or a virulent new strain of disease.

Working with local and national colleagues, our Health Resilience Partnership Director is developing and embedding Emergency Preparedness, Resilience and Response arrangements across the local health economy ahead of the 2013 handover to CCGs. The Local Area Team of the NHS Commissioning Board takes on the category 1 responder role from April 2013, with the local CCGs becoming category 2 responders from the same date.

Sustainability report

The mandate for sustainability reporting

Sustainability has been recognised at a national level as an integral part of delivering high quality healthcare efficiently[1]. The Department of Health Manual for Accounts[2] states that all NHS bodies are required to produce a Sustainability Report (SR) as part of their wider Annual Report, covering their performance on greenhouse gas emissions, waste management, and use of finite resources, in line with HM Treasury guidance. Furthermore, Monitor encourages NHS foundation trusts to also include this information as part of their annual reporting[3].

A framework for reporting sustainability information as part of the annual NHS financial reporting process has been developed by the NHS SDU and the Department of Health, to support Trusts in meeting the above mandate and to help monitor how every NHS organisation contributes towards meeting the national target of a 10% cut in NHS-wide carbon emissions by 2015, and a 34% cut in the overall national carbon footprint by 2020, the latter enshrined in the Climate Change Act[4].

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[1] NHS SDU: http://www.sdu.nhs.uk/publications-resources/34/Sustainable-Development-in-Annual-Reports/

[2] Chapter 2, Section 2.8, in DH (2012). *Manual of Financial Accounts* 2012/13.

[3] Page 98, in Monitor (2012). *NHS Foundation Trust Annual Reporting Manual 2012-13*. Available at: http://www.monitor-nhsft.gov.uk/home/news-events-and-publications/our-publications/browse-category/guidance-foundation-trusts/mandat-1

[4] A summary of the UK Climate Change Act (2008) key implications for the NHS is available at: http://www.sdu.nhs.uk/documents/publications/1232893824_kmNp_3_summary_of_the_main_provisions_of_the_climate_c.pdf#search=%22climate%20dhange%20act%22

Many leading trusts are already reporting on their sustainability performance, not only because this is now mandatory[5], but also because careful use of natural resources demonstrates good financial management. NHS organisations are also keen to show progress made against strategic commitments and achieve high standards of good corporate citizenship within their community.

The key principle behind this type of reporting is that it provides trusts with an opportunity to demonstrate how sustainability has been used to drive continuous environmental, health and wellbeing improvements in their organisation, and in doing so, unlock money to be better spent on patient treatment and care. Sustainability reporting which is published also enables trusts to showcase their achievements with staff, patients and other stakeholders, providing an opportunity to inspire positive behaviours in the wider community. Furthermore, once established across the board, trust-wide reporting can constitute a transparent, comparable and consistent framework for assessing their own environmental and benchmark it against that of other trusts and public sector bodies, a commonplace practice in the private sector.

Our performance to date

The NHS Northamptonshire Carbon Management Programme was approved in 2010. It established a 2008-09 baseline of 4,771 CO^2 tonnes for the organisation. The baseline measured only CO^2 generated from Buildings & Energy (4667 CO^2t 2008/09), Transport (unavailable), and Water (104 CO^2t). An ambitious target was set to achieve a 30% reduction in CO^2 tonnes by 2012/13 (down to 3340 CO^2t). At present we estimate that we will fall short of this target by 2012/13.

We estimate that we have successfully reduced our Carbon Footprint by 15% to date (down to 4060 CO^2t) and that given sufficient funding the successor organisations will achieve the full 30% target by the end of 2014/15.

Next steps

With the demise of NHS Northamptonshire, support was given to both Corby and Nene CCG's (who together are co-terminus with NHS Northamptonshire) in drafting their Sustainable Development Management Plan as an integral part of their CCG accreditation process. Each SDMP sets out three aims:

- An action plan for delivering the organizations sustainability objectives
- The metrics that will be used to monitor and review the delivery of the plan
- The governance and accountability arrangements for ensuring that the plan is delivered and the benefits realized.

Much of the work that has been carried out to date has been physical improvements to buildings such as improved thermal insulation, low energy lighting upgrades, replacement boilers, and upgraded heating controls. The next steps involve engaging with staff and

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Source: http://www.sdu.nhs.uk/sd_and_the_nhs/reporting.aspx

patients to increase awareness. There is a huge enthusiasm amongst staff to improve performance in areas such as recycling, reducing printing costs and lowering energy usage.

Full details of the PCTs sustainability reporting are included in Annex 1 to the Annual Report.

Financial Review

The information in the 2012/13 summary statements shown in our annual report has been taken from the audited accounts. As such, they might not contain sufficient information for a full understanding of the trust's financial position and performance. A full set of the audited accounts, together with the full statement of directors' responsibility in respect of internal control is available the Department of Health.

The PCT has prepared its financial statements for 2012/13 on a full IFRS (International Financial Reporting Standards) basis in accordance with NHS Treasury and the Department of Health directions.

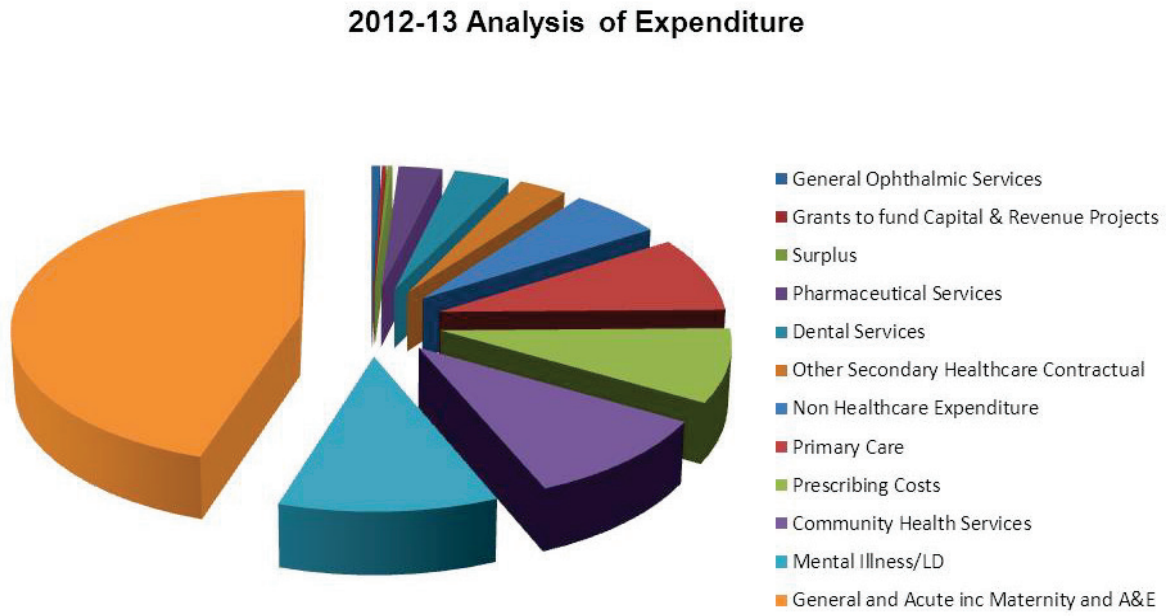
2012-13 Annual Accounts for NHS Northamptonshire
NHS Northamptonshire is responsible for ensuring that the funding received for local health services is spent effectively and with a focus on achieving good value for money. The summary financial statements and commentary that follow provide a picture of the results for the year ended 31 March 2013.

NHS Northamptonshire began 2012-13 with a financial surplus brought forward from 2011-12 of £7.1M. NHS Midlands and East, the Strategic Health Authority, provided NHS Northamptonshire with a control total for the 2012-13 financial year of £3.5M underspent. This formed Northamptonshire's part of the overall control total for NHS Midlands and East Strategic Health Authority.

Financial Targets
NHS Northamptonshire has the following financial targets:

Statutory Target	**Our Performance**
To achieve the operational financial plan	Revenue resource limit underspent by £3.5M as planned
Administrative Targets	**Our Performance**
To remain within the capital resource limit	Capital resource limit underspent by £2,870,000
To ensure all invoices are paid in line with the Better Payments Practice Code (BPPC)	99.7% of non-NHS invoices paid within 30 days against a target of 95% (see below for full performance details)

In meeting its overall financial target, NHS Northamptonshire spent its money in the following



way;

As in previous years, there were significant pressures within the local acute hospitals, caused by rising demand for services, particularly emergency admissions. In total, the PCT's commissioning budgets for hospital and community services were £38m overspent by the end of the financial year, a position which was managed through the redeployment of resources including the release of contingency provisions and reserves and the deferment of investment in strategic developments.

The following table shows a summary of some of the key data with regards to Northamptonshire's activity in 2012-13.

No. of elective spells	14,866
No. of emergency admissions	81,263
No. of day cases	69,225
No of GP referred outpatient first attendances	170,353

No. of A&E attendances	179,154

STATEMENT OF COMPREHENSIVE NET EXPENDITURE FOR YEAR ENDED 31 MARCH 2013

	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure		
Gross Employee Benefits	**19,572**	18,620
Other Costs	**1,121,386**	1,093,621
Income	**(44,589)**	(41,045)
Net Operating Costs Before Interest	**1,096,369**	1,071,196
Other (Gains)/Losses	**30**	(125)
Finance Costs	**1,472**	1,824
Net Operating Cost for the Financial Year	**1,097,871**	1,072,895

NHS Northamptonshire

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2013

	31 March 2013 £000	31 March 2012 £000
Non-Current Assets:		
Property, Plant and Equipment	**79,724**	77,010
Intangible Assets	**0**	0
Total Non-Current Assets	**79,724**	77,010
Current Assets:		
Trade and Other Receivables	**5.500**	11,136
Cash and Cash Equivalents	**13,163**	20
Total Current Assets	**18,663**	11,156
Non Current Assets Held for Sale	**700**	1,340
Total Current Assets	**19,363**	12,496
Total Assets	**99,087**	89,506
Current Liabilities:		
Trade and Other Payables	**(64,784)**	(60,734)
Provisions	**(1,087)**	(1,550)
Borrowings	**(736)**	(631)
Total Current Liabilities	**(66,607)**	(62,951)
Non-Current Assets Plus/Less Net Current Assets/Liabilities	**32,480**	26,591
Non Current Liabilities:		
Provisions	**(1,649)**	(920)
Borrowings	**(18,116)**	(18,808)
Total Non-Current Liabilities	**(19,765)**	(19,728)
Total Assets Employed	**12,715**	6,863
Financed by Taxpayers' Equity:		
General Fund	**(3,518)**	(10,573)
Revaluation Reserve	**16,233**	17,436
Total Taxpayers' Equity	**12,715**	6,863

NHS Northamptonshire

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY
For the Year Ended 31 March 2013

	General Fund £000	Revaluation Reserve £000	Other Reserves £000	Total Reserves £000
Balance at 1 April 2012				
Changes in Taxpayers' Equity for 2012-13	(10,573)	17,436	0	**6,863**
Net Operating Cost for the Year	(1,097,871)	0	0	**(1,097,871)**
Net Gain on Revaluation of Property, Plant & Equipment	0	1,894	0	**1,894**
Net Loss on revaluation of assets Held for Sale	0	(252)	0	**(252)**
Impairments and Reversals	0	(2,260)	0	**(2,260)**
Transfers Between Reserves	585	(585)	0	**0**
Total Recognised Income and Expense for 2012-13	(1,097,286)	(1,203)	0	**(1,098,489)**
Net Parliamentary Funding	1,104,341	0	0	**1,104,341**
Balance at 31 March 2013	**(3,518)**	**16,233**	**0**	**12,715**

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STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2013

	2012-13 £000	2011-12 £000
Cash Flows from Operation Activities		
Net Operating Cost Before Interest	**(1,096,369)**	(1,071,196)
Depreciation and Amortisation	**4,007**	3,919
Impairments and Reversals	**4,056**	63
Interest Paid	**(1,472)**	(1,329)
(Increase)/Decrease in Inventories	**0**	123
(Increase)/Decrease in Trade and Other Receivables	**5,636**	(846)
Increase/(Decrease) in Trade and Other Payables	**4,184**	791
Provisions Utilised	**(581)**	(1,665)
Increase/(Decrease) in Provisions	**847**	1,884
Net Cash Outflow from Operating Activities	**(1,079,692)**	(1,068,256)
Cash Flows from Investing Activities		
(Payments) for Property, Plant and Equipment	**(11,549)**	(8,147)
Proceeds of Disposal of Assets Held for Sale (PPE)	**629**	1,725
Net Cash Outflow from Investing Activities	**(10,920)**	(6,422)
Net Cash Outflow Before Financing	**(1,090,612)**	(1,074,678)
Cash Flows from Financing Activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI	**(586)**	(380)
Net Parliamentary Funding	**1,104,341**	1,074,827
Cash Transferred (to)/from Other NHS Bodies	**0**	222
Net Cash Inflow from Financial Activities	**1,103,755**	1,074,669
Net Increase/(Decrease) in Cash and Cash Equivalents	**13,143**	(9)
Cash and Cash Equivalents at Beginning of the Period	**20**	29
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies	**0**	0
Cash and Cash Equivalents at Year End	**13,163**	20

Operational Financial Balance

NHS Northamptonshire has a statutory obligation to achieve its operational financial plan. For 2012-13, the planned underspend was £3,508K, in line with the control total provided by NHS Midlands and East. This was delivered in full during the financial year, maintaining NHS Northamptonshire's sound financial footing.

The table below shows NHS Northamptonshire's performance against the operational financial balance duty for 2012-13 and 2011-12.

	2012-13 £000	2011-12 £000
Revenue Resource Limit	**1,101,411**	1,079,953
Net Operating Cost	**1,097,871**	1,072,895
Underspend for Period	**3,540**	7,058

Within the 2012-13 financial year, there have been a number of items which have impacted upon this financial position or which have resulted in a significant item of expenditure or saving. Most significantly, the PCT has experienced considerable over-performance against budget around its secondary care commissioning activity. This occurred in relation to both NHS and non-NHS services, and led to the requirement for savings to be identified and delivered in year to ensure financial balance.

Capital Resources

NHS Northamptonshire has a financial target to remain within its Capital Resource Limit. In 2012-13, NHS Northamptonshire's capital resource limit was £13,625,000. Following capital expenditure in year of £10,755,000, this gave an underspend against the Capital Resource Limit of £2,870,000. In comparison, for 2011-12 NHS Northamptonshire had a limit of £11,627,000 and spent £7,072,000 of this giving an underspend of £4,555,000. As at 31 March 2013 and 31 March 2012, NHS Northamptonshire had no capital commitments.

Management of Financial Resources

In order to most effectively manage the financial resources of NHS Northamptonshire, approved budgets are delegated to budget holders on an annual basis, in line with NHS Northamptonshire's Standing Financial Instructions (SFIs). Budget holders are responsible for the performance of budgets under their control, and these are monitored and reported upon on a monthly basis to both the budget holders and NHS Milton Keynes and Northamptonshire Cluster Board and its Committees. This enables early identification of financial pressures and risks within the system and allows corrective action to be taken as necessary.

In 2012-13 commissioning budgets were delegated to the CCGs who have been developing their own governance structure underneath the overarching NHS Milton Keynes and Northamptonshire Cluster Board.

Financial risk is also monitored using the above processes, with identified risks quantified and addressed clearly within the body of Cluster Board papers. Risk in the broader sense is also

monitored via NHS Milton Keynes and Northamptonshire's Audit Committee, which reviews and monitors performance against financial, operational and organisational risks identified during audit processes. Further information on the Audit Committee is provided below.

Asset Management

As at 31 March 2013, NHS Northamptonshire held fixed assets of £79,724,000 (£77,010,000 as at 31 March 2012). These assets support NHS Northamptonshire in achieving its objectives through providing premises and equipment (including IT hardware and software) to enable NHS Northamptonshire and local NHS services to carry out their core duties.

In addition to these assets, NHS Northamptonshire leases a range of buildings and equipment. More detail on both the fixed assets, operating leases and finance leases held by NHS Northamptonshire is available in the Annual Accounts.

Cash Management and Liquidity

Every year NHS Northamptonshire receives a cash allocation, known as the cash limit, which represents the total cash available to NHS Northamptonshire in year. Department of Health and HM Treasury cash management guidance states that this should not be drawn down before it is needed, that PCTs should not hold excessive bank balances at the end of any accounting period and the PCTs must fully spend their cash limit in year. For 2012-13, NHS Northamptonshire had a cash limit of £1,104,341,000 (2011-12 £1,082,817,000) and as at 31 March 2013, NHS Northamptonshire held cash and cash equivalents of £13,163,000, an increase of £13,143,000 on the previous year.

For 2012-13, NHS Northamptonshire's cash management ensured that there was sufficient cash to pay its creditors and no payments were delayed due to liquidity. Information on NHS Northamptonshire's performance against the Better Payments Practice Code (BPPC) is presented later in this report.

Other Resources

The main non-financial resource employed by NHS Northamptonshire is the staff body which comprised 352 average whole time equivalents (WTEs) in 2012-13 (315 average WTEs in 2011-12). These figures are calculated using the average WTE worked across the year based on a calculation of actual days worked. In total NHS Northamptonshire spent £19,572,000 on staffing costs in 2012-13. NHS Northamptonshire takes the development and welfare of its human resource seriously and during the year a number of activities have taken place to help develop and support staff in their duties. More detail on staff costs is provided below.

Value for Money

NHS Northamptonshire actively seeks value for money in all its business activities. As part of our continuing review of organisational efficiency, NHS Northamptonshire has reviewed all key areas of commissioned services and has identified a range of schemes and policies to promote best value for money. These include the introduction of benchmarking to measure best practice against peer organisations, the use of performance information in identifying and improving areas of inefficiency and a number of demand management schemes to ensure that patients are treated in the most appropriate setting.

Charitable Funds
As a result of PCTs ceasing to exist on 31 March 2013, action was taken during 2012-13 to transfer the trusteeship of the Charitable Funds to Northampton General Hospital NHS Trust. The Trust will continue to manage the funds on behalf of the fund managers to the benefit of the local health economy.

Pooled Budgets
NHS Northamptonshire hosts pooled budgets for the commissioning of adult mental health services and child & adolescent mental health services across Northamptonshire, both in partnership with Northamptonshire County Council. NHS Northamptonshire also contributes to pooled budgets hosted by Northamptonshire County Council for community equipment services across the county and the Northamptonshire Drug Action Team.

Audit Committee
NHS Milton Keynes and Northamptonshire's Audit Committee, a committee of NHS Milton Keynes and Northamptonshire Cluster Board, comprises Non-Executive Directors John Eaton (Committee Chair), Paul Bevan (until September 2012), Susan Hills, Peter Kara and Peter Kelby (from October 2012).

Audit sub-committee
In accordance with the guidance and Terms of Reference provided by the DH, an Audit sub-committee was established as a sub-committee of the Department of Health Audit and Risk Committee. The sub-committee's period of tenure is 1 April 2013 to 30 June 2013 and it consists of three members, all former Non-Executive Directors of the Cluster; John Eaton (Chair), Professor William Pope and Susan Hills. The remit of the sub-committee is to review and provide assurance on the annual report, financial statements and governance statement prior to signing by the Accountable Officer and Director of Finance.

External Audit
NHS Northamptonshire's external auditors for the year ending 31 March 2013 were KPMG LLP.

Audit Services
Statutory audit and services carried out in relation to the statutory audit for 2012-13 were £185,011.

Other KPMG Services
A further £143,000 in respect of organisational work undertaken on behalf of both Nene and Corby CCGs has been paid to the KPMG.

Better Payment Practice Code
NHS Northamptonshire's policy is to comply with the CBI Prompt Payment Code and the Government accounts rules. These state that the timing of payment should be stated in any contract. Where this is not the case, departments should pay within 30 days of receipt of goods and services or upon presentation of a valid invoice, whichever is later.

Performance against this target is stated below.

	Number	£000s
Non-NHS Creditors		
Total Bills Paid in the Year	28,283	153,025
Total Bills Paid Within Target	27,417	144,588
Percentage of Bills Paid Within Target	**96.94%**	**94.49%**
NHS Creditors		
Total Bills Paid in the Year	5,169	716,280
Total Bills Paid Within Target	4,903	713,977
Percentage of Bills Paid Within Target	**94.85%**	**99.68%**

Accounting Conventions including Estimation Techniques

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

Critical accounting judgements and key sources of estimation uncertainty

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

Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the entity's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

PCT Clustering

NHS Northamptonshire and NHS Milton Keynes clustered in 2011-12 to form a joint management structure. Recharges have been applied between the two PCTs to reflect the costs of the Joint Board apportioned on a capitation basis.

Key sources of estimation uncertainty

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

Bad Debt Provision
The Bad Debt provision at 31 March 2013 was £258,000 (as at 31 March 2012: £258,000) and was based on all non NHS outstanding debts following a review of all amounts over 3 months old and with no known repayment plan in place.

Prescribing Creditor
Prescribing expenditure data is received from the Prescription Pricing Division (PPD) of the NHS Business Services Authority two months in arrears. Therefore at the end of the financial year, the PCT has taken an accrual for the likely prescribing costs for February and March.

Work in Progress/Partially Completed Spells
NHS Northamptonshire has recognised liability in the accounts in relation to activity which is partially completed as at 31 March 2013. For 2012-13 the total amount recognised is £1,814,091.

Estimation Techniques for Accruals
Included within the accounts are a number of accruals which NHS Northamptonshire has had to take a view on the likely level of liability. The main areas of assumption concern the Prescribing creditor (detailed above) and final levels of activity completed by the PCT's healthcare providers as at 31 March 2013. Because of the time lag in receiving actual activity data, NHS Northamptonshire agreed the level of accrual required with the main providers, Northampton General Hospital NHS Trust, Kettering General Hospital NHS Foundation Trust, Northamptonshire Healthcare NHS Foundation Trust and with Leicestershire County & Rutland PCT for the Specialist Commissioning consortium. Smaller accruals were based on commitment accounting i.e. where goods or services were received on or before 31 March 2013, an accrual was taken for the expected liability.

Continuing Healthcare Provision & Contingency
In March 2012 the DH announced the introduction of a deadline for individuals to request an assessment of eligibility for NHS Continuing Care funding for the period 1 April 2004 to 31 March 2012 following which the PCT has been inundated with requests for reviews. Given the high level of requests received it will take a long time to evaluate whether these assessments will translate into claims. This workload is in addition to the existing retrospective claims currently being processed. The PCT has dealt with the existing retrospective claims and the request for retrospective assessments following the DH announcement as two separate work streams.

In respect of existing claims at 31 March 2013 there were 37 outstanding retrospective review claims. Of these; 26 cases are to be reviewed, 5 are under appeal and 6 are new claims received in year. These claims represent a maximum liability of £2,263,540. To date there have been a total of 228 cases reviewed with 67 successfully awarded payment equating to 29.39% of cases. The PCT has therefore taken a provision at 31 March 2013 for 29.39% of the maximum liability. This equates to £665,163 with the remaining balance of £1,598,377 being disclosed as a contingent liability.

In respect of the new assessment requests received in response to the DH announcement, the PCT has received a total of 546 enquiries which are currently being assessed. Of these enquiries 127 are sufficiently progressed to allow a potential claim to be evaluated which, after applying current local and regional review conversion rates, has resulted in the PCT taking a

provision of £1,650,000 against these claims. In respect of the remaining 419 enquiries the PCT has disclosed £4,058,000 as a contingent liability based on the average value of enquiries evaluated to date after applying local and regional review conversion rates.

Interest Costs and Interest Rate Changes
NHS Northamptonshire incurred £1,541,000 of Finance Costs in 2012-13 (£1,842,000 in 2011-12) associated with the embedded interest charge of a Finance Lease (£47,000) and the PFI contract (£1,494,000). As these interest rates are embedded within the financing of the assets, NHS Northamptonshire has minimal exposure from the fluctuations of interest rates.

Cashflows
The main source of funding for NHS Northamptonshire is allocations (Parliamentary Funding) from the Department of Health within an approved cash limit which is credited to the General Fund. Parliamentary funding is recognised in the financial period in which the cash is received. NHS Northamptonshire is obliged to remain within its cash limit for any given financial year and for 2012-13 the cash limit was £1,104,341,000 which was not exceeded.

In addition to the Cash Limit, NHS Northamptonshire receives miscellaneous revenue which is income that relates directly to the operating activities of the PCT. It principally comprises fees and charges for services provided on a full cost basis to external customers, as well as public repayment work.

Staff Costs
The average number of whole time equivalent staff employed by NHS Northamptonshire in 2012-13 was 349, an increase of 34 on the previous year. The increase was due to a build up of staff in the new successor organisations, particularly CCGs, prior to assuming full responsibility on 1 April 2013. This combined with the demising PCTs retaining staff to 31 March 2013 to manage the transition, accounted for the increase. Staff retained for the transition were then released early in 2013-14 reducing the spike in headcount. Costs associated with employing those staff were as follows:

	2012-13 £000	2010-11 £000
Employee Benefits		
Salaries and Wages	**15,024**	14,523
Social Security Costs	**1,271**	1,292
Employer Contributions to NHS Pension Scheme	**1,711**	1,918
Termination Benefits	**1,566**	887
Total Employee Benefits	**19,572**	18,620
Staff Sickness Absence	**2012-13 Number**	2011-12 Number
Total Days Lost	**4,340**	16,952
Total Staffing Years	**668**	1,840
Average Working Days Lost	**6.5**	9.21

Running Costs	Commissioning Services	Public Health	Total
PCT Running Costs 2012-13			
Running Costs (£000s)	**16,940**	**1,500**	**18,440**
Weighted Population (number in units)	**620,856**	**620,856**	**620,856**
Running Costs per head of Population (£ per head)	**27.28**	**2.42**	**29.70**

PCT Running Costs 2011-12			
Running Costs (£000s)	16,514	2,145	18,659
Weighted Population (number in units)	620,856	620,856	620,856
Running Costs per head of Population (£ per head)	26.60	3.45	30.05

NHS Pension Scheme
The NHS Pension Scheme is an unfunded, defined benefit scheme that covers NHS employers and other bodies. The scheme is accounted for as a defined benefit scheme and the cost is equal to the contributions payable to the scheme for the accounting period. Further information can be found in the full set of accounts. The annual NHS Pension Scheme can be viewed at www.nhsba.nhs.uk/pensions.

Remuneration Report

The remuneration report contains details of the significant interests, salaries and expenses of the Board of NHS Northamptonshire.

Remuneration and Terms of Services Committee – membership:

William Pope – Chair
John Eaton – Non Executive Director
Peter Kara – Non Executive Director

Significant interests
A number of our Board members belong to organisations or agencies with which NHS Northamptonshire does business. These organisations and agencies have received payments from NHS Northamptonshire and include:

Peter Kelby, Non Executive Director:
Ophis Ltd - Director
John Parkes, Chief Executive:
University of Northampton – Visiting Professor

William Pope, Chairman:
University of Northampton – Board Member, Centre for Health & Well Being Research
Sarah Whiteman, Medical Director:
Stonedean Practice - Partner

Disclosure of information to auditors
Each director has stated that as far as he/she is aware there is no relevant audit information of which the NHS body's auditors are unaware and he/she has taken all the steps that he/she ought to have taken as a director in order to make himself aware of any relevant audit information and to establish that the NHS body's auditors are aware of that information.

Policy on remuneration of senior managers
The Remuneration and Terms of Services Committee sets the salary for all directors. All other staff remuneration rates are set nationally.

Summary of policy on duration of contracts, notice periods and termination payments
NHS Northamptonshire adheres to Agenda for Change terms and conditions for duration of contracts, notice periods and termination of payments. NHS Northamptonshire's Chief Executive is recruited through national advertisement and is appointed by the Chair. The Executive Directors have been recruited through local and national advertisement and were appointed by the Chief Executive and Chair.

Details of service contract with each senior manager who has served during the year
Executive Directors (including the Chief Executive) have permanent contracts, which include a notice period of three months. NHS Northamptonshire's Remuneration and Terms of Service Committee, a committee of the Board, determines payment and terms of service for senior managers in accordance with national Very Senior Managers guidance. Executive Directors are subject to the standards set out in NHS Northamptonshire's Standing Orders, Code of Conduct and Human Resources policies.

Explanation of any significant awards
There have been no significant awards made between 1 April 2012 and 31 March 2013.

Senior Managers' Remuneration
The following tables contain details of the Directors' salaries and allowances from 1 April 2012 to 31 March 2013. Following the clustering arrangement of NHS Northamptonshire and NHS Milton Keynes, a new cluster wide Board was established on 1 July 2011. Details of the total salary costs of the Cluster Board members is included together with the proportion of their costs charged to NHS Northamptonshire's accounts. The basis for the apportionment of the costs is on weighted capitation resulting in 73.2% being charged to NHS Northamptonshire and 26.8% being charged to NHS Milton Keynes.

NHS Northamptonshire

Directors' Salaries and Allowances for the Period 1 April 2012 to 31 March 2013

NHS Milton Keynes and NHS Northamptonshire Cluster Board	2012-13 Total Salary				NHS Northamptonshire Share			
	Salary (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000	Bonus Payments (bands of £5,000) £000	Benefits in Kind (Rounded to nearest £00) £00	Salary (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000	Bonus Payments (bands of £5,000) £000	Benefits in Kind (Rounded to nearest £00) £00
Paul Bevan - Non Executive Director (until 30 September 2012)	0 - 5	0	0	0	0 - 5	0	0	0
Marvele Brown - Non Executive Director	5 - 10	0	0	0	5 - 10	0	0	0
John Eaton - Non Executive Director	10 - 15	0	0	0	5 - 10	0	0	0
Tansi Harper - Non Executive Director (from 1 January 2012 until 30 September 2012)	0 - 5	0	0	0	0 - 5	0	0	0
Dr Nick Hicks - Director of Public Health (Milton Keynes)	215 - 220	0	0	0	n/a	n/a	n/a	n/a
Susan Hills - Non Executive Director	5 - 10	0	0	0	5 - 10	0	0	0
Professor Stephen Horsley - Director of Public Health (Northamptonshire)	150 - 155	0	0	0	150 - 155	0	0	0
Peter Kara - Non Executive Director	5 - 10	0	0	0	5 - 10	0	0	0
Peter Kelby - Non Executive Director (from 1 October 2012)	0 - 5	0	0	0	0 - 5	0	0	0
Jan Norman - Director Nursing (until 31 December 2012)	75 - 80	0	0	0	55 - 60	0	0	0
Professor John Parkes - Chief Executive (until 30 September 2012)	90 - 95	0	0	0	65 - 70	0	0	0
Professor William Pope - Chair	35 - 40	0	0	0	25 - 30	0	0	0
Gill Scoular - Director of Finance (until 30 September 2012)	65 - 70	0	0	0	45 - 50	0	0	0
Dr Sarah Whiteman - Medical Director	75 - 80	0	0	0	55 - 60	0	0	0
Diana Wright - Non Executive Director (from 1 October 2012)	0 - 5	0	0	0	0 - 5	0	0	0

As part of the changes in the NHS, the Directors for the National Commissioning Board Local Area Teams (LAT) were appointed during 2012-13 and in October 2012, the Directors of the LAT where appointed as the Directors of the NHS Milton Keynes and NHS Northamptonshire Cluster. Under the direction of the National Commissioning Board, it was agreed that salary costs for the LAT Directors would be hosted by their current PCTs and that there would not be any recharges across other PCTs in the LAT area. Therefore, no charge is made to the NHS Milton Keynes and NHS Northamptonshire Cluster for the costs associated with Jane Halpin (Accountable Officer) or Chris Ford (Director of Finance). All other costs of the Cluster are apportioned across NHS Milton Keynes and NHS Northamptonshire on a weighted capitation basis with the exception of Dr Nick Hicks who was solely the Director of Public Health for Milton Keynes. The percentages applied are NHS Milton Keynes 26.8% and NHS Northamptonshire 73.2%.

Directors' Pension Benefits for the Period 1 April 2012 to 31 March 2013

NHS Milton Keynes and NHS Northamptonshire Cluster Board	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at aged 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2013 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2013 £000	Cash Equivalent Transfer Value at 31 March 2012 £000	Employer Contribution to the Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £000
Paul Bevan - Non Executive Director (until 30 September 2012)	Non Pensionable							
Marvelle Brown - Non Executive Director	Non Pensionable							
John Eaton - Non Executive Director	Non Pensionable							
Tansi Harper - Non Executive Director (from 1 January 2012 until 30 September 2012)	Non Pensionable							
Susan Hills - Non Executive Director	Non Pensionable							
Professor Stephen Horsley - Director of Public Health (Northamptonshire)	Non Pensionable							
Peter Kara - Non Executive Director	Non Pensionable							
Peter Kelby - Non Executive Director (from 1 October 2012)	Non Pensionable							
Jan Norman - Director Nursing (until 31 December 2012)	0 - 2.5	2.5 - 5	40 - 42	125 - 130	837	735	28	0
Professor John Parkes - Chief Executive (until 30 September 2012)	0 - 2.5	0 - 2.5	80 - 85	250 - 255	1,695	1,547	19	0
Professor William Pope - Chair	Non Pensionable							
Gill Scoular - Director of Finance (until 30 September 2012)	0 - 2.5	0 - 2.5	50 - 55	155 - 160	950	852	15	0
Dr Sarah Whiteman - Medical Director	5 - 7.5	15 - 17.5	25 - 30	85 - 90	515	381	73	0
Diana Wright - Non Executive Director (from 1 October 2012)	Non Pensionable							

Cash Equivalent Transfer Values

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

Real Increase in CETV

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

Exit Packages for Staff Leaving in 2012-13

	2012-13			2011-12		
Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
	Number	**Number**	**Number**	Number	Number	Number
Lees than £10,000	**5**	**0**	**0**	11	6	17
£10,001 - £25,000	**3**	**0**	**3**	6	4	10
£25,001 - £50,000	**1**	**0**	**1**	5	0	5
£50,001 - £100,000	**2**	**0**	**2**	4	1	5
£100,001 - £150,000	**4**	**0**	**4**	1	0	1
£150,001 - £200,000	**1**	**0**	**1**	0	0	0
> £200,000	**0**	**0**	**0**	0	0	0
Total number of exit packages by type (total cost)	**16**	**0**	**11**	27	11	38
	£000	**£000**	**£000**	£000	£000	£000
Total resource cost	**906**	**0**	**906**	690	180	870

This note provides an analysis of Exit Packages agreed during the year. Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Where the PCT has agreed early retirements, the additional costs are met by the PCT and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages taken by staff leaving in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

Pay Multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in NHS Northamptonshire in the financial year 2012-13 was £152,500 (2011-12: £162,500). This was times 4.7 (2011-12: 4.8) the median remuneration of the workforce which was £32,167 (2011-12: £34,189). For staff whose costs are shared between NHS Northamptonshire and NHS Milton Keynes due to the clustering arrangements, only the proportion of the costs which are charged to NHS Northamptonshire are included in these calculations. The percentage of their costs charged has been determined using a weighted capitation basis resulting in 73.2% being charged to NHS Northamptonshire and 26.8% to NHS Milton Keynes.

In 2012-13 and 2011-12 no employee received remuneration in excess of the highest paid director.

For 2012-13 total remuneration includes salary, non-consolidated performance related pay and benefits in kind if applicable for PCT employees and payments made for agency staff . It does not include severance payments, employer pension contributions or the cash equivalent transfer values of pensions.

STATEMENT OF THE RESPONSIBILITIES OF THE SIGNING OFFICER OF THE PRIMARY CARE TRUST

The Department of Health's Accounting Officer designates the Signing Officer of the accounts of PCTs in England, an officer of the Department of Health, to discharge the following responsibilities for the Department, to ensure that for the year ended 31 March 2013:

there were effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
value for money was achieved from the resources available to the primary care trust;
the expenditure and income of the primary care trust had been applied to the purposes intended by Parliament and conform to the authorities which govern them;
effective and sound financial management systems were in place; and
annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the net operating cost, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the above responsibilities, as designated Signing Officer and through experience in my role as Accountable Officer until 31 March 2013.

Signed.....Designated Signing Officer

Name:

Date.....

GOVERNANCE STATEMENT

NHS Northamptonshire (5PD)

1. INTRODUCTION

This year has been a year of transition, with the PCT successfully implementing the Health and Social Care Act 2012 that resulted in the abolition of the PCT on 31 March 2013. There has been a shift in focus from the clustering of NHS Northamptonshire and NHS Milton Keynes in 2011-12 to working with and transitioning to the newly established successor health bodies.

The Clustering arrangements established during 2011-12 remained in place during 2012-13 with the operation of a single executive team for the two PCTs and a single Board directing the business of both PCTs. This Statement will reflect and highlight those areas of joint enterprise and those where the PCTs are required to report separately on matters affecting the individual legal entities.

One of the key governance changes that occurred during the year was the establishment of the NHS Commissioning Board's Area Team (AT) for Northampton and Milton Keynes, which assumed the Executive responsibility for the PCT on 1st October 2012. The AT's Executive Directors have worked alongside the PCT's Non-Executive Board members to ensure the Cluster Board remained an effective vehicle for delivering the PCT's governance responsibilities.

2. SCOPE OF RESPONSIBILITY

Arising from the schemes of delegation approved by the Northampton PCT in 2011-12, the PCT's Board functions continued to be discharged during 2012-13 by a joint committee known as the Cluster Board. Therefore, any references to the Board within this document refer to the Cluster Board.

The Cluster Board, acting under delegated authority from the PCT Board, is accountable for internal control of the PCT. As Accountable Officer for this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the PCT and Cluster policies, aims and objectives. I also have responsibility for safeguarding the public funds and the PCTs assets for which I am personally responsible.

As the Accountable Officer for Northamptonshire Teaching PCT I am able to provide assurance that the PCT has in place robust accountability arrangements, not only for the discharge of my own responsibilities, but also in the achievement of performance targets and strategic objectives.

The PCT continued to be subject to reviews by the Midlands and East Strategic Health Authority (SHA). This is carried out via a combination of formal processes (e.g. annual and

quarterly reviews) and service driven reviews of our clinical governance, finance and operating framework arrangements.

Through the establishment of the Clinical Commissioning Groups (CCGs) NHS Northamptonshire continued to work alongside other health and social care partners to operate within a Health Community Planning Framework, ensuring delivery of appropriate and wide ranging NHS Targets.

Throughout the year the CCGs have assumed more of the PCT's responsibilities in order to prepare them for full authorisation and statutory body status.

One such example is where the CCGs assumed the PCT's relationships with Local Strategic Partners within the Northamptonshire locality, and took ownership of the joint targets for the improvement of Health Outcomes. Other examples include; the adoption of recommendations from the Director of Public Health Report, the development of sustainable community strategies at County and District level, and joint production of the Joint Strategic Needs Assessments.

There continued to be close collaborative working with the County Council as part of the implementation of 'Liberating the NHS' with regular scheduled meetings at senior officer level. There is also County Council membership of Regional Transition Networks, and representation at the steering groups for the transition of public health functions.

The PCT was represented at collaborative meetings that were held throughout the year including; Health and Wellbeing Boards; local government including local councils; all relevant CCGs (COO and GPs); and other agencies including local key providers (Mental Health, Acute Hospital etc), LINks (progressing to HealthWatch), and the University of Northampton.

A significant element of these collaborative meetings was dealing with the transfer of the public health functions, assets and resources to the County Council as part of the NHS reforms. This work was completed on schedule enabling the correct form of legal transfer to be enacted on 1st April 2013.

3. GOVERNANCE FRAMEWORK

Cluster Board

Throughout 2012/13 the Cluster Board has operated as a single entity with shared members on the Boards of both of the Cluster PCTs. In October 2012 the entire team of Executive Directors changed with the appointment of the NHS CB Area Team's Executive Director Team, which assumed the accountability and responsibility for the PCT's Executive Director functions.

During 2012-13 the Cluster Board met 11 times in total (full attendance records are available).

The Cluster Board has been effective in discharging the functions of the PCT Board. It has successfully steered the PCT through the changes and challenges brought about by the implementation of the NHS reforms, ensuring a smooth transition to the NHS Commissioning Board, CCGs and the Greater East Midlands Commissioning Support Unit (GEM CSU).

Cluster Board Sub-Committees
At the commencement of 2012-13 the Cluster Board had in place the following sub-committees:

- Joint Audit Committee
- Quality, Safety and Risk Committee
- Remuneration and Terms of Service Committee
- Finance and Resources Committee
- Nene CCG Board
- Milton Keynes CCG Board
- Corby CCG Board
- Transition & Closure Board
- Public Health Transition Group

From October 2012 onwards the Cluster also established, on behalf of the Cluster PCTs, a Transition and Closedown Board and Committee tasked with ensuring the closedown of both PCTs was carried out effectively and all that transferred to appropriate successor bodies was properly completed.

Joint Audit Committee
This committee was jointly established to act as a single committee on behalf of both PCTs under the Cluster's governance arrangements. It was constituted in line with the provisions of the NHS Audit Committee handbook and oversaw the audit of the 2011-12 accounts for PCTs, the internal and external audit plans and the risk management and internal control processes (financial and quality), including control processes around counter fraud. As part of the handover process a schedule of outstanding items resulting from the Cluster's internal audit programme was passed to the successor bodies.

During 2012-13 the Committee met 6 times and, in addition to the above, other key areas considered were:

- A series of reports on the Payments by Results Assurance Framework for the PCT;
- QIPP review follow-up work;
- Information Governance validation and
- Review and stress test the transition plans and risks.

Audit sub-committee
Audit Committee arrangements were also specified nationally to ensure that the essential scrutiny and governance function provided by an Audit Committee was retained, despite PCT closure.

In accordance with the guidance and Terms of Reference provided by the Department of Health an Audit sub-committee was established as a sub-committee of the Department of

Health Audit and Risk Committee. The sub-committee's period of tenure is 1 April 2013 to 30 June 2013 with a membership of three who are all former Non-Executive Directors of the Cluster.

The remit of the sub-committee is to support the final accounts process, thereby providing a mechanism to provide appropriate assurance for the discharge of statutory responsibilities

Quality, Safety and Risk Committee
The Quality, Safety & Risk Committee played a critical role in establishing and regularly reviewing the Governance Framework of the Cluster, and in maintaining an overview of the progress towards the authorisation of CCGs and the Commissioning Support Unit. It also ensured the routine governance business of the Cluster was maintained during the transition period.

The Committee also played an important role in helping to manage the transition to the new NHS system by including representatives from each CCG, and considering regular update reports from the Public Health Transition Group and QIPP committee.

The Committee had an assurance role for the Cluster's performance across a wide range of targets and quality measures, including the CCGs' delivery of QIPP and other financial targets and the quality of plans to achieve them.

However, as part of a mid-year review of Cluster resources, systems and processes it was decided to stand the Committee down at the end of January 2013, partly in recognition of the increasing autonomy that the CCGs acquired as a result of their authorisation in December 2012 and January 2013.

Governance continued to be exercised in this transition by direct attendance at Cluster Board by the Chief Officers or Chairs of each CCG. At its final meeting, the Committee received a report on how its functions would be picked up by other committees or parts of the NHS system for the remainder of 2012-13 in order to maintain continuity in the scrutiny and monitoring of statutory functions and performance.

In total the Committee met 6 times prior to it being stood down at the end of January 2013.

QIPP Coordination and Assurance Group (QCAG)
The PCT established a QIPP Assurance Committee to oversee the PCTs QIPP programme for 2012-13. It was comprised of representatives from both the CCGs and the Cluster and provided a detailed review of QIPP plans, which were drilled down and managed at a CCG level. The group reported each month to the Quality, Risk & Safety Committee, which added a further level of scrutiny.

Transition and Closure Board
The Board established a Transition and Closure Board in autumn 2012 and appointed a Director of Transition to act as chair.

The Transition and Closure Board has worked to a tight operational plan receiving monthly reports from a range of workstreams focussing on closing down and transitioning functions as appropriate. This work has been supported by a transition and close down risk register which was presented to and considered by the Transition and Closure Board. The remit of the board was to ensure:

- Successful closedown of the PCT;
- Support for the establishment of a range of new commissioning organisations;
- A seamless handover to receiving organisations; and
- Continuity of business as usual.

Senior staff attended the Transition and Closure Board and were appointed clear leadership roles for key functional transfers. Internal Audit was involved in the establishment and operational review of transition processes and significant assurance was provided that controls were adequate.

Completion of Handover and Closure Documents

The PCT has produced and published a hand-over document as required by the Midlands and East SHA, and this has informed much of the hand-over work to the CCGs and other new organisations created by the NHS reforms. To support this document a Library of Knowledge was established that stored all the supporting documents referenced in the hand-over document, and will continue to be available for a period of time after the PCT has ceased to function.

Accounts Scrutiny and Sign-Off

The accountability arrangements for the 2012-13 financial accounts were in line with the nationally defined accounts scrutiny and sign off process. From 1st April 2013 when PCTs were abolished, Area Team Directors continued to discharge the responsibilities associated with the closedown, until completion. For the PCTs this entailed the set-up of local delivery teams to secure effective accounts preparation and managing the audit process. The AT Directors, as PCT Accountable officers, have responsibility for signing the accounts and the supporting statements.

Discharge of Statutory Functions

An integral part of the transition has been the reconciliation of the statutory functions of the PCT and their destination after the end of March 2013. The PCT has used legal advice to establish the definitive list of statutory responsibilities to ensure that each function is transferred appropriately. In doing so the PCT has established that no irregularities have been identified and has assured itself that it is legally compliant

The System of Internal Control

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

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

The system of internal control was in place at NHS Northamptonshire for the whole year ending 31st March 2013.

4. CAPACITY TO HANDLE RISK

The PCT Corporate Entity
For the period of this statement the PCT, as a corporate entity, vested all its capacity to handle risk in the systems and structures of the Cluster, and therefore for the purposes of this statement it will be the Cluster's capacity to handle risk that is described.

The Cluster
For the period up to 30th September 2012 the Cluster Chief Executive had ultimate responsibility for risk management and was held to account through the Cluster Board, the Quality, Risk & Safety Committee, and the Cluster Audit Committee for the effectiveness of Cluster (and hence PCT) processes. For the period from 1st October 2012 to 31st March 2013 this responsibility passed to the Chief Executive of the NHS Commissioning Board's (NHS CB) Area Team for Northamptonshire & Milton Keynes. It is in this capacity that I am providing this statement.

Day to day responsibility for risk management was delegated to all Executive Directors of the Board with executive leadership being vested in the Cluster Director of Finance (up to 30th September 2012) and the NHS CB Area Team Director of Nursing and Clinical Quality from 1st October 2012, then the Transition Director from December 2012 to 31st March 2013.

In conjunction with these structures all appropriate staff were provided with training in the principles of risk management / assessment in order for them to manage and treat appropriate levels of risk within their designated authority and day to day duties.

Clinical Commissioning Groups
During 2012-13 the PCT, through the mechanism of the Cluster, has continued to support the development of four Clinical Commissioning Groups (CCGs) in Northamptonshire and Milton Keynes. Initially they were established as sub-committees of the Cluster Board but during 2012-13 all four of them successfully navigated the authorisation process and have been established as statutory bodies who will take on their full range of statutory responsibilities on 1st April 2013.

Throughout the year the following mechanisms were used to provide an environment in which risks could be identified and managed:

- Board to Board meetings between the Cluster Board and the Governing Bodies;
- CCG leaders attended Cluster Board meetings; and
- CCG leaders attended meetings of the Quality, Risk & Safety Committee.

Greater East Midlands Commissioning Support Unit (GEM)

In addition to supporting the development of the CCGs the Cluster has been actively involved in the establishment of the Greater East Midlands Commissioning Support Unit (GEM). Each Cluster within the GEM regional area established a Steering Group and an Operational Group to ensure that each Cluster received assurances on the establishment of GEM and the processes by which staff and assets would be transferred to the new body. Each area developed its own local risk register that fed into GEM's corporate risk register, which has been reviewed on a monthly basis by the Senior Management Team.

5. THE RISK AND CONTROL FRAMEWORK

Risk Management

The PCT adopted a revised Risk Management Strategy in September 2010. It was agreed at the Quality, Safety & Risk Committee that no further changes or revisions were required in 2012-13. The strategy outlined the Cluster's approach to risk and the manner in which it sought to eliminate and control all risks. Staffs at all levels of the organisation were able to identify and record risk, with appropriate levels of staff trained to evaluate and treat the risk accordingly.

Risk management was embedded in the activities of the organisation. Through its main sub-committees (CCG Boards, Governance Committee, and Audit Committee) and line management structures, the PCT was able to ensure accountability for risk at all levels of the organisation.

By ensuring that all staff were made aware of their responsibilities for both governance (all elements) and health and safety, a substantial amount of progress was made towards ensuring ownership of risk by staff. Staff were engaged in providing monthly updates on risks relevant to their area of responsibility to inform the Quality, Safety & Risk Committee and Board in a timely manner.

A key output from the risk management system was that each month the Cluster Board received a report on the high scoring corporate risks that impacted on the successful achievement of the Cluster's strategic objectives. In addition, the Quality, Safety and Risk Committee received monthly reports on the high scoring risks, and those due for a review in that month.

Major risks identified for 2012/13

- As a result of the Cluster's risk management process it was able to identify the following as its major risks for 2012-13:

- Lack of capability and capacity due to loss of key staff/ experience/ skills has resulted in an inability to deliver business as usual within the cluster and to create an effective CSU. This was mitigated by an effective HR process that mapped current roles to positions within the new organisations and a combination of "lift and shift" and pooling, slotting and matching processes.

- The fragmentation of duties and uncertainty of responsibilities during transition leading to poor performance. This was one of the highest scoring risks at the beginning of the year, but as can be evidenced in this statement a comprehensive range of mechanisms and processes were put in place to ensure such fragmentation did not occur.

- The successful authorisation of the emergent CCGs allowing them to assume their new statutory responsibilities from 1st April 2013.

- Ensuring all staff were transferred to their new destination organisations by 31st December 2012, and that the number of redundancies were kept to an absolute minimum. There was a tightly managed HR process that achieved this by the due date, with letters setting out new employment arrangements post-1st April being issued to all affected staff.

- Successful delivery of the QIPP plan, and the savings identified within it. These savings were essential for balancing the PCT's finances and driving forward quality, innovation and efficiency.

Corporate Objectives and the Board Assurance Framework
The Board approved its Corporate Objectives for 2012-13 at its meeting in April 2012. The PCT's Assurance Framework was approved by the Quality, Safety & Risk Committee in June 2012, following an exercise to integrate CCG key strategic risks into the Cluster risk portfolio. Adherence to the Assurance Framework allowed the PCT to identify its principal risks and the controls required to mitigate against them.

The framework was proactively reviewed by senior staff on a regular basis. The Quarter 4 Assurance Framework for 2012-13 was refocused to reflect the PCT's closedown and transition role and was authorised by the Cluster Board in March 2013.

Interal and External Audit
Both Internal and External Audit carry out independent reviews of systems and processes within the organisation. Recommendations and action plans are put in place following these reviews to ensure controls are safe and adequate, providing safeguard of assets and resources. Key risks highlighted in these reports are also added to the Cluster's Assurance Framework. Action plans are routinely tracked through the quarterly Audit Committee meetings.

Counter Fraud & Deterrence
During 2012-13 the PCT continued to commission a counter fraud service from RSM Tenon. The Local Counter Fraud Specialist regularly met with the Director of Finance to review the Counter Fraud plan and discuss cases. The LCFS also presented quarterly reports to the PCT's Audit Committee.

Information Governance
The Director of Finance was the Executive Lead on the Board for Information Governance and was also the Senior Information Risk Officer (SIRO).

The Caldicott Guardian was the Cluster Director of Nursing for the Northamptonshire & Milton Keynes PCTs.

Throughout 2012-13 work was undertaken to improve the PCT's compliance with the Information Governance Toolkit levels. This has strengthened the processes around mapping of information flows of personal data within the organisation and understanding the risks associated with records as they transfer to other organisations.

Data Security
At the PCT all Information Governance incidents are taken extremely seriously. These include incidents relating to person identifiable data loss, any breach of confidentiality, the insecure disposal of information and any other incidents where staff or patient information may have been at risk.

All staff are trained and encouraged to report all incidents and near misses to ensure we can investigate the reason for an incident occurring and take measures to prevent that incident happening again.

Appendix B of the Department of Health Guidance on Information Governance Assurance issued in May 2008 (Gateway reference 9912) only requires serious untoward data security breaches rated at level 3 or above to be declared in this statement. In 2012/-3 there were no reported serious incidents involving personal data.

There were no cases reported to the Information Commissioner in 2012-13.

Equality, Diversey and Human Rights
Control measures were in place to ensure that the organisation complied with its obligations under equality, diversity and human rights' legislation. The Director of Nursing led in this area on behalf of the Board

Equality and Inclusion (E&I) assurance reports, and relevant legal and Department of Health updates, have been presented to the Cluster Board, with operational E&I reports presented on a regular basis to the Quality, Safety & Risk Committee throughout the year. Action plans were in place to address identified gaps in control.

Following the adoption of the Equality Delivery System (EDS) in 2011-12 all committee reports included a section on how the report met the objectives of the EDS throughout 2012-13.

Sustainability
The Cluster has a Trust-wide commitment to reduce its carbon footprint from the 2008/09 baseline by 2013. A Sustainable Development Plan incorporating good practice and target Carbon Management Plans have been produced and approved by the Board.

The estate rationalisation programme has proved extremely successful and most of the surplus properties have now been disposed of further reducing the PCT's carbon footprint,

saving money to ensure best use of limited resources and improving the standard of accommodation for staff. Multi-functional devices with the capability to copy, fax and print have now been rolled out to most PCT premises.

Clinical Commissioning Groups have developed a baseline position to allow the formulation of a Sustainable Development Management Plan for their future needs.

6. SIGNIFICANT ISSUES

There is only one significant issue arising in 2012-13 that warrants additional reporting in this statement which relates to Continuing Healthcare retrospective reviews.

In March 2012 the DH announced the introduction of a deadline for individuals to request an assessment of eligibility for NHS Continuing Care funding for the period 1 April 2004 to 31 March 2012 following which the PCT has been inundated with requests for reviews.

Given the high level of additional requests received it will take a long time to evaluate whether these reviews will translate into claims. This workload is in addition to the existing retrospective claims currently being processed.

The PCT has received more than 500 requests for assessment following the DH announcement and processing these requests is placing a significant strain on existing resource. The liability to settle claims arising from this exercise will pass to the CCGs as successor organisations. In view of the current uncertainty surrounding the level of liability likely to emerge from this process this poses a significant financial risk to the receiving CCGs.

Additional resource is currently being redeployed into retrospective reviews and assessments to clear the backlog of work created by the DH announcement.

7. REVIEW OF EFFECTIVENESS

As Accountable Officer, I have responsibility for reviewing the effectiveness of the Cluster's governance systems. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of their annual programme of internal audit work.

The Head of Internal Audit's annual opinion on the system of internal control is based on an agreed programme of work undertaken throughout the financial year. This has resulted in a significant assurance opinion for the year. Executive Directors within the organisation, who have responsibility for the development and maintenance of the system of internal control, also provide me with assurance.

The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. The Framework for 2012-13 was actively managed and regularly reviewed by the

Quality, Safety & Risk Committee and the Board. I am satisfied that the Framework reflected the key challenges faced by the organisation at the start of the business year, and that it appropriately reflected the development of the new NHS structures as the year progressed.

My review is also informed via assurances provided by:-

- NHS Midlands and East (Strategic Health Authority);
- KMPG (External Audit); and
- Internal Audit reviews

I have also been advised on the implications of the results of my review of the effectiveness of the system of internal control by the:-

- Cluster Board;
- Executive Team;
- Audit Committee; and
- The Quality, Safety & Risk Committee

The PCT had a robust process in place to allow ongoing maintenance and review of the effectiveness of the system of internal control. PCT Directors held day to day responsibility for ensuring that controls existed within their designated areas of responsibility.

Existence and robustness of controls was tested by the PCT's Auditors, with any identified weaknesses being reported to the Audit Committee, as appropriate.

Additional assurances were received during the course of the year in respect of the PCT's Assurance Framework and associated Action Plan, predominantly from the PCT's Internal Auditors.

There has been no evidence presented to myself or the Board to suggest that at any time during 2012-13 the PCT has acted outside of its statutory authorities and duties. The PCT has complied with the provisions of the Corporate Governance Code and there have been no incidents where non-compliance has taken place.

My review confirms that NHS Northamptonshire had a generally sound system of internal control that supported the achievement of its policies, aims and objectives throughout the year ended 31 March 2013.

Signed ……

Jane Halpin
Chief Executive, Area Team, Milton Keynes & Northamptonshire NHS Commissioning Board

Dated …….

Appendix 1

NHS Northamptonshire – Summary of sustainability performance

Area (totals)		Performance (2008-09)	Performance (2009-10)	Performance (2010-11)	Performance (2011-12)
GHG emissions (tCO2e gross)		4,771	4,806	4,061	1,775
Energy in buildings	**Consumption** (1000x kWh)	13,807	14,005	12,690	5,989
	Expenditure (£)	£779,899	£923,983	£585,405	£272,168
Waste	**Amount** (tonnes)	403	510	148	58
	Expenditure (£)	£112,364	£119,106	£115,910	£97,996
Travel	**Mileage** (km)	*Not available*	*Not available*	*Not available*	Not available
	Expenditure (£)	*Not available*	*Not available*	*Not available*	Not available
Water	**Consumption** (m^3)	33,270	23,978	13,528	11,265
	Expenditure (£)	£72,820	£63,125	£33,312	£17,633

NOTES:

1. *All figures featured in the table above were obtained from ERIC returns[6].*

2. *The data collection for 2011-12 was the first to be collected under the new Transforming Community Services regime and data was submitted both by the PCT and users occupying space under TCS. It is therefore not possible to make direct comparisons with previous years.*

[6] ERIC (Estates Return Information Collection) data are collected and published by the NHS Information Centre (IC) on the Hospital Estates and Facilities Statistics (HEFS) portal: http://www.hefs.ic.nhs.uk/

3. *This report has been prepared in accordance with guidelines laid down by HM Treasury's Financial Reporting Manual (FReM), available at: http://www.hm-treasury.gov.uk/frem_sustainability.htm*

4. Our GHG emissions accounting includes Scope 1 and 2 emissions, along with Scope 3 emissions from water use and waste arisings. The scope 1 and 2 emissions include the wider carbon impact that is, direct emissions as a result of the combustion of fuel; and indirect emissions associated with the extraction and transport of fuel as well as the refining, distribution, storage and retail of finished fuels. These have all been calculated on an annual basis using the methodology in DEFRA and DECC (2009). *Guidance on how to measure and report your greenhouse gas emissions*. Available at: http://www.defra.gov.uk/environment/economy/business-efficiency/reporting/

5. Our GHG emissions accounting methodology uses the most recently published DEFRA and DECC GHG conversion factors for company reporting, in this case those of 2011, which are available at: http://www.defra.gov.uk/publications/2011/09/01/ghg-conversion-factors-reporting/

   Exceptions to this include:

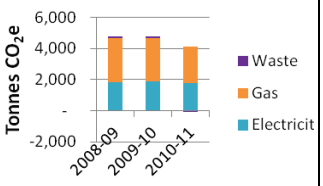
   - Scope 3 Carbon Conversion Factors for waste: Based on ERPHO's calculations and assumptions for NHS Scope 3 emissions using the DH Carbon Indicator values:
     - High temperature disposal / incineration: 220 $kgCO_2e$ per tonne of waste
     - Landfill disposal: 243.9 $kgCO_2e$ per tonne of waste
     - Recycling: -1,335.60 $kgCO_2e$ per tonne of waste
     - Non-burn / alternative treatment: 71.7 $kgCO_2e$per tonne of waste

   Source: NHS SDU and ERPHO, available at: www.sdu.nhs.uk/sd_and_the_nhs/measuring.aspx

NHS Northamptonshire - Sustainability Performance for year ending 31/03/11

Greenhouse Gas (GHG) Emissions		2008-09	2009-2010	2010-11	2011-12
Non-Financial Indicators (tCO_2e)	**Total emissions *(Gross)***	4,771	4,806	4,060	1,775
	Scope 1 emissions	1,843	1,868	1,764	*No data*
	Scope 2 emissions	2,824	2,811	2,337	*No data*
	Scope 3 emissions	104	126	-41	No data
Financial indicators (£k)	**Total expenditure on CRCEES**	*Not applicable*	*Not applicable*	*Not applicable*	*N/A*

GHG emissions by source



GHG emissions by source over 3 years

TARGETS AND COMMENTARY

Our commitment, given sufficient funding, is to reduce Building and Energy to reach our target of GHG to 3340 CO²t by the end of 2014/15.

DIRECT IMPACTS COMMENTARY

- The main direct impact for the Trusts is in its energy consumption.
- The Trusts GHG emissions are broken down above into scopes, following national guidelines for GHG accounting[7]:
- Scope 1 accounts for GHG emissions arising as a result of the use of gas to heat Trust-owned buildings and others from which it operate
- Scope 2 accounts for GHG emissions arising from the use of electricity supplied to all of Trust buildings, mostly to provide lighting and power equipment
- Scope 3 accounts for GHG emissions resulting from the management and disposal of all the Trust's waste arisings, and water usage, which accounted for - 41 $tC_{O2}e$ in 2010/11, this is due to the positive environmental benefit of recycling and recovery.
- Total footprint has fallen just under **15%** since 08-09
- Investment in improved insulation, low energy lighting and replacement boilers has had a significant impact on the energy use and spend in our buildings.
- The impact of higher world energy prices has been mitigated to some extent by our involvement in the national NHS energy contracts which give us access to the most cost effective suppliers.

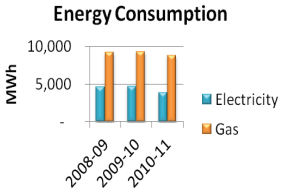
[7] http://www.defra.gov.uk/publications/2011/09/01/ghg-conversion-factors-reporting/

OVERVIEW OF INDIRECT IMPACTS

- The improvements in insulation, heating systems and heating controls in sites has reduced the need for portable heating and air conditioning units.
- We will consider the achievement of a national recycling Gold Award, to highlight the excellent work already carried out.

- We engage with both the local health community with regular meetings as well as the wider Northamptonshire Community using Patient groups.
- As a member of the Northamptonshire Climate Change Group and co-contribute to the Policy and action plan, we are supporting **Sustainable Procurement** - Identifying opportunities for reducing emissions through a county-wide sustainable public procurement and minimising waste initiatives and provide support to all local authorities to implement this.

Energy in buildings			2008-09	2009-10	2010-11	2011-12
Non-Financial Indicators (MWh)	Energy consumption	**Total consumption**	13,807	14,005	12,690	5,989
		Electricity	4,663	4,735	3,936	1,851
		Gas	9,144	9,270	8,754	4,138
Financial Indicators (£k)		**Total expenditure**	£780	£924	£585	£272
		Electricity				
		Gas				



Total buildings energy use by source

TARGETS AND COMMENTARY

- Our commitment, given sufficient funding, is to reduce Building and Energy GHG to 3340 CO^2t by the end of 2014/15.

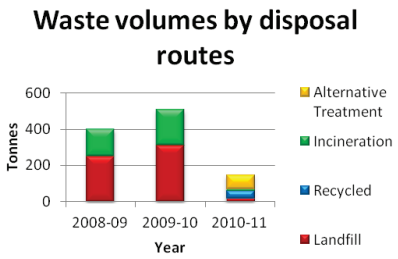
DIRECT IMPACTS COMMENTARY

- The main reasons behind the Trust's large energy use are heating and cooling, lighting, and powering equipment across the Trust's estate.
- The largest contributor of the Trust's Energy consumption is in its gas usage which accounted for 69% of the total energy consumption in 2010/11. New boilers have been installed in some sites in 2011 and this would show a reduction in gas usage.
- Total energy use has fallen by 8% since 08-09
- Investment in improved insulation, low energy lighting and replacement boilers has had a significant impact on the energy use and spend in our buildings.
- The impact of higher world energy prices has been mitigated to some extent by our involvement in the national NHS energy contracts which give us access to the most cost effective suppliers.

OVERVIEW OF INDIRECT IMPACTS

- Although we have been able to make savings in the energy used in our buildings, we recognise that as a community organisation we share premises with other organisations in Northamptonshire. These can include the local Authority and GP Practices. We are working closely with these partners to help and support their efforts to reduce their energy usage by sharing our expertise and advice on steps they can take.

Waste minimisation and management		2008-09	2009-10	2010-11	2011-12
Non-Financial Indicators (tonnes)	Total (all waste) arisings	403	510	148	58
	Landfill	252	309	17	2
	Recycled	0	0	43	47
	Incineration	152	201	11	2
	Alternative Treatment	0	0	78	7
Financial Indicators (£k)	Total (all waste) disposal cost	£112	£119	£116	£108



Total waste arising over 3 years

TARGETS AND COMMENTARY

- The massive reduction in waste volume may be the result of the over estimating of bin weights, in the past. Before the countywide waste tender was started the Trust had a number of different waste providers. This made reporting very difficult, so average bin weights were used in the preparation of the ERIC return. Shank's waste management provide actual bin weights, which has lead to a much better reporting.

DIRECT IMPACTS COMMENTARY

- Countywide waste management tender, which has resulted in no waste being sent to landfill. Shank's waste management redirect all of the Trust's waste to its own purpose built local MRF (materials recycling facility). Shank's recover 77% of the waste as recyclable material and the remaining 23% is reprocessed into a fuel. The Trust achieved a national recycling award from E2B carbon reduction forum for its recycling efforts.

- Site level recycling has been implemented at the majority of sites, with multiple waste bins. Through staff engagement the Trust has managed to recycle 15% of its waste before its collected by Shank's, which has saved the Trust a significant amount of money. Site level recycling also provide a very positive green message to staff and visitors alike.

OVERVIEW OF INDIRECT IMPACTS

- The carbon impact of waste management in the Trust is -45 tCO2e in 2010/11, and takes into consideration both the negative effects of landfill, incineration and alternative treatment, and offset by the positive environmental effects of recycling and recovery. Although emissions from waste was offset by the positive environmental benefit of recycling, waste is and will continue to be a priority area in the Trust's sustainability efforts, due to the wider potential environmental, social and health impacts derived from its disposal, together with the very significant -and rising- costs associated with its treatment and end disposal.

- Sustainability was consisted as part of the new waste contract, collection routes were looked at to reduce vehicle movements to save fuel. All waste is directed from landfill. The clinical waste company uses modern efficient vehicles to reduce fuel usage. Routes have been combined with the GP contract to further reduce vehicle mileage and fuel usage. Waste sent to incineration is sent to Nottingham where waste heat from the incinerator is used for steam generation to provide hot water and heating for local housing. Ash and flock from the incinerator is sent for recycling and not to landfill.

- A sustainability and recycling audit is carried out on an annual basis to indentify areas which need additional help with recycling.

Travel and transport		2008-09	2009-10	2010-11	2011-12
Non-Financial Indicators (1000x km)	**Total mileage**	*Not available*	*912*	*921*	859
	Owned & leased				*57*
	Grey fleet				802
	Rail				Not avail
	Air				18
	Taxi				Not avail
	Ferry				*n/a*
Financial Indicators (£k)	**Total expenditure**	*Not available*	*287*	*246*	246
	Owned & leased				5
	Grey fleet				241
	Rail				14.9
	Air				1
	Taxi				Not avail
	Ferry				*n/a*

TARGETS AND COMMENTARY

- The GHG emissions for travel and transport was excluded as the data is aggregated, therefore we could not apply emissions factors to it as cannot calculate what percentage of the mileage is for cars or other modes of transport.

DIRECT IMPACTS COMMENTARY

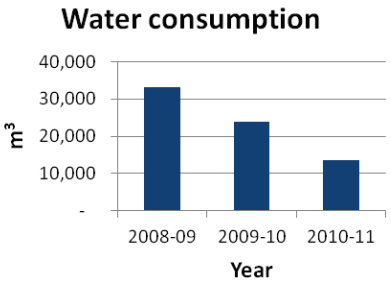
- A free to staff Liftshare scheme has been put in place to facilitate car sharing and a staff programme for car sharing, conference calls, video conferencing has been carried out, including a speed dating exercise to link home postcodes. Car sharing parking spaces will be considered when the parking policy is reviewed.

OVERVIEW OF INDIRECT IMPACTS

- There has been limited uptake for the Liftshare scheme and a further staff behavioural change programme is planned. Demonstrations on conference calls and web-ex have been carried out in recent weeks and the installation of video conferencing facilities at key sites is under review.

- As a partner of the Northamptonshire Climate Change Group we are supporting the Northants Transport Plan – Implementation ensures that more focus is given towards behaviour change to achieve carbon reduction.

Finite Resources		2008-09	2009-10	2010-11	2011-12
Non-Financial Indicators	Water consumption (m^3)	33,270	23,978	13,528	11265
Financial Indicators (£k)	Total expenditure on water	£73	£63	£33	£17



Total water used (m^3) over 3 years

TARGETS AND COMMENTARY

- Water is one of the key finite natural resources used by the Trust on a daily basis.
- Our commitment is to reduce water usage by the end of 2014/15 to achieve a 30% reduction on the 2007/08 baseline figures

DIRECT IMPACTS COMMENTARY

- Although in the Trust water use and its associated impacts are proportionally much smaller than those of energy use, water is an essential natural resource which all divisions depend on to deliver services effectively, and hence managing its use effectively and minimising wastage is a priority.
- The massive fall in consumption, down 59%, has been facilitated by the monitoring of consumptions regularly to detect leaks early and repair them before massive water loss is experienced. Water efficiency surveys are being carried out by the local water company, to help reduce the Trust's water consumption at the larger hospital sites. This good practice can then be rolled out to smaller Trust sites in house.
- Flushing regimes for Legionella control are being carefully looked at to avoid unnecessary water loss. Cleaning of water storage tanks is only untaken as required and not as a matter of course, as was the case in the past. Modern water efficient equipment is purchased, when older appliances are in need of replacement.

OVERVIEW OF INDIRECT IMPACTS

- Given that water shortages may increase in future years we will examine ways of further reducing water usage by collecting and recycling water and using 'grey water' methods for toilets etc.

Department of Health

NHS

Northamptonshire Teaching Primary Care Trust

2012-13 Accounts

Published to gov.uk, in PDF format only.

www.gov.uk/dh

Northamptonshire Teaching Primary Care Trust

2012-13 Accounts

STATEMENT OF THE RESPONSIBILITIES OF THE SIGNING OFFICER OF THE PRIMARY CARE TRUST

The Department of Health's Accounting Officer designates the Signing Officer of the accounts of PCTs in England, an officer of the Department of Health, to discharge the following responsibilities for the Department, to ensure that for the year ended 31 March 2013:

- there were effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money was achieved from the resources available to the primary care trust;
- the expenditure and income of the primary care trust had been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems were in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the net operating cost, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the above responsibilities, as designated Signing Officer and through experience in my role as Accountable Officer until 31 March 2013.

nb: sign and date in any colour ink except black

Signed.....Jane Halpin.....Designated Signing Officer

Name: JANE HALPIN

Date.....7.6.13.....

2012-13 Annual Accounts of Northamptonshire Teaching Primary Care Trust

STATEMENT OF RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

Primary Care Trusts as NHS bodies are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the primary care trust and the net operating cost, recognised gains and losses and cash flows for the year. From 1 April 2013 responsibility for finalising the accounts falls to the Secretary of State. Formal accountability lies with the Department of Health's Accounting Officer, and her letter of 28 March 2013 designated the Signing Officer and Finance Signing Officer, to discharge the following responsibilities for the Department in preparing the accounts:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;

- make judgements and estimates which are reasonable and prudent;

- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

- ensure that the PCT kept proper accounting records which disclosed with reasonable accuracy at any time the financial position of the primary care trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State.

- have taken reasonable steps for the prevention and detection of fraud and other irregularities.

The Signing Officer and the Finance Signing Officer confirm to the best of their knowledge and belief, they have complied with the above requirements in preparing the accounts.

By order of the Permanent Secretary.

nb: sign and date in any colour ink except black

7.6.13 Date ..... Signing Officer

7/6/13 Date ..... Finance Signing Officer

GOVERNANCE STATEMENT 2012-13

NHS Northamptonshire (5PD)

1. INTRODUCTION

This year has been a year of transition, with the PCT successfully implementing the Health and Social Care Act 2012 that resulted in the abolition of the PCT on 31 March 2013. There has been a shift in focus from the clustering of NHS Northamptonshire and NHS Milton Keynes in 2011-12 to working with and transitioning to the newly established successor health bodies.

The Clustering arrangements established during 2011-12 remained in place during 2012-13 with the operation of a single executive team for the two PCTs and a single Board directing the business of both PCTs. This Statement will reflect and highlight those areas of joint enterprise and those where the PCTs are required to report separately on matters affecting the individual legal entities.

One of the key governance changes that occurred during the year was the establishment of the NHS Commissioning Board's Area Team (AT) for Northampton and Milton Keynes, which assumed the Executive responsibility for the PCT on 1st October 2012. The AT's Executive Directors have worked alongside the PCT's Non-Executive Board members to ensure the Cluster Board remained an effective vehicle for delivering the PCT's governance responsibilities.

2. SCOPE OF RESPONSIBILITY

Arising from the schemes of delegation approved by the Northampton PCT in 2011-12, the PCT's Board functions continued to be discharged during 2012-13 by a joint committee known as the Cluster Board. Therefore, any references to the Board within this document refer to the Cluster Board.

The Cluster Board, acting under delegated authority from the PCT Board, is accountable for internal control of the PCT. As Accountable Officer for this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the PCT and Cluster policies, aims and objectives. I also have responsibility for safeguarding the public funds and the PCTs assets for which I am personally responsible.

As the Accountable Officer for Northamptonshire Teaching PCT I am able to provide assurance that the PCT has in place robust accountability arrangements, not only for the discharge of my own responsibilities, but also in the achievement of performance targets and strategic objectives.

The PCT continued to be subject to reviews by the Midlands and East Strategic Health Authority (SHA). This is carried out via a combination of formal processes (e.g. annual and quarterly reviews) and service driven reviews of our clinical governance, finance and operating framework arrangements.

Through the establishment of the Clinical Commissioning Groups (CCGs) NHS Northamptonshire continued to work alongside other health and social care partners to operate within a Health Community Planning Framework, ensuring delivery of appropriate and wide ranging NHS Targets.

Throughout the year the CCGs have assumed more of the PCT's responsibilities in order to prepare them for full authorisation and statutory body status.

One such example is where the CCGs assumed the PCT's relationships with Local Strategic Partners within the Northamptonshire locality, and took ownership of the joint targets for the improvement of Health Outcomes. Other examples include; the adoption of recommendations from the Director of Public Health Report, the development of sustainable community strategies at County and District level, and joint production of the Joint Strategic Needs Assessments.

There continued to be close collaborative working with the County Council as part of the implementation of 'Liberating the NHS' with regular scheduled meetings at senior officer level. There is also County Council membership of Regional Transition Networks, and representation at the steering groups for the transition of public health functions.

The PCT was represented at collaborative meetings that were held throughout the year including; Health and Wellbeing Boards; local government including local councils; all relevant CCGs (COO and GPs); and other agencies including local key providers (Mental Health, Acute Hospital etc), LINks (progressing to HealthWatch), and the University of Northampton.

A significant element of these collaborative meetings was dealing with the transfer of the public health functions, assets and resources to the County Council as part of the NHS reforms. This work was completed on schedule enabling the correct form of legal transfer to be enacted on 1st April 2013.

3. GOVERNANCE FRAMEWORK

Cluster Board

Throughout 2012/13 the Cluster Board has operated as a single entity with shared members on the Boards of both of the Cluster PCTs. In October 2012 the entire team of Executive Directors changed with the appointment of the NHS CB Area Team's Executive Director Team, which assumed the accountability and responsibility for the PCT's Executive Director functions.

During 2012-13 the Cluster Board met 11 times in total (full attendance records are available).

The Cluster Board has been effective in discharging the functions of the PCT Board. It has successfully steered the PCT through the changes and challenges brought about by the implementation of the NHS reforms, ensuring a smooth transition to the NHS Commissioning Board, CCGs and the Greater East Midlands Commissioning Support Unit (GEM CSU).

Cluster Board Sub-Committees

At the commencement of 2012-13 the Cluster Board had in place the following sub-committees:

- Joint Audit Committee
- Quality, Safety and Risk Committee
- Remuneration and Terms of Service Committee
- Finance and Resources Committee
- Nene CCG Board
- Milton Keynes CCG Board
- Corby CCG Board
- Transition & Closure Board
- Public Health Transition Group

From October 2012 onwards the Cluster also established, on behalf of the Cluster PCTs, a Transition and Closedown Board and Committee tasked with ensuring the closedown of both PCTs was carried out effectively and all that transferred to appropriate successor bodies was properly completed.

Joint Audit Committee

This committee was jointly established to act as a single committee on behalf of both PCTs under the Cluster's governance arrangements. It was constituted in line with the provisions of the NHS Audit Committee handbook and oversaw the audit of the 2011-12 accounts for PCTs, the internal and external audit plans and the risk management and internal control processes (financial and quality), including control processes around counter fraud. As part of the handover process a schedule of outstanding items resulting from the Cluster's internal audit programme was passed to the successor bodies.

During 2012-13 the Committee met 6 times and, in addition to the above, other key areas considered were:

- A series of reports on the Payments by Results Assurance Framework for the PCT;
- QIPP review follow-up work;
- Information Governance validation and
- Review and stress test the transition plans and risks.

Audit sub-committee

Audit Committee arrangements were also specified nationally to ensure that the essential scrutiny and governance function provided by an Audit Committee was retained, despite PCT closure.

In accordance with the guidance and Terms of Reference provided by the Department of Health an Audit sub-committee was established as a sub-committee of the Department of Health Audit and Risk Committee. The sub-committee's period of tenure is 1 April 2013 to 30 June 2013 with a membership of three who are all former Non-Executive Directors of the Cluster.

The remit of the sub-committee is to support the final accounts process, thereby providing a mechanism to provide appropriate assurance for the discharge of statutory responsibilities

Quality, Safety and Risk Committee

The Quality, Safety & Risk Committee played a critical role in establishing and regularly reviewing the Governance Framework of the Cluster, and in maintaining an overview of the progress towards the authorisation of CCGs and the Commissioning Support Unit. It also ensured the routine governance business of the Cluster was maintained during the transition period.

The Committee also played an important role in helping to manage the transition to the new NHS system by including representatives from each CCG, and considering regular update reports from the Public Health Transition Group and QIPP committee.

The Committee had an assurance role for the Cluster's performance across a wide range of targets and quality measures, including the CCGs' delivery of QIPP and other financial targets and the quality of plans to achieve them.

However, as part of a mid-year review of Cluster resources, systems and processes it was decided to stand the Committee down at the end of January 2013, partly in recognition of the increasing autonomy that the CCGs acquired as a result of their authorisation in December 2012 and January 2013.

Governance continued to be exercised in this transition by direct attendance at Cluster Board by the Chief Officers or Chairs of each CCG. At its final meeting, the Committee received a report on how its functions would be picked up by other committees or parts of the NHS system for the remainder of 2012-13 in order to maintain continuity in the scrutiny and monitoring of statutory functions and performance.

In total the Committee met 6 times prior to it being stood down at the end of January 2013.

QIPP Coordination and Assurance Group (QCAG)

The PCT established a QIPP Assurance Committee to oversee the PCTs QIPP programme for 2012-13. It was comprised of representatives from both the CCGs and the Cluster and provided a detailed review of QIPP plans, which were drilled down and managed at a CCG level. The group reported each month to the Quality, Risk & Safety Committee, which added a further level of scrutiny.

Transition and Closure Board

The Board established a Transition and Closedown Board in autumn 2012 and appointed a Director of Transition to act as chair.

The Transition and Closure Board has worked to a tight operational plan receiving monthly reports from a range of workstreams focussing on closing down and transitioning functions as appropriate. This work has been supported by a transition and close down risk register which was presented to and considered by the Transition and Closure Board. The remit of the board was to ensure:

- Successful closedown of the PCT;
- Support for the establishment of a range of new commissioning organisations;
- A seamless handover to receiving organisations; and
- Continuity of business as usual.

Senior staff attended the Transition and Closure Board and were appointed clear leadership roles for key functional transfers. Internal Audit was involved in the establishment and operational review of transition processes and significant assurance was provided that controls were adequate.

Completion of Handover and Closure Documents

The PCT has produced and published a hand-over document as required by the Midlands and East SHA, and this has informed much of the hand-over work to the CCGs and other new organisations created by the NHS reforms. To support this document a Library of Knowledge was established that stored all the supporting documents referenced in the hand-over document, and will continue to be available for a period of time after the PCT has ceased to function.

Accounts Scrutiny and Sign-Off

The accountability arrangements for the 2012-13 financial accounts were in line with the nationally defined accounts scrutiny and sign off process. From 1st April 2013 when PCTs were abolished, Area Team Directors continued to discharge the responsibilities associated with the closedown, until completion. For the PCTs this entailed the set-up of local delivery teams to secure

effective accounts preparation and managing the audit process. The AT Directors, as PCT Accountable officers, have responsibility for signing the accounts and the supporting statements.

Discharge of Statutory Functions

An integral part of the transition has been the reconciliation of the statutory functions of the PCT and their destination after the end of March 2013. The PCT has used legal advice to establish the definitive list of statutory responsibilities to ensure that each function is transferred appropriately. In doing so the PCT has established that no irregularities have been identified and has assured itself that it is legally compliant.

The System of Internal Control

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

- identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives; and

- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control was in place at NHS Northamptonshire for the whole year ending 31st March 2013.

4. CAPACITY TO HANDLE RISK

THE PCT CORPORATE ENTITY

For the period of this statement the PCT, as a corporate entity, vested all its capacity to handle risk in the systems and structures of the Cluster, and therefore for the purposes of this statement it will be the Cluster's capacity to handle risk that is described.

THE CLUSTER

For the period up to 30th September 2012 the Cluster Chief Executive had ultimate responsibility for risk management and was held to account through the Cluster Board, the Quality, Risk & Safety Committee, and the Cluster Audit Committee for the effectiveness of Cluster (and hence PCT) processes. For the period from 1st October 2012 to 31st March 2013 this responsibility passed to the Chief Executive of the NHS Commissioning Board's (NHS CB)

Area Team for Northamptonshire & Milton Keynes. It is in this capacity that I am providing this statement.

Day to day responsibility for risk management was delegated to all Executive Directors of the Board with executive leadership being vested in the Cluster Director of Finance (up to 30th September 2012) and the NHS CB Area Team Director of Nursing and Clinical Quality from 1st October 2012, then the Transition Director from December 2012 to 31st March 2013.

In conjunction with these structures all appropriate staff were provided with training in the principles of risk management / assessment in order for them to manage and treat appropriate levels of risk within their designated authority and day to day duties.

CLINICAL COMMISSIONING GROUPS

During 2012-13 the PCT, through the mechanism of the Cluster, has continued to support the development of four Clinical Commissioning Groups (CCGs) in Northamptonshire and Milton Keynes. Initially they were established as sub-committees of the Cluster Board but during 2012-13 all four of them successfully navigated the authorisation process and have been established as statutory bodies who will take on their full range of statutory responsibilities on 1st April 2013.

Throughout the year the following mechanisms were used to provide an environment in which risks could be identified and managed:

- Board to Board meetings between the Cluster Board and the Governing Bodies;
- CCG leaders attended Cluster Board meetings; and
- CCG leaders attended meetings of the Quality, Risk & Safety Committee.

GREATER EAST MIDLANDS COMMISSIONING SUPPORT UNIT (GEM)

In addition to supporting the development of the CCGs the Cluster has been actively involved in the establishment of the Greater East Midlands Commissioning Support Unit (GEM). Each Cluster within the GEM regional area established a Steering Group and an Operational Group to ensure that each Cluster received assurances on the establishment of GEM and the processes by which staff and assets would be transferred to the new body. Each area developed its own local risk register that fed into GEM's corporate risk register, which has been reviewed on a monthly basis by the Senior Management Team.

5. THE RISK AND CONTROL FRAMEWORK

RISK MANAGEMENT

The PCT adopted a revised Risk Management Strategy in September 2010. It was agreed at the Quality, Safety & Risk Committee that no further changes or revisions were required in 2012-13. The strategy outlined the Cluster's approach to risk and the manner in which it sought to eliminate and control all risks. Staffs at all levels of the organisation were able to identify and record risk, with appropriate levels of staff trained to evaluate and treat the risk accordingly.

Risk management was embedded in the activities of the organisation. Through its main sub-committees (CCG Boards, Governance Committee, and Audit Committee) and line management structures, the PCT was able to ensure accountability for risk at all levels of the organisation.

By ensuring that all staff were made aware of their responsibilities for both governance (all elements) and health and safety, a substantial amount of progress was made towards ensuring ownership of risk by staff. Staff were engaged in providing monthly updates on risks relevant to their area of responsibility to inform the Quality, Safety & Risk Committee and Board in a timely manner.

A key output from the risk management system was that each month the Cluster Board received a report on the high scoring corporate risks that impacted on the successful achievement of the Cluster's strategic objectives. In addition, the Quality, Safety and Risk Committee received monthly reports on the high scoring risks, and those due for a review in that month.

MAJOR RISKS IDENTIFIED IN 2012-13

As a result of the Cluster's risk management process it was able to identify the following as its major risks for 2012-13:

- Lack of capability and capacity due to loss of key staff/ experience/ skills has resulted in an inability to deliver business as usual within the cluster and to create an effective CSU. This was mitigated by an effective HR process that mapped current roles to positions within the new organisations and a combination of "lift and shift" and pooling, slotting and matching processes.

- The fragmentation of duties and uncertainty of responsibilities during transition leading to poor performance. This was one of the highest scoring risks at the beginning of the year, but as can be evidenced in this statement a comprehensive range of mechanisms and processes were put in place to ensure such fragmentation did not occur.

- The successful authorisation of the emergent CCGs allowing them to assume their new statutory responsibilities from 1st April 2013.

- Ensuring all staff were transferred to their new destination organisations by 31st December 2012, and that the number of redundancies were kept to an absolute minimum. There was a tightly managed HR process that achieved this by the due date, with letters setting out new employment arrangements post-1st April being issued to all affected staff.

- Successful delivery of the QIPP plan, and the savings identified within it. These savings were essential for balancing the PCT's finances and driving forward quality, innovation and efficiency.

CORPORATE OBJECTIVES AND THE BOARD ASSURANCE FRAMEWORK

The Board approved its Corporate Objectives for 2012-13 at its meeting in April 2012. The PCT's Assurance Framework was approved by the Quality, Safety & Risk Committee in June 2012, following an exercise to integrate CCG key strategic risks into the Cluster risk portfolio. Adherence to the Assurance Framework allowed the PCT to identify its principal risks and the controls required to mitigate against them.

The framework was proactively reviewed by senior staff on a regular basis. The Quarter 4 Assurance Framework for 2012-13 was refocused to reflect the PCT's closedown and transition role and was authorised by the Cluster Board in March 2013.

INTERNAL AND EXTERNAL AUDIT

Both Internal and External Audit carry out independent reviews of systems and processes within the organisation. Recommendations and action plans are put in place following these reviews to ensure controls are safe and adequate, providing safeguard of assets and resources. Key risks highlighted in these reports are also added to the Cluster's Assurance Framework. Action plans are routinely tracked through the quarterly Audit Committee meetings.

COUNTER FRAUD & DETERRENCE

During 2012-13 the PCT continued to commission a counter fraud service from RSM Tenon. The Local Counter Fraud Specialist regularly met with the Director of Finance to review the Counter Fraud plan and discuss cases. The LCFS also presented quarterly reports to the PCT's Audit Committee.

INFORMATION GOVERNANCE

The Director of Finance was the Executive Lead on the Board for Information Governance and was also the Senior Information Risk Officer (SIRO).

The Caldicott Guardian was the Cluster Director of Nursing for the Northamptonshire & Milton Keynes PCTs.

Throughout 2012-13 work was undertaken to improve the PCT's compliance with the Information Governance Toolkit levels. This has strengthened the processes around mapping of information flows of personal data within the organisation and understanding the risks associated with records as they transfer to other organisations.

DATA SECURITY

At the PCT all Information Governance incidents are taken extremely seriously. These include incidents relating to person identifiable data loss, any breach of confidentiality, the insecure disposal of information and any other incidents where staff or patient information may have been at risk.

All staff are trained and encouraged to report all incidents and near misses to ensure we can investigate the reason for an incident occurring and take measures to prevent that incident happening again.

Appendix B of the Department of Health Guidance on Information Governance Assurance issued in May 2008 (Gateway reference 9912) only requires serious untoward data security breaches rated at level 3 or above to be declared in this statement. In 2012/-3 there were no reported serious incidents involving personal data.

There were no cases reported to the Information Commissioner in 2012-13.

EQUALITY, DIVERSITY AND HUMAN RIGHTS.

Control measures were in place to ensure that the organisation complied with its obligations under equality, diversity and human rights' legislation. The Director of Nursing led in this area on behalf of the Board

Equality and Inclusion (E&I) assurance reports, and relevant legal and Department of Health updates, have been presented to the Cluster Board, with operational E&I reports presented on a regular basis to the Quality, Safety & Risk Committee throughout the year. Action plans were in place to address identified gaps in control.

Following the adoption of the Equality Delivery System (EDS) in 2011-12 all committee reports included a section on how the report met the objectives of the EDS throughout 2012-13.

SUSTAINABILITY

The Cluster has a Trust-wide commitment to reduce its carbon footprint from the 2008/09 baseline by 2013. A Sustainable Development Plan incorporating good practice and target Carbon Management Plans have been produced and approved by the Board.

The estate rationalisation programme has proved extremely successful and most of the surplus properties have now been disposed of further reducing the PCT's carbon footprint, saving money to ensure best use of limited resources and improving the standard of accommodation for staff. Multi-functional devices with the capability to copy, fax and print have now been rolled out to most PCT premises.

Clinical Commissioning Groups have developed a baseline position to allow the formulation of a Sustainable Development Management Plan for their future needs.

6. SIGNIFICANT ISSUES

There is only one significant issue arising in 2012-13 that warrants additional reporting in this statement which relates to Continuing Healthcare retrospective reviews.

In March 2012 the DH announced the introduction of a deadline for individuals to request an assessment of eligibility for NHS Continuing Care funding for the period 1 April 2004 to 31 March 2012 following which the PCT has been inundated with requests for reviews.

Given the high level of additional requests received it will take a long time to evaluate whether these reviews will translate into claims. This workload is in addition to the existing retrospective claims currently being processed.

The PCT has received more than 500 requests for assessment following the DH announcement and processing these requests is placing a significant strain on existing resource. The liability to settle claims arising from this exercise will pass to the CCGs as successor organisations. In view of the current uncertainty surrounding the level of liability likely to emerge from this process this poses a significant financial risk to the receiving CCGs.

Additional resource is currently being redeployed into retrospective reviews and assessments to clear the backlog of work created by the DH announcement.

7. REVIEW OF EFFECTIVENESS

As Accountable Officer, I have responsibility for reviewing the effectiveness of the Cluster's governance systems. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of their annual programme of internal audit work.

The Head of Internal Audit's annual opinion on the system of internal control is based on an agreed programme of work undertaken throughout the financial year. This has resulted in a significant assurance opinion for the year.

Executive Directors within the organisation, who have responsibility for the development and maintenance of the system of internal control, also provide me with assurance.

The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. The Framework for 2012-13 was actively managed and regularly reviewed by the Quality, Safety & Risk Committee and the Board. I am satisfied that the Framework reflected the key challenges faced by the organisation at the start of the business year, and that it appropriately reflected the development of the new NHS structures as the year progressed.

My review is also informed via assurances provided by:-

- NHS Midlands and East (Strategic Health Authority);
- KMPG (External Audit); and
- Internal Audit reviews

I have also been advised on the implications of the results of my review of the effectiveness of the system of internal control by the:-

- Cluster Board;
- Executive Team;
- Audit Committee; and
- The Quality, Safety & Risk Committee

The PCT had a robust process in place to allow ongoing maintenance and review of the effectiveness of the system of internal control. PCT Directors held day to day responsibility for ensuring that controls existed within their designated areas of responsibility.

Existence and robustness of controls was tested by the PCT's Auditors, with any identified weaknesses being reported to the Audit Committee, as appropriate.

Additional assurances were received during the course of the year in respect of the PCT's Assurance Framework and associated Action Plan, predominantly from the PCT's Internal Auditors.

There has been no evidence presented to myself or the Board to suggest that at any time during 2012-13 the PCT has acted outside of its statutory authorities and duties. The PCT has complied with the provisions of the Corporate Governance Code and there have been no incidents where non-compliance has taken place.

My review confirms that NHS Northamptonshire had a generally sound system of internal control that supported the achievement of its policies, aims and objectives throughout the year ended 31 March 2013.

Signed ..... Jane Halpin .....
Jane Halpin
Chief Executive, Area Team, Milton Keynes & Northamptonshire NHS Commissioning Board

Dated ..... 7.6.13 .....

KPMG

INDEPENDENT AUDITOR'S REPORT TO THE SIGNING OFFICER OF NORTHAMPTONSHIRE TEACHING PRIMARY CARE TRUST

We have audited the financial statements of Northamptonshire Teaching Primary Care Trust comprising the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers Equity, Statement of Cash Flows and related notes for the year ended 31 March 2013. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England. We have also audited the information in the Remuneration Report that is subject to audit.

This report is made solely to the signing officer of Northamptonshire Teaching Primary Care Trust in accordance with Part II of the Audit Commission Act 1998. Our audit work has been undertaken so that we might state to the signing officer of the PCT those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the signing officer of the PCT for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of Signing Officer and auditor

As explained more fully in the Statement of The Responsibilities of the Signing Officer of the Primary Care Trust, the Signing Officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of Northamptonshire Teaching Primary Care Trust as at 31 March 2013 and of its expenditure and income for the year then ended; and

- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on regularity prescribed by the Code of Audit Practice 2010 for local NHS bodies

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

Opinion on other matters prescribed by the Code of Audit Practice 2010 for local NHS bodies

In our opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and

- the information given in the directors' report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Code of Audit Practice 2010 for local NHS bodies requires us to report to you if:

- in our opinion, the Governance Statement does not reflect compliance with the Department of Health's requirements;
- any referrals to the Secretary of State have been made under section 19 of the Audit Commission Act 1998; or
- any matters have been reported in the public interest under the Audit Commission Act 1998 in the course of, or at the end of the audit.

Conclusion on the PCT's arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the PCT has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report any matters that prevent us being satisfied that the audited body has put in place such arrangements.

We have undertaken our audit in accordance with the Code of Audit Practice 2010 for local NHS bodies, having regard to the guidance issued by the Audit Commission in November 2012. We have considered the results of the following:

- our review of the Governance Statement; and
- the work of other relevant regulatory bodies or inspectorates, to the extent that the results of this work impact on our responsibilities at the PCT.

As a result, we have concluded that there are no matters to report.

Certificate

We certify that we have completed the audit of the accounts of Northamptonshire Primary Care Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission.

Jon Gorrie, for and on behalf of KPMG LLP, Statutory Auditor

One Snowhill,
Snowhill Queensway
Birmingham
B4 6GH

10 June 2013

FOREWORD TO THE ACCOUNTS

NORTHAMPTONSHIRE TEACHING PRIMARY CARE TRUST

These accounts for the year ended 31 March 2013 have been prepared by Northamptonshire Teaching Primary Care Trust under section 230(1) of the National Health Service Act 2006 in the form which the Secretary of State has, with approval of the Treasury, directed.

Statement of Comprehensive Net Expenditure for year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure			
Gross employee benefits	7.1	**19,572**	18,620
Other costs	5.1	**1,121,386**	1,093,621
Income	4	**(44,589)**	(41,045)
Net operating costs before interest		**1,096,369**	1,071,196
Investment income	9	**0**	0
Other (Gains)/Losses	10	**30**	(125)
Finance costs	11	**1,472**	1,824
Net operating costs for the financial year		**1,097,871**	1,072,895
Net (gain)/loss on transfers by absorption		**0**	0
Net operating costs and transfer gains/losses for the financial year		**1,097,871**	1,072,895
Of which:			
Administration Costs			
Gross employee benefits	7.1	**12,575**	13,160
Other costs	5.1	**10,855**	9,132
Income	4	**(5,043)**	(3,633)
Net administration costs before interest		**18,387**	18,659
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**0**	0
Net administration costs for the financial year		**18,387**	18,659
Programme Expenditure			
Gross employee benefits	7.1	**6,997**	5,460
Other costs	5.1	**1,110,531**	1,084,489
Income	4	**(39,546)**	(37,412)
Net programme expenditure before interest		**1,077,982**	1,052,537
Investment income	9	**0**	0
Other (Gains)/Losses	10	**30**	(125)
Finance costs	11	**1,472**	1,824
Net programme expenditure for the financial year		**1,079,484**	1,054,236

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**2,260**	0
Net (gain) on revaluation of property, plant & equipment	**(1,894)**	(3,721)
Net (gain) on revaluation of intangibles	**0**	0
Net (gain) on revaluation of financial assets	**0**	0
Net (gain)/loss on other reserves	**0**	0
Net Gain /(loss) on Assets Held for Sale	**252**	0
Release of Reserves to Statement of Comprehensive Net Expenditure	**0**	0
Net (gain)/loss on available for sale financial assets	**0**	0
Net actuarial (gain)/loss on pension schemes	**0**	0
Reclassification adjustment on disposal of available for sale financial assets	**0**	0
Total comprehensive net expenditure for the year	1,098,489	1,069,174

Statement of Financial Position at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	12	79,724	77,010
Intangible assets	13	0	0
Investment property	15	0	0
Other financial assets	21	0	0
Trade and other receivables	19	0	0
Total non-current assets		**79,724**	77,010
Current assets:			
Inventories	18	0	0
Trade and other receivables	19	5,500	11,136
Other financial assets	36	0	0
Other current assets	22	0	0
Cash and cash equivalents	23	13,163	20
Total current assets		**18,663**	11,156
Non-current assets held for sale	24	700	1,340
Total current assets		**19,363**	12,496
Total assets		**99,087**	89,506
Current liabilities			
Trade and other payables	25	(64,784)	(60,734)
Other liabilities	26,28	0	0
Provisions	32	(1,087)	(1,550)
Borrowings	27	(736)	(631)
Other financial liabilities	36.2	0	0
Total current liabilities		**(66,607)**	(62,915)
Non-current assets plus/less net current assets/liabilities		**32,480**	26,591
Non-current liabilities			
Trade and other payables	25	0	0
Other Liabilities	28	0	0
Provisions	32	(1,649)	(920)
Borrowings	27	(18,116)	(18,808)
Other financial liabilities	36.2	0	0
Total non-current liabilities		**(19,765)**	(19,728)
Total Assets Employed:		**12,715**	6,863
Financed by taxpayers' equity:			
General fund		(3,518)	(10,573)
Revaluation reserve		16,233	17,436
Other reserves		0	0
Total taxpayers' equity:		**12,715**	6,863

The notes on pages 5 to 32 form part of this account.

The financial statements on pages 1 to 32 were approved by the Board on May 2013 and signed on its behalf by

Chief Executive: Jane Halpin Date: 7.6.13

Statement of Financial Position at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	12	79,724	77,010
Intangible assets	13	0	0
Investment property	15	0	0
Other financial assets	21	0	0
Trade and other receivables	19	0	0
Total non-current assets		**79,724**	77,010
Current assets:			
Inventories	18	0	0
Trade and other receivables	19	5,500	11,136
Other financial assets	36	0	0
Other current assets	22	0	0
Cash and cash equivalents	23	13,163	20
Total current assets		**18,663**	11,156
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Total current assets		**19,363**	12,496
Total assets		**99,087**	89,506
Current liabilities			
Trade and other payables	25	(64,784)	(60,734)
Other liabilities	26,28	0	0
Provisions	32	(1,087)	(1,550)
Borrowings	27	(736)	(631)
Other financial liabilities	36.2	0	0
Total current liabilities		**(66,607)**	(62,915)
Non-current assets plus/less net current assets/liabilities		**32,480**	26,591
Non-current liabilities			
Trade and other payables	25	0	0
Other Liabilities	28	0	0
Provisions	32	(1,649)	(920)
Borrowings	27	(18,116)	(18,808)
Other financial liabilities	36.2	0	0
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Total Assets Employed:		**12,715**	6,863
Financed by taxpayers' equity:			
General fund		(3,518)	(10,573)
Revaluation reserve		16,233	17,436
Other reserves		0	0
Total taxpayers' equity:		**12,715**	6,863

Statement of Changes In Taxpayers Equity for the year ended 31 March 2013

	General fund	Revaluation reserve	Other reserves	Total reserves
	£000	£000	£000	£000
Balance at 1 April 2012	**(10,573)**	**17,436**	**0**	**6,863**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(1,097,871)	0	0	**(1,097,871)**
Net gain on revaluation of property, plant, equipment	0	1,894	0	**1,894**
Net gain on revaluation of intangible assets	0	0	0	**0**
Net gain on revaluation of financial assets	0	0	0	**0**
Net gain on revaluation of assets held for sale	0	(252)	0	**(252)**
Impairments and reversals	0	(2,260)	0	**(2,260)**
Movements in other reserves	0	0	0	**0**
Transfers between reserves	585	(585)	0	**0**
Release of Reserves to SOCNE	0	0	0	**0**
Net Gain/(loss) on transfers by absorption	0	0	0	**0**
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	**0**
Net actuarial gain/(loss) on pensions	0	0	0	**0**
Total recognised income and expense for 2012-13	(1,097,286)	(1,203)	0	**(1,098,489)**
Net Parliamentary funding	1,104,341			**1,104,341**
Balance at 31 March 2013	**(3,518)**	**16,233**	**0**	**12,715**

Balance at 1 April 2011	(8,126)	13,723	0	5,597
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(1,072,895)	0	0	(1,072,895)
Net gain on revaluation of property, plant, equipment	0	3,721	0	3,721
Net gain on revaluation of intangible assets	0	0	0	0
Net gain on revaluation of financial assets	0	0	0	0
Net gain on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	8	(8)	0	0
Transfers to/(from) other bodies within the group	(4,387)	0	0	(4,387)
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Net actuarial gain/(loss) on pensions	0	0	0	0
Total recognised income and expense for 2011-12	(1,077,274)	3,713	0	(1,073,561)
Net Parliamentary funding	1,074,827			1,074,827
Balance at 31 March 2012	(10,573)	17,436	0	6,863

Statement of Cash Flows for the year ended 31 March 2013

	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities		
Net Operating Cost Before Interest	(1,096,369)	(1,071,196)
Depreciation and Amortisation	4,007	3,919
Impairments and Reversals	4,056	63
Other Gains / (Losses) on foreign exchange	0	0
Donated Assets received credited to revenue but non-cash	0	0
Government Granted Assets received credited to revenue but non-cash	0	0
Interest Paid	(1,472)	(1,329)
Release of PFI/deferred credit	0	0
(Increase)/Decrease in Inventories	0	123
(Increase)/Decrease in Trade and Other Receivables	5,636	(846)
(Increase)/Decrease in Other Current Assets	0	0
Increase/(Decrease) in Trade and Other Payables	4,184	791
(Increase)/Decrease in Other Current Liabilities	0	0
Provisions Utilised	(581)	(1,665)
Increase/(Decrease) in Provisions	847	1,884
Net Cash Outflow from Operating Activities	**(1,079,692)**	(1,068,256)
Cash flows from investing activities		
Interest Received	0	0
(Payments) for Property, Plant and Equipment	(11,549)	(8,147)
(Payments) for Intangible Assets	0	0
(Payments) for Other Financial Assets	0	0
(Payments) for Financial Assets (LIFT)	0	0
Proceeds of disposal of assets held for sale (PPE)	629	1,725
Proceeds of disposal of assets held for sale (Intangible)	0	0
Proceeds from Disposal of Other Financial Assets	0	0
Proceeds from the disposal of Financial Assets (LIFT)	0	0
Loans Made in Respect of LIFT	0	0
Loans Repaid in Respect of LIFT	0	0
Rental Revenue	0	0
Net Cash Outflow from Investing Activities	**(10,920)**	(6,422)
Net cash outflow before financing	**(1,090,612)**	(1,074,678)
Cash flows from financing activities		
Other Loans Received	0	0
Other Loans Repaid	0	0
Other Capital Receipts	0	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	(586)	(380)
Net Parliamentary Funding	1,104,341	1,074,827
Capital Receipts Surrendered	0	0
Capital grants and other capital receipts	0	0
Cash Transferred (to)/from Other NHS Bodies	0	222
Net Cash Inflow from Financing Activities	**1,103,755**	1,074,669
Net increase/(decrease) in cash and cash equivalents	**13,143**	(9)
Cash and Cash Equivalents at Beginning of the Period	20	29
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies	0	0
Cash and Cash Equivalents at year end	13,163	20

1. Accounting Policies

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

The PCT is within the Government Resource Accounting Boundary and therefore has only consolidated interests in other entities where the other entity is also within the resource accounting boundary and the PCT exercises in-year budgetary control over the other entity.

In accordance with the directed accounting policy from the Secretary of State, the PCT does not consolidate the NHS charitable funds for which it is the corporate trustee.

1.1 Accounting Conventions

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

Acquisitions and Discontinued Operations

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

Critical accounting judgements and key sources of estimation uncertainty

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

Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the entity's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

PCT Clustering

Northamptonshire Teaching PCT and Milton Keynes PCT clustered in 2011-12 to form a joint management structure. Recharges have been applied between the two PCTs to reflect the costs of the management structure apportioned on a capitation basis.

Key sources of estimation uncertainty

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

1. Accounting policies (continued)

Bad Debt Provision
The Bad Debt provision at 31 March 2013 was £258,000 (as at 31 March 2012: £258,000) and was based on all non NHS outstanding debts, following a review of all amounts over 3 months old, where there is no known repayment plan
Prescribing Creditor
Prescribing expenditure data is received from the Prescription Pricing Division (PPD) of the NHS Business Services Authority two months in arrears. Therefore at the end of the financial year, the PCT will need to take an accrual for the likely prescribing costs for February and March. The accrual is based on the PPD's forecast spend for the PCT for the
Work in Progress/Partially Completed Spells
The PCT has recognised liability in the accounts in relation to activity which is partially completed as at 31 March 2013. For 2012-13 the total amount recognised is £1,814,091. For 2011-12 the comparative value was £1,517,251.
Estimation Techniques for Accruals
Included within the accounts are a number of accruals which the PCT has had to take a view on the likely level of liability. The main areas of assumption concern the Prescribing creditor (detailed above) and the final levels of activity completed by the PCT's healthcare providers as at 31 March 2013. Because of the time lag in receiving actual activity data, the PCT agreed the level of accrual required with its main providers, Northampton General Hospital NHS Trust, Kettering General Hospital NHS Foundation Trust and Northamptonshire Healthcare NHS Foundation Trust. Smaller accruals were based on commitment accounting i.e. where goods or services were received on or before 31 March 2013, an accrual was taken for the expected liability.
Continuing Healthcare Provision and Contingency

In March 2012 the DH announced the introduction of a deadline for individuals to request an assessment of eligibility for NHS Continuing Care funding for the period 1 April 2004 to 31 March 2012 following which the PCT has been inundated with requests for reviews. Given the high level of requests received it will take a long time to assess whether these assessments will translate into claims. This workload is in addition to existing retrospective claims currently being processed. The PCT has dealt with the existing retrospective claims and the request for retrospective assessments following the DH announcement as two separate workstreams.

In respect of existing claims at 31 March 2013 there were 37 outstanding retrospective review claims. Of these, 26 cases are to be reviewed, 5 are under appeal and 6 are new claims received in year. These claims represent a maximum liability of £2,263,540. To date there have been a total of 228 cases reviewed with 67 successfully awarded payment equating to 29.39% of cases. The PCT has therefore taken a provision at 31 March 2013 for 29.39% of the maximum liability. This equates to £665,163 with the remaining balance of £1,598,377 being disclosed as a contingent liability in the accounts.

In respect of the new assessment requests received in response to the DH announcement the PCT has received a total of 546 enquiries which are currently being assessed. Of these enquiries 127 are sufficiently progressed to allow a potential claim to be evaluated which, after applying current local and regional review rates, has resulted in the PCT taking a provision of £1,650,000 against these claims. In respect of the remaining 419 enquiries the PCT has disclosed £4,058,000 as a contingent liability based on the average value of enquiries evaluated to date after applying current local and regional review rates.

1.2 Revenue and Funding

The main source of funding for the PCT is allocations (Parliamentary Funding) from the Department of Health within an approved cash limit, which is credited to the General Fund of the PCT. Parliamentary funding is recognised in the financial period in which the cash is received.
Miscellaneous revenue is income which relates directly to the operating activities of the PCT. It principally comprises fees and charges for services provided on a full cost basis to external customers, as well as public repayment work. It includes both income appropriated-in-aid of the Vote and income to the Consolidated Fund which HM Treasury has agreed should be treated as operating income.
Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.
Where revenue has been received for a specific activity to be delivered in the following financial year, that income will be deferred.

1.3 Pooled Budgets

The PCT is the host of a pooled budget arrangements for the commissioning of Adult Mental Health Services across the county with Northamptonshire County Council. Under the arrangement, funds are pooled under S75 of the NHS Act 2006 for mental health commissioning activities.

1. Accounting policies (continued)

The PCT is the host of a pooled budget arrangement for the commissioning of Children & Adolescent Mental health Services across the county with Northamptonshire County Council. Under the arrangement funds are pooled under S75 of the NHS Act 2006 for the mental health commissioning activities and a memorandum note to the accounts provides details of the joint income and expenditure in the form of a memorandum trading account. This is unaudited and is included at page 44 of these accounts.

Northamptonshire County Council host the Drug and Alcohol Action team pooled budget arrangement on behalf of the PCT and is responsible for preparing financial monitoring information for the Drug Action Team management team. The unaudited pooled memorandum trading account is included at page 45 of these accounts.

Northamptonshire County Council host the integrated community equipment service pooled budget for the county. Under the arrangements, funds are pooled under S75 of the NHS Act 2006 and the PCT makes contributions to the pool for services to be delivered as a provider of healthcare services. The unaudited pooled budget memorandum trading account is included at page 46 of these accounts.

1.4 Taxation

The PCT is not liable to pay corporation tax. Expenditure is shown net of recoverable VAT. Irrecoverable VAT is charged to the most appropriate expenditure heading or capitalised if it relates to an asset.

1.5 Administration and Programme Costs

Treasury has set performance targets in respect of non-frontline expenditure (administration expenditure). From 2011-12, PCTs therefore analyse and report revenue income and expenditure by "admin and programme". For PCTs, the Department has defined "admin and programme" in terms of running costs.

The broad definition of running costs includes any cost incurred that is not a direct payment for the provision of healthcare or healthcare related services. Expense incurred under NHS transition redundancy programmes is however classed as "programme" under Treasury budgetary control arrangements and so is recorded as such in the financial statements.

1.6 Property, Plant & Equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation

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

Land and buildings used for the PCT's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

1. Accounting policies (continued)

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

Until 31 March 2008, the depreciated replacement cost of specialised buildings had been estimated for an exact replacement of the asset in its present location. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

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

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

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

1.7 Intangible Assets

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

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

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

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

1. Accounting policies (continued)

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

1.8 Depreciation, Amortisation and Impairments

Freehold land, properties under construction and assets held for sale are not depreciated.

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

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

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME) from 2011-12. This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set. AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.9 Donated Assets

Following the accounting policy change outlined in the Treasury FREM for 2011-12, a donated asset reserve is no longer maintained. Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.10 Government Grants

Following the accounting policy change outlined in the Treasury FREM for 2011-12, a government grant reserve is no longer maintained. The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.11 Non-Current Assets Held for Sale

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

1. Accounting policies (continued)

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

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

1.12 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.13 Cash and Cash Equivalents

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

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the PCT's cash management.

1.14 Losses and Special Payments

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

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

1.15 Clinical Negligence Costs

From 1 April 2000, the NHS Litigation Authority (NHSLA) took over the full financial responsibility for all Existing Liabilities Scheme (ELS) cases unsettled at that date and from 1 April 2002 all Clinical Negligence Scheme for Trusts (CNST) cases. Provisions for these are included in the accounts of the NHSLA. Although the NHSLA is administratively responsible for all cases from 1 April 2000, the legal liability remains with the PCTs.

The NHSLA operates a risk pooling scheme under which the PCT pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure in the year that it is due. The total value of clinical negligence provisions carried by the NHSLA on behalf of the PCT is disclosed at Note 32.

1.16 Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

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

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

1. Accounting policies (continued)

1.17 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Statement of Comprehensive Net Expenditure on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.18 Other Expenses

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

1.19 Grant Making

Under Section 256 of the National Health Service Act 2006, the PCT has the power to make grants to local authorities, voluntary bodies and registered social landlords to finance capital or revenue schemes. A liability in respect of these grants is recognised when the PCT has a present legal or constructive obligation which occurs when all of the conditions attached to the payment have been met.

1.20 Contingencies

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

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

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

1.21 Leases

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

The PCT as lessee

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

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

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

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

The PCT as lessor

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

1. Accounting policies (continued)

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

1.22 Foreign Exchange

Transactions which are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the date of each transaction, except where rates do not fluctuate significantly, in which case an average rate for a period is used. Resulting exchange gains and losses are taken to the Statement of Comprehensive Net Expenditure.

1.23 Provisions

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

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

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

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

1.24 Financial Instruments

Financial assets

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

Financial assets are initially recognised at fair value.

Financial assets are classified into the following categories: financial assets 'at fair value through profit and loss'; 'held to maturity investments'; 'available for sale' financial assets, and 'loans and receivables'. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to the Statement of Comprehensive Net Expenditure on de-recognition.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques as specified in IAS 39 AG 74.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the Statement of Financial Position date, the PCT assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Net Expenditure and the carrying amount of the asset is reduced directly, or through a provision for impairment of receivables.

objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the Statement of Comprehensive Net Expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

Financial liabilities
Financial liabilities are recognised on the Statement of Financial Position when the PCT becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are derecognised when the liability has been discharged, that is, the liability has been paid or has expired.

Financial liabilities are initially recognised at fair value.

Financial liabilities are classified as either financial liabilities 'at fair value through profit and loss' or other financial liabilities.

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

1. Accounting policies (continued)

1.25 PFI Transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The PCT therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

a) Services received
The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

b) PFI assets, liabilities, and finance costs
The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the PCT's approach for each relevant class of asset in accordance with the principles of IAS 16.

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Net Expenditure.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Net Expenditure.

c) Lifecycle replacement
Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the PCT's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the PCT to the operator for use in the scheme
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the PCT's Statement of Comprehensive Net Expenditure.

Other assets contributed by the PCT to the operator
Assets contributed (e.g. cash payments, surplus property) by the PCT to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the PCT, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1. Accounting policies (continued)

1.26 Accounting Standards Issued but Not Adopted

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

IAS 27 Separate Financial Statements - subject to consultation
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IFRS 9 Financial Instruments - subject to consultation
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation

2. Operating Segments

For 2012-13, the PCT identified five segments that meet reporting requirements, Cluster, Public Health, Nene CCG, Corby CCG and Borderline CCG. This reflects the move towards the new commissioning arrangements in the NHS from 2013-14 and the delegation of budgets to CCGs during 2012-13. As CCGs did not exist prior to 2012-13, there are no segmental prior year comparators.

	Cluster Segment £000	Public Health Segment £000	Nene CCG Segment £000	Corby CCG Segment £000	Borderline CCG Segment £000	**Total PCT £000**
Expenditure	318,396	41,368	686,577	78,749	17,394	**1,142,484**
Income	30,226	650	13,694	34	9	**44,613**
Surplus / (Deficit)	882	2,815	(99)	(20)	(38)	**3,540**
Net Assets	12,715	0	0	0	0	**12,715**

3. Financial Performance Targets

3.1 Revenue Resource Limit

	2012-13 £000	2011-12 £000
The PCT's performance for the year ended 2012-13 is as follows:		
Total Net Operating Cost for the Financial Year	1,097,871	1,072,895
Adjusted for prior period adjustments in respect of errors	0	0
Revenue Resource Limit	1,101,411	1,079,953
Under/(Over)spend Against Revenue Resource Limit (RRL)	3,540	7,058

3.2 Capital Resource Limit

	2012-13 £000	2011-12 £000
The PCT is required to keep within its Capital Resource Limit.		
Capital Resource Limit	13,625	11,627
Charge to Capital Resource Limit	10,755	7,072
(Over)/Underspend Against CRL	2,870	4,555

3.3 Provider Full Cost Recovery Duty

	2012-13 £000	2011-12 £000
The PCT is required to recover full costs in relation to its provider functions.		
Provider gross operating costs	0	0
Provider Operating Revenue	0	0
Net Provider Operating Costs	0	0
Costs Met Within PCT's Own Allocation	0	0
Under/(Over) Recovery of Costs	0	0

3.4 Under/(Over) Spend Against Cash Limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	1,104,341	1,074,827
Cash Limit	1,104,341	1,082,817
Under/(Over)spend Against Cash Limit	0	7,990

3.5 Reconciliation of Cash Drawings to Parliamentary Funding

	2012-13 £000	2011-12 £000
Total cash received from DH	956,857	938,798
Less: Trade Income from DH	0	0
Less/(Plus): movement in DH working balances	0	(25)
Sub total: net advances	956,857	938,773
(Less)/plus: transfers (to)/from other resource account bodies	0	0
Plus: cost of Dentistry Schemes (central charge to cash limits)	30,670	26,594
Plus: drugs reimbursement (central charge to cash limits)	116,814	109,460
Parliamentary funding credited to General Fund	1,104,341	1,074,827

4. Miscellaneous Income

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12 Total
	£000	£000	£000	£000
Fees and Charges	0	0	0	0
Dental Charge income from Contractor-Led GDS & PDS	8,365	0	8,365	8,270
Dental Charge income from Trust-Led GDS & PDS	0	0	0	0
Prescription Charge income	7,095	0	7,095	6,481
Strategic Health Authorities	6,733	45	6,688	4,411
NHS Trusts	254	36	218	82
NHS Foundation Trusts	2,230	36	2,194	1,540
Primary Care Trusts Contributions to DATs	0	0	0	0
Primary Care Trusts - Other	4,944	4,662	282	1,268
Primary Care Trusts - Lead Commissioning	0	0	0	0
English RAB Special Health Authorities	0	0	0	0
Other English Special Health Authorities	65	65	0	0
Department of Health - SMPTB	0	0	0	0
Department of Health - Other	25	25	0	0
Recoveries in respect of employee benefits	0	0	0	657
Local Authorities	13,824	0	13,824	13,949
Patient Transport Services	0	0	0	29
Education, Training and Research	0	0	0	0
Non-NHS: Private Patients	0	0	0	0
Non-NHS: Overseas Patients (Non-Reciprocal)	0	0	0	0
NHS Injury Costs Recovery	0	0	0	3
Other Non-NHS Patient Care Services	0	0	0	0
Charitable and Other Contributions to Expenditure	0	0	0	0
Receipt of donated assets	0	0	0	0
Receipt of Government granted assets	0	0	0	0
Rental income from finance leases	0	0	0	0
Rental income from operating leases	0	0	0	0
Other income	1,054	174	880	4,355
Total Miscellaneous Income	44,589	5,043	39,546	41,045
Of rental income from finance leases above:				
Contingent rent	0	0	0	0
Other	0	0	0	0
Rental income from finance leases	0	0	0	0
Of rental income from operating leases above:				
Rental revenue	0	0	0	0
Contingent rent	0	0	0	0
Rental income from operating leases	0	0	0	0

5. Operating Costs

5.1 Analysis of Operating Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
Goods and Services from Other PCTs				
Healthcare	120,301	0	120,301	107,691
Non-Healthcare	24	24	0	0
Total	120,325	24	120,301	107,691
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	265,723	0	265,723	259,554
Goods and services (other, excl Trusts, FT and PCT)	0	0	0	669
Total	265,723	0	265,723	260,223
Goods and Services from Foundation Trusts	313,693	2	313,691	322,059
Purchase of Healthcare from Non-NHS bodies	101,841	0	101,841	98,737
Social Care from Independent Providers	4,569	0	4,569	0
Expenditure on Drugs Action Teams	5,809	0	5,809	6,007
Non-GMS Services from GPs	0	0	0	405
Contractor Led GDS & PDS (excluding employee benefits)	39,124	0	39,124	36,017
Salaried Trust-Led PDS & PCT DS (excluding employee benefits)	0	0	0	0
Chair, Non-executive Directors & PEC remuneration	82	82	0	96
Executive committee members costs	0	0	0	16
Consultancy Services	2,850	2,682	168	1,348
Prescribing Costs	98,988	0	98,988	99,428
G/PMS, APMS and PCTMS (excluding employee benefits)	98,891	0	98,891	97,084
Pharmaceutical Services	3,078	0	3,078	2,960
Local Pharmaceutical Services Pilots	51	0	51	45
New Pharmacy Contract	27,697	0	27,697	27,125
General Ophthalmic Services	6,039	0	6,039	5,893
Supplies and Services - Clinical	3,099	974	2,125	4,133
Supplies and Services - General	328	42	286	352
Establishment	2,338	1,368	970	2,403
Transport	33	9	24	113
Premises	4,335	1,822	2,513	5,392
Impairments & Reversals of Property, plant and equipment	4,056	0	4,056	(78)
Impairments and Reversals of non-current assets held for sale	0	0	0	141
Depreciation	4,007	0	4,007	3,919
Amortisation	0	0	0	0
Impairment & Reversals Intangible non-current assets	0	0	0	0
Impairment and Reversals of Financial Assets	0	0	0	0
Impairment of Receivables	100	0	100	57
Inventory write offs	0	0	0	123
Research and Development Expenditure	187	0	187	159
Audit Fees	185	185	0	324
Other Auditors Remuneration	143	143	0	374
Clinical Negligence Costs	0	0	0	0
Education and Training	988	208	780	828
Grants for capital purposes	1,994	0	1,994	4,007
Grants for revenue purposes	959	0	959	2,226
Impairments and reversals for investment properties	0	0	0	0
Other	9,874	3,314	6,560	4,014
Total Operating costs charged to Statement of Comprehensive Net Expenditure	1,121,386	10,855	1,110,531	1,093,621
Employee Benefits (excluding capitalised costs)				
Employee Benefits associated with PCTMS	0	0	0	0
Trust led PDS and PCT DS	0	0	0	0
PCT Officer Board Members	102	102	0	904
Other Employee Benefits	19,470	12,473	6,997	17,716
Total Employee Benefits charged to SOCNE	19,572	12,575	6,997	18,620
Total Operating Costs	1,140,958	23,430	1,117,528	1,112,241

5.1 Analysis of Operating Costs (continued)

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
Analysis of grants reported in total operating costs				
For capital purposes				
Grants to fund Capital Projects - GMS	**524**	0	524	2,523
Grants to Local Authorities to Fund Capital Projects	**135**	0	135	600
Grants to Private Sector to Fund Capital Projects	**307**	0	307	0
Grants to Fund Capital Projects - Dental	**1,028**	0	1,028	884
Grants to Fund Capital Projects - Other	**0**	0	0	0
Total Capital Grants	1,994	0	1,994	4,007
Grants to fund revenue expenditure				
To Local Authorities	**0**	0	0	232
To Private Sector	**0**	0	0	119
To Other	**959**	0	959	1,875
Total Revenue Grants	959	0	959	2,226
Total Grants	2,953	0	2,953	6,233

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**18,387**	**16,887**	**1,500**
Weighted population (number in units) - see note	**620,856**	**620,856**	**620,856**
Running costs per head of population (£ per head)	**29.62**	**27.20**	**2.42**
PCT Running Costs 2011-12			
Running costs (£000s)	18,659	16,514	2,145
Weighted population (number in units)	620,856	620,856	620,856
Running costs per head of population (£ per head)	30.05	26.60	3.45

Weighted Population numbers 2012-13

Weighted population figures are not available for 2012-13 as the weighted capitation formula for PCT allocations was not updated for 2012-13. This was because it was decided to give all PCTs the same percentage growth in their allocations in this transitional year rather than differential growth based on a weighted capitation formula. Therefore, 2011-12 weighted populations have been used when calculated the Running Costs per head of population in 2012-13.

5.2 Analysis of Operating Expenditure by Expenditure Classification

	2012-13 £000	2011-12 £000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	**98,891**	97,084
Prescribing costs	**98,988**	99,428
Contractor led GDS & PDS	**39,124**	36,017
Trust led GDS & PDS	**0**	0
General Ophthalmic Services	**6,039**	5,893
Department of Health Initiative Funding	**0**	0
Pharmaceutical services	**3,078**	2,960
Local Pharmaceutical Services Pilots	**51**	45
New Pharmacy Contract	**27,697**	27,125
Non-GMS Services from GPs	**0**	0
Other	**600**	600
Total Primary Healthcare Purchased	274,468	269,152
Purchase of Secondary Healthcare		
Learning Difficulties	**23,267**	21,745
Mental Illness	**104,991**	107,583
Maternity	**24,446**	34,670
General and Acute	**466,791**	425,730
Accident and Emergency	**21,123**	19,409
Community Health Services	**114,746**	116,233
Other Contractual	**34,256**	45,482
Total Secondary Healthcare Purchased	789,620	770,852
Grant Funding		
Grants for capital purposes	**1,994**	4,007
Grants for revenue purposes	**959**	2,226
Total Healthcare Purchased by PCT	1,067,041	1,046,237
Included above:		
Secondary healthcare commissioned by the PCT itself	**0**	0
Social Care from Independent Providers	**4,569**	0
Healthcare from NHS FTs included above	**347,019**	343,092

6. Operating Leases

Northamptonshire Teaching PCT has entered into certain financial arrangements involving the use of GP practices. Under IAS17 - Leases, SIC27 - Evaluating the substance of transactions involving the legal form of a lease and IFRIC4 - Determining whether an arrangement contains a lease, the PCT has determined that the arrangements do not form operating or finance leases and as a consequence no further disclosure is required.

6.1 PCT as Lessee

The PCT leased 15 properties from third parties during the financial year 2012-13. The life of the leases range from 0 to 41 years and the PCT incurred rental charges amounting to £1,248,000 during 2012-13. Of these properties, 14 are utilised by Provider Services which transferred to Northamptonshire Healthcare NHS Foundation Trust during 2011-12. Under the Memorandum of Occupation, the PCT sub lease these properties to the Trust resulting in £768,000 of sub lease payments.

	2012-13 Total £000	2011-12 Total £000
Payments recognised as an expense		
Minimum lease payments	**1,248**	1,259
Contingent rents	**0**	0
Sub-lease payments	**(768)**	(656)
Total	**480**	603

	Land £000	Buildings £000	Other £000	2012-13 Total £000	2011-12 Total £000
Payable:					
No later than one year	0	1,172	0	**1,172**	1,239
Between one and five years	0	4,379	0	**4,379**	4,578
After five years	0	6,553	0	**6,553**	9,374
Total	**0**	**12,104**	**0**	**12,104**	15,191

Total future sublease payments expected are: £7,068,000

6.2 PCT as lessor

	2012-13 £000	2011-12 £000
Recognised as income		
Rents	**0**	0
Contingent rents	**0**	0
Total	**0**	0
Receivable:		
No later than one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Total	**0**	0

7. Employee Benefits and Staff Numbers

7.1 Employee Benefits

	2012-13 Total			Permanently Employed			Other		
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Employee Benefits - Gross Expenditure									
Salaries and wages	15,024	10,479	4,545	13,332	9,372	3,960	1,692	1,107	585
Social security costs	1,271	893	378	1,271	893	378	0	0	0
Employer contributions to NHS Pensions scheme	1,711	1,203	508	1,711	1,203	508	0	0	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	1,566	0	1,566	1,566	0	1,566	0	0	0
Total employee benefits	19,572	12,575	6,997	17,880	11,468	6,412	1,692	1,107	585
Less recoveries in respect of employee benefits (table below)	0	0	0	0	0	0	0	0	0
Total - Net Employee Benefits including capitalised costs	19,572	12,575	6,997	17,880	11,468	6,412	1,692	1,107	585
Employee costs capitalised	0	0	0	0	0	0	0	0	0
Total Employee Benefits excluding capitalised costs	19,572	12,575	6,997	17,880	11,468	6,412	1,692	1,107	585
Recognised as:									
Commissioning employee benefits	19,572	12,575	6,997	17,880	11,468	6,412	1,692	1,107	585
Provider employee benefits	0	0	0	0	0	0	0	0	0
Total Employee Benefits excluding capitalised costs	19,572	12,575	6,997	17,880	11,468	6,412	1,692	1,107	585
Employee Benefits - Income									
Salaries and wages	0	0	0	0	0	0	0	0	0
Social Security costs	0	0	0	0	0	0	0	0	0
Employer Contributions to NHS BSA - Pensions Division	0	0	0	0	0	0	0	0	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other Post Employment Benefits	0	0	0	0	0	0	0	0	0
Other Employment Benefits	0	0	0	0	0	0	0	0	0
Termination Benefits	0	0	0	0	0	0	0	0	0
Total excluding capitalised costs	0	0	0	0	0	0	0	0	0

7. Employee Benefits and Staff Numbers

7.1 Employee Benefits

	2012-13 Total £000	2012-13 Permanently Employed £000	2012-13 Other £000	2011-12 Total £000	2011-12 Permanently Employed £000	2011-12 Other £000
Net Expenditure						
Salaries and wages	**15,024**	**13,332**	**1,692**	14,523	11,213	3,310
Social security costs	**1,271**	**1,271**	**0**	1,292	1,155	137
Employer contributions to NHS Pensions scheme	**1,711**	**1,711**	**0**	1,918	1,679	239
Other pension costs	**0**	**0**	**0**	0	0	0
Other post-employment benefits	**0**	**0**	**0**	0	0	0
Other employment benefits	**0**	**0**	**0**	0	0	0
Termination benefits	**1,566**	**1,566**	**0**	887	887	0
Total employee benefits	**19,572**	**17,880**	**1,692**	18,620	14,934	3,686
Employee costs capitalised	**0**	**0**	**0**	0		
Net Employee Benefits excluding capitalised costs	**19,572**	**17,880**	**1,692**	18,620	14,934	3,686
Recognised as:						
Commissioning Employment Benefits	**19,572**	**17,880**	**1,692**	18,620	14,934	3,686
Provider Employment Benefits	**0**	**0**	**0**	0	0	0
Total - excluding capitalised costs	**19,572**	**17,880**	**1,692**	18,620	14,934	3,686

7.2 Staff Numbers

	2012-13 Total Number	2012-13 Permanently Employed Number	2012-13 Other Number	2011-12 Total Number	2011-12 Permanently Employed Number	2011-12 Other Number
Average Staff Numbers						
Medical and dental	**7.64**	**7.27**	**0.37**	15.00	10.00	5.00
Ambulance staff	**0.00**	**0.00**	**0.00**	0.00	0.00	0.00
Administration and estates	**317.46**	**272.27**	**45.19**	262.00	214.00	48.00
Healthcare assistants and other support staff	**0.00**	**0.00**	**0.00**	0.00	0.00	0.00
Nursing, midwifery and health visiting staff	**8.21**	**8.21**	**0.00**	21.00	16.00	5.00
Nursing, midwifery and health visiting learners	**0.00**	**0.00**	**0.00**	0.00	0.00	0.00
Scientific, therapeutic and technical staff	**16.01**	**16.01**	**0.00**	17.00	17.00	0.00
Social Care Staff	**0.00**	**0.00**	**0.00**	0.00	0.00	0.00
Other	**0.00**	**0.00**	**0.00**	0.00	0.00	0.00
TOTAL	**349.32**	**303.76**	**45.56**	315.00	257.00	58.00
Of the above - staff engaged on capital projects	**0.00**	**0.00**	**0.00**	0.00	0.00	0.00

The increase in staff number is due to the build up of staff in successor organisations combined with the PCT retaining staff to manage the transition who were subsequently released in April 2013.

7.3 Staff Sickness Absence and Ill Health Retirements

	2012-13 Number	2011-12 Number
Total Days Lost	4,340	16,952
Total Staff Years	668	1,840
Average working Days Lost	6.50	9.21

	2012-13 Number	2011-12 Number
Number of persons retired early on ill health grounds	0	1
	£000	£000
Total additional pensions liabilities accrued in the year	0	24

7.4 Exit Packages Agreed During the Year

	2012-13			2011-12		
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
	Number	Number	Number	Number	Number	Number
Lees than £10,000	5	0	5	1	0	1
£10,001 - £25,000	3	0	3	5	0	5
£25,001 - £50,000	1	0	1	2	0	2
£50,001 - £100,000	2	0	2	2	0	2
£100,001 - £150,000	4	0	4	1	0	1
£150,001 - £200,000	1	0	1	1	0	1
> £200,000	0	0	0	0	0	0
Total number of exit packages by type (total cost)	16	0	16	12	0	12
	£000	£000	£000	£000	£000	£000
Total resource cost	906	0	906	588	0	588

This note provides an analysis of Exit Packages agreed during the year. Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Where the PCT has agreed early retirements, the additional costs are met by the PCT and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages taken by staff leaving in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

7.5 Pension Costs

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

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2013, is based on the valuation data as 31 March 2012, updated to 31 March 2013 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions

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

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

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

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

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

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

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

8. Better Payment Practice Code

8.1 Measure of Compliance

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**28,283**	**153,025**	39,830	244,442
Total Non-NHS Trade Invoices Paid Within Target	**27,417**	**144,588**	39,108	237,869
Percentage of NHS Trade Invoices Paid Within Target	**96.94%**	**94.49%**	98.19%	97.31%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**5,169**	**716,280**	4,983	702,285
Total NHS Trade Invoices Paid Within Target	**4,903**	**713,977**	4,699	697,919
Percentage of NHS Trade Invoices Paid Within Target	**94.85%**	**99.68%**	94.30%	99.38%

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

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

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

9. Investment Income

As at 31 March 2013, the PCT did not have any investment income (nil as at 31 March 2012).

10. Other Gains and Losses

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
Gain/(loss) on disposal of property, plant and equipment	**(30)**	0	(30)	125
Gain/(loss) on disposal of intangible assets	**0**	0	0	0
Gain/(loss) on disposal of financial assets	**0**	0	0	0
Gain (Loss) on disposal of assets held for sale	**0**	0	0	0
Gain/(loss) on foreign exchange	**0**	0	0	0
Change in fair value of financial assets carried at fair value through the SoCNE	**0**	0	0	0
Change in fair value of financial liabilities carried at fair value through the SoCNE	**0**	0	0	0
Change in fair value of investment property	**0**	0	0	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	**0**	0	0	0
Total	**(30)**	**0**	**(30)**	125

11. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
Interest				
Interest on obligations under finance leases	**47**	0	47	495
Interest on obligations under PFI contracts:				
- main finance cost	**1,006**	0	1,006	1,066
- contingent finance cost	**419**	0	419	263
Interest on obligations under LIFT contracts:				
- main finance cost	**0**	0	0	0
- contingent finance cost	**0**	0	0	0
Interest on late payment of commercial debt	**0**	0	0	0
Other interest expense	**0**	0	0	0
Total interest expense	**1,472**	0	1,472	1,824
Other finance costs	**0**	0	0	0
Provisions - unwinding of discount	**0**	0	0	0
Total	**1,472**	0	1,472	1,824

12.1 Property, Plant and Equipment

2012-13	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:									
At 1 April 2012	20,595	55,057	91	0	646	0	6,948	1,605	84,942
Additions Purchased	0	4,290	0	0	137	0	7,018	(30)	11,415
Additions Donated	0	0	0	0	0	0	0	0	0
Additions Government Granted	0	0	0	0	0	0	0	0	0
Reclassifications	(270)	533	0	0	(195)	0	0	(68)	0
Reclassifications as Held for Sale	0	(161)	0	0	0	0	0	(27)	(188)
Disposals other than for sale	0	0	0	0	(87)	0	(852)	(253)	(1,192)
Upward revaluation/positive indexation	0	1,884	10	0	0	0	0	0	1,894
Impairments/negative indexation	0	(2,253)	0	0	(2)	0	0	(5)	(2,260)
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	0
At 31 March 2013	20,325	59,350	101	0	499	0	13,114	1,222	94,611
Depreciation									
At 1 April 2012	0	4,397	7	0	210	0	2,690	628	7,932
Reclassifications	0	99	0	0	(80)	0	0	(19)	0
Reclassifications as Held for Sale	0	(23)	0	0	0	0	0	(13)	(36)
Disposals other than for sale	0	0	0	0	(14)	0	(826)	(232)	(1,072)
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	0
Impairments	303	3,796	0	0	0	0	0	0	4,099
Reversal of Impairments	0	(43)	0	0	0	0	0	0	(43)
Charged During the Year	0	2,489	3	0	98	0	1,267	150	4,007
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	0
At 31 March 2013	303	10,715	10	0	214	0	3,131	514	14,887
Net Book Value at 31 March 2013	20,022	48,635	91	0	285	0	9,983	708	79,724
Purchased	20,022	47,365	91	0	285	0	9,983	708	78,454
Donated	0	1,270	0	0	0	0	0	0	1,270
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	20,022	48,635	91	0	285	0	9,983	708	79,724
Asset financing:									
Owned	20,022	33,008	91	0	285	0	9,983	708	64,097
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP PFI contracts	0	15,627	0	0	0	0	0	0	15,627
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	20,022	48,635	91	0	285	0	9,983	708	79,724

Revaluation Reserve Balance for PPE

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000s
At 1 April 2012	5,988	10,908	91	0	3	0	0	5	16,995
Movements	286	(1,033)	(40)	0	(3)	0	0	(5)	(795)
At 31 March 2013	6,274	9,875	51	0	0	0	0	0	16,200

12.2 Property, Plant and Equipment

2011-12	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:									
At 1 April 2011	21,051	49,575	84	0	557	0	4,131	1,534	76,932
Additions - purchased	0	2,231	0	0	89	0	6,231	71	8,622
Additions - donated	0	0	0	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as Held for Sale	(456)	(442)	0	0	0	0	0	0	(898)
Disposals other than by sale	0	(21)	0	0	0	0	(205)	0	(226)
Revaluation & indexation gains	0	3,714	7	0	0	0	0	0	3,721
Impairments	0	0	0	0	0	0	0	0	0
Reversals of impairments	0	0	0	0	0	0	0	0	0
In-year transfers to/from NHS bodies	0	0	0	0	0	0	(3,209)	0	(3,209)
Cumulative dep'n adjustment following revaluation	0	0	0	0	0	0	0	0	0
At 31 March 2012	20,595	55,057	91	0	646	0	6,948	1,605	84,942
Depreciation									
At 1 April 2011	0	2,123	3	0	141	0	1,553	476	4,296
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassifications as Held for Sale	0	0	0	0	0	0	0	0	0
Disposals other than for sale	0	0	0	0	0	0	(205)	0	(205)
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	0
Impairments	0	63	0	0	0	0	0	0	63
Reversal of Impairments	0	(141)	0	0	0	0	0	0	(141)
Charged During the Year	0	2,352	4	0	69	0	1,342	152	3,919
Transfers to NHS Bodies	0	0	0	0	0	0	0	0	0
Cumulative dep'n adjustment following revaluation	0	0	0	0	0	0	0	0	0
At 31 March 2012	0	4,397	7	0	210	0	2,690	628	7,932
Net Book Value at 31 March 2012	20,595	50,660	84	0	436	0	4,258	977	77,010
Purchased	20,180	49,186	84	0	436	0	4,258	977	75,121
Donated	0	1,474	0	0	0	0	0	0	1,474
Government Granted	415	0	0	0	0	0	0	0	415
At 31 March 2012	20,595	50,660	84	0	436	0	4,258	977	77,010
Asset financing:									
Owned	20,595	35,564	84	0	436	0	4,258	977	61,914
Held on finance lease	0	381	0	0	0	0	0	0	381
On-SOFP PFI contracts	0	14,715	0	0	0	0	0	0	14,715
PFI residual: interests	0	0	0	0	0	0	0	0	0
At 31 March 2012	20,595	50,660	84	0	436	0	4,258	977	77,010

Revaluation Reserve Balance for PPE

	Land	Buildings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2011	6,145	7,484	84	0	3	0	0	7	13,723
Movements	(157)	3,424	7	0	0	0	0	(2)	3,272
At 31 March 2012	5,988	10,908	91	0	3	0	0	5	16,995

12.3 Property, Plant and Equipment

Economic Lives of Tangible Non-Current Assets

	Min Life Years	Max Life Years
Property, Plant and Equipment		
Buildings exc Dwellings	2	82
Dwellings	39	39
Plant & Machinery	5	25
Transport Equipment	7	7
Information Technology	5	5
Furniture & Fittings	5	10

Open Market Value of Assets at Balance Sheet Date

	Land	Buildings exc Dwellings	Dwellings	Total
	£000s	£000s	£000s	£000s
Open Market Value at 31 March 2013	0	0	0	0
Open Market Value at 31 March 2012	0	0	0	0

Additions to Assets Under Construction

	£000
Land	0
Buildings excl Dwellings	0
Dwellings	0
Plant & Machinery	0
Balance as at 31 March 2013	**0**

13.1 Intangible Non-Current Assets

2012-13	Software internally generated £000	Software purchased £000	Licences & trademarks £000	Patents £000	Development expenditure £000	Total £000
At 1 April 2012	0	237	0	0	0	**237**
Additions - purchased	0	0	0	0	0	**0**
Additions - internally generated	0	0	0	0	0	**0**
Additions - donated	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	**0**
Reclassified as Held for Sale	0	0	0	0	0	**0**
Disposals other than by sale	0	(237)	0	0	0	**(237)**
Revaluation & indexation gains	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	**0**
In-year transfers (to)/from Other Public Sector bodies	0	0	0	0	0	**0**
At 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**
Amortisation						
At 1 April 2012	0	237	0	0	0	**237**
Reclassifications	0	0	0	0	0	**0**
Reclassified as Held for Sale	0	0	0	0	0	**0**
Disposals other than by sale	0	(237)	0	0	0	**(237)**
Revaluation or indexation gains	0	0	0	0	0	**0**
Impairments charged to operating expenses	0	0	0	0	0	**0**
Reversal of impairments charged to operating expenses	0	0	0	0	0	**0**
Charged during the year	0	0	0	0	0	**0**
In-year transfers (to)/from Other Public Sector bodies	0	0	0	0	0	**0**
At 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**
Net Book Value at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**
Net Book Value at 31 March 2013 comprises						
Purchased	0	0	0	0	0	**0**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	**0**
Total at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**

Revaluation reserve balance for intangible non-current assets

	Software internally generated £000	Software purchased £000	Licences & trademarks £000	Patents £000	Development expenditure £000	Total £000
At 1 April 2012	0	0	0	0	0	**0**
Movements	0	0	0	0	0	**0**
At 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**

13.2 Intangible Non-Current Assets

2011-12	Software internally generated £000	Software purchased £000	Licences & trademarks £000	Patents £000	Development expenditure £000	Total £000
Cost or valuation:						
At 1 April 2011	0	237	0	0	0	**237**
Additions - purchased	0	0	0	0	0	**0**
Additions - internally generated	0	0	0	0	0	**0**
Additions - donated	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation & indexation gains	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	**0**
In-year transfers to/from NHS bodies	0	0	0	0	0	**0**
At 31 March 2012	0	237	0	0	0	**237**
Amortisation						
At 1 April 2011	0	237	0	0	0	**237**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation or indexation gains	0	0	0	0	0	**0**
Impairments charged to operating expenses	0	0	0	0	0	**0**
Reversal of impairments charged to operating expenses	0	0	0	0	0	**0**
Charged during the year	0	0	0	0	0	**0**
In-year transfers to NHS bodies	0	0	0	0	0	**0**
At 31 March 2012	0	237	0	0	0	**237**
Net Book Value at 31 March 2012	0	0	0	0	0	**0**
Net Book Value at 31 March 2012 comprises						
Purchased	0	0	0	0	0	**0**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	**0**
Total at 31 March 2012	0	0	0	0	0	**0**

Revaluation reserve balance for intangible non-current assets

	Software purchased £000	Software internally generated £000	Licences & trademarks £000	Patents. £000	Development expenditure £000	Total £000
At 1 April 2011	0	0	0	0	0	**0**
Movements	0	0	0	0	0	**0**
At 31 March 2012	0	0	0	0	0	**0**

13.3 Intangible Non-Current Assets

Economic Lives of Intangible Non-Current Assets

	Min Life Years	Max Life Years
Intangible Assets		
Software Licences	5	5
Licences and Trademarks	0	0
Patents	0	0
Development Expenditure	0	0

14. Analysis of Impairments and Reversals Recognised in Year

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
Property, Plant and Equipment Impairments and Reversals Taken to SoCNE				
Loss or damage resulting from normal operations	0	0	0	0
Over-specification of assets	0	0	0	0
Abandonment of assets in the course of construction	0	0	0	0
Total Charged to Departmental Expenditure Limit	0	0	0	0
Unforeseen obsolescence	0	0	0	0
Loss as a result of catastrophe	0	0	0	0
Other	0	0	0	0
Changes in market price	4,056	0	4,056	(78)
Total Charged to Annually Managed Expenditure	4,056	0	4,056	(78)
Property, Plant and Equipment Impairments and Reversals Charged to the Revaluation Reserve				
Loss or damage resulting from normal operations	0	0	0	0
Over Specification of Assets	0	0	0	0
Abandonment of assets in the course of construction	0	0	0	0
Unforeseen obsolescence	0	0	0	0
Loss as a result of catastrophe	0	0	0	0
Other	0	0	0	0
Changes in market price	2,260	0	2,260	0
Total Impairments for PPE Charged to Reserves	2,260	0	2,260	0
Total Impairments of Property, Plant and Equipment	6,316	0	6,316	(78)
Intangible Assets Impairments and Reversals Charged to SoCNE				
Loss or damage resulting from normal operations	0	0	0	0
Over-specification of assets	0	0	0	0
Abandonment of assets in the course of construction	0	0	0	0
Total Charged to Departmental Expenditure Limit	0	0	0	0
Unforeseen obsolescence	0	0	0	0
Loss as a result of catastrophe	0	0	0	0
Other	0	0	0	0
Changes in market price	0	0	0	141
Total Charged to Annually Managed Expenditure	0	0	0	141
Intangible Assets Impairments and Reversals Charged to the Revaluation Reserve				
Loss or damage resulting from normal operations	0	0	0	0
Over-specification of assets	0	0	0	0
Abandonment of assets in the course of construction	0	0	0	0
Unforeseen obsolescence	0	0	0	0
Loss as a result of catastrophe	0	0	0	0
Other	0	0	0	0
Changes in market price	0	0	0	0
Total Impairments for Intangible Assets Charged to Reserves	0	0	0	0
Total Impairments of Intangibles	0	0	0	141
Total Impairments of Financial Assets	0	0	0	0
Total Impairments of Non-Current Assets Held for Sale	0	0	0	0
Total Impairments of Inventories	0	0	0	0
Total Investment Property Impairments	0	0	0	0
Total Impairments charged to Revaluation Reserve	2,260	0	2,260	0
Total Impairments charged to SoCNE - DEL	0	0	0	0
Total Impairments charged to SoCNE - AME	4,056	0	4,056	63
Overall Total Impairments	6,316	0	6,316	63
Of which:				
Impairment on revaluation to "modern equivalent asset" basis	0	0	0	0
Donated and Government Granted Assets, included above				
PPE - Donated and Government Granted Asset Impairments: amount charged to SoCNE -DEL	0	0	0	0
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SoCNE -AME	0	0	0	0

15. Investment Property

The PCT did not have investment property as at 31 March 2013 or 31 March 2012.

16. Commitments

16.1 Capital Commitments

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

	31 March 2013 £000	31 March 2012 £000
Property, plant and equipment	0	0
Intangible assets	0	0
Total	0	0

16.2 Other Financial Commitments

The payments to which the PCT is committed are as follows:

	31 March 2013 £000	31 March 2012 £000
Property, plant and equipment	0	0
Intangible assets	0	0
Total	0	0

17. Intra-Government and Other Balances

	Current receivables £000	Non-current receivables £000	Current payables £000	Non-current payables £000
Balances with other Central Government Bodies	4,480	0	5,044	0
Balances with Local Authorities	1,332	0	6,048	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	297	0	6,005	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	(609)	0	47,687	0
At 31 March 2013	5,500	0	64,784	0
Balances with other Central Government Bodies	2,894	0	1,465	0
Balances with Local Authorities	3,513	0	3,775	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	1,946	0	9,014	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	2,783	0	46,480	0
At 31 March 2012	11,136	0	60,734	0

18. Inventories

The PCT did not have inventory as at 31 March 2013 or 31 March 2012.

19.1 Trade and Other Receivables

	Current		Non-Current	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
NHS receivables - revenue	1,056	4,840	0	0
NHS receivables - capital	0	0	0	0
NHS prepayments and accrued income	3,134	0	0	0
Non-NHS receivables - revenue	434	4,578	0	0
Non-NHS receivables - capital	0	0	0	0
Non-NHS prepayments and accrued income	513	1,057	0	0
Provision for the impairment of receivables	(258)	(258)	0	0
VAT	582	779	0	0
Current part of PFI and other PPP arrangements prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables	39	140	0	0
Total	5,500	11,136	0	0
Total current and non current	5,500	11,136		
Included above:				
Prepaid pensions contributions	0	0		

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

19.2 Receivables Past Their Due Date but not Impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	303	2,447
By three to six months	592	167
By more than six months	75	845
Total	970	3,459

19.3 Provision for Impairment of Receivables

	2012-13 £000	2011-12 £000
Balance at 1 April 2012	(258)	(201)
Amount written off during the year	100	0
Amount recovered during the year	0	0
(Increase)/decrease in receivables impaired	(100)	(57)
Balance at 31 March 2013	(258)	(258)

20. NHS LIFT Investments

As at 31 March 2013 the PCT did not have any NHS LIFT investments (nil as at 31 March 2012).

21. Other Financial Assets

As at 31 March 2013 the PCT did not have any Other Financial Assets (nil as at 31 March 2012).

22. Other Current Assets

As at 31 March 2013 the PCT the PCT did not have any Other Current Assets (nil as at 31 March 2012).

23. Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	20	29
Net change in year	13,143	(9)
Closing balance	13,163	20
Made up of		
Cash with Government Banking Service	13,163	20
Commercial banks	0	0
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	13,163	20
Bank overdraft - Government Banking Service	0	0
Bank overdraft - Commercial banks	0	0
Cash and cash equivalents as in statement of cash flows	13,163	20
Patients' money held by the PCT, not included above	0	0

In response to uncertainty surrounding the funding of the PCTs working capital requirements post 31 March 2013, the decision was taken to drawdown funds to the maximum cash limit and not to return any surplus funds to the DH. The year end cash balance was further inflated by a £7.3m refund from an Acute Trust in late March resulting in a cash surplus of £13.2m at 31 March 2013.
Subsequent to this decision drawdown facilities were made available to the PCT and the year end surplus position reversed out in the next cash drawdown.

24. Non-Current Assets Held for Sale	Land	Buildings, excl. dwellings	Dwellings	Asset Under Construction and Payments on Account	Plant and Machinery	Transport and Equipment	Information Technology	Furniture and Fittings	Intangible Assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Balance at 1 April 2012	1,040	300	0	0	0	0	0	0	0	1,340
Plus assets classified as held for sale in the year	0	152	0	0	0	0	0	0	0	152
Less assets sold in the year	(540)	0	0	0	0	0	0	0	0	(540)
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	0
Transfers (to)/from other Public Sector Bodies	0	0	0	0	0	0	0	0	0	0
Revaluation	0	(252)	0	0	0	0	0	0	0	(252)
Balance at 31 March 2013	**500**	**200**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	700
Liabilities associated with assets held for sale at 31 March 2013	**0**	**0**	**0**	**0**	0	**0**	0	0	0	0
Balance at 1 April 2011	1,661	501	0	0	0	0	0	0	0	2,162
Plus assets classified as held for sale in the year	1,076	470	0	0	0	0	0	0	0	1,546
Less assets sold in the year	(1,077)	(502)	0	0	0	0	0	0	0	(1,579)
Less impairment of assets held for sale	0	(141)	0	0	0	0	0	0	0	(141)
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0
Less assets no longer classified as held for sale, for reasons other than disposal by sale	(620)	(28)	0	0	0	0	0	0	0	(648)
Balance at 31 March 2012	**1,040**	**300**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	1,340
Liabilities associated with assets held for sale at 31 March 2012	0	0	0	0	0	0	0	0	0	0

25. Trade and Other Payables

	Current		Non-Current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Interest payable	**0**	0	**0**	0
NHS payables - revenue	**5,871**	2,168	**0**	0
NHS payables - capital	**0**	39	**0**	0
NHS accruals and deferred income	**4,173**	8,272	**0**	0
Family Health Services (FHS) payables	**0**	0	**0**	0
Non-NHS payables - revenue	**6,114**	4,737	**0**	0
Non-NHS payables - capital	**2,143**	2,238	**0**	0
Non-NHS accruals and deferred income	**45,483**	43,280	**0**	0
Social security costs	**563**	0	**0**	0
VAT	**0**	0	**0**	0
Tax	**437**	0	**0**	0
Payments received on account	**0**	0	**0**	0
Other	**0**	0	**0**	0
Total	**64,784**	60,734	**0**	0
Total payables (current and non-current)	**64,784**	60,734		

Other payables include £0 (2011-12: £0) in respect of payments due in future years under arrangements to buy out the liability for early retirements over 5 instalments; and £0 (2011-12: £0) in respect of outstanding pensions contributions at 31 March.

26. Other Liabilities

	Current		Non-Current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
PFI/LIFT deferred credit	**0**	0	**0**	0
Lease incentives	**0**	0	**0**	0
Other	**0**	0	**0**	0
Total	**0**	0	**0**	0
Total other liabilities (current and non-current)	**0**	0		

27. Borrowings

	Current		Non-Current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Bank overdraft - Government Banking Service	**0**	0	**0**	0
Bank overdraft - commercial banks	**0**	0	**0**	0
PFI liabilities:				
Main liability	**734**	629	**17,042**	17,733
Lifecycle replacement received in advance	**0**	0	**0**	0
LIFT liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**2**	2	**1,074**	1,075
Other	**0**	0	**0**	0
Total	**736**	631	**18,116**	18,808
Total other liabilities (current and non-current)	**18,852**	19,439		

28. Other Financial Liabilities

As at 31 March 2013, the PCT did not have any Other Financial Liabilities (nil as at 31 March 2012).

29. Deferred Income

	Current		Non-Current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Opening balance at 1 April 2012	**243**	283	**0**	0
Deferred income addition	**0**	0	**0**	0
Transfer of deferred income	**(40)**	(40)	**0**	0
Current deferred Income at 31 March 2013	**203**	243	**0**	0
Total other liabilities (current and non-current)	**203**	243		

30. Finance Lease Obligations

Amounts payable under finance leases (Buildings)	Minimum lease payments		Present value of minimum lease payments	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Within one year	**47**	47	**2**	2
Between one and five years	**188**	188	**8**	7
After five years	**3,529**	3,575	**1,066**	1,068
Less future finance charges	**(2,688)**	(2,733)	**0**	0
Present value of minimum lease payments	**1,076**	1,077	**1,076**	1,077
Included in:				
Current borrowings			**2**	2
Non-current borrowings			**1,074**	1,075
			1,076	1,077

The PCT has one finance lease for the use of Battle House on Northampton General Hospital NHS Trust site for the provision of healthcare services. The lease was entered into on 1 April 1994 with a life of 99 years. This is classified as a Building finance lease; the PCT does not hold any Land or Other finance leases.

31. Finance Lease Receivables as Lessor

The PCT did not have any Finance Leases (as lessor) in 2012-13 or in 2011-12.

32. Provisions

	Total £000	Pensions to Former Directors £000	Pensions Relating to Other Staff £000	Legal Claims £000	Restructuring £000	Continuing Care £000	Equal Pay £000	Agenda for Change £000	Other £000	Redundancy £000
Balance at 1 April 2012	**2,470**	0	0	50	0	432	0	0	1,988	0
Arising During the Year	**2,366**	0	0	2	202	1,990	0	0	120	52
Utilised During the Year	**(581)**	0	0	(4)	0	(108)	0	0	(469)	0
Reversed Unused	**(1,519)**	0	0	0	0	0	0	0	(1,519)	0
Unwinding of Discount	**0**	0	0	0	0	0	0	0	0	0
Change in Discount Rate	**0**	0	0	0	0	0	0	0	0	0
Transferred (to)/from other Public Sector bodies	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2013	**2,736**	**0**	**0**	**48**	**202**	**2,314**	**0**	**0**	**120**	**52**
Expected Timing of Cash Flows:										
No Later than One Year	**1,087**	0	0	48	202	665	0	0	120	52
Later than One Year and not later than Five Years	**1,649**	0	0	0	0	1,649	0	0	0	0
Later than Five Years	**0**	0	0	0	0	0	0	0	0	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

As at 31 March 2013	**1,899**
As at 31 March 2012	**801**

Analysis of Provisions - Current / Non Current

	Current		Non-Current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Pensions to Former Directors	**0**	0	**0**	0
Pensions Relating to Other Staff	**0**	0	**0**	0
Legal Claims	**48**	50	**0**	0
Restructuring	**202**	0	**0**	0
Continuing Care	**665**	432	**1,649**	0
Equal Pay	**0**	0	**0**	0
Agenda for Change	**0**	0	**0**	0
Other	**120**	1,068	**0**	920
Redundancy	**52**	0	**0**	0
Total	**1,087**	1,550	**1,649**	920
Total Provisions (current and non-current)	2,736	2,470		

32. Provisions (continued)

Legal Claims

These are costs that are based on legal advice as to the probability of claims materialising and the likely costs arising from injury allowance, claims from employees and non clinical claims.

Restructuring

A new provision has been taken of £202,091 for future costs arising from the PCT closure and transition to new commissioners. Such costs include agency fees for staff employed to close the PCT's books and produce the annual accounts.

Continuing Healthcare

As stated in Note 1, Accounting Policies the PCT has dealt with thhe treatment of provisions arising from Continuing Healthcare claims as two separate workstreams; existing retrospective claims and those arising from the DH announcement in March 2012 of a deadline for individuals to request an assessment of eligibility for NHS Continuing Care funding for the period 1 April 2004 to 31 March 2013.
The Continuing Care provision relating to existing retrospective claims refers to the potential cost of patients entitled to financial support for the care they received backdated to 1996 following the Cochrane Enquiry and the subsequent Ombudsman report. The number of cases paid, or agreed, and the potential costs arising from an assessment of the claims not yet reviewed , is covered by the value of the current provision. The closing balance of the provision for the year 2012-13 is £665,163 (2011-12: £431,944).
In respect of the new requests for assessment following the DH announcement in March 2012, the Continuing Care provision relates to those assessments which are sufficiently well progressed to allow a provision to be taken. The closing balance of the provision for the year 2012-13 is £1,650.000 (2011-12: £0)

Other

Included within Other was a provision for £77,484 in respect of payroll advances which had been identified as requiring action but which had not been confirmed as recoverable. Following a review of the control accounts, the provision has been released to offset the write off of balances considered to be non recoverable.

In 2011-12 a provision of £300,000 was taken for the potential cost of specialist treatment for a patient. The provision is now longer required and has been reversed unused.

A provision for the sinking fund for dilapidation works required when the PCT vacates Francis Crick House was taken in 2011-12. This was provided for given the uncertainty on whether the building would be required following the changes taking place in the NHS. The provision has been reversed unused in 2012-13 following confirmation that the building would remain occupied by NHS organisations taking over the PCT's responsibilities.

A provision of £120,000 has been taken in 2012-13 for the potential liability of redundancy costs associated with the restructuring of audit services hosted by Kettering General Hospital NHS Foundation Trust. The amount of the provision equates to the maximum liability that the Trust will incur.

A provision was taken in 2011-12 for potential costs arising from employment tribunal claims following the TUPE of LD staff to a new provider. An amount of £392,110 was released during the year to fund successful claims. The remainder of the provision has been released unused as the probability of any further successful claims being made is considered to be unlikely.

Redundancy

A provision of £562,020 for potential future redundancy costs for staff displaced through the reconfiguration of NHS commissioning services but who have been retained for a time limited period to assist with the closure and other transitional requirements for the PCT.

NHS Litigation Authority

The NHS Litigation Authority has included £1,899,000 of provisions in their accounts as at 31 March 2013 in respect of clinical negligence claims of the PCT (£801,000 at 31 March 2012).

33. Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent Liabilities		
Equal Pay	0	0
Other	(5,656)	(1,065)
Amounts Recoverable Against Contingent Liabilities	0	0
Net Value of Contingent Liabilities	(5,656)	(1,065)
Contingent Assets		
Contingent Assets	0	0
Net Value of Contingent Assets	0	0

Contingent liabilities includes the following:

Continuing Healthcare

A contingent liability is disclosed for potential claims in respect of known continuing care cases or those which might arise from unprocessed requests for retrospective assessment.

A provision has been made for the likely future costs arising from existing retrospective claims and also for those likely to arise from the recent DH announcement of a deadline for individuals to request an assessment of eligibility for NHS Continuing Care funding for the period 1 April 2004 to 31 March 2013, included in Note 32. However if all existing retrospective claims were settled against the PCT, the potential liability based upon past payouts would be £1,598,377 (2011-12: £1,038,058) and if outstanding requests for retrospective assessment were settled against the PCT based on the current local and regional review conversion rates, the potential liability based on the average value of assessments taken to provision would be £4,058,000 (2011-12: £0). There is a possibility that further continuing care cases may materialise but the potential cost of these is uncertain.

NHS Litigation Authority Member Liability

A contingent liability is disclosed for employers' public liability claims being dealt with on behalf of the PCT by the NHS Litigation Authority (NHSLA). The value of the contingent liability has been notified to the PCT by the NHSLA as £14,670 (2011-12: £26,500). A provision has also been disclosed as advised by the NHSLA and is included in Note 32.

34. Private Finance Initiative Schemes

The Daventry Community Hospital project reached Financial Close on 5 March 2005. The preferred bidder was United Medical Enterprises (UME) Consortium. The Consortium, which comprised UME, Clingstones (construction and facilities manager), Aedas (architects) delivered a £22M capital build project which involved the design, build, finance and operation of healthcare accommodation in the form of a new community hospital with 28 inpatient places. The project also included the provision of community health teams and day hospital together with administrative and community team accommodation. The Hospital became operational on 13 January 2007 and the estimate total operating period of the project is 30 years. The PCT has the rights to use the assets for the length of the Project Agreement and has the rights to expect provision of the range of allied and clinical support services. At the end of the Project Agreement the assets will transfer back to the PCT's ownership.

Under IFRIC12, the PFI asset is treated as an asset of the PCT and the substance of the contract is that the PCT has a finance lease and payments comprise two elements - imputed finance lease charges and service charges. As the PCT has control over the services and the residual interest of the agreement, it is considered that the PFI scheme should be accounted for as an on-Statement of Financial Position PFI scheme. Therefore included within the Non Current Assets balance on the SoFP is £15,627,000 being the net book value of the asset as at 31 March 2013.

34.1 Charges to operating expenditure and future commitments in respect of On and Off SoFP PFI

	31 March 2013 £000	31 March 2012 £000
Total charge to operating expenses in year - Off SoFP PFI	0	0
Service element of on SoFP PFI charged to operating expenses in year	769	594
Total	769	594
Payments committed to in respect of off SoFP PFI and the service element of on SoFP PFI		
No Later than One Year	691	741
Later than One Year, No Later than Five Years	4,923	4,153
Later than Five Years	31,815	31,934
Total	37,429	36,828

The estimated annual payments in future years are expected to be materially different from those which the Trust is committed to make materially different from those which the Trust is committed to make during the next year. The likely financial effect of this is:

	31 March 2013 £000	31 March 2012 £000
Estimated Capital Value of Project - off SoFP PFI	0	0
Value of Deferred Assets - off SoFP PFI	0	0
Value of Reversionary Interest - off SoFP PFI	0	0

34.2 Imputed "finance lease" obligations for on SoFP PFI contracts due

No Later than One Year	1,704	1,590
Later than One Year, No Later than Five Years	5,350	5,603
Later than Five Years	24,611	25,312
Subtotal	31,665	32,505
Less: Interest Element	(13,889)	(14,143)
Total	17,776	18,362

35. Impact of IFRS Treatment

	Total £000	Admin £000	Programme £000
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g. LIFT/PFI)			
Depreciation charges	362	0	362
Interest Expense	1,426	0	1,426
Impairment charge - AME	0	0	0
Impairment charge - DEL	0	0	0
Other Expenditure	768	0	768
Revenue Receivable from subleasing	0	0	0
Total IFRS Expenditure (IFRIC12)	2,556	0	2,556
Revenue consequences of LIFT/PFI schemes under UK GAAP / ESA95 (net of any sublease income)	(2,779)	0	(2,779)
Net IFRS change (IFRIC12)	(223)	0	(223)

36. Financial Instruments

Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. As the cash requirements of the PCT are met through Parliamentary Funding, financial instruments play a more limited role in creating risk that would apply to a non-public sector body of a similar size. The majority of financial instruments relate to contracts for non-financial items in line with the PCT's expected purchase and usage requirements and the PCT is therefore exposed to little credit, liquidity or market list.

Currency risk

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

Interest rate risk

PCTs are not permitted to borrow. The PCT therefore has low exposure to interest-rate fluctuations

Credit Risk

Because the majority of the PCT's income comes from funds voted by Parliament the PCT has low exposure to credit risk.

Liquidity Risk

The PCT is required to operate within limits set by the Secretary of State for the financial year and draws down funds from the Department of Health as the requirement arises. The PCT is not, therefore, exposed to significant liquidity risks.

36.1 Financial Assets

	At 'fair value through profit and loss' £000	Loans and receivables £000	Available for sale £000	Total £000
Embedded derivatives	0	0	0	0
Receivables - NHS	0	1,056	0	1,056
Receivables - non-NHS	0	1,055	0	1,055
Cash at bank and in hand	0	13,163	0	13,163
Other financial assets	0	0	0	0
Total at 31 March 2013	0	15,274	0	15,274
Embedded derivatives	0	0	0	0
Receivables - NHS	0	4,840	0	4,840
Receivables - non-NHS	0	5,239	0	5,239
Cash at bank and in hand	0	20	0	20
Other financial assets	0	0	0	0
Total at 31 March 2012	0	10,099	0	10,099

36.2 Financial Liabilities

	At 'fair value through profit and loss' £000	Other £000	Total £000
Embedded derivatives	0	0	0
NHS payables	0	5,871	5,871
Non-NHS payables	0	8,257	8,257
Other borrowings	0	0	0
PFI & finance lease obligations	0	18,852	18,852
Other financial liabilities	0	0	0
Total at 31 March 2013	0	32,980	32,980
Embedded derivatives	0	0	0
NHS payables	0	2,207	2,207
Non-NHS payables	0	6,984	6,984
Other borrowings	0	0	0
PFI & finance lease obligations	0	19,439	19,439
Other financial liabilities	0	0	0
Total at 31 March 2012	0	28,630	28,630

37. Related Party Transactions

Northamptonshire Teaching PCT is a body corporate established by order of the Secretary for State for Health.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Northamptonshire Teaching PCT with the exception of those shown below:

Board Member	Related Party	Relationship to Related Party	Payments to Related Party	Receipts from Related Party	Amounts Owed to Related Party	Amounts Due from Related Party
Peter Kelby, Non Executive Director (from 1 October 2012)	Ophis Ltd	Director	£3,144	£0	£0	£0
Prof John Parkes, Chief Executive Officer (until 30 September 2012)	University of Northampton	Visiting Professor	£530,530	£170,000	£0	£0
Prof William Pope, Chair	University of Northampton	Board Member of Centre for Health & Well Being Research	£530,530	£170,000	£0	£0
Dr Sarah Whiteman, Medical Director	Stonedean Practice	GP Partner	£295	£0	£0	£0

The Department of Health is regarded as a related party. During the year, Northamptonshire Teaching PCT has had a significant number of material transactions with the Department and with other entities for this the Department is regarded as the parent department. These entities are listed below:

Central NHS Organisations	NHS Trusts	NHS Foundation Trusts	PCTs	SHAs
Department of Health	East Midlands Ambulance Service NHS Trust	Kettering General Hospital NHS Foundation Trust	Leicestershire County & Rutland PCT	East Midlands SHA
NHS Business Services Authority	Northampton General Hospital NHS Trust	Luton & Dunstable Hospital NHS Foundation Trust	Milton Keynes PCT	
NHS Litigation Authority	Oxford University Hospitals NHS Trust	Milton Keynes Hospital NHS Foundation Trust		
NHS Pensions Agency	University Hospitals Coventry & Warwickshire NHS Trust	Northamptonshire Healthcare NHS Foundation Trust		
	University Hospitals of Leicester NHS Trust	Oxford Health NHS Foundation Trust		
		Peterborough & Stamford Hospitals NHS Foundation Trust		

In 2012-13 the PCT ceased to be the Trustees of the Charitable Funds. The funds have been transferred to Northampton General Hospital NHS Trust and are held by the Trust in a separate Charitable Funds account.

38. Losses and Special Payments

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

	Total Value of Cases £s	Total Number of Cases
Losses - PCT management costs	109,403	76
Special payments - PCT management costs	0	0
Losses in respect of the provision of family practitioner services	0	0
Special payments in respect of he provision of family practitioner services	0	0
Total losses	109,403	76
Total special payments	0	0
Total losses and special payments	109,403	76

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

	Total Value of Cases £s	Total Number of Cases
Losses - PCT management costs	77,864	57
Special payments - PCT management costs	111	2
Losses in respect of the provision of family practitioner services	0	0
Special payments in respect of he provision of family practitioner services	0	0
Total losses	77,864	57
Total special payments	111	2
Total losses and special payments	77,975	59

39. Third Party Assets

The PCT did not hold any third party assets in 2012-13 or 2011-12.

40. Cashflows Relating to Exceptional Items

There were no cashflows relating to exceptional items in 2012-13 or 2011-12.

41. Events After the End of the Reporting Period

The Transition to Local Clinically-led Commissioning

The PCT has successfully implemented the Health and Social Care Act 2012. This resulted in the abolition of the PCT on 31 March 2013 and the transfer of statutory responsibilities and relevant assets and liabilities, as appropriate, to the successor organisations; Clinical Commissioning Groups, Greater East Midlands Commissiong Support Unit, NHS Proprty Services Limited, Northamptonshire County Council and the National Commissioning Board.

The Act transferred the majority of the NHS annual budget of approximately £80b to GP's who will commission services on behalf of their patients. By 1 April 2013 all GP practices in England will join with colleagues to become part of a Clinical Commissioning Group (CCG).

Northamptonshire has two CCGs; NHS Nene CCG with 70 practices and NHS Corby CCG with 5 pracices. Two practices have decided to join out of county CCGs.

To facilitate the transition process the Board of NHS Northamptonshire established a Transition and Closure Board in the autumn of 2012 with the remit to ensure:

- Successful closedown of the PCT;
- Support for the establishment of a range of new commissioning organisations;
- A seamless handover to receiving organisations; and
- Continuity of business as usual

The group was chaired by a Director of Transition, with senior staff holding clear leadership roles for key functional transfers. Internal Audit was involved in the establishment and operational review of transition processes and significant assurance was provided that controls were adequate.

The Transition and Closedown Board worked to a tight operational plan and received monthly update reports on the relevant workstreams focussing on the closing down and transition functions supported by a Transition and Closedown Risk Register which was presented to and considered by the Board on a monthly basis.

The Transition and Closedown Board discharged its duties effectively and efficiently ensuring a smooth transition of responsibilities to successor organisations on 1 April 2013.

Glossary of NHS Abbreviations

AME	Annually Managed Expenditure
APMS	Alternative Provider Medical Services
AVC	Additional Voluntary Contributions
CCG	Clinical Commissioning Group
CNST	Clinical Negligence Scheme for Trusts
CRL	Capital Resource Limit
DAT	Drug Action Team
DEL	Departmental Expenditure Limits
DEP'N	Depreciation
DH	Department of Health
DS	Dental Services
ELS	Existing Liabilities Scheme
ESA	European System of Accounts
FHS	Family Health Services
FREM	Finance Reporting Manual
FT	Foundation Trust
GAAP	Generally Accepted Accounting Principles
GDS	General Dental Services
GMS	General Medical Services
IAS	International Accounting Standards
IFRIC	Internal Financial Reporting Interpretations Committee
IFRS	International Financial Reporting Standards
IPSAS	International Public Sector Accounting Standards
LIFT	Local Improvement Finance Trust
NBV	Net Book Value
NHS BSA	NHS Business Services Authority
NHSLA	NHS Litigation Authority
PCT	Primary Care Trust
PCTMS	Primary Care Trust Medical Services
PDS	Personal Dental Services
PEC	Professional Executive Committee
PFI	Private Finance Initiative
PMS	Personal Medical Services
PPD	Prescription Pricing Division
PPE	Property, Plant & Equipment
RAB	Resource Accounting & Budgeting
RRL	Revenue Resource Limit
SIC	Standing Interpretation Committee
SMPTB	Substance Misuse Pooled Treatment Budget
SoCNE	Statement of Comprehensive Net Expenditure
SoFP	Statement of Financial Position
TCS	Transforming Community Services