Department of Health

NHS

# Shropshire County Primary Care Trust

## 2012-13 Annual Report and Accounts

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# Shropshire County Primary Care Trust

## 2012-13 Annual Report

NHS
Shropshire County

Shropshire County PCT

# Annual Report 2012/13

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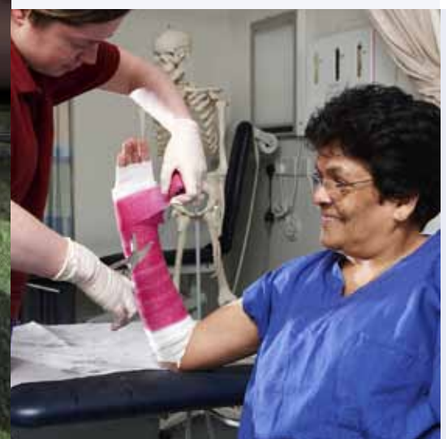


# Message from Graham Urwin, Chief Executive

Welcome to your annual report for Shropshire County Primary Care Trust (PCT), which covers the period 1 April 2012 to 31 March 2013.

Once again, over the last 12 months we have witnessed unprecedented change within the NHS as we move towards the delivery of the Government's vision to modernise the health service with the key aim of securing the best possible health outcomes for patients by prioritising them in every decision we make.

Shropshire County PCT has continued this year to work as part of the Staffordshire and Shropshire Cluster of PCTs which includes NHS Telford and Wrekin.

At the heart of the Government's proposals for a new way of buying health services are Clinical Commissioning Groups (CCGs), led by local clinicians. Shropshire County CCG has worked as a sub-committee of the PCT Board. This year, the CCG has undergone a rigorous assessment to become authorised and formally comes into being on 1 April 2013. The CCG will plan and commission hospital, community health and mental health services for its populations.

Major changes to the provision of public health services, to ensure improvements to the health of the local population, have also been progressed this year. The Public Health Team has transferred over to Shropshire County Council which will formally take over this service in April 2013.

During the transformation we have not lost sight of the health needs of our local population and progress has been made in achieving service reconfigurations and securing greater quality outcomes across patient safety, patient experience and clinical effectiveness through an emphasis on commissioning for quality. However, there are still significant quality improvements we need to achieve across the health system.

The Quality Innovation, Productivity and Prevention (QIPP) challenge continues to be driven by the CCG which has taken a strong leadership role in system redesign and QIPP delivery making sure that every penny spent benefits patients.

Patient engagement activity continues to grow and Patient Participation Groups (PPGs) are now active in a number of practices in Shropshire. All patient groups meet on a regular basis and we would like to thank everyone who has been actively involved. The CCG will use a model of engagement called 'Customer Insight,' which has been shortlisted for a number of awards. This model includes capturing insight through many routes including complaints, Patient Advice and Liaison Service (PALS), PPGs, Patient Members and community engagement, including work with health care professionals, voluntary sector and a range of stakeholder groups. Insight ensures that the experiences of patients, carers and service users drive everything that the NHS does.

The Robert Francis QC Public Inquiry into the system of oversight of Mid Staffordshire NHS Foundation Trust (MSFT) reported in February 2013. The enquiry produced 290 recommendations, which the Government is developing a response to. We are working across the health economy in Shropshire to learn from the report and ensure that in future we are proactive in identifying poor standards of quality and care to make certain that patients and families never again experience the unnecessary anguish – caused by poor levels of care.

We are mindful that the significant changes experienced over the last twelve months have affected staff and we would like to express our sincere thanks to them and wish them success in whatever organisations they work with in the future.

We would also like to thank clinicians, stakeholders and partners who have greatly assisted us in driving forward change and reaching a wider community.

Finally, we would like to thank the public and our patients for their support and engagement, particularly their contribution towards the authorisation of the CCG. Patient engagement is a key part of the NHS reforms and is vital for the development of the CCG. More than any other time in history patients have the chance to shape the way health services are delivered and the transformed health service is committed to establishing an open and honest dialogue with the local community to ensure that services are patient centred.

**Graham Urwin**
**Chief Executive**
**On behalf of Shropshire County Primary Care Trust**

# About us, who we are and what we do

In October 2012 the first joint meeting of the 'north cluster' was held between Shropshire County PCT and NHS Telford and Wrekin. This followed the separation of four PCTs (Shropshire County PCT, NHS Telford and Wrekin, NHS Herefordshire and NHS Worcestershire) which had come together in January 2012 to form a 'Cluster of PCTs' called West Mercia Cluster.

Shropshire County PCT although working as a Cluster remains the statutory organisation responsible for commissioning health services and improving the health of local residents – particularly the most disadvantaged – until it is abolished on 31 March 2013.

Shropshire is the largest in-land county in England and with its 17 market towns and patchwork of villages, it represents one of the country's most rural areas. Situated on the border with Wales, the county's primary and secondary health care services also provide support to the town and villages of Powys.

Shropshire has a population of approximately 289,300, 45 GP practices and covers the geographical boundaries of Shropshire County Council. The county town of Shrewsbury is home to around a quarter of the population, but approximately 36% of the population live in rural areas.

**Shropshire County PCTs key objectives are:**

- Improving the health and well-being of our population.
- Ensuring the delivery of high-quality, safe and responsive services.
- Developing our engagement strategy with stakeholders to improve the patient and carer experience.
- Exercising good stewardship of public resources.
- Become an employ of choice in Shropshire.

In 2012/13 the PCT had a turnover of £486 million. We are held to account on a cluster basis through the West Mercia Board 'north Cluster', but the NHS Code of Accountability allows the Board to delegate some of it business to board committees and to the executive.

This year has seen many changes to the Board as it moves towards the NHS England Area Team structure, including Graham Urwin replacing Eamonn Kelly as the Chief Executive and Accountable Officer in October.

2012/13 is the final year that Shropshire County PCT will be responsible for all local NHS services. We pay for all these services on your behalf, manage performance and oversee services to ensure the quality of care is always improving.

We contract for all NHS services provided by GPs, pharmacists, dentists and opticians in Shropshire and also pay for hospital care on behalf of patients registered with Shropshire GPs, care for mental health patients, prescriptions and community healthcare, such as community hospitals, health visitors and district nurses.

There is one shadow CCG in place in Shropshire that will be authorised by March 2013 without conditions. This essentially means that from April 2013, when PCTs are dissolved, Shropshire CCG will take on its full statutory responsibilities, which is described as 'full authorisation'. Legally this is described as 'established without conditions'.

Shropshire CCG has a designate Chair, an Accountable Officer, a Chief Finance Officer and a Governing Body in place and is in the final stages of the authorisation process. Staff assignment to confirmed organisations, including the CCG, has been ongoing throughout the year.

The CCG already has delegated budgetary responsibility for a significant proportion of the PCT allocation. This means the shadow CCG will move to full authorisation with a significant amount of responsibility already resting with them. The scheme of delegation clearly sets out the devolved responsibilities/ accountability and allows the CCG to demonstrate that they have a 'proven track record' and can meet the challenges of authorisation.

The Cluster has continued to monitor progress using the objectives outlined in the Shared Operating Model and has a performance management matrix in place to monitor CCG development and QIPP delivery.

**Our main providers of services**

The main providers of services in Shropshire are Shrewsbury and Telford Hospitals NHS Trust (SaTH).

Serving patients in a variety of community setting, including in their own homes, is Shropshire Community Health NHS Trust. They deliver a variety of services including district nursing, health visiting, school nursing, sexual health services, podiatry and physiotherapy and occupational therapy.

Mental health, learning disability and some specialist children's services are provided by South Staffordshire and Shropshire Healthcare NHS Foundation Trust.

**Commissioning Support Unit**

To support the CCGs to deliver their duties Commissioning Support Units (CSUs) have been created. Staffordshire CSU has been appointed as the preferred supplier to Shropshire CCG.

**Public Health Transition**

Public Health work has been ongoing during 2012/13, led by a Director of Public Health within Shropshire County Council, in preparation for the transition in 2013.

# How we performed in 2012/13

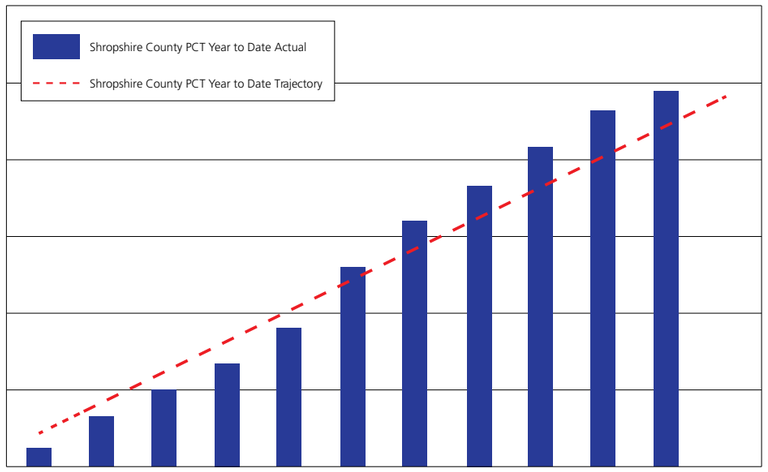
## Maintaining strong clinical governance is vital at Shropshire County PCT.

The PCT is dedicated to the ongoing development of clinical governance and has focused on meeting all Integrated Performance Measures. This is why a range of challenging targets were introduced to cover all aspects of healthcare, including patient safety, clinical effectiveness and cost effectiveness.

## Incidence of Clostridium difficile

Shropshire County PCT has continued to focus on reducing the incidences of C diff infection.

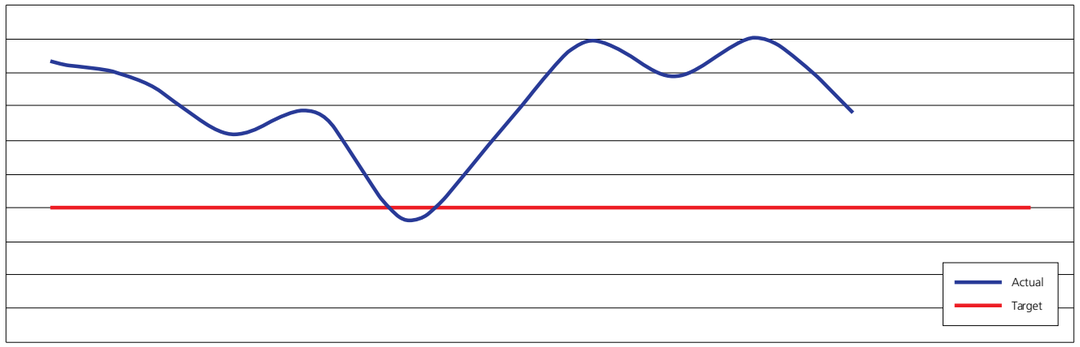
**C diff Cumulative Year to Date**
**Shropshire County PCT**




## Cancer two-week wait from GP referral

The PCT achieved the cancer two week wait target for all months Year-to-Date (YTD) in 2012/13.

**SCPCT - Cancer Two Week Wait 2012/13**




## Performance achieved year to date (YTD)

| What | Target | Achieved (as at January 2013 unless otherwise stated) |
|---|---|---|
| Category A calls meeting the 8 minute standard | 75% | 76.2% (Feb) |
| Category A calls meeting the 19 minute standard | 95% | 97.4% (Feb) |
| Cancer two week wait from urgent GP referral | 93% | 96.2% (Dec '12) |
| Cancer two week wait from GP referral (symptomatic breast) | 93% | 95.2% (Dec '12) |
| Cancer 31 day (one month) wait to first definitive treatment | 96% | 97.8% (Jan) |
| 31 day standard for subsequent cancer treatments (drug) | 98% | 98.70% (Jan) |
| 31 day standard for subsequent cancer treatments (Radiotherapy) | 94% | 98.3% (Jan) |
| Cancer 62 day (two month) wait from urgent referral to treatment | 85% | 85.7% (Jan) |
| Cancer 62 day wait (referral from NHS Cancer Screening Service) | 90% | 91.10% (Jan) |
| Referral to Treatment (admitted) within 18 weeks | 90% | 88.0% (Jan) |
| Referral to Treatment (non-admitted) within 18 weeks | 95% | 95.0% (Jan) |
| Referral to Treatment (incomplete) % within 18 weeks | 92% | 87.46% (Jan) |
| Stroke Care – time spent in hospital on a stroke unit | 80% | 86.4% up to quarter three |
| Stroke Care – suspected TIAs assessed and treated within 24 hours | 60% | 71.4% up to quarter three |
| Maternity 12 weeks | 90% | 100% |
| Mental health measure – the care programme approach | 95% | 95.1% (Jan) |
| Mental Health Crisis Resolution | 95% | 100% up to quarter three |
| MRSA bacteraemia | 6 cases | 4 cases (Jan) |
| Cdiff | 97 cases | 93 cases |
| NHS health checks (offered) | 20% plan | 13.37% up to quarter three |
| NHS health checks (received) | 10% plan | 5.64% plan up to quarter three |

## Performance measures not achieving (YTD)

| What | Target | Achieved (as at January 2013 unless otherwise stated) |
|---|---|---|
| Mixed Sex accommodation breaches | 0 breaches | 2 breaches (Jan) |
| 31 day standard for subsequent cancer treatments (surgery) | 94% | 93.7% (Jan) |
| Referral to Treatment (admitted) | 90% | 81% (Jan) |
| Referral to treatment (incomplete pathways) | 92% | 90.6% (Jan) |
| Mental Health – Improved access to psychological therapies (general need of population) | 4.9% | 2.69% up to quarter three |
| Mental Health – Improved access to psychological therapies (moving to recovery) | 50% | 50.10% up to quarter three |
| Diagnostic Waiting times | <1% | 0.2% (Jan) |

# Achievements


## Infection Prevention and Control

Reducing Healthcare Associated Infections (HCAI) has been identified by the Shropshire and Telford health economy as a key safety and quality objective. Contractual measures are in place with our NHS providers to ensure processes exist to improve infection prevention practices and to continue to reduce the number of cases of Meticillin Resistant *Staphylococcus Aureus* (MRSA) bloodstream and *Clostridium difficile* infections – in line with the national reduction programme. In 2012/13 both Shrewsbury and Telford NHS Trust Hospital and Robert Jones and Agnes Hunt Orthopaedic Hospital achieved their MRSA bloodstream and *Clostridium difficile* infection targets.

We remain committed to a zero tolerance approach concerning all avoidable HCAI. This is evident across the health economy through a combination of good hygiene practice, appropriate use of antibiotics and improved techniques in the care and use of medical devices. Investigations are also undertaken to understand the cause of an infection and ensure we learn how future cases can be avoided.

Shropshire County PCT is committed to improving infection prevention practices within the independent care sector, general medical and general dental practices and is actively involved in the health economy programme for reducing HCAI. This pledge is further demonstrated by the inclusion of an infection prevention and control service in the quality structure of the Shropshire CCG.

## Serious Incidents

The quality team work with providers to ensure the robust reporting and investigation of Serious Incidents (SIs) and monitors the progress of any subsequent action plans. The PCT is also responsible for reporting serious incidents on behalf of independent providers.

**Shropshire County PCT**

| Total number of SIs reported during 2012/13 | Number reported on behalf of external independent providers | Number of Information Governance incidents level 3-5 |
|---|---|---|
| 4 | 2 | 0 |

Two MRSA (pre 48-hour) bacteraemias reported in the community; two external providers.

## West Midlands Specialised Commissioning Group

The West Midlands Specialised Commissioning Group buys specialised healthcare and secures mental health services on behalf of the 17 West Midlands Primary Care Trusts, covering a population of approximately 5.5 million people.

The group's six engagement projects received valuable feedback in 2012-2013. Patient and public involvement activities included workshops, question and answer sessions and increased opportunities for groups to have their say across the following projects:

- Safe and Sustainable Children's Heart Surgery and Neurosurgery Services Review
- Adult Congenital Heart Disease Standards
- Implementation of Trauma Care System
- Commissioning intentions workshop
- Intestinal Failure Peer Review
- Child and Adolescent Mental Health Tier 4 Service

**Key achievements for 2012-2013 included:**

1. New congenital heart networks introduced across England and Wales to ensure safe and sustainable care for all children. These networks will be structured around specialist Surgical Centres in Bristol, Birmingham, Liverpool, Newcastle and Southampton.
2. The review into how neurological services are delivered to children continued, including an assessment of centres against agreed standards.
3. Views were gathered on services for adults with congenital heart disease, through workshops with patients, families, clinicians, young people and people from black and minority ethnic communities.
4. A network of 22 new trauma centres was announced in April 2012, including the University Hospital of North Staffordshire (UHNS). The Local Involvement Networks (LINks) represent the North West Midlands and Wales Major Trauma Network.
5. A new operating model for commissioning specialised services was published, setting out how a single, national system will ensure patients are offered consistent, high quality services across the country.
6. A national peer review took place into intestinal failure, with input from the UHNS.
7. A range of providers were commissioned to ensure children and young people could be offered mental health services as close to home as possible and involve young people in their treatment plans.

## Dental Services

Shropshire County PCT has undertaken a significant stocktake of primary care dental services in readiness for the transition of this service to NHS England in April 2013. Funding has been secured for dental nurse training – in order to provide fluoride treatments for patients and health promotion advice.

# Safety and environment

## Emergency Planning Resilience and Response

Emergency Planning Resilience and Response (EPRR ) is a statutory function under the Civil Contingencies Act 2004. All NHS organisations and healthcare providers need to have plans and processes in place to respond effectively in the event of a major incident.

Structures across Shropshire and Telford and Wrekin enable the cluster of PCTs to work with multi-agency partners to help ensure a co-ordinated response in such circumstances. This strong partnership approach resulted in a safe and memorable Olympic Torch Relay, Tour of Britain and an effective response to several public health outbreaks, industrial action and severe weather.

The Staffordshire and Shropshire Cluster of PCTs has 24/7 on call arrangements to support provider organisations across the region. These arrangements have been put to the test in an exercise scenario and during live incidents.

Health planning structures created by the Cluster have been easily adapted to meet the EPRR requirements of NHS England. This will allow for a smooth transition from one organisation to another when the planned changes to the NHS take place.

## Improvement Grants

This investment has focused on improving infection control, providing better facilities and equipment and creating a safer environment. Included in the improvements were; the introduction of a purpose built medical centre in Shrewsbury, the relocation of one GP practice to a new facility in Oswestry and an extension to a practice in Shrewsbury.

In 2012, the NHS invested £250,000 to assist Shropshire GP practices in meeting the standards required by the Care Quality Commission.

## Environmental Footprint

Work continued to make a positive difference to the communities served by Shropshire County PCT. The organisation has a responsibility to consider the impact that property makes on the environment. We have continued to invest in sustainable technologies helping to reduce the carbon footprint and contribute to QIPP targets. These have been implemented via the Capital Programme and Backlog Maintenance and include improvements in:

- Thermal performance
- Building management control systems
- Lighting solutions to reduce energy consumption

## Sustainability Strategy

We are committed to playing a major role in carbon management across Shropshire. The PCT is continuing to support the aims, initiatives and annual targets set out in the Carbon Reduction Strategy to achieve the demanding targets in reducing its carbon footprint.

## Estates Development

The capital resource allowance allocated to Shropshire County PCT in 2012/13 has been invested in the improvement and refurbishment of health properties – particularly in backlog maintenance.

The Scheme of Transfer has been prepared for its property assets to transfer to: 'NHS Property Services Ltd' and local NHS providers in accordance with the Department of Health Guidance: 'PCT Estate: future ownership and management of estate in the ownership of Primary Care Trusts in England'. Due diligence has been completed by the PCT for these transfers and all property related costs determined for the funding of the receiving organisations.

## Equality and Diversity

Shropshire County PCT is committed to understanding and respecting human rights and treating everyone fairly, openly and honestly. We are striving to achieve equality for the diverse mix in our communities and our own workforce, recognising that people have different needs, cultures, experiences and expectations. We realise that valuing equality and diversity will lead to more sensitive services that are responsive to the needs of the communities and a workforce that reflects the diversity of the community.

The PCT has a legal duty to protect human rights and promote equality and diversity by eliminating unfairness and discrimination in its role as service commissioner and employer.

## The Equality Delivery System (EDS)

Over the last 12 months we have been working towards one of our EDS improvement objectives, as agreed following a stakeholder workshop in March 2012. The objective we focused on this year is developing our staff so they have a better understanding of the needs of the protected characteristic groups within the community. We worked with our staff and the protected characteristic groups in our communities to understand how we can achieve this and the outcome was the development of a short film called: 'Hats off to Humanity'. This film endorses that it is within acceptable limits to ask people from protected characteristic groups about their specific needs rather than making assumptions about what they may need.

The next year will focus on our other improvement objectives, where work is already underway and ensure that, throughout the transition, we maintain and nurture our links with the protected characteristic groups in our communities and sustain the good work carried out to date.

# Quality through QIPP

The Quality, Innovation, Productivity and Prevention (QIPP) programme is all about improving quality and innovation, so that every pound spent brings maximum benefit and quality of care to patients.

The Shropshire County PCT QIPP savings target for 2012/13 is £11.146m. This is important in making sure the required financial position (a £1m surplus) can be delivered at year-end. Performance against QIPP initiatives delivered in the 2012/13 financial year is reported to meetings of the Shropshire CCG Board, Quality, Performance and Resources Committee, Supporting Delivery Group, Clinical Advisory Panel and the West Mercia Cluster Board.

## Better understanding the needs of local people

The 2012/13 Joint Strategic Needs Assessment (JSNA) is a large technical document containing a robust and detailed analysis on various health and health related topics. It is a useful source of local data and available on the PCT and council website. During the year we have:

- Added additional JSNA pages to the website.
- Produced smaller fact sheets of data from the original JSNA to make it easier for people to understand.
- Included links to other data sources e.g. national reports/guidance and work areas e.g. partnership and engagement.

## Improving public health

- Introduced the 'who I am' passport for dementia.
- Improved flu vaccination uptake.
- Re-designed the pathway for smoking in pregnancy.
- Increased uptake for the NHS Health Check programme.
- Developed a revised service specification for integrated Sexual Health services and tendered the service with a new provider starting in April 2013.
- Implemented every contact counts with local health colleagues.

## Mental Health

- Opened the Redwood Centre to replace Shelton Hospital as the inpatient facility for mental health in Shropshire.
- Introduced a Rapid Assessment Interface and Discharge (RAID) scheme into the local health economy to improve care for people with mental health problems that also have physical problems.

## Patient Involvement

Forty of the 45 practices in Shropshire have PPGs. These groups come together as a Shropshire Patients' Group that informs the CCG. A sub-group of the board has been formed to oversee the involvement of the public in all areas of the CCGs work. The Shropshire Patients' Group and Shropshire CCG has agreed a code of conduct for commissioning in partnership as the basis for a productive relationship. There are 10 principles that apply to all those involved in joint working:

1. Collective responsibility for local healthcare decisions.
2. Use experiences and opinions to inform meetings.
3. Trust each other enough to respect views.
4. Individual experiences and stories as valid as research.
5. Use language that empowers other people's contributions.
6. Attitudes and behaviours that show we are all in this together.
7. Discuss the boundaries of confidentiality for the specific meeting.
8. Discussion focused on the objectives of the meeting.
9. Come to meetings prepared.
10. Adhere to methods available for conflict resolution.

## QIPP priorities

Our priorities for the QIPP programme have been developed with local clinical knowledge and benchmarking and reflect the needs of our area now and in the future.

**The four identified priorities are:**

1. Medicines management.
2. Scheduled care and outpatient redesign.
3. Unscheduled care.
4. Long term conditions and preventative health.

## Medicines Management

- Supported practices, areas and CCG level service re-design in scheduled and unscheduled care.
- Developed a CCG-wide drugs formulary (linked to GP computer systems).
- Given practical support to GP practices in 'better-value' drug changes.
- Worked with care homes around medicines optimisation and further clinical support – especially in relation to prescribing anti-psychotic medication and education on dementia care.

## Unscheduled Care

- Worked together to 'join up' the urgent care service across the county through implementing the unscheduled care strategy.
- Introduced ambulatory care.
- Commissioned a team across the hospital and community settings to deal with patients who are frail and have complex needs.
- Developed a new model of care for child and adolescent mental health services.

## Long Term Conditions

- Developed a long term conditions strategy and structure.
- Supported GP practices in getting local networks of people to support their communities' health and care. This has been helped by the commissioning of a service in the majority of practices to help co-ordinate care.
- Supported primary care to improve the management of patients with long term conditions through best use of the quality and outcomes framework.

## Scheduled care and outpatient redesign

- Introduced a referral assessment service for all referrals from Shropshire GPs to support choice and the patient experience.
- Introduced a revised policy on procedures of limited clinical value.
- Introduced 11 new clinical pathways.
- Developed access to an advice and guidance system
  - where GPs can get support from consultants on patient conditions via secure e mail.
- Introduced increased access for GPs for diagnostic tests (particularly cardiology tests).



# Make your voice heard

## Patient Experience

A series of quality assurance activities helped to capture all patient information in a consistent and timely way. The use of real time monitoring of patients using voice feedback continued, which is collected by the team through ward and department visits. Caring and listening to patients, relatives and staff in this way provides a robust opportunity to review the safety and effectiveness of care. This holistic focus on all aspects of care led to the identification of areas of good practice and improvement and the development of action plans with the provider organisation.

## Patient Advice and Liaison Service

PALS is integral to Shropshire County PCT's commitment to working closely with patients and staff to improve services. All enquiries received through PALS are recorded on the insight database and used in the ongoing programme of service improvement.

PALS is an informal and impartial way to resolve the concerns of patients, relatives, carers and members of the public. The service is intermediary and a useful source of information, often signposting people to the healthcare they need.

During 2012/2013 269 contacts were received through PALS – and most of these were requests for information.

## Consultations

Shropshire County PCT has supported the reviews on Trauma, Stroke Services and Pathology which took place at a regional level by the Strategic Health Authority and the West Midlands Specialist Commissioning Group.

## Patient and Public Engagement

With the NHS Reforms, and the establishment of the Shropshire CCG, patients and the public continue to be to be at the centre our commissioning processes, from informing service design right through to their influence at board level.

**During 2012/2013, we have developed the structures for patient involvement:**

**Our work this year has seen:**

- The number of GP practice PPGs growing from 33 to 44.
- We continue to host two PPG network meetings each year, attended by representatives from each of the PPGs and invite groups from the voluntary sector.
- The development of a focus group network that maximises the number of people taking part in this form of engagement.
- A pilot project has been established to look at personalised care planning, enlisting patients to take part. Each patient has been given the option to have a plan in paper format, on a website, or using a specially designed App.
- Ongoing engagement with our long term condition support group, a group led by the patients themselves and a representative sits on and chairs the over-arching strategy group.
- In depth involvement with the Any Qualified Provider process with patients sitting alongside commissioners to develop service specifications with patient designed quality measures.
- Patient representation on the project board for the local implementation of NHS 111 and their involvement in the communication and engagement of the general public about the new service.

## Local partners

Shropshire PCT has worked with Shropshire Council, Shropshire Patients Group & all PPGs, Shropshire LINk (now transitioned to Shropshire HealthWatch), Shropshire Youth, the Voluntary Community Sector Assembly and any member of the public who comes forward with an interest in using their experiences of healthcare to drive improvement.

## Complaints

Last year Shropshire County PCT received 50 complaints which covered all areas of healthcare. NHS National Complaints regulations are followed when dealing with complaints – together with the principles set out by the Parliamentary and Health Service Ombudsman.

Based on the guidelines: "Listen, Improve and Respond," customer care systems are designed to support clinical and administrative staff through any changes. Every complaint is entered into the insight database which helps highlight areas for development.

This integrated approach to handling complaints allows a flexible response to complaints, concerns and compliments and embraces tangible changes to be made to services based on patient feedback.

For example:

- A patient suffering from anxiety called a GP Practice to book an appointment and complained that the receptionist, not understanding the patient's condition, repeatedly spoke over her then hung up
  - The practice uses this patient experience as an example for staff customer training.
- A patient was informed that the Pain Management Programme was to end, which subsequently resulted in all the patients' appointments being cancelled
  - As a result the CCG requested that hospitals provide written notice to commissioners before cancelling any patients' treatment. This will help to avoid any similar impact on patients in future and ensure urgent action is taken to resolve the matter – without impacting on patient care.
- Following a delay diagnosing meningitis in a child, the following actions were put in place by a local provider:
  - Published NICE guidance in the provider's operational news and clinical internet hub.
  - Put the Meningitis Trust link on the provider's public website.
  - Ensured meningitis leaflets available in all providers' bases.
  - Reminded all clinicians of the signs and symptoms of meningitis.
  - Stored this case for future clinical education sessions.

## Freedom of Information

The Freedom of Information Act 2000 (FOI) gives people a general right of access to information held by or on behalf of public authorities. It is intended to promote a culture of openness and accountability amongst public sector bodies and facilitate a better public understanding of how public authorities carry out their duties, why they make the decisions they do and how they spend public money.

Exemptions deal with instances where a public authority may withhold information under the Freedom of Information Act or Environmental Information Regulations. Exemptions mainly apply where releasing the information would not be in the public interest, for example, where it would affect law enforcement, or harm commercial interests.

Requests are handled in accordance with the terms of the Freedom of Information Act 2000 and, wherever possible, best practice guidelines from the Information Commissioner's Office and the Ministry of Justice are followed to maximise openness and transparency:

| Organisation | Numbers of requests received |
|---|---|
| Shropshire County PCT | 277 |

| Organisation | Number responded to within 20 working days | | Number responded to over 20 working days | |
|---|---|---|---|---|
| Shropshire County PCT | 273 | 98.6% | 4 | 1.4 % |

| Organisation | Exemption applied | | | | |
|---|---|---|---|---|---|
| | **Section 12** Costs | **Section 21** Publication Scheme | **Section 22** Intended for Future Publication | **Section 40** Personal Information | **Section 43** Commercial Interest |
| Shropshire County PCT | 14 | 0 | 0 | 0 | 0 |

# How we work in partnership


Shropshire CCG has worked closely with Shropshire County Council to establish the HWBB for Shropshire and agree the local health and wellbeing strategy. The CCG is also a member of the Shropshire Leaders Board, working in partnership with the Local Authority, the Police, the Fire Service and local voluntary, independent and third sector agencies.

The CCG has established strong partnerships with patient groups – in particular with local PPGs – and with Healthwatch.

Shropshire and Telford and Wrekin CCGs have worked together with local NHS providers and the two Local Authorities in the development of a compact agreement. This will provide a framework for joint planning and co-operative working on our shared priorities.



# A healthy future for us all

A range of initiatives across the county have continued to reduce health inequalities. But the commitment to improve health outcomes remains an important priority.

## Tobacco Control

Smoking is the leading cause of death and illness in Shropshire, with an estimated 45,000 smokers in the county, aged 18 years or above. Smoking is also a key driver behind health inequalities and, whilst smoking prevalence in Shropshire is significantly lower than the national figure, inequalities still exist. Smoking in pregnancy is significantly higher in Shropshire than the national figure.

The success of the stop smoking services continued in 2012/13, with an increase in the number of quitters – as measured at four weeks. Access to these services increased by commissioning a number of qualified providers and by the end of December the services were performing at 113% of target.

Referrals to services have also been strongly promoted through Making Every Contact Count (MECC). NHS organisations signed up to the scheme to provide all health professionals with the skills and resources to offer brief opportunistic lifestyle interventions to patients.

Since the introduction of the hugely successful smoke free legislation in public places, there has been a dramatic fall in child asthma hospital admissions. To continue to protect children from the effects of second hand smoke, a local campaign has been instigated with partners including health visitors, midwives and pharmacies, to further encourage smoke free homes and cars.

## Integrated sexual health

A new model of sexual health service will be delivered across the county by the Staffordshire and Stoke-on-Trent Partnership Trust (SSoTPT) from 1 April 2013. This followed a formal tender exercise about providing community based integrated sexual health services. The new model will be delivered to significantly increase access to services, providing integrated levels

1, 2 and 3 contraception and sexual health services, using 'one stop shops' – where all needs can be met at one site, through extended opening hours and easily accessible locations.

## NHS Health Checks

Cardio-vascular disease (CVD) is the most common cause of death in Shropshire accounting for around 35% of all deaths annually. Most premature death (under 75 years) from CVD is caused by modifiable risk factors, such as smoking, poor diet and raised blood pressure. The NHS Health Check offers a cardiovascular risk assessment and route into prevention services, for people aged 40-74 years, without pre-existing CVD.

Rollout of the NHS Health Check programme has grown rapidly during 2012-13 and full operational capacity is expected to be reached by quarter one 2013-14. A successful tender process has secured a provider to deliver the NHS Health Check in community settings, to supplement the main provision in general practice. Uptake of invitations to attend has steadily increased, assisted by successful social media initiatives and currently stands at around 42%. The programme is on course to exceed 50% uptake in 2013.

## Making Every Contact Count

Making Every Contact Count (MECC) is about systematic delivery of consistent and simple healthy lifestyle messages by frontline staff, combined with appropriate signposting to Lifestyle Risk Management Services (LRMS). The focus of MECC is on organisational change and transforming working in the NHS, local government and the community and voluntary sector, to ensure that no appropriate opportunity is missed in signposting people to behaviour change support.

MECC has senior support at Board level throughout the local health economy and is being included in NHS and local government commissioning contracts. An action plan has been developed to install MECC which includes training, resources and organisational support.

## Healthy Shropshire Lifestyle Hub

Shropshire Public Health Department has been working with the Shropshire Council Customer Services Division to develop and pilot a central 'Healthy Shropshire' hub, which serves as a single point of access to (LRMS). The public will be able to call a telephone helpline to receive information, advice and support to stay healthy and access prevention services. Professional groups will be able to signpost patients and clients to one place for all prevention services, including self-help groups, community activities and social care services. A Healthy Shropshire website has also been created.

## Mental Health

Whilst promoting physical wellbeing is a key public health priority, so too is promoting mental health. During 2012/13 mental health promotion has been linked to physical health promotion programmes such as obesity prevention and smoking cessation, where there is a strong relationship between unhealthy patterns of eating and the compulsion to smoke cigarettes. Local programmes have helped a wide range of people to reduce weight and quit smoking. Shropshire's shadow HWBB has identified two priorities for the coming year namely; 'Improving Child and Adolescent Mental Health Services' and 'Improving Services for People affected by Dementia'.

## Cancer Awareness Activity

Cancer is the second most common cause of death in Shropshire, accounting for around 27% of deaths every year. It is estimated that more than a third of all cancers could be prevented by reducing lifestyle risk factors – such as smoking and poor diet.

Shropshire has a similar premature cancer mortality rate compared with national figures and – overall – premature mortality has declined in the last two decades. Between 2005-2007 cancer trends increased slightly, though not significantly, and then decreased again from 2008-2010. Premature mortality from cancer is higher in males than in females and there are significantly more premature deaths in the most deprived fifth of the county than the national average.

Early diagnosis, referral and effective treatment is key to preventing death from cancer. Cancer screening services are one way of diagnosing cancer early and there are cancer screening programmes for breast, cervical and bowel cancer. The screening uptake rates in Shropshire are consistently higher in the county compared with national and regional levels. There is variation between GP practices for screening uptake rates and the Public Health department is working with the CCG to reduce this. In March 2013, the national Cervical Screening HPV Triage and Test of Cure programme was introduced. Work is currently underway to expand the Breast Screening Programme to women aged 47-49 and 71-73 and the Bowel Screening Programme to women and men aged 70 up to their 75th Birthday. From 1 April 2013, the commissioning responsibility for the screening programmes transferred to NHS England.

# Our Staff

The NHS landscape during 2012/13 has seen an unprecedented period of change. Over this 12 month period, staff have been supported through the recruitment and transfer phase, as new organisations continue to develop and PCT functions continued to be delivered.

Managing staff has focused on securing posts into the new era. This function was carried out through a programme called; Investing in Your Future, giving advice and support to staff to help consider the options available to them.

The transfer of staff to different and new NHS organisations has been managed in line with the nationally agreed process through TUPE transfer, or a Transfer Order, which safeguards staff by protecting their employment rights. Staff from Shropshire County PCT are transferring into a number of different organisations – which either sit under the NHS or Local Authorities.

Consultation has been important throughout this process, as the PCTs worked with the trade unions and professional bodies. As part of the closedown of PCTs, any outstanding issues relating to staff have been identified and will be dealt with through the legacy programme in 2014.

## Workforce

The overall approach of the Cluster has been to establish a new structure that fits with the proposed transition set out in the Health and Social Care Act. We have focused on the business critical skill sets required and rapidly assigned or aligned all commissioning staff, from each PCT, to either the newly emerging CCGs, the CSU, NHS England, the Area Team, or the Cluster itself. By aligning and assigning staff quickly, there has been minimal disruption to business continuity and business functions are well-placed for the remaining changes.

All staff have been offered 1:1 review sessions about the future and these have taken place each month. A support programme has also been developed for all staff, which has been shaped by feedback from the 1:1s and discussions with trade unions.

## Equality and Disability Policy

The PCT has a Single Equality Scheme and a specific policy on Equal Opportunities and continues to use the two ticks - 'Positive About Disabled' award, which not only recognises good practice, but having policies and procedures in place to support equality of opportunity for people with disabilities.

## Sickness absence

The tables below indicate the sickness absence rates for April 2012 to March 2013 – by PCT and as a whole. The sickness absence rate is defined as the percentage of Full Time Equivalent (FTE) days lost, from those that were available to be worked within the period in question.

| Apr 12 | May 12 | Jun 12 | Jul 12 | Aug 12 | Sep 12 | Oct 12 | Nov 12 | Dec 12 | Jan 13 | Feb 13 | Mar 13 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1.5% | 1.5% | 1.8% | 2.0% | 1.8% | 2.0% | 2.2% | 2.4% | 2.7% | 3.0% | 1.9% | 1.2% |

Overall, sickness rates for February 2013 are lower than for January 2013, although rates for each PCT have remained relatively stable over the 12 month period. Reliable PCT sickness figures are available from April 2012 onwards, following computer system changes to separate out community services provider staff from PCT records.

All NHS organisations in the West Midlands are committed to achieving an annual sickness absence rate of 3.39% or lower by March 2013. The initial target for April 2012 was to maintain a level of 4.00% or lower. The combined rate for the two PCTs for April 2012 was 2.49% and the overall annual rate for 2011/12 was 2.31%, both of which are well within the March 2012 and 2013 targets.

In terms of sickness absence episodes, the table below indicates the total number of days lost by sickness duration:

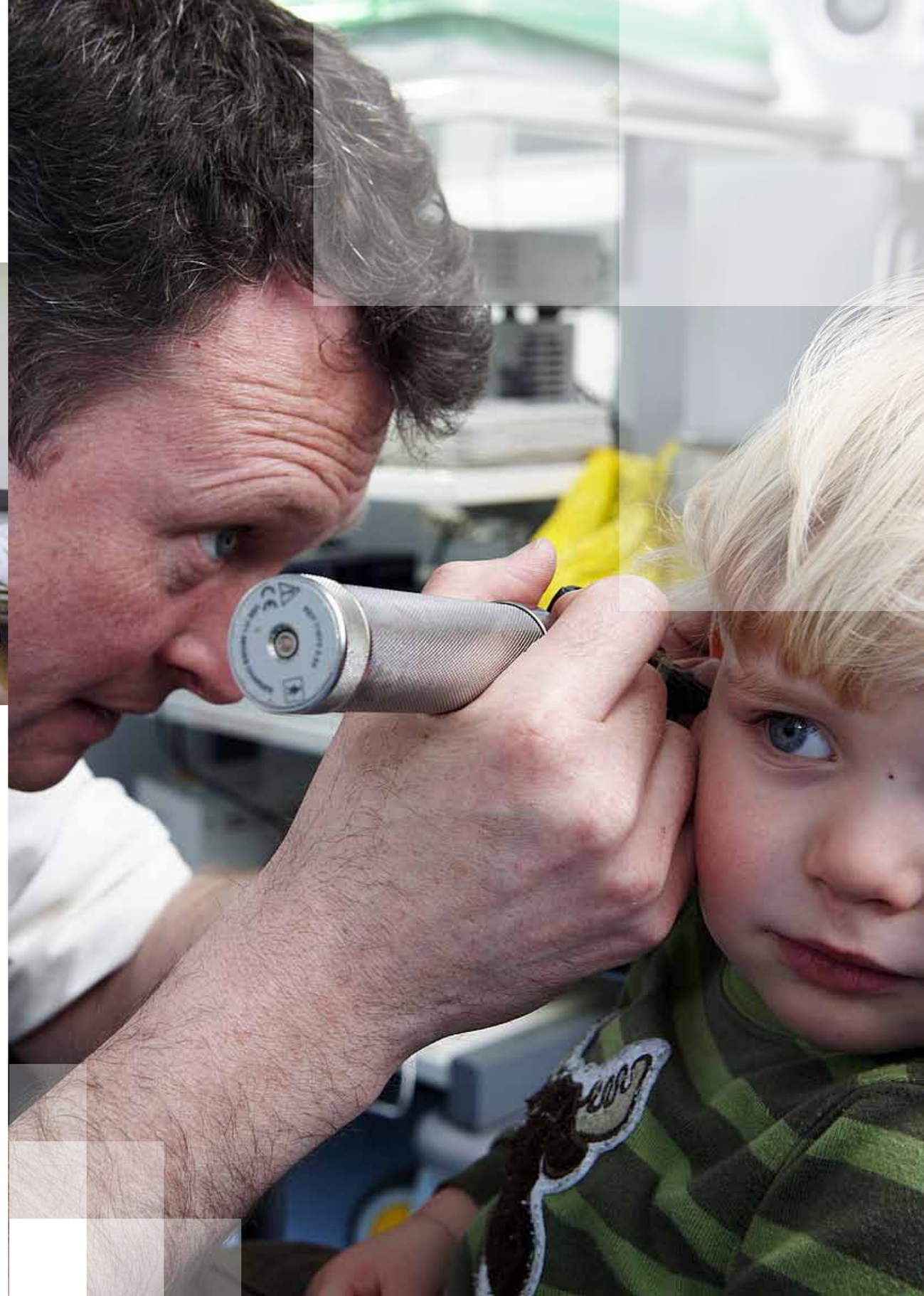
| Reason | |
|---|---|
| Long-Term (28+ Days) | 11 |
| Medium-Term (8 - 27 Days) | 23 |
| Short-Term (1 - 7 Days) | 151 |
| **Overall** | **185** |

# Looking Forward

As mentioned in the introduction to the annual report, Shropshire County PCT is in a period of great change, and the Cluster of PCTs has to tackle this change. To support this, a 2012/13 Integrated System Plan was developed for the whole health economy, to enable the delivery of better services and better health outcomes for the population.

The strategic challenges for the Cluster in 2013/14 and beyond are:

- Ensuring healthcare services across the Cluster are provided in a safe, clinically effective and responsive manner.
- Closing the financial gap over a four-year period, up until 2014/15, whilst continually improving the quality of healthcare service provision.
- Implementing the QIPP Plans across Shropshire and delivering the transformational and sustainable change required to transport our health economies to new levels.
- Ensuring an effective transition and integration of key services, including public health and community services – ensuring all service changes are reflective of the four key national tests.  Firstly, there must be clarity about the clinical evidence base underpinning any proposals. Secondly, they must have the support of the GP commissioners involved. Thirdly, they must genuinely promote choice for their patients; and finally, the process must have genuinely engaged the public, patients and local authorities.
- Ensuring the workforce is supported through this substantial period of organisational change and that staff have the skills, knowledge and capacity to deliver their roles effectively.



# Annual Governance Statement 2012/13

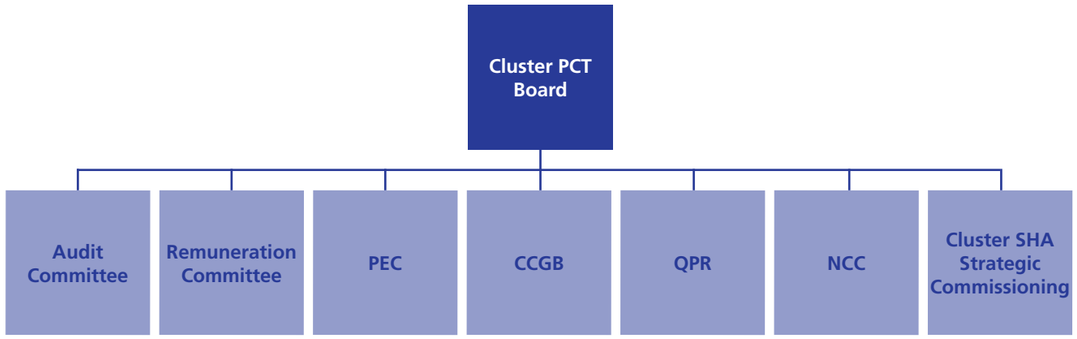
## Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Shropshire County Primary Care Trust's policies, aims and objectives. I also have responsibility for safeguarding the public funds and organisations assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

## The governance framework of the organisation

The governance structure for the PCT changed during 2012/13 to reflect the requirement for National Commissioning Board Local Area Teams to assume executive responsibility for PCT Cluster areas. Shropshire County Primary Care Trust forms part of the West Mercia Cluster of PCTs, but the Cluster area was divided between the Staffordshire Local Area Team and the Arden, Herefordshire and Worcestershire Local Area Team, with Shropshire County Primary Care Trust coming under the remit of the former. The revised governance arrangements came into effect in October 2012. Shropshire County Primary Care Trust remains the statutory body covering its registered population until April 2013. West Mercia Cluster of PCTs has operated a single shared board model, which means that the PCT Board meets concurrently unless it facilitates good governance to meet separately.

The sub-committee structure of the PCT Board, and the arrangements for discharge of PCT statutory functions that operated during 2012/13 was as follows:




- **Audit Committee** (held concurrently for all PCTs) provides assurance to the Board that the organisation's overall internal control/governance system operates in an adequate and effective way. The Committee's work focuses not only on financial controls, but also risk management and clinical governance controls.
- **Remuneration Committee** (held concurrently for all PCTs) recommends to the Board appropriate salaries, payments and terms & conditions of employment.
- **Quality Performance and Resources Committee** (QPR) (held concurrently for all PCTs) provides assurance to the Board that the PCT is meeting its performance targets, commissioning high quality services and using its resources wisely.
- **National Commissioning Committee** (NCC) (held concurrently for all PCTs) provides assurance to the Board the PCT is meeting its performance in primary care and commissioning high quality services.
- **Clinical Commissioning Group Boards** (CCGB) (held individually for each CCG in the cluster area) provides assurance to the Board that they are undertaking delegated authority for commissioning as outlined in the scheme of delegation.
- **Professional Executive Committee** (PEC) (held individually for each PCT in the cluster area) is chaired by a local GP and is made up of a majority of clinical members: GPs, Nurses and Allied Health Professionals working in Shropshire County. The Committee provides clinical advice and assurance to the Board.
- **Strategic Commissioning** (held on East and West SHA Cluster footprint) which oversee the commissioning of low volume, high value strategic commissioning decisions.

Membership of these sub committees of the PCT Board is outlined in terms of reference and attendance at these meeting was recorded in the minutes of each meeting.

In October 2012, the following sub committees were stood down by the PCT Board to reflect the split of the PCT Cluster between two Local Area Teams:

- Quality, Performance and Resources Committee
- National Commissioning Committee
- Professional Executive Committee

The functions of these committees were transferred to the respective Clinical Commissioning Group Boards, for assurance and reporting to the PCT Board. Audit Committee and Remuneration Committee continued to meet as sub committees of the PCT Board.

The following areas were highlighted in Board sub-committee reports to the Board:

**Audit Committee:**

- Development of CCG audit and assurance arrangements

**Quality, Performance and Resources Committee:**

- Assurance on QIPP delivery
- SATH A&E under performance due to patient flow
- Underperformance against target for referral to treatment within 18 weeks (RTT) at SaTH and Robert Jones and Agnes Hunt Foundation Trust (RJAH).

**National Commissioning Committee:**

- Risks around loss of key primary care staff leading to lack of resilience
- The complicated operating model for public health, resulting from the split of public health functions across a number of receiving organisations.

The Board reflected on its own effectiveness during the year, particularly focussing on the results of the Annual Accountability Review meeting with Cluster in 2012. The review provided assurance that the Cluster, although has challenging performance issues, demonstrated clearly that it understood the issues involved and could provide a sharper emphasis on outcomes for 2012/13.

**The arrangements for completing operational and closure documents were presented to the PCT Board on 24th July 2012. Key milestones were set out for the PCT to work to:**

- September 2012 – version 1 of the quality handover document (following further guidance from National Quality Board) and revision of the operational legacy document to be completed ready for submission to the SHA Cluster and National Quality board.
- October to December 2012 – PCTs maintain and update quality handover and legacy document as NHS architecture begins to change. National Quality Board visit SHA Clusters to gain assurance that appropriate quality handover plans are in place.
- January to March 2013 – Quality and legacy data kept live and handover document revised to reflect current circumstances. Final quality handover document and operational legacy document approved by final board meeting of PCT in March 2013. Approved versions of both quality handover and operational legacy documents sent to receiving organisations and National Quality Board.
- April 1st 2013 Accountability Transfers - Receiving organisations adopt all relevant documents formally at first public Board. Receiving organisations develop and agree plan for taking forward quality issues.

The Area Team Director, as PCT Accountable Officer and the Area Team Finance Director has responsibility for signing accounts and the supporting statements. The day to day preparation of the Annual Accounts during the period of transition between PCT and its successor bodies will be undertaken by the PCTs existing outsourced financial accounting service supported by retained PCT staff.

When the PCT ceases to be statutory body on 1 April 2013, the statutory status of the audit committees is lost. This role will be undertaken by cluster Audit Committees utilising existing Non-Executive Directors in line with national policy.

Corporate Governance is the system by which the PCT Board directs and controls the organisation at the most senior level in order to achieve its objectives and meet the necessary standards of accountability and probity. Using a risk management mechanism, the PCT Board brings together the various aspects of governance; corporate, clinical, financial, and information to provide assurance on its direction and control across the whole organisation in a co-ordinated way. The co-ordinating body for receiving assurance on these strands of governance is the Audit Committee, which oversees integrated governance on behalf of the PCT Board. In addition the other sub committees also oversee the risks within their specific remits, providing assurance to the Audit Committee where appropriate.

The PCT Board complies with the Corporate Code of Governance and demonstrates this by individual Board members affirming their compliance with the Codes of Accountability and Codes of Conduct for the NHS when declaring their interests.

The arrangements in place for the discharge of statutory functions have been checked that they are legally compliant via a number of mechanisms: internal auditing, self-assessment via the IG Toolkit, serious incident reporting, counter fraud annual plan, regulation and peer assessment, the outcomes of which have been reported to Audit Committee and its sub committees, and by exception to the PCT Board.

## The risk and control framework and risk assessment

**System of risk control:**

The system of risk control, forms part of the PCT's system of internal control and is defined in the Risk Management Strategy, which is reviewed annually. The strategy defines the risk management responsibilities and common methodologies for the identification and assessment of risks for the whole organisation. It requires that risks are managed to a reasonable level, within the parameters of a defined risk appetite, rather requiring the elimination of all risk of failure to achieve the PCT's objectives. The risk control system facilitates the assessment of risk by:

- identifying and prioritising the risks to the achievement of the organisation's objectives,
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The risk appetite was approved by the board and the strategy outlines the processes for maintaining and monitoring the Strategic Risk Register and the hierarchy of risk registers below it with due regard to this appetite.

**Risk assessment:**

Risks are identified, assessed and recorded in accordance with the Risk Management Strategy and Risk Assessment Code of Practice. The principle processes and the matrix described in these documents are applied to all risk registers, incident management and risk assessment activity across Shropshire County Primary Care Trust. These processes are used to identify risks:

- retrospectively following the occurrence of an adverse incident;
- proactively by identifying of potential risks to service delivery; and
- during development of new activities.

Since June 2011 the risk registers have followed the format used for the cluster Board Assurance Framework for ease of comparison across the cluster and to facilitate escalation and de-escalation of risks between the cluster and the PCT.

It is acknowledged that risks may be shared with other organisations that the PCT works with jointly to deliver services consequently the Strategic Risk Register is discussed with risk management leads and reflects the identified strategic risks of these organisations.

The following details are recorded for each risk recorded on a risk register:

- risk category
- risk description
- inherent risk
- existing controls
- risk grading with controls
- and gaps in controls
- actions to reduce the risk to an acceptable level
- amendments.

Where necessary actions include the identification of budgets and resources to facilitate their implementation.

## Shropshire County Primary Care Trust's major risks

A summary of the major risks identified, during 2012/13, in the Board Assurance Framework is set out below. The framework was last presented to the PCT Board on 26th February 2013:

| Description of major risks added to the Corporate Risk register during 2012/13 | Existing controls: | Further actions: |
|---|---|---|
| Risk associated with potential failure to embed robust systems and process to manage quality and safety of provider services during transition period to CSU/LAT | Quality, Performance and Resource Committee receives regular monthly reports on patient safety, patient experience and clinical effectiveness seeking assurance in relation to these areas across providers.<br><br>Standards of care specified in all service specifications / SLAs and Quality Schedules e.g. "markers of good practice". These are monitored through regular contract meetings with service providers Partnership arrangements in place such as the Local Safeguarding Board, across Shropshire for adults and children to ensure adherence to legal obligations. | Continued review of specific systems and processes to increase the level of assurance and improvement of quality and safety for patients.<br><br>Complete Quality Strategy and seek board approval.<br><br>Review and negotiate appropriate support from the CSU to ensure robust system and processes to ensure monitor quality and safety of provider services. |
| Use of standard NHS contracts with providers includes the commitment to deliver on the Constitutional requirements. | Use of standard NHS contracts with providers includes the commitment to deliver on the Constitutional requirements. | SaTH compliant for non-admitted for all specialties except Thoracic, Neurology, Ophthalmology, Dermatology and Rheumatology. Will be compliant from 1st April 2013.<br><br>RJAH achieving admitted and non-admitted at a trust level (since October) slightly behind trajectory for delivery by specialty from the 1st April but have plans in place to recover by the end of the financial year. |
| Failure to sustain the quality and safety of maternal health and antenatal care | Clinical Quality review meetings with SaTH - maternal health dedicated agenda item. | Review dashboard routinely at SaTH CQR Meeting.<br><br>Commissioner to attend Root Cause Analysis Meetings. External Review to be undertaken of Hub and Spoke Model of care following outcome of recent inquest. |
| Consistent failure to maintain Accident and Emergency 4 hour target. | Urgent Care Rapid Recovery Silver Command Group set up across the LHE with clear terms of reference (TOR). | Remedial Action Plan in place<br><br>Weekly meetings established to monitor compliance with remedial action plan and associated KPIs. Delivering at PRH from the 21st January, still to achieve at RSH. |
| High levels concerns regarding quality assurance at individual providers in relation to various key areas identified as:<br><br>SaTH - Pressure Ulcers, Infection Control CDiff and Safeguarding (ratification on mitigating actions to be sought at LHE Safeguarding Board on 29 January 2013<br><br>RJAH - Potential for Professional Isolation<br><br>SCHT - Pressure Ulcers, Consistency of care at Community Hospital and Business Continuity<br><br>SSSFT Absconcions, Transparency around safeguarding and capacity in relation to continuity of care | Ongoing challenge and quality assurance via Clinical Quality Review meetings with SaTH.<br><br>Quality, Performance and Resources Committee Minutes. | Continual monitoring and support<br><br>Collate evidence to triangulate information. |
| Sath over performance | Monthly Contract Review meetings to challenge over performance.<br>Monthly QIPP Board meetings to challenge<br><br>deliverability of SATH CIPs and CCG QIPPs | Challenge A&E coding, ECG OP Procedures shadow counting, backlog activity and OCA activity – contracts team.<br><br>Engage Urgent Care Network in understanding and management of emerging adverse pressures – Clinical Director of resources, CFO and Practice Support teams<br><br>Urgently review timing and impact of QIPP initiatives to affect performance – QIPP Programme leads.<br><br>Task and finish group set up to validate activity submissions between unify and SUS. |
| Failure to identify QIPP programme savings and contingency for 2013/2014. | QIPP savings plans integral part of overall Financial and Performance Plan. Monitoring of finance and performance. | CCG CFO gained assurance of Management & Clinical lead sign up to schemes including phasing of savings and robust source data identified. Schemes that were not signed off were dropped from the programme and contingency schemes are being identified to replace them.<br><br>Majority of Investment plans approved by the beginning of June and implemented almost immediately where they impact on QIPP savings. Slippage has been identified on the F&C scheme which is not now anticipated to make savings until Q4. This has been factored into the forecast outturn.<br><br>Overachievement of CHC QIPP has mitigated under performances in other schemes. |
| Provider Trust issues associated with Foundation Trust pipeline and instability due to executive changes at Shropshire Community Health Trust - risk of destabilising the local health economy. | Finnamore engaged to undertake work across the Local Health Economy to establish whole systems approach. | CCG Board to provide strategic leadership. |
| Failure to define, plan and commission against public health information pertaining to health inequalities. | Health and Wellbeing Board. Health and Wellbeing Executive. Joint Strategic Needs Assessment. Health and Wellbeing Strategy. | Increase locality focus to incorporate knowledge from clinician members.<br><br>CM / RT<br><br>31 December 2012 |
| Failure to provide staff support and development programme and recruit staff during and after the transition period. | Team meetings 1:1 meetings.<br><br>Annual Staff Personal Development Plans | Establish CCG staff briefings.<br><br>Prepare staff training and development programme for 2013/14<br><br>Undertake 1 to 1 meetings. |
| There is a risk that a major incident impacts on business continuity and delivery of priority services. | Risk Management Policy in place.<br><br>Business continuity support and expertise available. | Develop detailed incident and business continuity planning in the CCG and local providers to mitigate the risks associated with a major incident.<br><br>Formalise expertise and support from Emergency Planning Officer.<br><br>Provide emergency planning training for key members of the Board. |
| Failure to manage handover and closedown. | HR transition being managed by HR<br><br>Estates and Finance being managed by CFO | Complete closedown and handover and submit information to DOH as required.<br><br>Prepare Board Paper - to outline transition arrangements. |

## Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. The Head of Internal Audit Opinion for 2012/13 is that there is that significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

My review is also informed by:

- Counter Fraud and Security Management assurance
- Audit Committee programme and review
- Infection Control Audit
- Internal and external audit reports
- External auditors in their management letter and other reports
- Monthly performance monitoring by the Strategic Health Authority
- Serious incident reporting
- Information Governance Toolkit assurance

I have been advised of the implications of the result of my review of the effectiveness of the system of internal control in the following ways:

**The Board** has received both the minutes and a regular report from the Chair of the Audit Committee based upon the minutes of each Audit Committee meeting summarising activityand its concerns. Through this mechanism the chair of the committee has ensured that theBoard is aware of any significant challenges to the system of internal control and updates on progress in addressing these.

**Audit Committee:** The work of the Audit Committee has been informed by the activity of a number of working groups/PCT functions and has received exception summaries for these groups within the Group Summaries element of the Assurance Framework.

**Executive Managers:** Individual Executive Directors of the PCT/CCG review their respective parts of the Strategic Risk Register with the Risk Manager and amend where necessary.

**Audit recommendations:** Implementation of both internal and external audit recommendations are monitored within the recommendation tracking element of the Assurance Framework.

**Internal reviews:** Internal reviews, including clinical and infection control audits are monitored within the Quality performance element of the Assurance Framework.

A plan to address weaknesses, (including the specific control issues listed in 6.1 below), and ensure continuous improvement of the system is in place.

## Significant control issues

The Chief Executive can give assurance that no significant control issues have been raised that would require reporting in the Annual Governance Statement. This is supported in the opinion of the Head of Internal Audit for 2012/13. However, the Internal Auditor has identified some weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk, and these are detailed below in section 6.1.

## Other control issues

**Control issues raised by Internal Audit:**

Information Governance: Internal Audit has given moderate assurance on Information Governance, and raised concerns with regard to the effectiveness of controls. An action plan has been agreed between Internal Audit and management, and the implementation of this plan will continue to be implemented by Staffordshire CSU and monitored by both the CSU and Shropshire CCG Audit committees.

**Breaches of data security**

Shropshire County Primary Care Trust has no reported data security incident during 2012/13.

**Serious incidents (SIs):**

Shropshire County Primary Care Trust reported no other serious incidents during 2012/13.

This report contains a summary of the Annual Governance Statement for 2012/13. Copies of the full statement can be obtained from the Chief Executive's Office on: 01743 277500.

## Conclusion

As Accountable Officer and based on the review process outlined above, the PCT has identified and is taking action on the control issues arising in year which have been identified in detail in the body of the Annual Governance Statement above.

**Mr Graham Urwin – Accountable Officer**

**Shropshire County Primary Care Trust**

Signature:

Date:

# Summary financial statements 2012/13

## Introduction

The attached Summary Financial Statements are those required by the Department of Health. They are intended to convey to the public the financial performance and state of affairs of the PCT. The main points and statements are listed below.

## Operating and financial review

Shropshire County PCT was formed as an NHS Primary Care Trust in 2002, and took over many of the roles of the former Shropshire Health Authority. This is the final year the PCT will purchase NHS-funded services on behalf of the county's population. In the financial year 2013/14 this responsibility will pass to the Shropshire Clinical Commissioning Group (CCG), National Commissioning Board (NCB), Shropshire Local Authority and Public Health England.

Shropshire is a large county in the West Midlands, with a population of around 297,000 of mainly white British ethnicity and a high proportion of people aged over 50 years old. The county is fairly affluent; however there are areas of deprivation and factors of rural sparsity which create challenges over access to services. Shropshire also has a low earnings rate, although it benefits from a relatively low unemployment rate. A significant amount of employment is in the public sector and is therefore affected by public service reductions in the current climate. We also have a small but significant number of migrant workers.

In 2012/13, Shropshire County PCT received a total uplift to its funding of 3.0%, increasing the recurrent resource by £13m. Of the total 3.0% uplift, 2.8% was provided to cover increases in the PCT's costs and the other 0.2% covered an increase in reablement funding. This increase is slightly higher than the 2.2% uplift in the previous year.

During 2012/13 NHS Shropshire Clinical Commissioning Group developed its policies and processes, has become constituted and takes on the commissioning responsibility from the PCT post 1st April 2013.

Also, in the financial year 2012/13 the Local Area Team assumed responsibility and management of the PCT and remains responsible during the closedown process.

**PCTs are required to achieve three statutory financial duties and Shropshire County's performance against each is summarised below:**

- Revenue Resource Limit (RRL) - to contain revenue expenditure within the notified revenue resource limit of £485m
- Capital Resource Limit (CRL) - to contain capital expenditure within the notified capital resource limit of £0.025m
- Cash Limit - to contain receipts and payments within the annual cash limit published by the Department of Health of £483m.

**All of these targets have been met in 2012/13.**

A key tool in meeting the first of these duties is the delivery of savings through the Government's Quality, Innovation, Productivity and Prevention (QIPP) strategy. As at March 2013, total in-year savings of £11m have been achieved.

In 2012/13, Shropshire County PCT running cost target of £33.17 per head of population, was achieved. Running costs are a central Government set target for the non-healthcare costs that NHS organisations incur. For 2013/14 the CCG is receiving an administrative budget of £25 per head to cover running costs.

Taking account of the particular local circumstances of Shropshire's diverse communities, the PCT operated within a broad framework of national policies and priorities for the NHS as a whole.

The PCT worked in partnership with other NHS organisations, including NHS hospital trusts and other PCTs, to ensure that Shropshire patients had access to the best possible services. The PCT also worked closely with Shropshire Council to plan, purchase and provide a range of services that require the collaboration of both the NHS and local government.

## Financial duties

The PCT has four key financial duties:

2.1 A statutory duty to maintain expenditure within resource limits set by the Department

of Health, one for revenue and one for capital. There was a revenue underspend of £1,016,000 (representing about 0.2% of the allocation) and a capital underspend of £1,092,000

2.2 An administrative duty to remain in operational financial balance, that is not to exceed its

resource limit when unplanned resource brokerage is excluded. The PCT achieved its

£1,016,000 surplus without any unplanned brokerage, and therefore fulfilled the duty

2.3 A statutory duty to remain within the cash limit set by the Department of Health. The PCT drew down £1,000,000 less than the notified cash limit.

# Statement of Comprehensive Net Expenditure for year ended 31 March 2013

The Statement of Comprehensive Net Expenditure shows the net operating costs of the PCT (£484.7m) split between its administration and programme costs. Net operating costs consist mostly of expenditure less miscellaneous income from sources other than Government funds. The PCT's biggest item of expenditure is for commissioning services from local NHS trusts.

| | 2012-13<br>£000 | 2011-12<br>£000 |
|---|---|---|
| **Administration Costs and Programme Expenditure** | | |
| Gross employee benefits | **8,921** | 7,776 |
| Other costs | **486,716** | 483,048 |
| Income | **(11,701)** | (11,327) |
| **Net operating costs before interest** | **483,936** | **479,497** |
| | | |
| Other (Gains)/Losses | **715** | 1 |
| Finance costs | **15** | 20 |
| **Net operating costs for the financial year** | **484,666** | **479,518** |
| | | |
| **Net Operating Costs for the Financial Year including absorption transfers** | **484,666** | **479,518** |
| | | |
| **Of which:** | | |
| Administration Costs | | |
| Gross employee benefits | 5,297 | 5,161 |
| Other costs | 6,430 | 6,319 |
| Income | (2,656) | (2,160) |
| Net administration costs before interest | 9,071 | 9,320 |
| | | |
| Other (Gains)/Losses | 0 | 1 |
| Finance costs | 0 | 20 |
| Net administration costs for the financial year | 9,071 | 9,341 |
| | | |
| Programme Expenditure | | |
| Gross employee benefits | 3,624 | 2,615 |
| Other costs | 480,286 | 476,729 |
| Income | (9,045) | (9,167) |
| Net programme expenditure before interest | 474,865 | 470,177 |
| | | |
| Other (Gains)/Losses | 715 | 0 |
| Finance costs | 15 | 0 |
| Net programme expenditure for the financial year | 475,595 | 470,177 |

| | 2012-13<br>£000 | 2011-12<br>£000 |
|---|---|---|
| **Other Comprehensive Net Expenditure** | | |
| Impairments and reversals put to the Revaluation Reserve | **141** | 1 |
| Net (gain) on revaluation of property, plant & equipment | **(20)** | (1,437) |
| **Total comprehensive net expenditure for the year*** | **484,787** | **478,082** |

The notes on pages 5 to 37 form part of this account.

# Statement of Financial Position at 31 March 2013

The Statement of Financial Position summarises the assets and liabilities of the PCT.

The non-current assets section mainly shows the value of land, buildings and equipment (£31.7m). The value has decreased mainly due to the transfer of land at Ludlow to Shropshire Community Trust £1m and the disposal of various assets valued at £0.8m.

The main item in the current assets section is the trade and other receivables (i.e. amounts owed to the PCT) which have decreased by £1m. This is due to a number of invoices being raised to local NHS organisations at the end of the previous year.

Trade and other payables (i.e. amounts owed by the PCT) have remained at a similar level to the previous year with a slight reduction of £0.1m.

Provisions (i.e. estimated costs of settling future claims against the PCT) have decreased by £1.4m.

Taxpayers equity shows the distribution of the financing of the PCT's net assets.

| | 31 March 2013<br>£000 | 31 March 2012<br>£000 |
|---|---|---|
| **Non-current assets:** | | |
| Property, plant and equipment | **31,694** | 34,089 |
| **Total non-current assets** | **31,694** | **34,089** |
| | | |
| **Current assets:** | | |
| Trade and other receivables | **3,965** | 4,636 |
| Cash and cash equivalents | **5** | 242 |
| **Total current assets** | **3,970** | **4,878** |
| | | |
| Non-current assets held for sale | **0** | 80 |
| | | |
| **Total current assets** | **3,970** | **4,958** |
| **Total assets** | **35,664** | **39,047** |
| | | |
| **Current liabilities** | | |
| Trade and other payables | **(27,603)** | (27,749) |
| Provisions | **(700)** | (1,241) |
| **Total current liabilities** | **(28,303)** | **(28,990)** |
| | | |
| **Non-current assets plus/less net current assets/liabilities** | **7,361** | **10,057** |
| | | |
| **Non-current liabilities** | | |
| Provisions | **(1,560)** | (2,410) |
| **Total non-current liabilities** | **(1,560)** | **(2,410)** |
| | | |
| **Total Assets Employed:** | **5,801** | 7,647 |
| | | |
| **Financed by taxpayers' equity:** | | |
| General fund | **(4,130)** | (2,648) |
| Revaluation reserve | **9,931** | 10,295 |
| Other reserves | **0** | 0 |
| **Total taxpayers' equity:** | **5,801** | **7,647** |

The notes on pages 5 to 39 form part of this account.

**The financial statements on pages 1 to 40 were approved by the Board on [date] and signed on its behalf by**

**Chief Executive:**

**Date:**

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

The Statement of Changes in Taxpayers Equity shows the movement of the General Fund (which basically is a balancing entry on the statement) and on other reserves. There are no significant values.

| | General fund | Revaluation reserve | | Other reserves | | Total reserves |
|---|---|---|---|---|---|---|
| | £000 | £000 | | £000 | | £000 |
| **Balance at 1 April 2012** | **(2,648)** | **10,295** | **0** | **0** | **0** | **7,647** |
| **Changes in taxpayers' equity for 2012-13** | | | | | | |
| Net operating cost for the year | (484,666) | | | | | (484,666) |
| Net gain on revaluation of property, plant, equipment | | 20 | | | | 20 |
| Impairments and reversals | | (141) | | | | (141) |
| Transfers between reserves* | 243 | (243) | | | | 0 |
| **Reclassification Adjustments** | | | | | | |
| **Total recognised income and expense for 2012-13** | **(484,423)** | **(364)** | | **0** | | **(484,787)** |
| Net Parliamentary funding | 482,941 | | | | | 482,941 |
| **Balance at 31 March 2013** | **(4,130)** | **9,931** | | **0** | | **5,801** |
| | | | | | | |
| **Balance at 1 April 2011** | **(4,915)** | **8,862** | | **0** | | **3,947** |
| **Changes in taxpayers' equity for 2011-12** | | | | | | |
| Net operating cost for the year | (479,518) | | | | | (479,518) |
| Net Gain / (loss) on Revaluation of Property, Plant and Equipment | | 1,437 | | | | 1,437 |
| Impairments and Reversals | | (1) | | | | (1) |
| Transfers between reserves* | 3 | (3) | | | | 0 |
| **Total recognised income and expense for 2011-12** | **(479,515)** | **1,433** | | **0** | | **(478,082)** |
| Net Parliamentary funding | 481,782 | | | | | 481,782 |
| **Balance at 31 March 2012** | **(2,648)** | **10,295** | | **0** | | **7,647** |

# Statement of cash flows for the year ended 31 March 2013

The Statement of Cash Flows shows where the PCT's cash has come from, how it has been used and the net increase/decrease in cash during the year. Payments in respect of healthcare and non-healthcare (£483.9m) were financed mainly by cash drawings from the Department of Health £482.9m

| | 2012-13 | 2011-12 |
|---|---|---|
| | £000 | £000 |
| **Cash Flows from Operating Activities** | | |
| Net Operating Cost Before Interest | **(483,936)** | (479,497) |
| Depreciation and Amortisation | **1,240** | 1,314 |
| Impairments and Reversals | **47** | 1 |
| Other Gains / (Losses) on foreign exchange | **0** | 0 |
| Donated Assets received credited to revenue but non-cash | **0** | (17) |
| Government Granted Assets received credited to revenue but non-cash | **0** | 0 |
| Interest Paid | **0** | 0 |
| Release of PFI/deferred credit | **0** | 0 |
| (Increase)/Decrease in Inventories | **0** | 0 |
| (Increase)/Decrease in Trade and Other Receivables | **671** | (2,479) |
| (Increase)/Decrease in Other Current Assets | **0** | 0 |
| Increase/(Decrease) in Trade and Other Payables | **28** | 1,611 |
| (Increase)/Decrease in Other Current Liabilities | **0** | 0 |
| Provisions Utilised | **(1,037)** | (922) |
| Increase/(Decrease) in Provisions | **(369)** | 208 |
| **Net Cash Inflow/(Outflow) from Operating Activities** | **(483,356)** | **(479,781)** |
| | | |
| **Cash flows from investing activities** | | |
| Interest Received | **0** | 0 |
| (Payments) for Property, Plant and Equipment | **(902)** | (1,775) |
| (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) | **1,080** | 2 |
| 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 Inflow/(Outflow) from Investing Activities** | **178** | **(1,773)** |
| | | |
| **Net cash inflow/(outflow) before financing** | **(483,178)** | **(481,554)** |
| | | |
| **Cash flows from financing activities** | | |
| Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT | **0** | (3) |
| Net Parliamentary Funding | **482,941** | 481,782 |
| Capital Receipts Surrendered | **0** | 0 |
| Capital grants and other capital receipts | **0** | 17 |
| Cash Transferred (to)/from Other NHS Bodies (free text note required) | **0** | 0 |
| **Net Cash Inflow/(Outflow) from Financing Activities** | **482,941** | **481,796** |
| | | |
| **Net increase/(decrease) in cash and cash equivalents** | **(237)** | **242** |
| | | |
| **Cash and Cash Equivalents ( and Bank Overdraft) at Beginning of the Period** | **242** | **0** |
| Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies | **0** | 0 |
| **Cash and Cash Equivalents (and Bank Overdraft) at year end** | **5** | **242** |

# 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 risk.

### Currency risk

The PCT is 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.

# Better Payment Practice Code

As required by the Department of Health, the creditor payment policy of the PCT is to comply with both the CBI Better Payment Practice Code and Government Accounting Rules. This requires that all invoices are paid within 30 days of the receipt of goods or a valid invoice, whichever is later, unless other payment terms have been agreed with the supplier.

There are two measures of performance – numbers of invoices and value of invoices. 86% of invoices were paid within the 30 day target and 96% of the total value paid. The Department of Health expects 95% as a minimum. The PCT has signed up to the Prompt Payments Code. Suppliers can have confidence that signatories to the Code will pay them promptly.

| | 2012-13 Number | 2012-13 £000 | 2011-12 Number | 2011-12 £000 |
|---|---|---|---|---|
| **Measure of Compliance** | | | | |
| **Non-NHS Payables** | | | | |
| Total Non-NHS Trade Invoices Paid in the Year | 8,938 | 54,804 | 8,496 | 57,115 |
| Total Non-NHS Trade Invoices Paid Within Target | 8,252 | 51,767 | 7,818 | 50,475 |
| Percentage of NHS Trade Invoices Paid Within Target | 92.3% | 94.5% | 92.0% | 88.4% |
| **NHS Payables** | | | | |
| Total NHS Trade Invoices Paid in the Year | 3,719 | 326,220 | 3,037 | 308,224 |
| Total NHS Trade Invoices Paid Within Target | 2,654 | 315,565 | 1,955 | 301,810 |
| Percentage of NHS Trade Invoices Paid Within Target | 71.4% | 96.7% | 64.4% | 97.9% |

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.

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

There were no payments under the Late Payment of Commercial Debts (Interest) Act 1998.

# Audit

The PCT's external auditors are Grant Thornton. Fees for audit services during the year were £104,000 of which £79,000 related to the audit of the annual accounts and £25,000 related to other specific pieces of work such as on Payment by Results (PBR).

# Charges for information

Shropshire County PCT has complied with the Treasury guidance on setting Charges for Information, which appears as appendix 6.3 to the Treasury's Managing Public Money.

# 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 Trust 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:

### 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) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

### 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.

### 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.

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

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

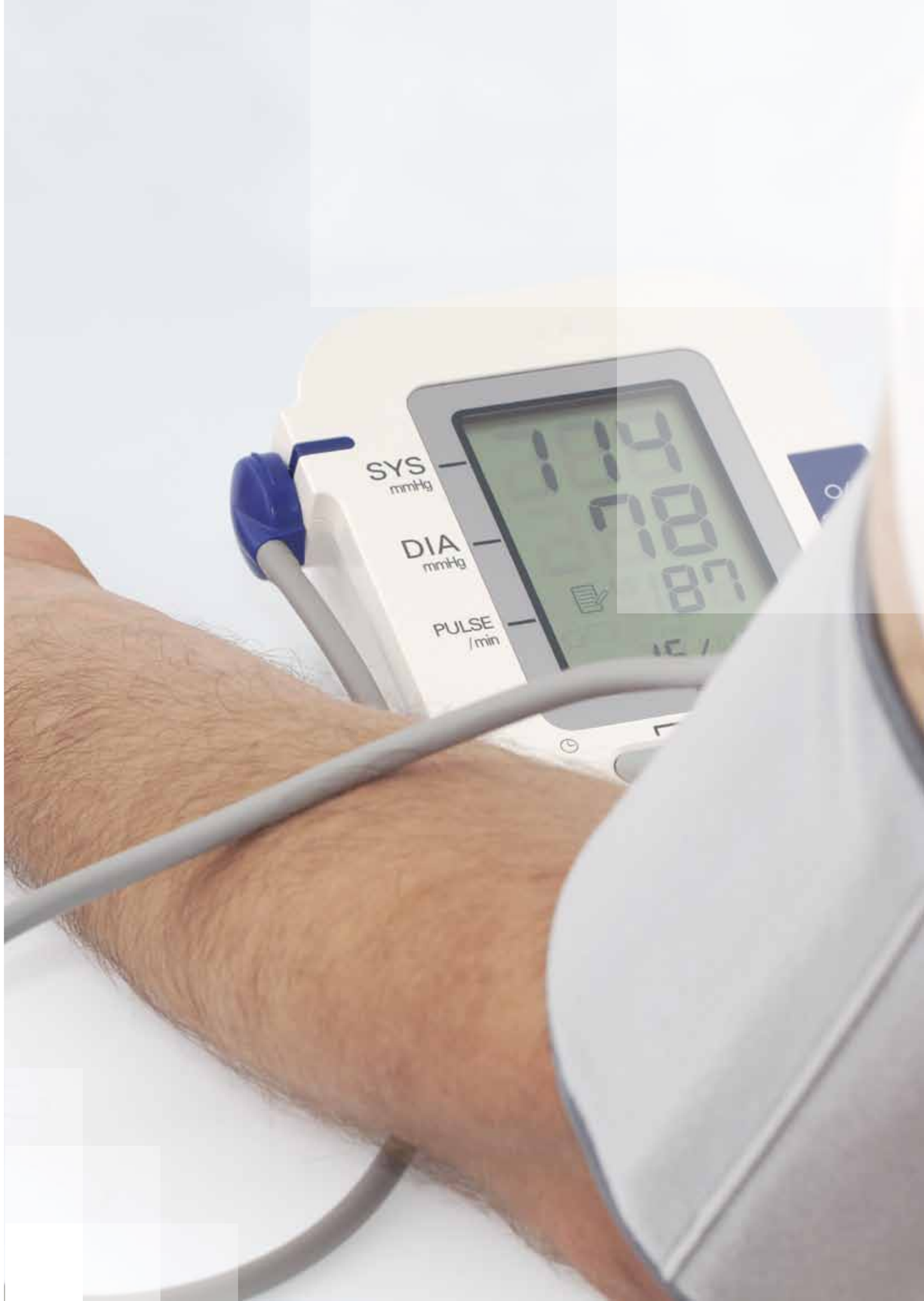
# Financial Performance Targets

| | 2012-13 £000 | 2011-12 £000 |
|---|---|---|
| **Revenue Resource Limit** | | |
| The PCTs' performance for the year ended 2012-13 is as follows: | | |
| Total Net Operating Cost for the Financial Year | | 479,518 |
| Net operating cost plus (gain)/loss on transfers by absorption | 484,666 | |
| Revenue Resource Limit | 485,682 | 480,813 |
| Under/(Over)spend Against Revenue Resource Limit (RRL) | 1,016 | 1,295 |

| | 2012-13 £000 | 2011-12 £000 |
|---|---|---|
| **Capital Resource Limit** | | |
| The PCT is required to keep within its Capital Resource Limit. | | |
| Capital Resource Limit | 25 | 1,425 |
| Charge to Capital Resource Limit | (1,067) | 848 |
| **(Over)/Underspend Against CRL** | **1,092** | **577** |

| | 2012-13 £000 | 2011-12 £000 |
|---|---|---|
| **Under/(Over)Spend Against Cash Limit** | | |
| Total Charge to Cash Limit | 482,941 | 481,782 |
| Cash Limit | 482,941 | 481,782 |
| **Under/(Over)spend Against Cash Limit** | **0** | **0** |

| | 2012-13 £000 |
|---|---|
| **Reconciliation of Cash Drawings to Parliamentary Funding (Current Year)** | |
| Total cash received from DH (Gross) | 424,416 |
| Less: Trade Income from DH | (1) |
| Less/(Plus): movement in DH working balances | 0 |
| **Sub total: net advances** | **424,415** |
| (Less)/plus: transfers (to)/from other resource account bodies (free text note required) | 0 |
| Plus: cost of Dentistry Schemes (central charge to cash limits) | 9,883 |
| Plus: drugs reimbursement (central charge to cash limits) | 48,643 |
| **Parliamentary funding credited to General Fund** | **482,941** |



# Operating Costs

| | 2012-13 Total £000 | 2012-13 Admin £000 | 2012-13 Programme £000 | 2011-12 Total £000 |
|---|---|---|---|---|
| **Analysis of operating costs:** | | | | |
| **Goods and Services from Other PCTs** | | | | |
| Healthcare | 38,531 | | 38,531 | 35,611 |
| Non-Healthcare | 242 | 240 | 2 | 300 |
| **Total** | **38,773** | **240** | **38,533** | **35,911** |
| **Goods and Services from Other NHS Bodies other than FTs** | | | | |
| Goods and services from NHS Trusts | 206,576 | 1,628 | 204,948 | 216,068 |
| Goods and services (other, excl Trusts, FT and PCT) | 9 | 9 | 0 | 3,547 |
| **Total** | **206,585** | **1,637** | **204,948** | **219,615** |
| Goods and Services from Foundation Trusts | 67,470 | 344 | 67,126 | 57,614 |
| Purchase of Healthcare from Non-NHS bodies | 38,336 | | 38,336 | 37,068 |
| Expenditure on Drugs Action Teams | 4,404 | | 4,404 | 3,894 |
| Non-GMS Services from GPs | 41 | 0 | 41 | 50 |
| Contractor Led GDS & PDS (excluding employee benefits) | 13,502 | | 13,502 | 13,419 |
| Chair, Non-executive Directors & PEC remuneration | 56 | 56 | 0 | 77 |
| Executive committee members costs | 708 | 626 | 82 | 497 |
| Consultancy Services | 659 | 449 | 210 | 600 |
| Prescribing Costs | 49,560 | | 49,560 | 51,397 |
| G/PMS, APMS and PCTMS (excluding employee benefits) | 42,389 | 73 | 42,316 | 41,557 |
| Pharmaceutical Services | 2,764 | | 2,764 | 2,833 |
| New Pharmacy Contract | 9,987 | | 9,987 | 9,110 |
| General Ophthalmic Services | 2,748 | | 2,748 | 2,762 |
| Supplies and Services - Clinical | 1,868 | 0 | 1,868 | 1,451 |
| Supplies and Services - General | 69 | 60 | 9 | 42 |
| Establishment | 752 | 625 | 127 | 711 |
| Premises | 1,285 | 425 | 860 | 630 |
| Impairments & Reversals of Property, plant and equipment | 47 | 47 | 0 | 1 |
| Depreciation | 1,240 | 1,201 | 39 | 1,314 |
| Impairment of Receivables | 11 | 11 | 0 | 14 |
| Audit Fees | 79 | 79 | 0 | 130 |
| Other Auditors Remuneration | 25 | 25 | 0 | 36 |
| Clinical Negligence Costs | 3 | 0 | 3 | 6 |
| Education and Training | 86 | 92 | (6) | 222 |
| Grants for capital purposes | 251 | 0 | 251 | 100 |
| Grants for revenue purposes | 1,933 | 50 | 1,883 | 1,160 |
| Other | 1,085 | 390 | 695 | 827 |
| Total Operating costs charged to Statement of Comprehensive Net Expenditure | 486,716 | 6,430 | 480,286 | 483,048 |

| | 2012-13 Total £000 | 2012-13 Admin £000 | 2012-13 Programme £000 | 2011-12 Total £000 |
|---|---|---|---|---|
| **Employee Benefits (excluding capitalised costs)** | | | | |
| PCT Officer Board Members | 544 | 544 | 0 | 517 |
| Other Employee Benefits | 8,377 | 4,753 | 3,624 | 7,259 |
| Total Employee Benefits charged to SOCNE | 8,921 | 5,297 | 3,624 | 7,776 |
| Total Operating Costs | 495,637 | 11,727 | 483,910 | 490,824 |
| **Analysis of grants reported in total operating costs** | | | | |
| For capital purposes | | | | |
| **Grants to fund Capital Projects - GMS** | 251 | 0 | 251 | 100 |
| **Total Capital Grants** | 251 | 0 | 251 | 100 |
| Grants to fund revenue expenditure | | | | |
| To Local Authorities | 13 | 0 | 13 | 0 |
| To Private Sector | 1,920 | 50 | 1,870 | 1,126 |
| To Other | 0 | 0 | 0 | 34 |
| Total Revenue Grants | 1,933 | 50 | 1,883 | 1,160 |
| Total Grants | 2,184 | 50 | 2,134 | 1,260 |

| | Total | Commissioning Services | Public Health |
|---|---|---|---|
| **PCT Running Costs 2012-13** | | | |
| Running costs (£000s) | 9,071 | 7,444 | 1,627 |
| Weighted population (number in units)* | 292,372 | 292,372 | 292,372 |
| **Running costs per head of population (£ per head)** | **31** | **25** | **6** |
| **PCT Running Costs 2011-12** | | | |
| Running costs (£000s) | 9,341 | 7,634 | 1,707 |
| Weighted population (number in units) | 281,572 | 281,572 | 281,572 |
| **Running costs per head of population (£ per head)** | **33** | **27** | **6** |

* 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

# Obtaining a copy of the PCT's full accounts

This annual report contains a summary of the PCT's financial accounts for 2012/13.

A copy of the full 2012/13 Annual Accounts and the Annual Governance Report is available from:

Personal Assistant to the Director of Finance, NHS England, Shropshire and Staffordshire Area Team
Anglesey House, Towers Business Park, Wheelhouse Road, Rugeley, Staffs, WS15 1UZ

Tel: 0300 7900 233


# Remuneration Report 2012/ 2013

This report provides information about the remuneration of those senior managers who influence the decisions of the PCT as a whole, which the Chief Executive has confirmed to be the Executive and Non-Executive Directors. Non-Executive Directors are appointed independently by the national Appointments Commission, with remuneration at nationally determined rates.

## Role and Membership of the PCT Remuneration & Terms of Service Committee

The Remuneration & Terms of Service Committee is a Committee of the Cluster Board, comprised of the Cluster Chair and Non-Executive Directors. The Committee, on behalf of the Board, determines the remuneration, allowances, terms of service and, where appropriate, termination of employment of the Chief Executive and those Executive Directors reporting to the Chief Executive. The Committee determines payments to members of the Professional Executive Committee and other senior staff where appropriate. The Committee also approves recommendations for redundancies and consultants' clinical excellence awards.

The Committee's policy on remuneration is to take into account guidance from the Department of Health and to apply the national framework for the remuneration of Very Senior Managers in the NHS, including the proportions of remuneration subject to performance conditions.

Directors' objectives are set in line with overall PCT objectives and achievement of the latter is monitored regularly. Directors' achievements of objectives are assessed by the Chief Executive with each Director individually at least annually. The Remuneration & Terms of Service Committee monitors and evaluates the performance of the Chief Executive and the Executive Directors.

Usual policy is for Senior Managers to be on on-going contracts, unless there are specific other circumstances, for example a Director is employed by another body and is seconded to the PCT for a time-limited period. Notice periods are as defined in national arrangements or guidance.

The committee approved recommendations for redundancies in the year, which had followed a change management process implemented in accordance with all relevant national policies.

Members of the Committee for the year comprised the Cluster Chair and all Non-Executive Directors.

## Roles and members of the Audit Committee

The Audit Committee provides the Board with independent scrutiny of governance arrangements across the full spectrum of the PCT's functions and processes, including clinical and corporate governance and internal and external audit. It incorporates the role of the statutory Audit Committee.

**Membership comprises Non-Executive Directors of the PCT:**

Rob Parker (Non Executive Director and Chair of the Committee)

William Hutton (Non Executive Director)

Andrew Mason (Non Executive Director)

Sue Mead (Non Executive Director)

# Salaries and Allowances - Shropshire County PCT

| | | | 2012/13 | | | | 2011/12 | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Name | Title | Total Salary | Salary Attributable (Bands of £5,000) £0000 | Other Remuneration to PCT (Bands of £5,000) £0000 | Bonus Payments (Bands of £5,000) | Benefits in Kind (Bands of £5,000) | Salary Attributable (to nearest £100) | Other Remuneration to PCT (Bands of £5,000) £0000 | Bonus Payments (Bands of £5,000) | Benefits in Kind (Bands of £5,000) |
| Eamonn Kelly | PCT Chief Exec and Cluster Chief Exec | 145-150 | 30-35 | | | | 25-30 | | | |
| Graham Urwin* | PCT Chief Exec and Cluster Chief Exec | | | | | | | | | |
| Brian Hanford | Director of Finance for PCT and Cluster | 120-125 | 25-30 | | | | 20-25 | | | |
| Ros Francke* | Director of Finance for PCT and Cluster | | | | | | | | | |
| Kiran Patel | Medical Director (Cluster) | 80-85 | 5-10 | | | | 5-10 | | | |
| Dr Ken Deacon* | Medical Director (Cluster) | | | | | | | | | |
| Susan Doheny | Director of Quality & Clinical Leadership (Cluster) | 95-100 | 0-5 | | | | 0-5 | | | 0-5 |
| Brigid Stacey* | Director of Nursing (Cluster) | | | | | | | | | |
| Rod Thomson | Director of Public Health/Infection Prevention | 90-95 | 90-95 | | | | 80-85 | | | |
| Leigh Griffin | Managing Director of PCT/Deputy CEO (Cluster) | 100-105 | 20-25 | | | | 60-65 | | | 0-5 |
| Paul Maubach | Director of Commissioning Development (Cluster) | 60-65 | 10-15 | | | | 20-25 | | | |
| Dawn Wickham* | Director of Operations and Delivery (Cluster) | | | | | | | | | |
| Jo Leahy | Medical Director (PCT) | 80-85 | 15-20 | | | | 30-35 | | | |
| Donna McGrath | Interim Director of Finance (PCT) | 65-70 | 0-5 | | | | N/A | | | |
| Helen Herritty | Chair of PCT / Non-Executive Director - Cluster | 20-25 | 20-25 | | | | 25-30 | | | |
| William Hutton | Non-Executive Director - PCT | 5-10 | 5-10 | | | | 5-10 | | | |
| Paula Burton | Non-Executive Director - PCT | 5-10 | 5-10 | | | | 5-10 | | | |
| Harmesh Darbhanga | Non-Executive Director - PCT | 5-10 | 5-10 | | | | 5-10 | | | |
| Alan Healy | Non-Executive Director - PCT | 5-10 | 5-10 | | | | 5-10 | | | |
| Susan Mead | Non-Executive Director - Cluster | 15-20 | 0-5 | | | | 0-5 | | | |
| Andrew Mason | Non-Executive Director - Cluster | 20-25 | 0-5 | | | | 0-5 | | | |
| Louise Lomax* | Non-Executive Director - Cluster | | | | | | | | | |
| Rob Parker* | Non-Executive Director - Cluster | | | | | | | | | |
| Dr Bryan Smith* | Non-Executive Director - Cluster | | | | | | | | | |
| Margaret Jackson* | Non-Executive Director - Cluster | | | | | | | | | |
| Joanna Newton | Chair - Cluster | 40-45 | 5-10 | | | | 5-10 | | | |

* There are no disclosures in respect of this Board member as no payments were made by the PCT in respect of their Salaries and Allowances

Notes:

1. In accordance with the Manual for Accounts 2012/13, the above figures include the costs of the PCT's Board and the PCT's proportion of the costs of the Cluster Board.
2. Costs relating to Cluster Directors have been provided by the relevant employing organisations. Costs have been split between PCTs according to capitation.
3. Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions
4. 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 Shropshire County PCT in the financial year 2012-13 was £90,000 – £95,000 (2011-12, £80,000 – £85,000).This was 3.05 times (2011-12, 2.53) the median remuneration of the workforce, which was £30,460 (2011-12, £32,573). In 2012-13, three (2011-12, one) employee received remuneration in excess of the highest paid director.

During 2012/13 the PCT recruited a number of employees on fixed term contracts below the median value. This has had the effect of reducing the Median downwards by £2,113 from 2011/12 to 2012/13. If the median were calculated excluding these employees the median would have been £32,573 the same as the previous year. Also during 2012/13, the highest paid director had a pay rise changing the banded remuneration from £80,000-£85,000 in 2011/12 to £90,000-£95,000 in 2012/13. These two factors have had the effect of increasing the 'pay-multiple' (ratio of highest to the mid-ranking salary) from 2.53 times in 2011/12 to 3.05 times in 2012/13.

Remuneration ranged from £14,100 to £130,000 (2011-12, £14,100 to £82,200).

# Pension Benefits - Shropshire County PCT

| Name | Title | Real Increase in Pension at age 60 (Bands of £2,500) | Real Increase in Pension Lump Sum at age 60 (Bands of £2,500) | Total Accrued Pension at Age 60 at 31 March 2013 (Bands of £5,000) | Lump Sum at Age 60 related to accrued Pension at 31 March 2013 (Bands of £5,000) | Cash Equivalent Transfer Value at 31 March 2013 | Cash Equivalent Transfer Value at 31 March 2012 | Real Increase in Cash Equivalent Transfer Value |
|---|---|---|---|---|---|---|---|---|
| | | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Eamonn Kelly | Chief Executive – West Mercia Cluster | 0-2.5 | 2.5-5 | 65-70 | 200-205 | 1433 | 1317 | 47 |
| Brian Hanford | Director of Finance – West Mercia Cluster | (0-2.5) | (0-2.5) | 35-40 | 105-110 | 611 | 569 | 12 |
| Leigh Griffin | Managing Director of PCT/Deputy CEO (Cluster) | (0-2.5) | (0-2.5) | 50-55 | 160-165 | 1041 | 1041 | 0 |
| Sue Doheny | Director of Quality & Clinical Leadership – West Mercia Cluster | 0-2.5 | 0.2.5 | 15-20 | 50-55 | 297 | 202 | 95 |
| Donna McGrath | Director of Finance for PCT | NDA | NDA | 15-20 | 50-55 | 228 | NDA | NDA |
| Rod Thomson | Director of Public Health/Infection Prevention | 5-7.5 | 17.5-20 | 40-45 | 120-125 | 876 | 730 | 108 |
| Paul Maubach | Director of Commissioning Development (Cluster) | NDA | NDA | NDA | NDA | NDA | 384 | NDA |
| Kiran Patel | Medical Director (Cluster) | NDA | NDA | NDA | NDA | NDA | 478 | NDA |

NDA No data available from the Pensions Agency

Notes:

1. The Pension Benefits table only includes those Directors who are members of the NHS Pension scheme.
2. P Maubach and Kiran Patel left the organisation during the year, therefore, data on their pensions at 31st March 2013 is not available.
3. D McGrath was not a PCT Director in 2011-12, therefore, pension data for this period is not available.
4. The total pension benefits included in the table are those accrued by each named officer, they are not all directly attributable to the PCT (see also note 2 on the salary and allowances table)
5. Real Increase in Cash Equivalent used to take into account the recommended inflation rate of 5.2%

# Statement of the Chief Executives Responsibilities as the Accountable Officer of the Primary Care Trust

The Chief Executive of the NHS has designated that the Chief Executive should be the Accountable Officer to the primary care trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Department of Health. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the primary care trust;
- the expenditure and income of the primary care trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them ;
- effective and sound financial management systems are 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 responsibilities set out in my letter of appointment as an Accountable Officer.

**Graham Urwin**
**Chief Executive**
**Date:**

# Statement of Directors Responsibilities in respect of the accounts

The Directors 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. In preparing these accounts, directors are required to:

- 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.

The Directors are responsible for keeping proper accounting records which disclose 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. They are also responsible for safeguarding the assets of the primary care trust and hence for taking reasonable steps for the prevention and direction of fraud and other irregularities.

By order of the board.

**Graham Urwin**
**Chief Executive**
**Date:**

**Ros Francke**
**Finance Director**
**Date:**

Each director must state 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.

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



# Independent Auditor's Report to the Accountable Officer of Shropshire County PCT

We have examined the summary financial statement for the year ended 31 March 2013 which comprises the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers Equity, Statement of Cash Flows and related notes set out on pages 34 to 47.

This report is made solely to the accountable officer of Shropshire County PCT in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust's accountable officer and the Trust as a body, for our audit work, for this report, or for opinions we have formed.

**Respective responsibilities of accountable officer and auditor**

The accountable officer is responsible for preparing the Annual Report.

Our responsibility is to report to you our opinion on the consistency of the summary financial statement within the Annual Report with the statutory financial statements.

We also read the other information contained in the Annual Report and consider the implications for our report if we become aware of any misstatements or material inconsistencies with the summary financial statement.

We conducted our work in accordance with Bulletin 2008/03 "The auditor's statement on the summary financial statement in the United Kingdom" issued by the Auditing Practices Board. Our report on the statutory financial statements describes the basis of our opinion on those financial statements.

**Opinion**

In our opinion the summary financial statement is consistent with the statutory financial statements of Shropshire County PCT for the year ended 31 March 2013.

*Grant Thornton UK LLP*

Grant Thornton UK LLP
Colmore Plaza
20 Colmore Circus
BIRMINGHAM
West Midlands
B4 6AT

7 June 2013

# Declared Interests 2012/13

**Shropshire Country PCT Board Members**

| | | |
|---|---|---|
| **Mrs Joanna Newton** | PCT Chair | 1. Chair of Governors, Weobley Primary School<br>2. Shareholder, Glaxo Smith Kline (GSK) |
| **Mr Eamonn Kelly**<br>To 30/09/12 | PCT Chief Executive | None declared |
| **Mr Brian Hanford**<br>To 30/09/12 | Director of Finance | 1. Trustee and Treasurer of HALO (non pecuniary)<br>2. Spouse employed by Hoople (contractor to Herefordshire PCT) |
| **Mr Andrew Mason** | Chair<br>Non Executive Director | 1. Trustee, Wyldwoods Charity |
| **Mrs Louise Lomax** | Non Executive Director | 1. Director, Severn Gorge countryside trust<br>2. Consultant trainer, Citizens' Advice |
| **Dr Helen Herritty** | Non Executive Director | 1. Husband employed by company supplying pumps to public sector building refurbishments<br>2. Chair, Shropshire CCG |
| **Mrs Susan Mead** | Non Executive Director | 1. Husband NED, NHS Midlands & East SHA |
| **Mr William Hutton** | Non Executive Director | 1. Fiancee employed by Shropshire Community Health Trust as Ward Sister<br>2. Employed by Oracle Corporation supplying IT products and services to NHS |
| **Mr Rob Parker** | Non Executive Director | 1. Rob Parker coaching & development (owner) |
| **Dr Bryan Smith**<br>From 17/01/12<br>To 31/05/12 | Non Executive Director | None declared |
| **Mrs Margaret Jackson**<br>From 01/06/12 | Non Executive Director | None declared |
| **Mrs Susan Doheney**<br>To 30/09/12 | Director of Nursing | None declared |
| **Dr Kiran Patel**<br>To 30/09/12 | Medical Director | 1. Consultant Cardiologist and Honarary Senior Lecturer, Sandwell and West Birmingham NHS Trust |

**Shropshire Country PCT Board Members** Continued

| | | |
|---|---|---|
| **Prof Rod Thomson** | Director of Public Health | 1. Foundation Governor - Alder Hey Foundation NHS Hospital Trust<br>2. Council Member Royal College of Nursing<br>3. Visiting Professor Liverpool John Moores University<br>4. Visiting Professor, Faculty of Health, Staffordshire<br>5. Fordhall Community Farm, Market Drayton (Not for profit shareholder) |
| **Dr Mike Innes** | PEC Chair/Clinical Commissioning Chair | 1. GP Partner, Stirchley Medical Practice |
| **Dr Leigh Griffin**<br>To 31/10/12 | Managing Director<br>Deputy Chief Executive | 1. Director, Sefton for Africa |
| **Mr Paul Clifford** | Corporate Director Telford and Wrekin Council | 1. Director, Telford and Wrekin Council<br>2. PCT/LA Pooled budgets |
| **Mrs Lin Jonsberg** | Trust Board Secretary | 1. Tribunal judge, mental health tribunals service<br>2. Trustee, Deaf Direct, Worcester (non-pecuniary) |
| **Mr Paul Maubach**<br>To 30/09/12 | Director of Commissioning Development | None declared |
| **Mrs Suzanne Penny**<br>To 30/09/12 | Interim Head of HR | 1. Director, Dinedor Associates Ltd |
| **Mr Graham Urwin**<br>From 01/10/12 | PCT Chief Executive | None declared |
| **Donna McGrath** | Director of Finance | None declared |
| **Mrs Ros Francke**<br>From 14/01/13 | Director of Finance | 1. Member of the Healthcare Financial Management Association Commissioning Faculty.<br>2. Husband is Managing Director of Claritas Consulting who provides services to the NHS in England and Wales. |
| **Mrs Brigid Stacey**<br>From 01/10/12 | Director of Nursing | None declared |
| **Dr Ken Deacon**<br>From 01/10/12 | Medical Director | 1. NHS General Practice Principal, Greenridge Surgery, Birmingham<br>2. Company Director, Greenridge Healthcare Ltd |

# CAP Members and Declared Interests as at 31st March 2013

**Shropshire County Primary Care Trust**

| | | |
|---|---|---|
| **Dr Bill Gowans** | Chair and Clinical Director of Transformational Change | None declared |
| **Dr Caron Morton** | Accountable Officer | None declared |
| **Mrs Donna McGrath** | Chief Finance Officer | None declared |
| **Dr Stephen James** | GP Member | 1. Local Medical Director, Malling Health (Shropshire, Telford & Wrekin)<br>2. Wife (Kathryn James) voluntary worker for Kaleidoscope<br>3. GP Federation Member of Shropdoc |
| **Dr Peter Clowes** | GP Member | Member of ShropDoc |
| **Dr C Beanland** | GP Member | None declared |
| **Dr K McCormack** | | 1. Member of Shropdoc<br>2. Worthen Medical Practice /GP Partner |
| **Dr Ruth Clayton** | Locality Chair North | Member of Shropdoc |
| **Dr Nigel Russell** | Locality Chair – S&A | None Declared |
| **Dr Colin Stanford** | Locality Chair - South | None Declared |
| **Mrs Linda Izquierdo** | Director of Nursing, Quality, Patient Safety & Experience | West Midlands Regional Professional Lead for Nurses – St John Ambulance (Lead Nurse) |
| **Dr Julie Davies** | Director of Strategy & Service Redesign | Company Secretary of 12D (husband's consultancy) |

**Shropshire County Primary Care Trust** Continued

| | | |
|---|---|---|
| **Mr Paul Tulley** | Chief Operating Officer | None declared |
| **Prof Rod Thomson** | Director of Public Health | 1. Foundation Governor - Alder Hey Foundation NHS Hospital Trust<br>2. Council Member Royal College of Nursing<br>3. Visiting Professor Liverpool John Moores University<br>4. Visiting Professor, Faculty of Health, Staffordshire<br>5. Fordhall Community Farm, Market Drayton (Not for profit shareholder) |
| **Dr Julian Povey** | GP Member | 1. Partner in Medical Practice<br>2. Wife Director of Dr Jane<br>3. Povey Ltd |
| **Dr Sal Riding** | GP Member | None declared |
| **Dr Josh Dixey** | Secondary Care Clinical Member | Trustee Arthritis Research UK |

# Clinical Commissioning Board Members
# Declaration of Interests - March 2013

**Shropshire County Primary Care Trust**

| Name | Title | Declared interests in full |
|---|---|---|
| **Dr Helen Herritty** | Lay Chair | Family Business – Trebles |
| **Dr Caron Morton** | Accountable Officer | None Declared |
| **Dr Bill Gowans** | Vice Chair | None Declared |
| **Dr Julian Povey** | GP Member | 1. Partner in Medical Practice<br>2. Wife Director of Dr Jane Povey Ltd |
| **Dr Catherine Beanland** | GP Member | 1. Member of Shropdoc<br>2. Partner Portcullis Surgery<br>3. GP Assistant – Ludlow Community Hospital |
| **Dr Sal Riding** | GP Member | Member of Shropdoc |
| **Dr Peter Clowes** | GP Member | Member of Shropdoc |
| **Dr Stephen James** | GP Member | 1. Local Medical Director, Malling Health (Shropshire, Telford & Wrekin)<br>2. Wife (Kathryn James) voluntary worker for Kaleidoscope<br>3. GP Federation<br>4. Member of Shropdoc |
| **Dr Kieran McCormack** | GP Member | 1. Member of Shropdoc<br>2. Worthen Medical Practice |
| **Mr Paul Tulley** | Chief Operating Officer | None declared |

**Shropshire County Primary Care Trust** Continued

| Name | Title | Declared interests in full |
|---|---|---|
| **Mrs Donna McGrath** | Chief Finance Officer | None declared |
| **Dr Julie Davies** | Director of Strategy & Service Redesign | Company Secretary |
| **Mrs Linda Izquierdo** | Director of Nursing, Quality, Patient Safety & Experience | West Midlands Regional Professional Lead for Nurses – St John Ambulance |
| **Mrs Bharti Patel-Smith** | Director of Governance & Involvement | None declared |
| **Prof Rod Thomson** | Director of Public Health | 1. Foundation Governor - Alder Hey Foundation NHS Hospital Trust<br>2. Council Member Royal College of Nursing<br>3. Visiting Professor Liverpool John Moores University<br>4. Visiting Professor, Faculty of Health, Staffordshire<br>5. Fordhall Community Farm, Market Drayton (Not for profit shareholder) |
| **Dr Josh Dixey** | Secondary Care Clinical Member | Trustee Arthritis Research UK |
| **Mr William Hutton** | Lay Member (Audit) | 1. Employed by Oracle Corporation UK Ltd<br>2. Wife employed by Shropshire Community Health Trust as a Ward Sister |
| **Mrs Paula Burton** | Non-Executive Member | 1. NMC Panel Chair – Fitness to Practice Panels<br>2. Additional Inspector Health Social Care Learning & Skills – Ofsted<br>3. Education Associate GMC Education |

## This document is also available in other languages, large print and audio format upon request.

**ይህ ጽሁፍ በሌሎች ቋንቋዎችም ይገኛል: እንዲሁም በታላቅ ቀለሞችና እንዲሁም በሬድዮ ካሴት ቅርጽ ለመስማት ይቻላል።**

هذه الوثيقة متاحة أيضا بلغات أخرى والأحرف الطباعية الكبيرة وبطريقة سمعية عند الطلب.

**এই ডকুমেন্ট অন্য ভাষায়, বড় প্রিন্ট আকারে এবং অডিও টেপ আকারেও অনুরোধে পাওয়া যায়।**

Tento dokument je na vyžádání k dispozici také v jiných jazycích, ve velkém tištěném formátu a zvukovém formátu.

این مدرک همچنین بنا به درخواست به زبانهای دیگر، در چاپ درشت و در فرمت صوتی موجود است.

Ce document est également disponible dans d'autres langues, en gros caractères et en cassette audio sur simple demande.

આ દસ્તાવેજ વિનંતી કરવાથી બીજી ભાષાઓ, મોટા છાપેલા અક્ષરો અથવા ઓડિઓ રચનામાં પણ મળી રહેશે.

**ئەم بەلگەیە هەروەها بە زمانەکانی کە، بە چاپی درشت و بە شریتی تەسجیل دەس دەکەویت**

本文件也可应要求，制作成其它语文或特大字体版本，也可制作成录音带。

Dokument ten jest na życzenie udostępniany także w innych wersjach językowych, w dużym druku lub w formacie audio.

ਇਹ ਦਸਤਾਵੇਜ਼ ਹੋਰ ਭਾਸ਼ਾਵਾਂ ਵਿਚ, ਵੱਡੇ ਅੱਖਰਾਂ ਵਿਚ ਅਤੇ ਆਡੀਓ ਟੇਪ 'ਤੇ ਰਿਕਰਾਡ ਹੋਇਆ ਵੀ ਮੰਗ ਕੇ ਲਿਆ ਜਾ ਸਕਦਾ ਹੈ।

Waxaa kale oo lagu heli karaa dokumentigaan luqado kale, daabacaad ballaaran, iyo cajal duuban haddii la soo waydiisto.

Hati hii vile vile inapatikana katika lugha nyingine, kwa maandishi makubwa na katika sauti kwa maombi.

நீங்கள் கேட்டுக்கொண்டால், இந்த ஆவணம் வேறு மொழிகளிலும், பெரிய எழுத்து அச்சிலும் அல்லது ஒலிநாடா வடிவிலும் அளிக்கப்படும்.

**እዚ ጽሑፍ'ዚ ብካልኦ ቋንቋታት እውን ይርከብ ኢዩ: ወይ ኣዕቢይ ዝተጻሕፈ ማሕተም ወይ ድማ ብዝስማዕ (ድምጺ) እንተሓቲኩምዩ።**

درخواست پر یہ دستاویز دیگر زبانوں میں، بڑے حروف کی چھپائی اور سننے والے ذرائع پر بھی میسر ہے۔

**Shropshire and Staffordshire Area Team of NHS England,**
**Anglesey House, Units 107 – 111 Anglesey Court, Towers Plaza,**
**Wheelhouse Road, Rugeley, Staffordshire, WS15 1UL**

**Tel: 0300 790 233** **Website: www.southstaffordshirepct.nhs.uk**

**Shropshire and Staffordshire Area Team**
**NHS England, Anglesey House**
**Wheelhouse Road**
**Rugeley**
**Staffordshire**
**WS15 1UL**

**Tel: 0300 7900 233**

Department of Health

NHS

# Shropshire County Primary Care Trust

## 2012-13 Accounts

Published to gov.uk, in PDF format only.

www.gov.uk/dh

# Shropshire County Primary Care Trust

2012-13 Accounts

**2012-13 Annual Accounts of Shropshire County Primary Care Trust (non-London)**

## 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: Graham Urwin

Date 7 June 2013

**2012-13 Annual Accounts of Shropshire County Primary Care Trust (non-London)**

## 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.

7 June 2013 Date.....Signing Officer

7 June 2013 Date.....Finance Signing Officer

Shropshire County NHS
Primary Care Trust

# ANNUAL GOVERNANCE STATEMENT 2012/13

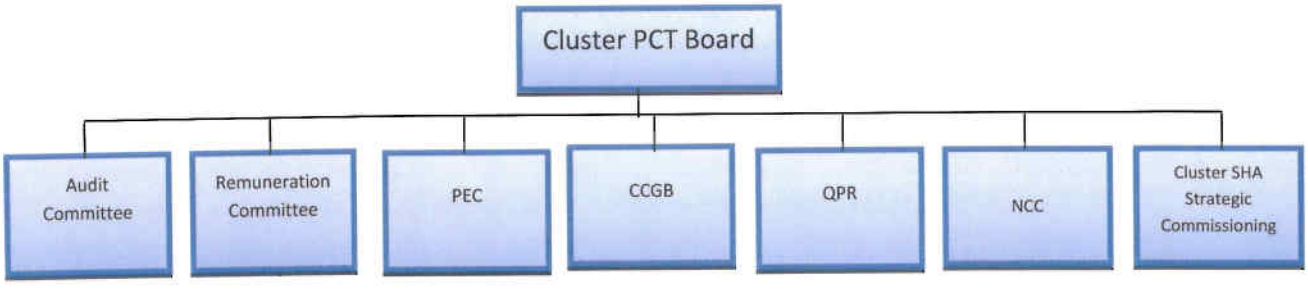
## 1. Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Shropshire County Primary Care Trust's policies, aims and objectives. I also have responsibility for safeguarding the public funds and organisations assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

## 2. The governance framework of the organisation

The governance structure for the PCT changed during 2012/13 to reflect the requirement for National Commissioning Board Local Area Teams to assume executive responsibility for PCT Cluster areas. Shropshire County Primary Care Trust forms part of the West Mercia Cluster of PCTs, but the Cluster area was divided between the Staffordshire Local Area Team and the Arden, Herefordshire and Worcestershire Local Area Team, with Shropshire County Primary Care Trust coming under the remit of the former. The revised governance arrangements came into effect in October 2012. Shropshire County Primary Care Trust remains the statutory body covering its registered population until April 2013. West Mercia Cluster of PCTs has operated a single shared board model, which means that the PCT Board meets concurrently unless it facilitates good governance to meet separately.

The sub-committee structure of the PCT Board, and the arrangements for discharge of PCT statutory functions that operated during 2012/13 was as follows:




- Audit Committee (held concurrently for all PCTs) provides assurance to the Board that the organisation's overall internal control/governance system operates in an adequate and effective way. The Committee's work focuses not only on financial controls, but also risk management and clinical governance controls.
- Remuneration Committee (held concurrently for all PCTs) recommends to the Board appropriate salaries, payments and terms & conditions of employment.
- Quality Performance and Resources Committee (QPR) (held concurrently for all PCTs)

provides assurance to the Board that the PCT is meeting its performance targets, commissioning high quality services and using its resources wisely.

- National Commissioning Committee (NCC) (held concurrently for all PCTs) provides assurance to the Board the PCT is meeting its performance in primary care and commissioning high quality services.
- Clinical Commissioning Group Boards (CCGB) (held individually for each CCG in the cluster area) provides assurance to the Board that they are undertaking delegated authority for commissioning as outlined in the scheme of delegation.
- Professional Executive Committee (PEC) (held individually for each PCT in the cluster area) is chaired by a local GP and is made up of a majority of clinical members: GPs, Nurses and Allied Health Professionals working in Shropshire County. The Committee provides clinical advice and assurance to the Board.
- Strategic Commissioning (held on East and West SHA Cluster footprint) which oversee the commissioning of low volume, high value strategic commissioning decisions.

Membership of these sub committees of the PCT Board is outlined in terms of reference and attendance at these meeting was recorded in the minutes of each meeting.

In October 2012, the following sub committees were stood down by the PCT Board to reflect the split of the PCT Cluster between two Local Area Teams:

- Quality, Performance and Resources Committee
- National Commissioning Committee
- Professional Executive Committee

The functions of these committees were transferred to the respective Clinical Commissioning Group Boards, for assurance and reporting to the PCT Board. Audit Committee and Remuneration Committee continued to meet as sub committees of the PCT Board.

The following areas were highlighted in Board sub-committee reports to the Board:

Audit Committee:

- Development of CCG audit and assurance arrangements

Quality, Performance and Resources Committee:

- Assurance on QIPP delivery
- SATH A&E under performance due to patient flow
- Underperformance against target for referral to treatment within 18 weeks (RTT) at SaTH and Robert Jones and Agnes Hunt Foundation Trust (RJAH).

National Commissioning Committee:

- Risks around loss of key primary care staff leading to lack of resilience
- The complicated operating model for public health, resulting from the split of public health functions across a number of receiving organisations.

The Board reflected on its own effectiveness during the year, particularly focussing on the results of the Annual Accountability Review meeting with Cluster in 2012. The review

provided assurance that the Cluster, although has challenging performance issues, demonstrated clearly that it understood the issues involved and could provide a sharper emphasis on outcomes for 2012/13.

The arrangements for completing operational and closure documents were presented to the PCT Board on 24th July 2012. Key milestones were set out for the PCT to work to:

- September 2012 – version 1 of the quality handover document (following further guidance from National Quality Board) and revision of the operational legacy document to be completed ready for submission to the SHA Cluster and National Quality board.
- October to December 2012 – PCTs maintain and update quality handover and legacy document as NHS architecture begins to change. National Quality Board visit SHA Clusters to gain assurance that appropriate quality handover plans are in place.
- January to March 2013 – Quality and legacy data kept live and handover document revised to reflect current circumstances. Final quality handover document and operational legacy document approved by final board meeting of PCT in March 2013. Approved versions of both quality handover and operational legacy documents sent to receiving organisations and National Quality Board.
- April 1st 2013 Accountability Transfers - Receiving organisations adopt all relevant documents formally at first public Board. Receiving organisations develop and agree plan for taking forward quality issues.

The Area Team Director, as PCT Accountable Officer and the Area Team Finance Director has responsibility for signing accounts and the supporting statements. The day to day preparation of the Annual Accounts during the period of transition between PCT and its successor bodies will be undertaken by the PCTs existing outsourced financial accounting service supported by retained PCT staff.

When the PCT ceases to be statutory body on 1 April 2013, the statutory status of the audit committees is lost. This role will be undertaken by cluster Audit Committees utilising existing Non-Executive Directors in line with national policy.

Corporate Governance is the system by which the PCT Board directs and controls the organisation at the most senior level in order to achieve its objectives and meet the necessary standards of accountability and probity. Using a risk management mechanism, the PCT Board brings together the various aspects of governance; corporate, clinical, financial, and information to provide assurance on its direction and control across the whole organisation in a co-ordinated way. The co-ordinating body for receiving assurance on these strands of governance is the Audit Committee, which oversees integrated governance on behalf of the PCT Board. In addition the other sub committees also oversee the risks within their specific remits, providing assurance to the Audit Committee where appropriate.

The PCT Board complies with the Corporate Code of Governance and demonstrates this by individual Board members affirming their compliance with the Codes of Accountability and Codes of Conduct for the NHS when declaring their interests.

The arrangements in place for the discharge of statutory functions have been checked that they are legally compliant via a number of mechanisms: internal auditing, self-assessment via the IG Toolkit, serious incident reporting, counter fraud annual plan, regulation and peer

assessment, the outcomes of which have been reported to Audit Committee and its sub committees, and by exception to the PCT Board.

## 3 The risk and control framework and risk assessment

### 3.1 System of risk control:

The system of risk control, forms part of the PCT's system of internal control and is defined in the Risk Management Strategy, which is reviewed annually. The strategy defines the risk management responsibilities and common methodologies for the identification and assessment of risks for the whole organisation. It requires that risks are managed to a reasonable level, within the parameters of a defined risk appetite, rather requiring the elimination of all risk of failure to achieve the PCT's objectives. The risk control system facilitates the assessment of risk by:

- identifying and prioritising the risks to the achievement of the organisation's objectives,
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The risk appetite was approved by the board and the strategy outlines the processes for maintaining and monitoring the Strategic Risk Register and the hierarchy of risk registers below it with due regard to this appetite.

### 3.2 Risk assessment:

Risks are identified, assessed and recorded in accordance with the Risk Management Strategy and Risk Assessment Code of Practice. The principle processes and the matrix described in these documents are applied to all risk registers, incident management and risk assessment activity across Shropshire County Primary Care Trust. These processes are used to identify risks:

- retrospectively following the occurrence of an adverse incident;
- proactively by identifying of potential risks to service delivery; and
- during development of new activities.

Since June 2011 the risk registers have followed the format used for the cluster Board Assurance Framework for ease of comparison across the cluster and to facilitate escalation and de-escalation of risks between the cluster and the PCT.

It is acknowledged that risks may be shared with other organisations that the PCT works with jointly to deliver services consequently the Strategic Risk Register is discussed with risk management leads and reflects the identified strategic risks of these organisations.

The following details are recorded for each risk recorded on a risk register:

- risk category
- risk description
- inherent risk
- existing controls
- risk grading with controls

- and gaps in controls
- actions to reduce the risk to an acceptable level
- amendments.

Where necessary actions include the identification of budgets and resources to facilitate their implementation.

### 3.3 Shropshire County Primary Care Trust's major risks

A summary of the major risks identified, during 2012/13, in the Board Assurance Framework is set out below. The framework was last presented to the PCT Board on 26th February 2013:

| Description of major risks added to the Corporate Risk register during 2012/13 | Existing controls: | Further actions: |
|---|---|---|
| Risk associated with potential failure to embed robust systems and process to manage quality and safety of provider services during transition period to CSU/LAT | Quality, Performance and Resource Committee receives regular monthly reports on patient safety, patient experience and clinical effectiveness seeking assurance in relation to these areas across providers.<br><br>Standards of care specified in all service specifications / SLAs and Quality Schedules e.g. "markers of good practice". These are monitored through regular contract meetings with service providers Partnership arrangements in place such as the Local Safeguarding Board, across Shropshire for adults and children to ensure adherence to legal obligations. | Continued review of specific systems and processes to increase the level of assurance and improvement of quality and safety for patients.<br><br>Complete Quality Strategy and seek board approval.<br><br>Review and negotiate appropriate support from the CSU to ensure robust system and processes to ensure monitor quality and safety of provider services. |
| Use of standard NHS contracts with providers includes the commitment to deliver on the Constitutional requirements. | Use of standard NHS contracts with providers includes the commitment to deliver on the Constitutional requirements. | SaTH compliant for non-admitted for all specialties except Thoracic, Neurology, Ophthalmology, Dermatology and Rheumatology. Will be compliant from 1st April 2013.<br><br>RJAH achieving admitted and non-admitted at a trust level (since October) slightly behind trajectory for delivery by specialty from the 1st April but have plans in place to recover by the end of the financial year. |
| Failure to sustain the quality and safety of maternal health and antenatal care | Clinical Quality review meetings with SaTH - maternal health dedicated agenda item. | Review dashboard routinely at SaTH CQR Meeting.<br><br>Commissioner to attend Root Cause Analysis Meetings. External Review to be undertaken of Hub and Spoke Model of care following outcome of recent inquest. |
| Consistent failure to maintain Accident and Emergency 4 hour target. | Urgent Care Rapid Recovery Silver Command Group set up across the LHE with clear terms of reference | Remedial Action Plan in place<br><br>Weekly meetings established to monitor compliance with remedial |

| | | |
|---|---|---|
| | (TOR). | action plan and associated KPIs. Delivering at PRH from the 21st January, still to achieve at RSH. |
| High levels concerns regarding quality assurance at individual providers in relation to various key areas identified as:<br>SaTH - Pressure Ulcers, Infection Control CDiff and Safeguarding (ratification on mitigating actions to be sought at LHE Safeguarding Board on 29 January 2013<br>RJAH - Potential for Professional Isolation<br>SCHT - Pressure Ulcers, Consistency of care at Community Hospital and Business Continuity<br>SSSFT Absconcions, Transparency around safeguarding and capacity in relation to continuity of care | Ongoing challenge and quality assurance via Clinical Quality Review meetings with SaTH.<br><br>Quality, Performance and Resources Committee Minutes. | Continual monitoring and support<br><br>Collate evidence to triangulate information. |
| Sath over performance | Monthly Contract Review meetings to challenge over performance.<br>Monthly QIPP Board meetings to challenge deliverability of SATH CIPs and CCG QIPPs | Challenge A&E coding, ECG OP Procedures shadow counting, backlog activity and OCA activity – contracts team.<br><br>Engage Urgent Care Network in understanding and management of emerging adverse pressures – Clinical Director of resources, CFO and Practice Support teams<br><br>Urgently review timing and impact of QIPP initiatives to affect performance – QIPP Programme leads.<br><br>Task and finish group set up to validate activity submissions between unify and SUS. |
| Failure to identify QIPP programme savings and contingency for 2013/2014. | QIPP savings plans integral part of overall Financial and Performance Plan. Monitoring of finance and performance. | CCG CFO gained assurance of Management & Clinical lead sign up to schemes including phasing of savings and robust source data identified. Schemes that were not signed off were dropped from the programme and contingency schemes are being identified to replace them.<br><br>Majority of Investment plans approved by the beginning of June and implemented almost immediately where they impact on QIPP savings. Slippage has been identified on the F&C scheme which is not now anticipated to make savings until Q4. This has been factored into the forecast outturn.<br><br>Overachievement of CHC QIPP has mitigated under performances in other schemes. |

| | | |
|---|---|---|
| Provider Trust issues associated with Foundation Trust pipeline and instability due to executive changes at Shropshire Community Health Trust - risk of destabilising the local health economy. | Finnamore engaged to undertake work across the Local Health Economy to establish whole systems approach. | CCG Board to provide strategic leadership. |
| Failure to define, plan and commission against public health information pertaining to health inequalities. | Health and Wellbeing Board. Health and Wellbeing Executive. Joint Strategic Needs Assessment. Health and Wellbeing Strategy. | Increase locality focus to incorporate knowledge from clinician members. CM / RT 31 December 2012 |
| Failure to provide staff support and development programme and recruit staff during and after the transition period. | Team meetings 1:1 meetings.<br><br>Annual Staff Personal Development Plans | Establish CCG staff briefings.<br><br>Prepare staff training and development programme for 2013/14<br><br>Undertake 1 to 1 meetings. |
| There is a risk that a major incident impacts on business continuity and delivery of priority services. | Risk Management Policy in place.<br><br>Business continuity support and expertise available. | Develop detailed incident and business continuity planning in the CCG and local providers to mitigate the risks associated with a major incident.<br><br>Formalise expertise and support from Emergency Planning Officer.<br><br>Provide emergency planning training for key members of the Board. |
| Failure to manage handover and closedown. | HR transition being managed by HR Estates and Finance being managed by CFO | Complete closedown and handover and submit information to DOH as required.<br><br>Prepare Board Paper - to outline transition arrangements. |

## 4 Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. The Head of Internal Audit Opinion for 2012/13 is that there is that significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.
My review is also informed by:

- Counter Fraud and Security Management assurance
- Audit Committee programme and review

- Infection Control Audit
- Internal and external audit reports
- External auditors in their management letter and other reports
- Monthly performance monitoring by the Strategic Health Authority
- Serious incident reporting
- Information Governance Toolkit assurance

I have been advised of the implications of the result of my review of the effectiveness of the system of internal control in the following ways:

**The Board** has received both the minutes and a regular report from the Chair of the Audit Committee based upon the minutes of each Audit Committee meeting summarising activity and its concerns. Through this mechanism the chair of the committee has ensured that the Board is aware of any significant challenges to the system of internal control and updates on progress in addressing these.

**Audit Committee**: The work of the Audit Committee has been informed by the activity of a number of working groups/PCT functions and has received exception summaries for these groups within the Group Summaries element of the Assurance Framework.

**Executive Managers**: Individual Executive Directors of the PCT/CCG review their respective parts of the Strategic Risk Register with the Risk Manager and amend where necessary.

**Audit recommendations:** Implementation of both internal and external audit recommendations are monitored within the recommendation tracking element of the Assurance Framework.

**Internal reviews:** Internal reviews, including clinical and infection control audits are monitored within the Quality performance element of the Assurance Framework.

A plan to address weaknesses, (including the specific control issues listed in 6.1 below), and ensure continuous improvement of the system is in place.

## 5 Significant control issues

5.1 The Chief Executive can give assurance that no significant control issues have been raised that would require reporting in the Annual Governance Statement. This is supported in the opinion of the Head of Internal Audit for 2012/13. However, the Internal Auditor has identified some weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk, and these are detailed below in section 6.1.

## 6 Other control issues:

### 6.1 Control issues raised by Internal Audit:

Information Governance: Internal Audit has given moderate assurance on Information Governance, and raised concerns with regard to the effectiveness of controls. An action plan has been agreed between Internal Audit and management, and the implementation of this plan will continue to be implemented by Staffordshire CSU and monitored by both the CSU and Shropshire CCG Audit committees.

### 6.2 Breaches of data security

Shropshire County Primary Care Trust has no reported data security incident during 2012/13.

### 6.3 Serious incidents (SIs):

Shropshire County Primary Care Trust reported no other serious incidents during 2012/13.

## 7 Conclusion

As Accountable Officer and based on the review process outlined above, the PCT has identified and is taking action on the control issues arising in year which have been identified in detail in the body of the Annual Governance Statement above.

Mr Graham Urwin – Accountable Officer

Shropshire County Primary Care Trust

Signature: 

Date: 7/6/13.

## INDEPENDENT AUDITOR'S REPORT TO THE ACCOUNTABLE OFFICER OF SHROPSHIRE COUNTY PRIMARY CARE TRUST

We have audited the financial statements of Shropshire County PCT for the year ended 31 March 2013 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. 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, being:

- the table of salaries and allowances of senior managers and related narrative notes on pages 50-51;
- the table of pension benefits of senior managers and related narrative notes on page 52; and
- the pay multiples narrative on page 51.

This report is made solely to the accountable officer of Shropshire County PCT in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust's accountable officer and the Trust as a body, for our audit work, for this report, or for opinions we have formed.

### Respective responsibilities of the signing officer, finance signing officer and auditor

As explained more fully in the Statement of Responsibilities, the signing officer and finance signing officer are responsible for overseeing the preparation of the financial statements and for being satisfied that they 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 Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Trust; 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.

In addition, we are required to obtain evidence sufficient to give reasonable assurance that the expenditure and income reported in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

**Opinion on regularity**

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 financial statements**

In our opinion the financial statements:

- give a true and fair view of the financial position of Shropshire County PCT as at 31 March 2013 and of its net operating costs 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 other matters**

In our opinion:

- the part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements 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 annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

**Matters on which we report by exception**

We report to you if:

- in our opinion the governance statement does not reflect compliance with the Department of Health's Guidance;
- we refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have a reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

We have nothing to report in these respects.

**Other matters on which we are required to conclude**

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are also required by the Audit Commission's Code of Audit Practice 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 and, having regard to the guidance issued by the Audit Commission, we have considered the results of the following:

· our review of the annual governance statement;

· the work of other relevant regulatory bodies or inspectorates, to the extent the results of the work have an impact on our responsibilities; and

· our locally determined risk-based work on transition.

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

**Certificate**

We certify that we have completed the audit of the financial statements of Shropshire County PCT in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

James Cook

James Cook
Senior Statutory Auditor, for and on behalf of Grant Thornton UK LLP

Colmore Plaza
20 Colmore Circus
BIRMINGHAM
West Midlands
B4 6AT

7 June 2013

## 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 | **8,921** | 7,776 |
| Other costs | 5.1 | **486,716** | 483,048 |
| Income | 4 | **(11,701)** | (11,327) |
| **Net operating costs before interest** | | **483,936** | 479,497 |
| Other (Gains)/Losses | 9 | **715** | 1 |
| Finance costs | 10 | **15** | 20 |
| **Net operating costs for the financial year** | | **484,666** | 479,518 |
| **Net Operating Costs for the Financial Year including absorption transfers** | | **484,666** | 479,518 |
| **Of which:** | | | |
| **Administration Costs** | | | |
| Gross employee benefits | 7.1 | **5,297** | 5,161 |
| Other costs | 5.1 | **6,430** | 6,319 |
| Income | 4 | **(2,656)** | (2,160) |
| **Net administration costs before interest** | | **9,071** | 9,320 |
| Other (Gains)/Losses | 9 | **0** | 1 |
| Finance costs | 10 | **0** | 20 |
| **Net administration costs for the financial year** | | **9,071** | 9,341 |
| **Programme Expenditure** | | | |
| Gross employee benefits | 7.1 | **3,624** | 2,615 |
| Other costs | 5.1 | **480,286** | 476,729 |
| Income | 4 | **(9,045)** | (9,167) |
| **Net programme expenditure before interest** | | **474,865** | 470,177 |
| Other (Gains)/Losses | 9 | **715** | 0 |
| Finance costs | 10 | **15** | 0 |
| **Net programme expenditure for the financial year** | | **475,595** | 470,177 |

| **Other Comprehensive Net Expenditure** | 2012-13 £000 | 2011-12 £000 |
|---|---|---|
| Impairments and reversals put to the Revaluation Reserve | **141** | 1 |
| Net (gain) on revaluation of property, plant & equipment | **(20)** | (1,437) |
| **Total comprehensive net expenditure for the year*** | **484,787** | 478,082 |

The notes on pages 5 to 37 form part of this account.

## Statement of Financial Position at 31 March 2013

| | NOTE | 31 March 2013 £000 | 31 March 2012 £000 |
|---|---|---|---|
| **Non-current assets:** | | | |
| Property, plant and equipment | 11 | **31,694** | 34,089 |
| **Total non-current assets** | | **31,694** | 34,089 |
| **Current assets:** | | | |
| Trade and other receivables | 15 | **3,965** | 4,636 |
| Cash and cash equivalents | 16 | **5** | 242 |
| **Total current assets** | | **3,970** | 4,878 |
| Non-current assets held for sale | 17 | **0** | 80 |
| **Total current assets** | | **3,970** | 4,958 |
| **Total assets** | | **35,664** | 39,047 |
| **Current liabilities** | | | |
| Trade and other payables | 18 | **(27,603)** | (27,749) |
| Provisions | 19 | **(700)** | (1,241) |
| **Total current liabilities** | | **(28,303)** | (28,990) |
| **Non-current assets plus/less net current assets/liabilities** | | **7,361** | 10,057 |
| **Non-current liabilities** | | | |
| Provisions | 19 | **(1,560)** | (2,410) |
| **Total non-current liabilities** | | **(1,560)** | (2,410) |
| **Total Assets Employed:** | | **5,801** | 7,647 |
| **Financed by taxpayers' equity:** | | | |
| General fund | | **(4,130)** | (2,648) |
| Revaluation reserve | | **9,931** | 10,295 |
| Other reserves | | **0** | 0 |
| **Total taxpayers' equity:** | | **5,801** | 7,647 |

The notes on pages 5 to 39 form part of this account.

The financial statements on pages 1 to 39 were approved by the Board on 5 June 2013 and signed on its behalf by

**Chief Executive:** Date: 7/6/13

## 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** | **(2,648)** | **10,295** | **0** | **7,647** |
| **Changes in taxpayers' equity for 2012-13** | | | | |
| Net operating cost for the year | **(484,666)** | | | **(484,666)** |
| Net gain on revaluation of property, plant, equipment | | **20** | | **20** |
| Impairments and reversals | | **(141)** | | **(141)** |
| Transfers between reserves* | **243** | **(243)** | | **0** |
| **Reclassification Adjustments** | | | | |
| **Total recognised income and expense for 2012-13** | **(484,423)** | **(364)** | **0** | **(484,787)** |
| Net Parliamentary funding | **482,941** | | | **482,941** |
| **Balance at 31 March 2013** | **(4,130)** | **9,931** | **0** | **5,801** |
| | | | | |
| **Balance at 1 April 2011** | (4,915) | 8,862 | 0 | 3,947 |
| **Changes in taxpayers' equity for 2011-12** | | | | |
| Net operating cost for the year | (479,518) | | | (479,518) |
| Net Gain / (loss) on Revaluation of Property, Plant and Equipment | | 1,437 | | 1,437 |
| Impairments and Reversals | | (1) | | (1) |
| Transfers between reserves* | 3 | (3) | | 0 |
| **Total recognised income and expense for 2011-12** | (479,515) | 1,433 | 0 | (478,082) |
| Net Parliamentary funding | 481,782 | | | 481,782 |
| **Balance at 31 March 2012** | (2,648) | 10,295 | 0 | 7,647 |

## Statement of cash flows for the year ended 31 March 2013

| | NOTE | 2012-13 £000 | 2011-12 £000 |
|---|---|---|---|
| **Cash Flows from Operating Activities** | | | |
| Net Operating Cost Before Interest | | **(483,936)** | (479,497) |
| Depreciation and Amortisation | | **1,240** | 1,314 |
| Impairments and Reversals | | **47** | 1 |
| Other Gains / (Losses) on foreign exchange | | **0** | 0 |
| Donated Assets received credited to revenue but non-cash | | **0** | (17) |
| Government Granted Assets received credited to revenue but non-cash | | **0** | 0 |
| Interest Paid | | **0** | 0 |
| Release of PFI/deferred credit | | **0** | 0 |
| (Increase)/Decrease in Inventories | | **0** | 0 |
| (Increase)/Decrease in Trade and Other Receivables | | **671** | (2,479) |
| (Increase)/Decrease in Other Current Assets | | **0** | 0 |
| Increase/(Decrease) in Trade and Other Payables | | **28** | 1,611 |
| (Increase)/Decrease in Other Current Liabilities | | **0** | 0 |
| Provisions Utilised | | **(1,037)** | (922) |
| Increase/(Decrease) in Provisions | | **(369)** | 208 |
| **Net Cash Inflow/(Outflow) from Operating Activities** | | **(483,356)** | (479,781) |
| **Cash flows from investing activities** | | | |
| Interest Received | | **0** | 0 |
| (Payments) for Property, Plant and Equipment | | **(902)** | (1,775) |
| (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) | | **1,080** | 2 |
| 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 Inflow/(Outflow) from Investing Activities** | | **178** | (1,773) |
| **Net cash inflow/(outflow) before financing** | | **(483,178)** | (481,554) |
| **Cash flows from financing activities** | | | |
| Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT | | **0** | (3) |
| Net Parliamentary Funding | | **482,941** | 481,782 |
| Capital Receipts Surrendered | | **0** | 0 |
| Capital grants and other capital receipts | | **0** | 17 |
| Cash Transferred (to)/from Other NHS Bodies (free text note required) | | **0** | 0 |
| **Net Cash Inflow/(Outflow) from Financing Activities** | | **482,941** | 481,796 |
| **Net increase/(decrease) in cash and cash equivalents** | | **(237)** | 242 |
| **Cash and Cash Equivalents ( and Bank Overdraft) at Beginning of the Period** | | **242** | 0 |
| Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies | | **0** | 0 |
| **Cash and Cash Equivalents (and Bank Overdraft) at year end** | | **5** | 242 |

# 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 PCTs 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

**Transforming Community Services (TCS) transactions**

Under the TCS initiative, services historically provided by PCTs have transferred to other providers - notably NHS Trusts and NHS Foundation Trusts. Such transfers fall to be accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCNE, and is disclosed separately from operating costs.

**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

**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.

1. Determining whether substantially all the significant risks and rewards of ownership of leased assets have transferred.

**1. Accounting policies (continued)**

**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. Payables accrual for GP prescribing £8,655,000 - the last 2 months figures are estimated based on profiles for those months published by the NHS Business Services Authority's Prescription Pricing Division.
2. Provision for Continuing Healthcare appeals £1,201,000 – the provision for retrospective cases and appeals is calculated using the total number of known outstanding claims multiplied by a probability of success and costed at the average successful claim cost
3. Land and buildings (£30,447,000) are valued periodically by an external valuer who makes assumptions concerning values. Estimates are also made concerning the lives of those assets.

## 1.2 Revenue and funding

The main source of funding for the Primary Care Trust is allocations (Parliamentary Funding) from the Department of Health within an approved cash limit, which is credited to the General Fund of the Primary Care Trust. 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 Primary Care Trust. 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 has entered into a pooled budget with Shropshire Council. Under the arrangement funds are pooled under S75 of the NHS Act 2006.

The pool is hosted by the Council. As a commissioner of healthcare services, the PCT makes contributions to the pool, which are then used to purchase healthcare services. The PCT accounts for its share of the assets, liabilities, income and expenditure of the pool as determined by the pooled budget agreement.

## 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. Accounting policies (continued)**

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

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.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value. The PCT's policy on equipment valuations is that where a piece of equipment has a life of more than 10 years and a value in excess of £30,000, it is indexed using the Health Services Cost Index.

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. Accounting policies (continued)**

## 1.7 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.

## 1.8 Donated assets

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.

## 1.9 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.

### 1.10 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.

### 1.11 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).

### 1.12 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 19.

### 1.13 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.

**1. Accounting policies (continued)**

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.

## 1.14 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.

## 1.15 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.

## 1.16 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**

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.

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**

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.

## 1.17 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 a 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.

**1. Accounting policies (continued)**

## 1.18 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.

**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.

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.

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

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related 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

**1. Accounting policies (continued)**

**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 effective interest method.

## 1.19 Accounting Standards that have been issued but have not yet been adopted

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

IAS 27 Separate Financial Statements - subject to consultation
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IFRS 9 Financial Instruments - subject to consultation
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IPSAS 32 - Service Concession Arrangement - subject to consultation

## 1.20 Closure of the PCT

Under the provisions of the Health & Social Care Act 2012 (Commencement No.4. Transitional, Savings and Transitory Provisions) Order 2013, Shropshire County PCT was dissolved on 1st April 2013. The PCT's functions, assets and liabilities transferred to other public sector entities as outlined in Note 24 Events After The Reporting Period. Where reconfigurations of this nature take place within the public sector, Government accounting requires that the activities concerned are to be considered as continuing operations, and so the closing entity prepares accounts on a "going concern" basis.

The SOFP has therefore been drawn up at 31 March 2013 on the same basis as in previous years, reporting balances on the same basis as would a continuing entity. In particular, there has been no general revaluation of assets or liabilities, and no disclosures have been made under IFRS 5 Non-Current Assets Held for Sale and Discontinued Operation.

## 2. Operating Segments

The operating segments over which financial performance is analysed are based on the way this is reported to the Board.

| | Clinical Commissioning Consortia 2012-13 £000 | National Commissioning Board 2012-13 £000 | Public Health Service 2012-13 £000 | Corporate Functions & Reserves 2012-13 £000 | Total 2012-13 £000 |
|---|---|---|---|---|---|
| Gross operating costs | **354,930** | **120,182** | **10,052** | **10,473** | **495,637** |
| - Miscellaneous revenue | **(383)** | **(8,629)** | **(97)** | **(2,592)** | **(11,701)** |
| Net operating costs before interest | **354,547** | **111,553** | **9,955** | **7,881** | **483,936** |
| Gains/losses & finance costs | | | | **730** | **730** |
| Net operating costs | **354,547** | **111,553** | **9,955** | **8,611** | **484,666** |
| Revenue resource limit | **349,302** | **112,467** | **10,143** | **13,770** | **485,682** |
| Surplus/(deficit) | **(5,245)** | **914** | **188** | **5,159** | **1,016** |

| | Clinical Commissioning Consortia 2011-12 £000 | National Commissioning Board 2011-12 £000 | Public Health Service 2011-12 £000 | Corporate Functions & Reserves 2011-12 £000 | Total 2011-12 £000 |
|---|---|---|---|---|---|
| Gross operating costs | 358,754 | 110,651 | 12,719 | 8,699 | 490,823 |
| Miscellaneous revenue | (449) | (8,059) | (110) | (2,708) | (11,326) |
| Net operating costs before interest | 358,305 | 102,592 | 12,609 | 5,991 | 479,497 |
| Gains/losses & finance costs | | | | 21 | 21 |
| Net operating costs | 358,305 | 102,592 | 12,609 | 6,012 | 479,518 |
| Revenue resource limit | 357,278 | 102,986 | 12,711 | 7,838 | 480,813 |
| Surplus/(deficit) | (1,027) | 394 | 102 | 1,826 | 1,295 |

# 3. Financial Performance Targets

## 3.1 Revenue Resource Limit

| | 2012-13 £000 | 2011-12 £000 |
|---|---|---|
| The PCTs' performance for the year ended 2012-13 is as follows: | | |
| Total Net Operating Cost for the Financial Year | | 479,518 |
| Net operating cost plus (gain)/loss on transfers by absorption | **484,666** | |
| Revenue Resource Limit | **485,682** | 480,813 |
| **Under/(Over)spend Against Revenue Resource Limit (RRL)** | **1,016** | 1,295 |

## 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 | **25** | 1,425 |
| Charge to Capital Resource Limit | **(1,067)** | 848 |
| **(Over)/Underspend Against CRL** | **1,092** | **577** |

## 3.3 Under/(Over)Spend Against Cash Limit

| | 2012-13 £000 | 2011-12 £000 |
|---|---|---|
| Total Charge to Cash Limit | **482,941** | 481,782 |
| Cash Limit | **482,941** | 481,782 |
| **Under/(Over)spend Against Cash Limit** | **0** | 0 |

## 3.4 Reconciliation of Cash Drawings to Parliamentary Funding (Current Year)

| | 2012-13 £000 |
|---|---|
| Total cash received from DH (Gross) | **424,416** |
| Less: Trade Income from DH | **(1)** |
| **Sub total: net advances** | **424,415** |
| Plus: cost of Dentistry Schemes (central charge to cash limits) | **9,883** |
| Plus: drugs reimbursement (central charge to cash limits) | **48,643** |
| **Parliamentary funding credited to General Fund** | **482,941** |

## 4. Miscellaneous Revenue

| | 2012-13 Total £000 | 2012-13 Admin £000 | 2012-13 Programme £000 | 2011-12 £000 |
|---|---|---|---|---|
| Dental Charge income from Contractor-Led GDS & PDS | **3,831** | | **3,831** | 3,772 |
| Prescription Charge income | **2,545** | | **2,545** | 2,402 |
| Strategic Health Authorities | **0** | **0** | **0** | 164 |
| NHS Trusts | **223** | **197** | **26** | 1,398 |
| NHS Foundation Trusts | **43** | **43** | **0** | 39 |
| Primary Care Trusts - Other | **721** | **392** | **329** | 761 |
| Department of Health - Other | **1** | **0** | **1** | 0 |
| Education, Training and Research | **2,201** | **0** | **2,201** | 1,725 |
| Other Non-NHS Patient Care Services | **0** | **0** | **0** | 2 |
| Receipt of donated assets | **0** | | **0** | 17 |
| Rental revenue from operating leases | **1,970** | **1,970** | **0** | 924 |
| Other revenue | **166** | **54** | **112** | 123 |
| **Total miscellaneous revenue** | **11,701** | **2,656** | **9,045** | 11,327 |

## 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 | 38,531 | | 38,531 | 35,611 |
| Non-Healthcare | 242 | 240 | 2 | 300 |
| **Total** | 38,773 | 240 | 38,533 | 35,911 |
| **Goods and Services from Other NHS Bodies other than FTs** | | | | |
| Goods and services from NHS Trusts | 206,576 | 1,628 | 204,948 | 216,068 |
| Goods and services (other, excl Trusts, FT and PCT) | 9 | 9 | 0 | 3,547 |
| **Total** | 206,585 | 1,637 | 204,948 | 219,615 |
| Goods and Services from Foundation Trusts | 67,470 | 344 | 67,126 | 57,614 |
| Purchase of Healthcare from Non-NHS bodies | 38,336 | | 38,336 | 37,068 |
| Expenditure on Drugs Action Teams | 4,404 | | 4,404 | 3,894 |
| Non-GMS Services from GPs | 41 | 0 | 41 | 50 |
| Contractor Led GDS & PDS (excluding employee benefits) | 13,502 | | 13,502 | 13,419 |
| Chair, Non-executive Directors & PEC remuneration | 56 | 56 | 0 | 77 |
| Executive committee members costs | 708 | 626 | 82 | 497 |
| Consultancy Services | 659 | 449 | 210 | 600 |
| Prescribing Costs | 49,560 | | 49,560 | 51,397 |
| G/PMS, APMS and PCTMS (excluding employee benefits) | 42,389 | 73 | 42,316 | 41,557 |
| Pharmaceutical Services | 2,764 | | 2,764 | 2,833 |
| New Pharmacy Contract | 9,987 | | 9,987 | 9,110 |
| General Ophthalmic Services | 2,748 | | 2,748 | 2,762 |
| Supplies and Services - Clinical | 1,868 | 0 | 1,868 | 1,451 |
| Supplies and Services - General | 69 | 60 | 9 | 42 |
| Establishment | 752 | 625 | 127 | 711 |
| Premises | 1,285 | 425 | 860 | 630 |
| Impairments & Reversals of Property, plant and equipment | 47 | 47 | 0 | 1 |
| Depreciation | 1,240 | 1,201 | 39 | 1,314 |
| Impairment of Receivables | 11 | 11 | 0 | 14 |
| Audit Fees | 79 | 79 | 0 | 130 |
| Other Auditors Remuneration | 25 | 25 | 0 | 36 |
| Clinical Negligence Costs | 3 | 0 | 3 | 6 |
| Education and Training | 86 | 92 | (6) | 222 |
| Grants for capital purposes | 251 | 0 | 251 | 100 |
| Grants for revenue purposes | 1,933 | 50 | 1,883 | 1,160 |
| Other | 1,085 | 390 | 695 | 827 |
| **Total Operating costs charged to Statement of Comprehensive Net Expenditure** | 486,716 | 6,430 | 480,286 | 483,048 |
| | | | | |
| **Employee Benefits (excluding capitalised costs)** | | | | |
| PCT Officer Board Members | 544 | 544 | 0 | 517 |
| Other Employee Benefits | 8,377 | 4,753 | 3,624 | 7,259 |
| **Total Employee Benefits charged to SOCNE** | 8,921 | 5,297 | 3,624 | 7,776 |
| **Total Operating Costs** | 495,637 | 11,727 | 483,910 | 490,824 |
| | | | | |
| **Analysis of grants reported in total operating costs** | | | | |
| **For capital purposes** | | | | |
| Grants to fund Capital Projects - GMS | 251 | 0 | 251 | 100 |
| **Total Capital Grants** | 251 | 0 | 251 | 100 |
| **Grants to fund revenue expenditure** | | | | |
| To Local Authorities | 13 | 0 | 13 | 0 |
| To Private Sector | 1,920 | 50 | 1,870 | 1,126 |
| To Other | 0 | 0 | 0 | 34 |
| **Total Revenue Grants** | 1,933 | 50 | 1,883 | 1,160 |
| **Total Grants** | 2,184 | 50 | 2,134 | 1,260 |

| | Total | Commissioning Services | Public Health |
|---|---|---|---|
| **PCT Running Costs 2012-13** | | | |
| Running costs (£000s) | 9,071 | 7,444 | 1,627 |
| Weighted population (number in units)* | 292,372 | 292,372 | 292,372 |
| Running costs per head of population (£ per head) | 31 | 25 | 6 |
| | | | |
| **PCT Running Costs 2011-12** | | | |
| Running costs (£000s) | 9,341 | 7,634 | 1,707 |
| Weighted population (number in units) | 281,572 | 281,572 | 281,572 |
| Running costs per head of population (£ per head) | 33 | 27 | 6 |

## 5.2 Analysis of Operating Expenditure by Expenditure Classification

| | 2012-13 £000 | 2011-12 £000 |
|---|---|---|
| **Purchase of Primary Health Care** | | |
| GMS / PMS/ APMS / PCTMS | **42,389** | 41,557 |
| Prescribing costs | **49,560** | 51,397 |
| Contractor led GDS & PDS | **13,502** | 13,419 |
| General Ophthalmic Services | **2,748** | 2,762 |
| Pharmaceutical services | **2,764** | 2,833 |
| New Pharmacy Contract | **9,987** | 9,110 |
| Non-GMS Services from GPs | **41** | 50 |
| **Total Primary Healthcare purchased** | **120,991** | 121,128 |
| | | |
| **Purchase of Secondary Healthcare** | | |
| Learning Difficulties | **9,099** | 9,577 |
| Mental Illness | **39,705** | 38,527 |
| Maternity | **9,172** | 9,315 |
| General and Acute | **200,870** | 194,989 |
| Accident and emergency | **8,191** | 7,560 |
| Community Health Services | **54,391** | 56,431 |
| Other Contractual | **28,585** | 32,430 |
| **Total Secondary Healthcare Purchased** | **350,013** | 348,829 |
| | | |
| **Grant Funding** | | |
| Grants for capital purposes | **251** | 100 |
| Grants for revenue purposes | **1,933** | 1,160 |
| **Total Healthcare Purchased by PCT** | **473,188** | 471,217 |
| | | |
| Healthcare from NHS FTs included above | **67,109** | 57,141 |

## 6. Operating Leases

### 6.1 PCT as Lessee

The lease payments are property leases for premises used by the PCT, and lease cars for staff.

| | Buildings £000 | Other £000 | 2012-13 Total £000 | 2011-12 £000 |
|---|---|---|---|---|
| **Payments recognised as an expense** | | | | |
| Minimum lease payments | | | **563** | 91 |
| **Total** | | | **563** | 91 |
| **Payable**: | | | | |
| No later than one year | **558** | **8** | **566** | 121 |
| Between one and five years | **2,165** | **13** | **2,178** | 358 |
| After five years | **7,578** | **0** | **7,578** | 1,189 |
| **Total** | **10,301** | **21** | **10,322** | 1,668 |

### 6.2 PCT as Lessor

The leases income in 2012/13 comprises the provider properties which still belong to the PCT and are due to transfer to the local Community Trust in 2013/14, as well as provider properties not transferring.

| | 2012-13 £000 | 2011-12 £000 |
|---|---|---|
| **Recognised as income** | | |
| Rental Revenue | **1,970** | 924 |
| **Total** | **1970** | 924 |

## 7. Employee Benefits and Staff Numbers

### 7.1 Employee Benefits

| 2012-13 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Permanently employed | | | Other | | |
| | Total | Admin | Programme | Total | Admin | Programme | Total | Admin | Programme |
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Employee Benefits - Gross Expenditure** | | | | | | | | | |
| Salaries and wages | 7,527 | 4,568 | 2,959 | 6,711 | 4,161 | 2,550 | 816 | 407 | 409 |
| Social security costs | 464 | 288 | 176 | 464 | 288 | 176 | 0 | 0 | 0 |
| Employer Contributions to NHS BSA - Pensions Division | 689 | 427 | 262 | 689 | 427 | 262 | 0 | 0 | 0 |
| Other pension costs | 23 | 14 | 9 | 23 | 14 | 9 | 0 | 0 | 0 |
| Termination benefits | 218 | 0 | 218 | 218 | 0 | 218 | 0 | 0 | 0 |
| **Total employee benefits** | 8,921 | 5,297 | 3,624 | 8,105 | 4,890 | 3,215 | 816 | 407 | 409 |
| **Recognised as:** | | | | | | | | | |
| Commissioning employee benefits | 8,921 | | | 8,105 | | | 816 | | |
| **Gross Employee Benefits excluding capitalised costs** | 8,921 | | | 8,105 | | | 816 | | |

There was no employee benefits revenue.

**Employee Benefits - Prior- year**

| | Total | Permanently employed | Other |
|---|---|---|---|
| | £000 | £000 | £000 |
| **Employee Benefits Gross Expenditure 2011-12** | | | |
| Salaries and wages | 5,543 | 4,805 | 738 |
| Social security costs | 828 | 828 | 0 |
| Employer Contributions to NHS BSA - Pensions Division | 1,388 | 1,388 | 0 |
| Other pension costs | 10 | 10 | 0 |
| Termination benefits | 7 | 7 | 0 |
| **Total gross employee benefits** | 7,776 | 7,038 | 738 |
| **Recognised as:** | | | |
| Commissioning employee benefits | 7,776 | | |
| Provider employee benefits | 0 | | |
| **Gross Employee Benefits excluding capitalised costs** | 7,776 | | |

The 11/12 figures for social security costs & employer pension contributions were overstated by a total of £1,128K and the salaries & wages understated by an equal amount.

### 7.2 Staff Numbers

| | 2012-13 | | | 2011-12 | | |
|---|---|---|---|---|---|---|
| | Total | Permanently employed | Other | Total | Permanently employed | Other |
| | Number | Number | Number | Number | Number | Number |
| **Average Staff Numbers** | | | | | | |
| Medical and dental | 4 | 4 | 0 | 4 | 4 | 0 |
| Administration and estates | 76 | 74 | 2 | 71 | 70 | 1 |
| Nursing, midwifery and health visiting staff | 15 | 15 | 0 | 14 | 14 | 0 |
| Scientific, therapeutic and technical staff | 13 | 9 | 4 | 12 | 8 | 4 |
| Social Care Staff | 3 | 0 | 3 | 28 | 0 | 28 |
| Other | 51 | 34 | 17 | 43 | 33 | 10 |
| TOTAL | 162 | 136 | 26 | 172 | 129 | 43 |

## 7.3 Staff Sickness Absence and Ill Health Retirements

| | 2012-13 Number | 2011-12 Number |
|---|---|---|
| Total days lost | **1,307** | 4,555 |
| Total staff years | **260** | 515 |
| Average working days lost | **5.0** | 8.8 |

Sickness absence information, provided by the Department of Health is for a calendar year i.e. the 12/13 figures are for Jan-Dec 2012. The 11/12 figures include Apr-Jun 2011 figures for provider staff who transferred to the new Community Trust when it was established in July 2011.

There were no early retirements on ill-health grounds.

## 7.4 Exit Packages Agreed During 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 | **1** | **0** | **1** | 1 | 0 | 1 |
| £50,001-£100,000 | **1** | **0** | **1** | 1 | 0 | 1 |
| £100,001 - £150,000 | **1** | **0** | **1** | 1 | 0 | 1 |
| **Total number of exit packages by type (total cost** | **3** | **0** | **3** | 3 | 0 | 3 |
| | **£000s** | **£000s** | **£000s** | **£000s** | **£000s** | **£000s** |
| **Total resource cost** | **218** | **0** | **218** | 190 | 0 | 190 |

Redundancy and other departure costs have been paid in accordance with the provisions of NHS Agenda for Change rules on pay. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed during the year. 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 Trust 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) Resource Account, published annually. These accounts can be viewed on the NHS Pensions

**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

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.

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

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

# 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 | **8,938** | **54,804** | 8,496 | 57,115 |
| Total Non-NHS Trade Invoices Paid Within Target | **8,252** | **51,767** | 7,818 | 50,475 |
| Percentage of NHS Trade Invoices Paid Within Target | **92.3%** | **94.5%** | 92.0% | 88.4% |
| **NHS Payables** | | | | |
| Total NHS Trade Invoices Paid in the Year | **3,719** | **326,220** | 3,037 | 308,224 |
| Total NHS Trade Invoices Paid Within Target | **2,654** | **315,565** | 1,955 | 301,810 |
| Percentage of NHS Trade Invoices Paid Within Target | **71.4%** | **96.7%** | 64.4% | 97.9% |

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.

## 9. Other Gains and Losses

| | 2012-13 Total £000 | 2012-13 Admin £000 | 2012-13 Programme £000 | 2011-12 £000 |
|---|---|---|---|---|
| Gain/(loss) on disposal of assets other than by sale (PPE) | (715) | 0 | (715) | (1) |
| **Total** | (715) | 0 | (715) | (1) |

## 10. Finance Costs

| | 2012-13 Total £000 | 2012-13 Admin £000 | 2012-13 Programme £000 | 2011-12 £000 |
|---|---|---|---|---|
| Provisions - unwinding of discount | 15 | | 15 | 20 |
| **Total** | 15 | 0 | 15 | 20 |

## 11.1 Property, Plant and Equipment

| 2012-13 | Land | Buildings excluding dwellings | Assets under construction and payments on account | Plant & machinery | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Cost or valuation:** | | | | | | | |
| **At 1 April 2012** | **8,072** | **24,972** | **0** | **290** | **1,753** | **42** | **35,129** |
| Additions of Assets Under Construction | | | 301 | | | | **301** |
| Additions Purchased | 0 | 255 | | 0 | 172 | 0 | **427** |
| Reclassifications as Held for Sale | (1,000) | 0 | 0 | 0 | 0 | 0 | **(1,000)** |
| Disposals other than for sale | 0 | (715) | 0 | (255) | (279) | 0 | **(1,249)** |
| Upward revaluation/positive indexation | 0 | 20 | 0 | 0 | 0 | 0 | **20** |
| Impairments/negative indexation | 0 | (141) | 0 | 0 | 0 | 0 | **(141)** |
| **At 31 March 2013** | **7,072** | **24,391** | **301** | **35** | **1,646** | **42** | **33,487** |
| **Depreciation** | | | | | | | |
| **At 1 April 2012** | **0** | **0** | **0** | **275** | **755** | **10** | **1,040** |
| Disposals other than for sale | 0 | 0 | | (255) | (279) | 0 | **(534)** |
| Impairments | 0 | 47 | 0 | 0 | 0 | 0 | **47** |
| Charged During the Year | 0 | 969 | | 11 | 256 | 4 | **1,240** |
| **At 31 March 2013** | **0** | **1,016** | **0** | **31** | **732** | **14** | **1,793** |
| **Net Book Value at 31 March 2013** | **7,072** | **23,375** | **301** | **4** | **914** | **28** | **31,694** |
| Purchased | 7,072 | 22,517 | 301 | 4 | 914 | 28 | **30,836** |
| Donated | 0 | 836 | 0 | 0 | 0 | 0 | **836** |
| Government Granted | 0 | 22 | 0 | 0 | 0 | 0 | **22** |
| **Total at 31 March 2013** | **7,072** | **23,375** | **301** | **4** | **914** | **28** | **31,694** |
| **Asset financing:** | | | | | | | |
| Owned | 7,072 | 21,880 | 301 | 4 | 914 | 28 | **30,199** |
| Held on finance lease | 0 | 1,495 | 0 | 0 | 0 | 0 | **1,495** |
| **Total at 31 March 2013** | **7,072** | **23,375** | **301** | **4** | **914** | **28** | **31,694** |

**Revaluation Reserve Balance for Property, Plant & Equipment**

| | Land | Buildings | Assets under construction & payments on account | Plant & machinery | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|
| | £000's | £000's | £000's | £000's | £000's | £000's | £000's |
| **At 1 April 2012** | **1,820** | **8,392** | **0** | **10** | **0** | **2** | **10,224** |
| Movements (DV revaluation & indexation) | 0 | (281) | 0 | (10) | 0 | (2) | **(293)** |
| **At 31 March 2013** | **1,820** | **8,111** | **0** | **0** | **0** | **0** | **9,931** |

## 11.2 Property, Plant and Equipment

| 2011-12 | Land | Buildings excluding dwellings | Assets under construction and payments on account | Plant & machinery | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Cost or valuation:** | | | | | | | |
| **At 1 April 2011** | **8,073** | **28,968** | **456** | **290** | **1,539** | **42** | **39,368** |
| Additions - purchased | 0 | 528 | 100 | 0 | 220 | 0 | **848** |
| Additions - donated | 0 | 17 | 0 | 0 | 0 | 0 | **17** |
| Reclassifications | 0 | 556 | (556) | 0 | 0 | 0 | **0** |
| Reclassified as held for sale | 0 | 0 | 0 | 0 | (6) | 0 | **(6)** |
| Revaluation & indexation gains | 0 | 1,437 | 0 | 0 | 0 | 0 | **1,437** |
| Impairments | 0 | (1) | 0 | 0 | 0 | 0 | **(1)** |
| Cumulative dep netted off cost following revaluatio | (1) | (6,533) | 0 | 0 | 0 | 0 | **(6,534)** |
| **At 31 March 2012** | **8,072** | **24,972** | **0** | **290** | **1,753** | **42** | **35,129** |
| | | | | | | | |
| **Depreciation** | | | | | | | |
| **At 1 April 2011** | **0** | **5,542** | | **217** | **498** | **5** | **6,262** |
| Reclassifications as Held for Sale | 0 | 0 | | 0 | (3) | 0 | **(3)** |
| Impairments | 1 | 0 | 0 | 0 | 0 | 0 | **1** |
| Charged During the Year | 0 | 991 | | 58 | 260 | 5 | **1,314** |
| Cumulative dep netted off cost following revaluatio | (1) | (6,533) | 0 | 0 | 0 | 0 | **(6,534)** |
| **At 31 March 2012** | **0** | **0** | **0** | **275** | **755** | **10** | **1,040** |
| **Net Book Value at 31 March 2012** | **8,072** | **24,972** | **0** | **15** | **998** | **32** | **34,089** |
| | | | | | | | |
| Purchased | 8,072 | 24,039 | 0 | 15 | 998 | 32 | **33,156** |
| Donated | 0 | 911 | 0 | 0 | 0 | 0 | **911** |
| Government Granted | 0 | 22 | 0 | 0 | 0 | 0 | **22** |
| **At 31 March 2012** | **8,072** | **24,972** | **0** | **15** | **998** | **32** | **34,089** |
| | | | | | | | |
| **Asset financing:** | | | | | | | |
| Owned | 8,072 | 24,972 | 0 | 15 | 998 | 32 | **34,089** |
| **At 31 March 2012** | **8,072** | **24,972** | **0** | **15** | **998** | **32** | **34,089** |

## 11.3 Property, Plant and Equipment

The PCT's land and buildings includes properties used by Shropshire Community Health NHS Trust. These will not transfer to them until 2013/14.

The last full revaluation of land and building assets was undertaken by Jon Jones MRICs of the Valuation Office agency with an effective date of 30th September 2009.

Each year since then, desk-top revaluations of the same assets have been undertaken by Jon Jones MRICS of the Valuation Office. BCIS indices are used to reflect changes in value of other assets not previously valued, and where there has been capital expenditure since the 2009 valuation date.

Asset lives for each class of asset fall into the following ranges :-

- Buildings : 2 to 80 years
- Plant & machinery : 5 to 15 years
- Transport equipment : 7 years
- Information technology : 2 to 5 years
- Furniture & fittings : 10 years

No asset lives have been changed during the year.

## 12. Analysis of Impairments and Reversals Recognised in 2012-13

| | 2012-13 Total £000 | 2012-13 Admin £000 | 2012-13 Programme £000 |
|---|---|---|---|
| **Property, Plant and Equipment impairments and reversals taken to SoCNE** | | | |
| Loss or damage resulting from normal operations | 47 | 47 | 0 |
| **Total charged to Departmental Expenditure Limit** | **47** | **47** | **0** |
| | | | |
| **Property, Plant and Equipment impairments and reversals charged to the revaluation reserve** | | | |
| Changes in market price | 141 | | |
| **Total impairments for PPE charged to reserves** | **141** | | |
| | | | |
| **Total Impairments of Property, Plant and Equipment** | **188** | **47** | **0** |

There were no impairments or reversals relating to intangible assets, financial assets, assets held for sale, inventories or investment property.

The impairments above did not relate to donated or government grant assets.

There were no significant impairment losses.

## 13. Commitments

### 13.1 Capital Commitments

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

| | **31 Mar 2013** | 31 Mar 2012 |
|---|---|---|
| | **£000** | £000 |
| Property, plant and equipment | **49** | 0 |
| **Total** | **49** | **0** |

## 14. Intra-Government and Other Balances

| | **Current receivables £000s** | **Current payables £000s** |
|---|---|---|
| Balances with other Central Government Bodies | **359** | **937** |
| Balances with Local Authorities | **709** | **4,616** |
| Balances with NHS Trusts and Foundation Trusts | **827** | **4,131** |
| Balances with bodies external to government | **2,070** | **17,919** |
| **At 31 March 2013** | **3,965** | **27,603** |
| | | |
| **Prior period:** | | |
| Balances with other Central Government Bodies | 423 | 401 |
| Balances with Local Authorities | 635 | 2,734 |
| Balances with NHS Trusts and Foundation Trusts | 1,641 | 7,008 |
| Balances with Public Corporations & Trading Funds | 113 | 487 |
| Balances with bodies external to government | 1,824 | 17,119 |
| **At 31 March 2012** | 4,636 | 27,749 |

## 15.1 Trade and Other Receivables

| | Current | | | |
|---|---|---|---|---|
| | **31 Mar 2013** | 31 Mar 2012 | | |
| | **£000** | £000 | | |
| NHS receivables - revenue | **1,126** | 2,064 | | |
| NHS prepayments and accrued income | **27** | 0 | | |
| Non-NHS receivables - revenue | **2,021** | 1,787 | | |
| Non-NHS prepayments and accrued income | **755** | 672 | | |
| VAT | **33** | 113 | | |
| Other receivables | **3** | 0 | **0** | 0 |
| **Total** | **3,965** | 4,636 | | |

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

## 15.2 Receivables Past Their Due Date But Not Impaired

| | **31 Mar 2013** | 31 Mar 2012 |
|---|---|---|
| | **£000** | £000 |
| By up to three months | **59** | 284 |
| By three to six months | **0** | 3 |
| By more than six months | **18** | 12 |
| **Total** | **77** | 299 |

## 15.3 Provision for Impairment of Receivables

| | **2012-13** | 2011-12 |
|---|---|---|
| | **£000** | £000 |
| **Balance at 1 April 2012** | **0** | (136) |
| Amount written off during the year | **11** | 150 |
| (Increase)/decrease in receivables impaired | **(11)** | (14) |
| **Balance at 31 March 2013** | **0** | 0 |

## 16. Cash and Cash Equivalents

| | **31 Mar 2013** | 31 Mar 2012 |
|---|---|---|
| | **£000** | £000 |
| **Opening balance** | **242** | 0 |
| Net change in year | **(237)** | 242 |
| **Closing balance** | **5** | 242 |
| | | |
| **Made up of** | | |
| Cash with Government Banking Service | **5** | 242 |
| **Cash and cash equivalents as in statement of financial position** | **5** | 242 |
| **Cash and cash equivalents as in statement of cash flows** | **5** | 242 |

## 17. 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** | **30** | **50** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **80** |
| Plus assets classified as held for sale in the year | **1,000** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **1,000** |
| Less assets sold in the year | **(1,030)** | **(50)** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **(1,080)** |
| **Balance at 31 March 2013** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| **Balance at 1 April 2011** | 30 | 50 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 80 |
| Plus assets classified as held for sale in the year | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 0 | 0 | 3 |
| Less assets sold in the year | 0 | 0 | 0 | 0 | 0 | 0 | (3) | 0 | 0 | (3) |
| **Balance at 31 March 2012** | 30 | 50 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 80 |

**Revaluation reserve balances in respect of non-current assets held for sale were:**

| | |
|---|---|
| At 31 March 2012 | 71 |
| At 31 March 2013 | 0 |

The asset held for sale which was brought forward from the previous year and subsequently sold is a former clinic which became surplus to requirements.

The land that became classified as held for sale in the year and subsequently sold was the land for building the new Ludlow healthcare facility which was transferred to the local Community Trust as they are responsible for the scheme.

The equipment that was classed as held for sale and subsequently sold, both in this year was office/IT equipment which was no longer required.

## 18. Trade and Other Payables

| | Current | |
|---|---|---|
| | **31 Mar 2013** | 31 Mar 2012 |
| | **£000** | £000 |
| NHS payables - revenue | **4,477** | 7,409 |
| Family Health Services (FHS) payables | **8,655** | 8,699 |
| Non-NHS payables - revenue | **4,023** | 1,233 |
| Non-NHS payables - capital | **309** | 483 |
| Non_NHS accruals and deferred income | **6,556** | 6,647 |
| Social security costs | **93** | 61 |
| Tax | **131** | 70 |
| Other | 3,359 | 3,147 |
| **Total** | **27,603** | 27,749 |
| Total payables (current and non-current) | **27,603** | 27,749 |

## 19. Provisions

| | Total £000s | Pensions to Former Directors £000s | Pensions Relating to Other Staff £000s | Legal Claims £000s | Continuing Care £000s | Other £000s |
|---|---|---|---|---|---|---|
| **Balance at 1 April 2012** | **3,651** | 59 | 530 | 107 | 2,085 | 870 |
| Arising During the Year | **337** | 6 | 68 | 2 | 0 | 261 |
| Utilised During the Year | **(1,037)** | (7) | (66) | (108) | (277) | (579) |
| Reversed Unused | **(706)** | 0 | 0 | (1) | (607) | (98) |
| Unwinding of Discount | **15** | 1 | 14 | 0 | 0 | 0 |
| **Balance at 31 March 2013** | **2,260** | **59** | **546** | **0** | **1,201** | **454** |
| | | | | | | |
| **Expected Timing of Cash Flows:** | | | | | | |
| No Later than One Year | **700** | **7** | **66** | **0** | **432** | **195** |
| Later than One Year and not later than Five Years | **1,322** | **29** | **264** | **0** | **769** | **260** |
| Later than Five Years | **238** | **23** | **216** | **0** | **0** | **(1)** |

Amount included in the provisions of the NHS Litigation Authority in respect of Clinical Negligence liabilities:

| | |
|---|---|
| **As at 31 March 2013** | 200 |
| **As at 31 March 2012** | 9 |

"Other" provisions are made up of:
Prescribing Incentive Scheme £454k

## 20. Contingencies

| | 31 Mar 2013 £000 | 31 Mar 2013 £000 |
|---|---|---|
| **Contingent liabilities** | | |
| Other (employers/public liability claims) | **0** | (1) |
| **Net Value of Contingent Liabilities** | **0** | (1) |

## 21. 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 risk.

**Currency risk**
The PCT is 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.

## 21.1 Financial Assets

| | Loans and receivables |
|---|---|
| | £000 |
| Receivables - NHS | **1,153** |
| Receivables - non-NHS | **2,024** |
| Cash at bank and in hand | **5** |
| **Total at 31 March 2013** | **3,182** |
| Receivables - NHS | 2,064 |
| Receivables - non-NHS | 1,787 |
| Cash at bank and in hand | 242 |
| **Total at 31 March 2012** | 4,093 |

## 21.2 Financial Liabilities

| | Other |
|---|---|
| | £000 |
| NHS payables | **4,477** |
| Non-NHS payables | **10,905** |
| **Total at 31 March 2013** | **15,382** |
| NHS payables | 7,409 |
| Non-NHS payables | 8,410 |
| **Total at 31 March 2012** | 15,819 |

## 22. Related Party Transactions

Details of related party transactions with individuals who exercise control over the PCT are as follows.

The following transactions are GMS and PMS payments made to GP practices where GPs are PCT Board, CCG Board or CAP members.

| GP Practice | Board/PEC/CCG Member | 2012/13 Payments* £000 |
|---|---|---|
| Ludlow (Portcullis) | Catherine Beanland | 825 |
| Pontesbury | Julian Povey | 1,146 |
| Shrewsbury (Mount Pleasant) | Peter Clowes | 863 |
| Shropshire Walk-In Centre | Stephen James | 1,106 |
| Worthen | Kieran McCormack | 341 |

* including year end creditors

In addition, Shropdoc (the out of hours GP service) is regarded as a related party as the GPs above are members. Total payments to Shropdoc in 12/13 were £4,724,000.

There were no other PCT Board, CCG Board or CAP members or employees with a declared interest.

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

Birmingham East & North PCT
RJAH Orthopaedic Hospital NHS Foundation Trust
Shrewsbury & Telford Hospitals NHS Trust
Shropshire Community Health NHS Trust
South Staffordshire & Shropshire Healthcare NHS Foundation Trust
West Midlands Ambulance Service NHS Foundation Trust

In addition, the PCT has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Shropshire Council in respect of joint enterprises.

The PCT has also had transactions with Shropshire Community Health NHS Trust in relation to charitable funds as, for administrative reasons, they manage Shropshire County PCT's charitable funds.

## 23. 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 | **11,355** | **2** |
| Special payments - PCT management costs | **10,000** | **1** |
| **Total losses and special payments** | **21,355** | **3** |

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 | 13,900 | 1 |
| Special payments - PCT management costs | 10,952 | 2 |
| **Total losses and special payments** | 24,852 | 3 |

There were no cases over £250,000.

## 24. Events After the Reporting Period

The main functions carried out by the PCT in 2012/13 are to be carried out in 2013/14 by the following public sector bodies. Revenue values where significant are given:

Shropshire County CCG (£364m)
NHS England (£97m)
NHS Property Services (£0.5m)
Shropshire Council (£8.2m)
Public Health England (£1m)

Assets and liabilities transferred in connection with the transfer of functions are:

Shropshire Community Health NHS Trust (assets £15.3m)
NHS Property Services (assets £14.8m)
South Staffordshire & Shropshire NHS Foundation Trust (assets £0.7m)
NHS England (liabilities £0.5m)
Department of Health (liabilities £10.7m)
Shropshire County CCG (liabilities £13.8m)