Telford and Wrekin Primary Care Trust

2012-13 Annual Report and Accounts

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Telford and Wrekin Primary Care Trust

2012-13 Annual Report

NHS
Telford and Wrekin

NHS Telford and Wrekin
Annual Report 2012/13

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	Page
Message from Graham Urwin, Chief Executive, NHS Telford & Wrekin	2
About us, who we are and what we do	4
How we performed in 2012/13	6
Achievements	9
Safety and environment	12
Quality through QIPP	14
Make your voice heard	16
How we work in partnership	18
A healthy future for us all	19
Our staff	21
Looking forward	23
Summary of financial statement and remuneration	38

Message from Graham Urwin, Chief Executive

Welcome to your annual report for NHS Telford and Wrekin, 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.

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

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. Telford and Wrekin 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 Telford and Wrekin 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 activities continue to build. Patient Participation Groups (PPGs) are now active in 18 of the 22 practices across Telford and Wrekin. 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 has responded to. We are working across the health economy in Staffordshire and 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 12 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 NHS Telford and Wrekin

About us, who we are and what we do

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

NHS Telford and Wrekin, 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.

The PCT covers the geographical boundaries of Telford and Wrekin Council – a Unitary Authority covering 112 square miles with a population of approximately 167,000 people. At its heart is the modernized Telford Town Centre, which is the local focus for both population and economic growth.

The Telford and Wrekin area also has older market towns including Wellington, Dawley, Donnington, Madeley and Oakengates. To the north of Telford is the market town of Newport and to the south, on the bank of the River Severn, is the World Heritage Site of Ironbridge. Although Telford is the hub of the area's economy and population, there is a significant rural area to the north and west of Telford which covers around 72% of Telford and Wrekin's total area. There are also significant deprivation and inequality issues within Telford and Wrekin.

NHS Telford and Wrekin's vision

"We will improve the health and life expectancy of the population of Telford and Wrekin, reduce inequalities and support people in improving their own health. We will meet people's health care needs through the provision of safe, high quality services that are closer to home and achieve the best value from NHS resources."

The goals to support the delivery of this vision are:

- To improve the health and wellbeing of children.
- To improve life expectancy and reduce health inequalities.
- To improve access to quality care closer to home.
- To improve patient and public involvement.

In 2012/13 the PCT had a turnover of £279 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 its 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 Chief Executive and Accountable Officer in October.

2012/13 is the final year that NHS Telford and Wrekin will be responsible for all local NHS services. We pay for 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 Telford and Wrekin and also pay for hospital care on behalf of patients registered with Telford and Wrekin 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 the Telford and Wrekin area that will be authorised by March 2013 without conditions. This essentially means that, from April 2013 when the PCTs are dissolved, Telford and Wrekin CCG will take on its full statutory responsibilities, which is described as 'full authorisation'. Legally this is described as 'established without conditions'.

Telford and Wrekin 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 continues 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 Telford and Wrekin are Shrewsbury and Telford Hospitals NHS Trust (SaTH).

Serving patients in a variety of community settings, 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 Telford and Wrekin CCG.

Public Health Transition

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

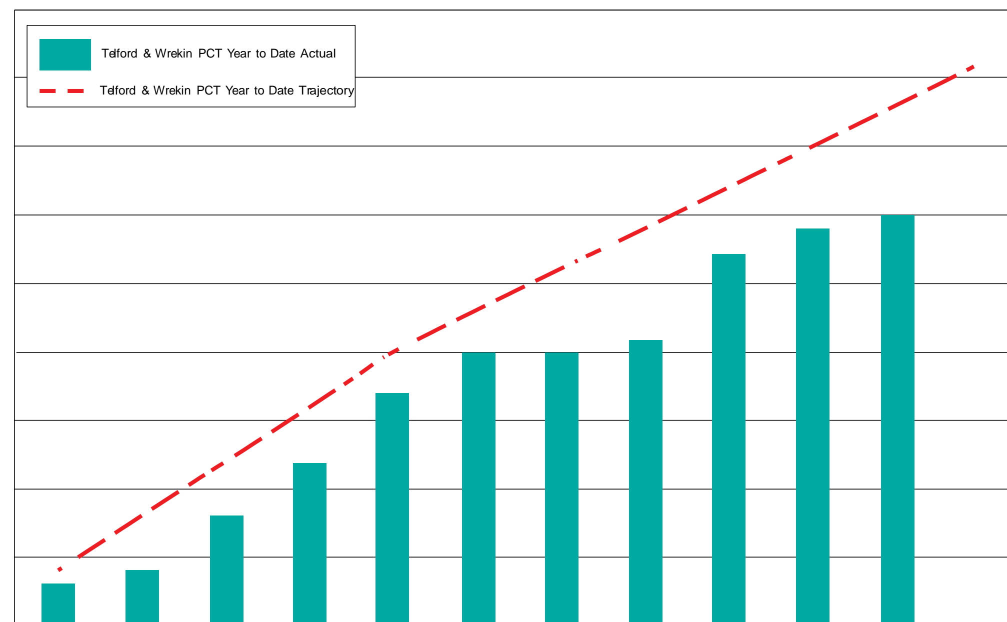
How we performed in 2012/13

Maintaining strong clinical governance is vital at NHS Telford and Wrekin.

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.

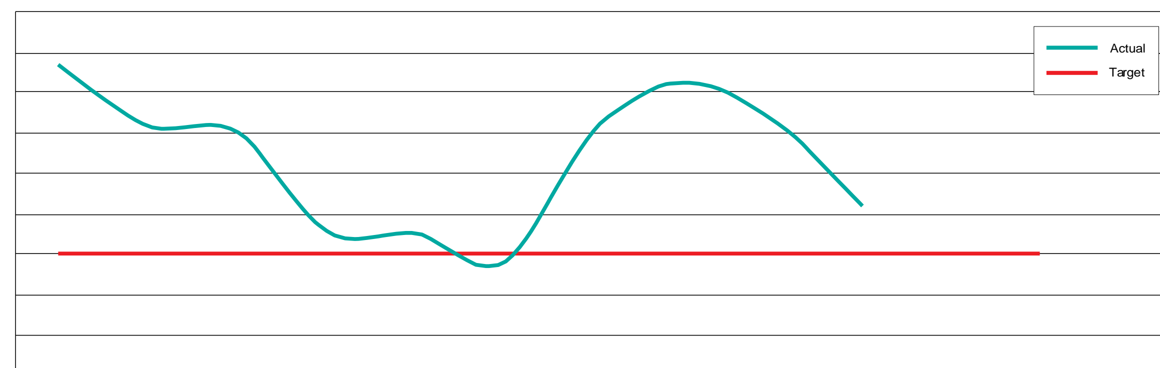
Incidence of Clostridium difficile

NHS Telford and Wrekin has continued to focus on reducing incidences of C diff infection.



Cancer two-week wait from GP referral

The PCT achieved the cancer two week wait target for nine out of 10 months (up to January 2013).



Performance achieved year to date (YTD)

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%	95% (Feb)
Cancer two week wait from GP referral (symptomatic breast)	93%	94.7% (Feb)
Cancer 31 day (one month) wait to first definitive treatment	96%	98.2% (Jan)
31 day standard for subsequent cancer treatments (drug)	98%	99.5% (Jan)
31 day standard for subsequent cancer treatments	94%	96% (Jan)
Cancer 62 day (two month) wait from urgent referral to treatment	85%	85.8% (Jan)
Cancer 62 day wait (referral from NHS Cancer Screening	90%	92.5% (Jan)
Referral to Treatment (non-admitted)	95%	96.6% (Jan)
Stroke Care – time spent in hospital on a stroke unit	80%	83.6% up to quarter three
Stroke Care – suspected TIAs assessed and treated within 24	60%	72.1% up to quarter three
Maternity 12 weeks	90%	100%
Mental health measure – the care programme approach	95%	95.5% (Jan)
Mental Health Crisis Resolution	95%	100% up to quarter three
MRSA bacteraemia	1 cases	0 cases (Jan)
Cdiff	41 cases	29 cases
NHS health checks (offered)	20% plan	22.86% up to quarter three
NHS health checks (received)	10% plan	9.98% plan up to quarter three
Mixed Sex accommodation breaches	0 breaches	0 breaches
Smoking quitters	1875 quitters	1289 quitters up to quarter three

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Performance measures not achieving (YTD)

What	Target	Achieved (as at January 2013 unless otherwise stated)
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 Telford and Shropshire 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.

NHS Telford and Wrekin 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 Telford and Wrekin 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.

NHS Telford & Wrekin

Total number of SIs reported during 2012/13	Number reported on behalf of external independent providers	Number of Information Governance incidents level 3-5
1	0	0

One internal confidential information leak, contained with the PCT.

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:

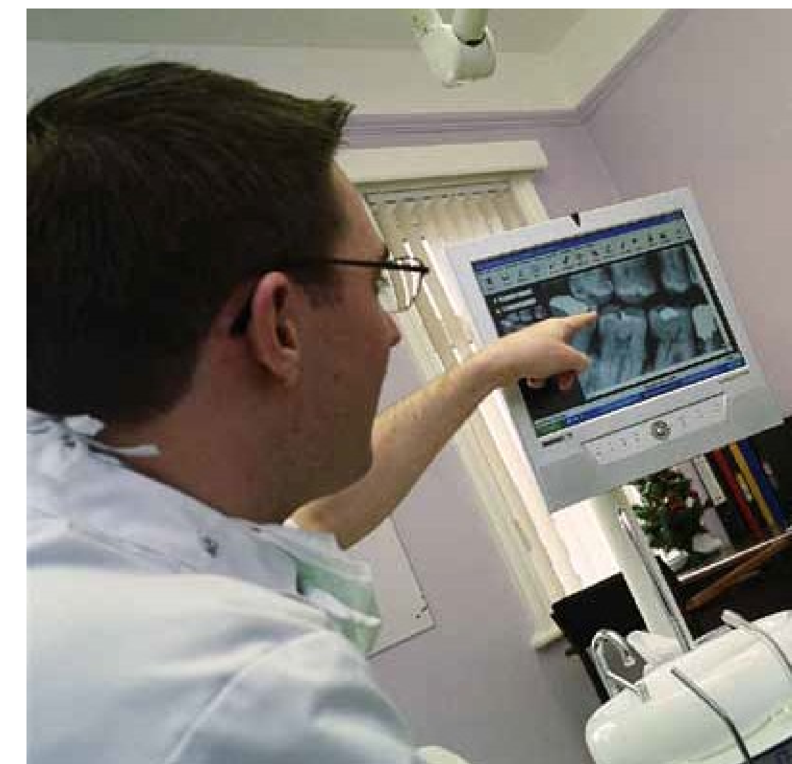
- Safe and Sustainable Children's Heart Surgery and Neurosurgery Services Review.
- Adult Congenital Heart Disease Standards.
- Implementation of Trauma Care System.
- Commissioning intentions workshop.
- Intestinal Failure Peer Review.
- Child and Adolescent Mental Health Tier 4 Service.

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.

Dental

NHS Telford and Wrekin 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.



2. The review into how neurological services are delive

red 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.

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 Telford and Wrekin and Shropshire 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. In 2012-13, NHS Telford and Wrekin invested over £285,000 in grants to 11 practices to meet the standards required by the Care Quality Commission.

Environmental Footprint

Work continued to make a positive difference to the communities served by NHS Telford and Wrekin. 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

As a commissioner of services, an employer and a user of products and services, the PCT is in a position to directly and indirectly influence the sustainability agenda. As part of the move to CCG authorization – a sustainable development plan was agreed. This set out the commitments and roles of respective organisations as 'exemplary corporate citizens' including the following areas:

- Travel.
- Healthcare and non-healthcare procurement.
- Buildings and facilities management.
- Workforce education.
- Community engagement.

Estates Development

The capital resource allowance allocated to NHS Telford and Wrekin 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.

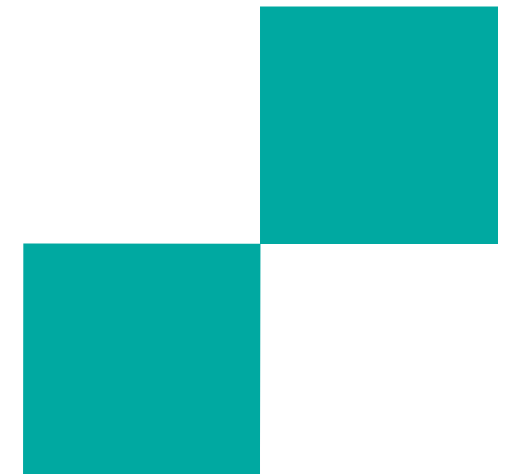
Equality and Diversity

NHS Telford and Wrekin firmly believe that equality and diversity is vital to its success. These opportunities are also essential in delivering care that is accessible, appropriate and responsive to meeting the diverse needs of everyone concerned.

To achieve these goals, it is more important than ever that staff and users of services are treated fairly and with dignity and respect. They should also be involved and considered in every aspect of change that could affect their employment or health care.

NHS Telford and Wrekin consider this to be fundamental to all employment practices and service provision across the business, from Board to grass roots level – from planning to delivery. The PCT firmly believes in equality of opportunity and recognises the benefits of having a diverse and culturally competent workforce that engages with local community interest groups. This is key to commissioning and providing the best possible care for all.

Over the last year, mandatory staff training sessions on equality and diversity have been held – an approach followed in the PCT Equal Opportunities Policy and Procedure.



Quality through QIPP

What is QIPP?

The Quality, Innovation, Productivity and Prevention (QIPP) is a national programme that aims to:

- Improve quality.
- Make innovative service changes.
- Reduce waste by improving the productivity of services.
- Focus on 'up stream' support to prevent ill health rather than deal with the consequences.

The NHS needs to achieve up to £20 billion of efficiency savings by 2015, which will be reinvested back into frontline care. Telford and Wrekin has to find £28 million of this. Every saving made will be put back into patient care by supporting frontline staff, funding innovative treatments and giving patients more choice.

NHS Telford and Wrekin is on target to save £4 million in 2012/13 through the achievements summarised below.

QIPP Achievements

Planned care

The CCG developed a new referral management service called the Telford Referral and Quality Service (TRAQs).

This offers patients choice and ensures only CCG commissioned procedures and pathways are used. It also maintains a high standard of referral to improve the quality of care.

There has been an extensive programme for the redesign of clinical pathways, led by our local GPs. This is to deliver our vision of reducing activity in secondary care, by providing more out-patient services e.g. dermatology in the community, that are closer to home and at a reduced cost.

We have also stopped commissioning procedures of limited clinical value and reviewed and updated the consultant-to-consultant policy.

Urgent Care

Our patients told us:

- Help me understand the urgent care service.
- Let me access it appropriately.
- Assess and treat me promptly and in the right place.
- Admit me to hospital only when necessary.
- Make my stay in hospital short, safe and effective.
- Try to care for me at home, even when I'm ill.

This is why our QIPP programme has worked on improving patient information; offering more care closer to home and developing a new service to support patients who are frail and/or have complex needs. This is helping us to avoid unnecessary admissions and facilitate prompter discharges.

We have saved money by reducing emergency medical admissions and 'excess bed days'.

Medicines Management QIPP

During 2012/13 NHS Telford and Wrekin focused on the national Medicines Management QIPP indicators. These indicators balance quality and cost with respect to prescribing recommendations. All of the indicators are evidence-based, clear, easily understood and applicable at practice level.

Examples of what the national QIPP indicators helped NHS Telford and Wrekin to achieve during 2012/13 include:

- 9.5% reduction in the volume of hypnotic prescribing. Risks associated with the long-term use of hypnotics include falls, accidents, cognitive impairment, dependence and withdrawal symptoms. A recent study suggested that these drugs may also increase the risk of dementia.

  that increase the risk of MRSA, Clostridium difficile

- Over a 20.5% relative reduction in antibiotics prescribed as cephalosporins, quinolones and co-amoxiclav. These are all broad spectrum antibiotics
- 3.3% absolute reduction in insulins prescribed as detemir and glargine. This has improved our compliance with the National Institute for Health and Care Excellence (NICE) clinical guideline on type 2 diabetes, which recommends that when insulin therapy is necessary, human NPH (isophane) insulin is the preferred option. Long acting analogues (i.e. detemire and galrgine) should not be used routinely, but should be reserved for patients who meet the NICE criteria.
- 9% reduction in Non-Steroidal Anti-Inflammatory Drugs (NSAID) prescribing. There are long standing and there are well recognised gastrointestinal and renal safety concerns with all NSAIDs. There is also an increased risk of cardiovascular events with many NSAIDs, including COX-2 inhibitors and diclofenac.

In addition to the improved quality of prescribing, the national Medicines Management QIPP indicators helped NHS Telford and Wrekin achieve savings in excess of £1 million against the primary care prescribing budget during 2012/13.

ealth

We have introduced a Rapid Assessment Interface Discharge (RAID) service, to offer better quality care to patients with mental health needs who are in an acute hospital. This scheme has a strong evidence base for its patient-centred approach and the ability to save money – by making sure patients do not stay too long in an acute environment – when their needs could be met more appropriately in the community.

The two elements of the RAID model are in place, which are:

1. Training of staff to improve quality of care and understand the benefits of early discharge.
2. The creation of the RAID Team to complete rapid assessments within one hour in the emergency department and ambulatory medical units. The team was fully operational from January 2013 so significant savings are yet to materialise. The quality of care and experience of both patients and staff has improved.

that increase the risk of MRSA, Clostridium difficile

Make your voice heard

Patient Experience

Quality monitoring of patient experience is carried out regularly and forms part of the Quality Report made to the PCT Boards and Cluster Quality Committee.

Provider patient experience is currently being monitored through patient experience reports from their respective Clinical Quality Review Meetings (CQRM) and through quality visits from Cluster staff, which includes a specific element on feedback about patient experience and treatment.

Any feedback from the above is assessed for its level of concern and if the concern is an issue of patient safety then immediate action is taken between the Cluster and the provider – whilst other concerns are addressed through the provider's CQRM.

Patient experience logged through the DATIX system is discussed at the monthly meeting of the Triangulation Group which has representatives from PALS, Complaints, Purple Cards (provider incidents), Safeguarding and Serious Incidents.

In NHS Telford and Wrekin PPGs have been established. The individual PPGs feed into the Telford and Wrekin PPG network and then link into the newly established Telford and Wrekin Health Roundtable.

To broaden the spectrum of patient involvement, the CCG links into the Local Authority Community Panel, which is sent out four times a year to registered members living in the Borough.

Patient Advice and Liaison Service (PALS)

PALs is integral to NHS Telford and Wrekin's commitment to working closely with patients and staff to improve services. All enquiries received through PALS are recorded on the DATIX system and used in the ongoing programme of service improvement.

This 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 2012/13 152 contacts were received through PALS – and most of these were requests for information.

Complaints

Last year, NHS Telford and Wrekin received 58 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.

Consultations

NHS Telford and Wrekin has supported 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

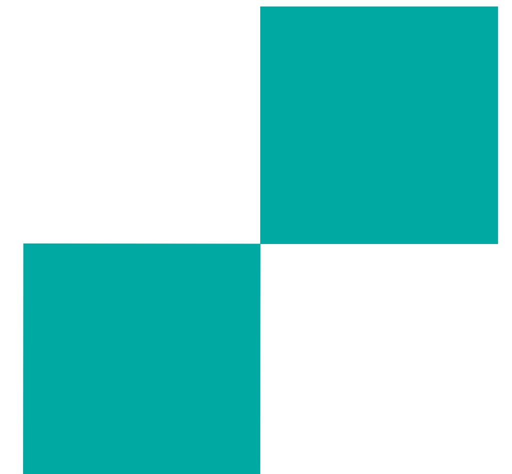
With the NHS Reforms and the establishment of the Telford and Wrekin CCG, patients and the public are now at the heart of all service improvements and processes, making patients central to the decision making process, from practice to board level.

During 2012/2013, the emphasis on public and patient involvement has been to establish a structure for these activities in the Telford and Wrekin area. Our work this year has seen:

- The formation of the Telford and Wrekin Health Roundtable. Membership is made up of local patients, elected by their own networks to sit on this sub-group of the Clinical Commissioning Board.
- The initiation and development of PPGs, resulting in 20 groups out of 22 practices. Two PPG Network Meetings have been held attended by representatives from each PPG.
- The development of focus groups to look at service development and redesign, including urgent care and transgender.
- 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 by using a specially designed App.
- Ongoing engagement with our long term condition support group, with quarterly chit chat drop in events. This way of engaging with patients was developed from the self care management programmes previously delivered.
- Building on the foundations of the long term conditions reference group. A small group of patients with long term conditions are helping to develop the long term conditions strategy for the CCG.
- Patient representation on the project board for local implementation of NHS 111 and involving them in communicating and engaging with the general public about the new service.

Local partners

Telford and Wrekin CCG will continue to work with the Local Authority, Telford and Wrekin LINks, Telford and Wrekin Youth LINk and the newly established Healthwatch – as well as all voluntary organisations.



How we work in partnership

Telford and Wrekin CCG has worked closely with Telford and Wrekin Council to establish the Health and Wellbeing Board (HWBB) to improve how we work collaboratively on the JSNA and agree the local Health and Wellbeing Strategy. There is a strong tradition of joint commissioning in Telford and both organisations are keen to build on this to develop a co-operative approach to shared priorities.

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

Telford and Wrekin and Shropshire CCGs have worked together with local NHS providers and the two Local Authorities to develop 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

Overall the health of the local population is improving, but there are still clear health inequalities. NHS Telford and Wrekin and the Public Health Department have been working with the council, the CCG and other partners, to develop local lifestyle and preventative programmes.

The key developments during 2012/13 are:

Healthy Lifestyles Hub at First Point, Telford

This gives the public access to: health information; telephone advice and signposting; face to face brief interventions; health trainer support and onward referral to specialist programmes for weight management. Other services at the hub include; physical activity, smoking cessation, alcohol advice and emotional health and wellbeing guidance.

Making Every Contact Count (MECC) programme

MECC initially focused on training frontline staff in local hospital and community settings, to deliver brief advice across a range of issues. These include: smoking, alcohol advice, physical activity and healthy weight and signposting and referring into the appropriate services.

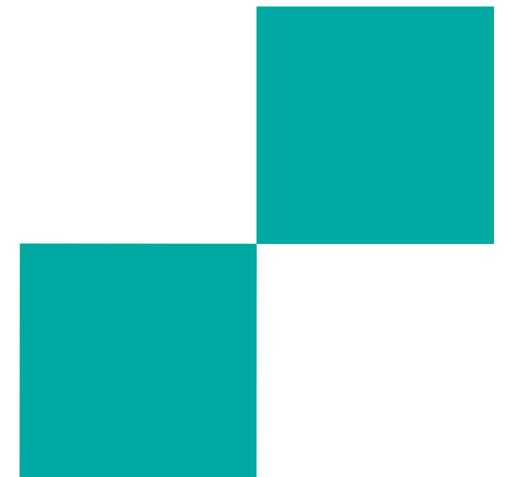
NHS Health Check Programme

Well established, this is one of the top performing programmes in England. Delivered by GP practices in Telford and Wrekin, these checks are carried out by practice nurses or health care assistants during a single visit, using a point of care blood testing model, making the results immediately available.

Stop Smoking Programmes

Offered across the borough, this programme is rolled out from hospitals, GP surgeries, children's centres and supermarkets. Behavioural support includes one to one support, closed group support or proactive telephone outreach. NHS Telford and Wrekin has taken part in a three year project, run by a consortium of West Midlands Primary Care Trusts, to pilot an Any Qualified Provider (AQP) model using Payment by Results (PbR). This project has culminated in quitter rates staying high.

In recognition of the significant local issue of smoking in pregnancy, midwives check the smoking status of a pregnant woman at every antenatal contact, with many trained to give brief advice on smoking cessation. More specialised smoking cessation services for pregnant women are also available, including home visits and text and telephone follow-ups.



Healthy Weight, Nutrition and Physical Activity

This comprises a varied programme of services commissioned by the PCT's Public Health department to support children, young people and adults in achieving and maintaining a healthy weight through the following initiatives:

- Why Weight Mums.
- HENRY – Health Exercise Nutrition for the Really Young.
- YW8? – a family weight management programme for families with children.
- Why Weight? Plus – a 12-week weight management programme for adults, with one to one and group sessions, using a cognitive behavioural therapy (CBT) approach.
- Physical activity programmes – led by trained community volunteers to encourage adults to take their first steps into physical activity.

Emotional Health and Well being

'My Time,' a third sector organisation, was commissioned to consult with working age men about their emotional health and wellbeing. The findings of the report are informing future commissioning intentions for suicide prevention work in Telford and Wrekin.

Alcohol awareness

Community-based, these are alcohol health promotion information and workshop sessions, which are delivered to children and young people and parents and carers. A programme of alcohol Identification and Brief Advice (IBA) training has also been delivered to frontline professionals working in the Telford and Wrekin area.

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.

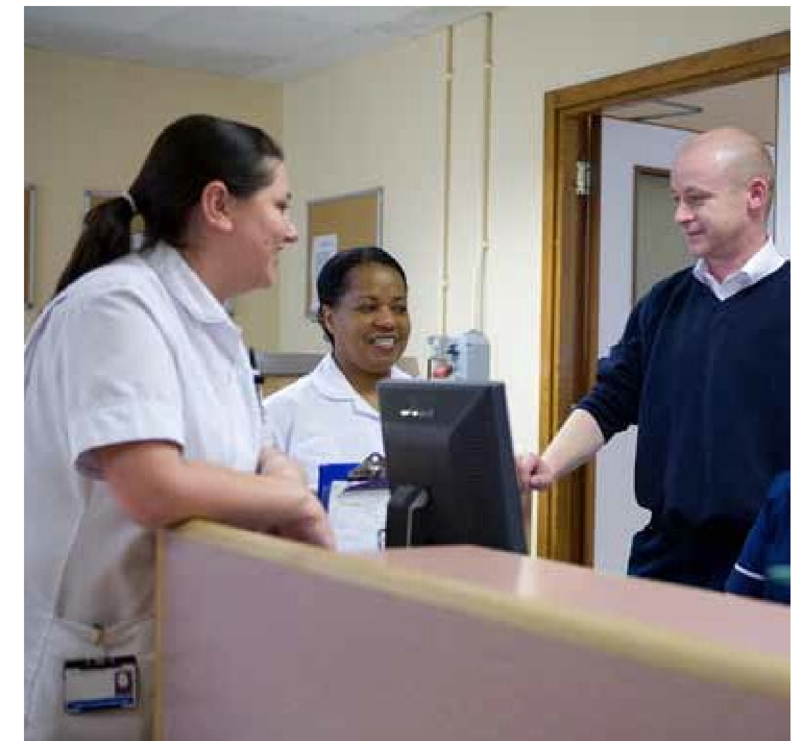
Managing staff has focused on securing posts into the new era. This function was carried out through a programme called; Investing in Your Future, giving advice and support to staff to help consider the options available to them.

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 NHS Telford and Wrekin 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.

Sickness absence

The tables below indicate the sickness absence rates from 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 days that were available to be worked within the period in question.

Monthly sickness absence rates – by host PCT

PCT	Apr 12	May 12	Jun 12	Jul 12	Aug 12	Sep 12	Oct 12	Nov 12	Dec 12	Jan 13	Feb 13	Mar 13
T & W	4.0%	1.8%	3.0%	2.1%	2.9%	3.6%	3.6%	2.7%	1.6%	2.5%	2.3%	3.4%
Shrops	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	**2.5%**	**1.6%**	**2.3%**	**2.0%**	**2.2%**	**2.6%**	**2.8%**	**2.5%**	**2.2%**	**2.8%**	**2.1%**	**2.0%**

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:

Days lost in month due to sickness absence rates – by duration

Reason	Telford and Wrekin
Long-Term (28+ Days)	7
Medium-Term (8 - 27 Days)	15
Short-Term (1 - 7 Days)	46
Overall	**68**

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.

Looking forward

As mentioned in the introduction to the annual report, NHS Telford and Wrekin 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 Telford and Wrekin 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

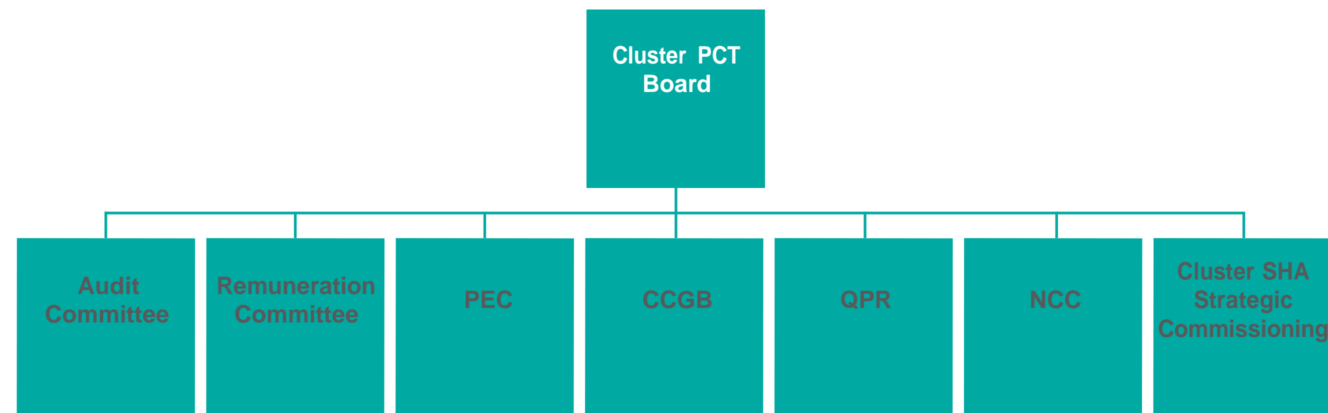
Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Telford and Wrekin'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. NHS Telford and Wrekin 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 NHS Telford and Wrekin coming under the remit of the former. The revised governance arrangements came into effect in October 2012. NHS Telford and Wrekin 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 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

PCTs) provides assurance to the 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

- **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 Telford and Wrekin. 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 on outcomes for 2012/13.

Board that the organisation's overall internal control/governance system operates in an adequate and effective

Audit Committee:

- Development of CCG audit and assurance arrangements

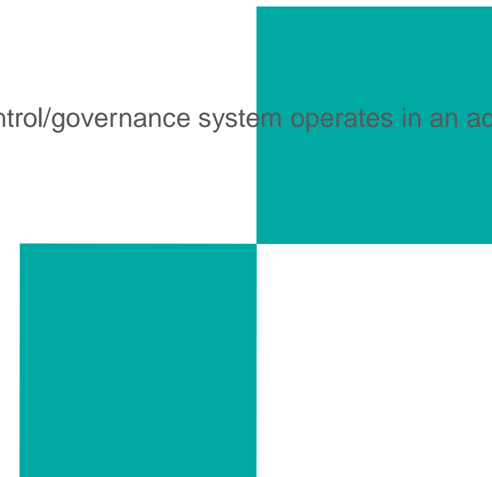
Quality, Performance and Resources Committee:

- 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).
- Under 18 conception rate in Telford and Wrekin

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 SHA in July 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



way.

- **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

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:

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

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

Audit Committee:

- Development of CCG audit and assurance arrangements

Quality, Performance and Resources Committee:

- Assurance on QIPP delivery

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 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 facilitiates 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 NHS Telford and Wrekin. 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.

NHS Telford and Wrekin'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:
Focus on change management detracts from planning for health care commissioning and provision. This may lead to failure to progress reconfiguration, to provide integrated care pathways that facilitate care closer to home, at the acute and community trusts.	• Existing organisations • Transition arrangements including public contact activity • Current service provision arrangements • Existing demographic and health inequalities data • Public opinion and patient experience data • Legacy document • Public Health Transition Plan	The CEO in collaboration with the CCG to develop a vision for health and healthcare Develop robust communication strategy
Failure to develop sustainable systems for delivery of care across the health economy and identify opportunities for investment for change, in the context of financial and resource constraints could increasingly be detrimental to the provision of healthcare and may lead to unmet need and failure to address health inequalities.	• CEO to CEO review and discussion • outline business case • PCT, CCG and cluster board reports • cluster support for foundation trust status applicants • Health Overview and Scrutiny Committee forward plan • commissioner led pathway development for stroke, urgent care and community outpatient clinics, with clinician involvement • investment in community services • local authority service redesign and T&W co-operative council projects including the Health Hub developed in partnership with the PCT business continuity plans	• Forward plan for LHE Clinical Assurance Group • Robust arrangements for on going financial review and assurance established • Engagement of the CCGs • Continued public engagement and media briefings to maintain openness and address issues as they are raised • Close financial, resource and timescale monitoring • Action plan to be signed off by LHE Health Systems Improvement Board Graham Urwin, David Evans and Mike Innes
Failure to maintain effective business continuity or significant delay in the development of the CCGs and cluster will increase the chance that corporate risks may not be managed effectively and may result in loss of engagement with clinicians.	• Meetings between the CCG and PCT and cluster leads. • CCG and cluster board and governance arrangements. • Cluster Director of Commissioning Development working with CCGs. • Organisational memory. • Business continuity and emergency planning.	Close working between the CCG, PCT and cluster. Cluster agreement on the shape of commissioning support. Maintain robust governance mechanisms for ensuring the transfer of legal and regulatory responsibility, organisational memory and maintenance of leadership and ownership through transition. March 2013
Uncertainly about the future may result in a poor staff morale and staff leaving the local healthcare organisations because of uncertainty about their continued employment. This may lead to exacerbation of risks and skills gaps in future organisations. Long term absences may exacerbate this risk.	• Current and transitional structures. • HR department / monitoring data. • TUPE arrangements. • Business continuity plans. • Occupational health services. • Staff counselling, HR and H&S processes including stress management arrangements. • HR presence at Halesfield. • It is acknowledged that there are a number of very capable specialist staff. • NED with responsibility for staff well being throughout transition. • NEDs with responsibility for whistleblowing.	Intergrated working with Shropshire County PCT. Staff briefings. March 2013

New risks added to the Strategic Risk Register during 2012/13:		
Failure to develop sustainable systems of delivery of care across the health economy and identify opportunities for investment for change, in the context of financial and resource constraints could increasingly become detrimental to the provision of healthcare	• Financial governance: arrangements to oversee development and delivery of annual financial plan (budget) through: • Board (monthly report) • CCG PPQ and Governance Board (monthly report) • Budgetary control: through accountable budget holders (executive directors) and budget managers (senior managers) with monthly budget statements. Performance is discussed with accountants at routine monthly meetings. • Local Authority representation on PCT Board: provides an outlet to highlight our current issues. Regular liaison meetings to oversee and manage issues arising. • Health Outcome reports: routinely (monthly) provided to PPQ assurance statement to boards outlining progress. Included within these reports is an impact assessment against health inequalities. Additionally any deterioration against relevant service performance targets highlighted, with action plans produced as required. • Cluster governance arrangements.	Workforce capacity: monitoring thorugh change to ensure key roles are covered. Delivery of QIPP: QIPP action plan. Local Authority financial pressures: impact assessment of proposed budget reductions and mitigating plan produced. Financial governance arrangements: • Formal reporting through established committees to oversee delivery of financial targets • Dedicated programme officer to prepare detailed reports • Monthly reporting to the CCG and cluster board and detailed monitoring by PPQ and QIPP committee. CCG Engagement: Planning and Prioritising Group, chaired by a CCG representative, to provide support and leadership as we move to a clinically led planning process.
Poor quality information or untimely information streams from providers or internally generated sources and lack of capability to effectively analyse these will exacerbate the risk of bad decision making and performance monitoring.	• Existing informatics and monitoring mechanisms	Information: Robust review of the quality and timeliness of data streams from providers and the capability of PCT staff to effectively use information provided. Continued review via the internal audit plan. TRAQS implementation will act as an information resource.
Significant pending list at the acute trust and the Trust have reported that it did not have capacity to meet the 18 weeks target within deadlines	• Arrangements, including additional funding of £9m, have been implemented to enable the trust to meet a deadline of 7 weeks from 05/11/11, which are now non-negotiable.	Weekly review meetings with telephone monitoring of progress by the SHA and cluster. Continued monitoring by the LHE Board to ensure targets are met and the backlog reduced. Fran Beck (31/03/13)
Failure to establish effective mechanisms for monitoring and providers activity, or to work effectively with them, may lead to poor quality care and outcomes for patients.	• Contract monitoring • CQR • Joint working arrangements	Review contract and quality monitoring processes to ensure they are effective in identifying quality, outcomes and patient experience poor practice by all providers. Discussions with CSU re: future operation of CQR Consideration of the use of implementation of the 5Cs and patient stories in the cluster and CCGs. Christine Morris (31/03/13)

New risks added to the Strategic Risk Register during 2012/13: Continued...		
Governance structures within existing organisations may not maintain robust quality and risk management through the transition period and these services may not be fit for purpose in the new organisations.	• Newly defined governance arrangements, including quality, clinical governance and risk management • Governance planning for future organisations (cluster and CCGs) • CQC and NHSLA • Audit Committee • CQR • Legislation, DH requirements, specialist staff	Continued monitoring of compliance with safety and quality standards and legislation via quality meetings with providers. Multi-agency implementation of actions to address lessons to be learnt identified by RCA activity including those for acute mental health admission and concerns re: Winterbourne View. Christine Morris Shared risk reporting with emerging organisations. David Evans Develop policy to achieve full compliance with the Equality Act. Alison Smith Mapping of areas for the future attention of the CCG. Karen Stringer (Mandy Gatt) (all on going)
Shropshire Community Health Trust There is the potential for the community trust to fail to establish a viable business model, leading to failure to deliver services, reduction in quality and ultimately business collapse. This risk will be exacerbated by a lack of effective business continuity plans in the community and acute trusts and the local CCGs that ensure that failing services are identified and supported or decommissioned and replaced	• Community trust business planning processes • CCG business and commissioning plans • Contract monitoring • CQR meetings and monitoring	The community trust will be required to demonstrate the effectiveness of its future business plans and provide detailed evidence of the continuing management of the risks on its BAF. Revise business continuity plans for various scenarios of failure to deliver services by the community trust (this will need to include a risk appetite for the levels of tolerable failure). David Evans (31/03/13)

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:

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.

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.

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 implementa- tion of this plan will continue to be implemented by Staffordshire CSU and monitored by both the CSU and Telford and Wrekin CCG Audit committees.

Breaches of data security

NHS Telford and Wrekin has reported one data security incident during 2012/13. The incident took place at PCT premises during March 2013, when a copy of a GP performers meeting agenda was circulated to GPs in a training session erroneously. The agenda did not contain any patient identifiable information, and although it did include the names of GPs, the agenda was in relation to admittance to the PCTs performers list and did not contain any other information, and consequently this incident was not required to be reported to the Information Commissioner. An internal investigation is taking place and a serious incident reported.

Serious incidents (SIs):

NHS Telford and Wrekin reported no other serious incidents during 2012/13.

Remuneration Report 2012/ 2013

Arrangements for Annual Statement of Accounts Production

The arrangements for producing its annual statement of accounts did not work as effectively as intended. As a consequence, the Trust did not submit a set of auditable accounts for audit until 30 April 2013. This is after the deadline of by the Department of Health of 22 April 2013.

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

NHS Telford and Wrekin

Signature:

Date:

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. In attendance were the Chief Executive (except where relates to personal interests), the Head of Corporate Management and the Assistant Director for OD and Workforce.

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 – Telford & Wrekin PCT

		2012-13 relating to T&W PCT				2012 – 13 Total	2011-12 relating to T&W PCT			
Name	**Title**	Salary (bands of £5000)	Other remuneration (bands of £5000)	Bonus Payments (bands of £5000)	Benefits in kind (bands of £100)	2012 – 13 Total Cluster Salary (bands of £5000)	Salary (bands of £5000)	Other remuneration	Bonus Payments (bands of £5000)	Benefits in kind
Joanna Newton	Chairman - West Mercia Cluster / Area Team	5-10				40-45	20-25			
Sue Mead	Non Executive Director - West Mercia Cluster / Area Team	0-5				15-20	0-5			
Dr Bryan Smith OBE	Non Executive Director - West Mercia Cluster	0-5				15-20	0-5			
Rob Parker	Non Executive Director - West Mercia Cluster	0-5				15-20	0-5			
Eamonn Kelly	Chief Executive - West Mercia Cluster	25-30				145-150	15-20			
Leigh Griffin	Deputy Chief Executive - West Mercia Cluster	15-20				120-125	55-60			1100
Brian Hanford	Director of Finance - West Mercia Cluster / Area Team	20-25				120-125	10-15			
Sue Doheny	Director of Quality & Clinical Leadership - West Mercia Cluster / Area Team	15-20				95-100	0-5			23
Paul Maubach	Director of Commissioning Development - West Mercia Cluster (Commenced 16th may 2011)	5-10				60-65	10-15			
Dr Kiran Patel	Medical Director - West Mercia Cluster (Commenced 1st September 2011)	10-15				80-85	5-10			
Catherine Woodward	Director of Public Health	150-155				150-155	145-150			
Andrew Mason	Non Exec Director	20-25				20-25	25-30			
Louise Lomax	Non Exec Director	5-10				5-10	5-10			
Dr Helen Herritty*	Non Exec Director									
Mrs Susan Mead*	Non Exec Director									

		2012-13 relating to T&W PCT				2012 – 13 Total	2011-12 relating to T&W PCT			
		Salary (bands of £5000)	Other remuneration (bands of £5000)	Bonus Payments (bands of £5000)	Benefits in kind (bands of £100)	2012 – 13 Total Cluster Salary (bands of £5000)	Salary (bands of £5000)	Other remuneration	Bonus Payments (bands of £5000)	Benefits in kind
Name	**Title**	£000	£000	£000		£000	£000	£000	£000	
Mr William Hutton*	Non Exec Director									
Mr Rob Parker*	Non Exec Director									
Dr Bryan Smith*	Non Exec Director									
Mrs Margaret Jackson*	Non Exec Director									
Mr Paul Clifford*	Corporate Director Telford and Wrekin Council									
Mr Graham Urwin*	PCT Chief									
Executive Mr Andrew Nash*	Director of									
Finance Mrs Ros Francke*	Director of									
Finance Mrs Brigid Stacey*	Director of									
Nursing										

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. * No declaration of Salaries and Allowances is made for these individuals, for whom no charge was made to the PCT for their services.

Pension Benefits – Telford & Wrekin PCT

Name	Title	Real increase / decrease) in pension at age 60 (bands of £2,500)	Real increase / (decrease) in 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 / (decrease) in cash equivalent transfer value
		£'000	£'000	£100	£'000	£'000	£'000	£100
Eamonn Kelly	Chief Executive - West Mercia Cluster	0-2.5	0-2.5	65-70	200-205	1433	1317	116
Leigh Griffin	Deputy Chief Executive - West Mercia Cluster	(0.2.5)	(2.5-5)	50-55	160-165	1041	1041	0
Brian Hanford	Director of Finance - West Mercia Cluster / Area Team	(0-2.5)	(0-2.5)	35-40	105-110	611	569	42
Sue Doheny	Director of Quality & Clinical Leadership - West Mercia Cluster / Area Team	0-2.5	2.5-5	15-20	50-55	297	202	95
Paul Maubach	Director of Commissioning Development - West Mercia Cluster (Commenced 16th may 2011)	NDA	NDA	NDA	NDA	NDA	384	NDA
Dr Kiran Patel	Medical Director - West Mercia Cluster (Commenced 1st September 2011)	NDA	NDA	NDA	NDA	NDA	478	NDA
Catherine Woodward	Director of Public Health	0-2.5	2.5-5	50-55	155-160	950	853	97

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. 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)

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 Telford and Wrekin PCT in the financial year 2012/13 was £150,000 to £155,000 (2011/12 - £145,000 to £150,000). This was 4.50 times (2011/12 – 3.67) the median remuneration of the workforce which was £34,189 (2011/12 - £40,157). The median remuneration of the workforce reduced in year because as the PCT was progressing towards disbanding a number of senior posts were held vacant and some of the Director functions, including the Director of Finance post were managed at a cluster level where the PCT was charged for a proportion only of these senior posts as the individuals were performing similar functions for other local PCTs.

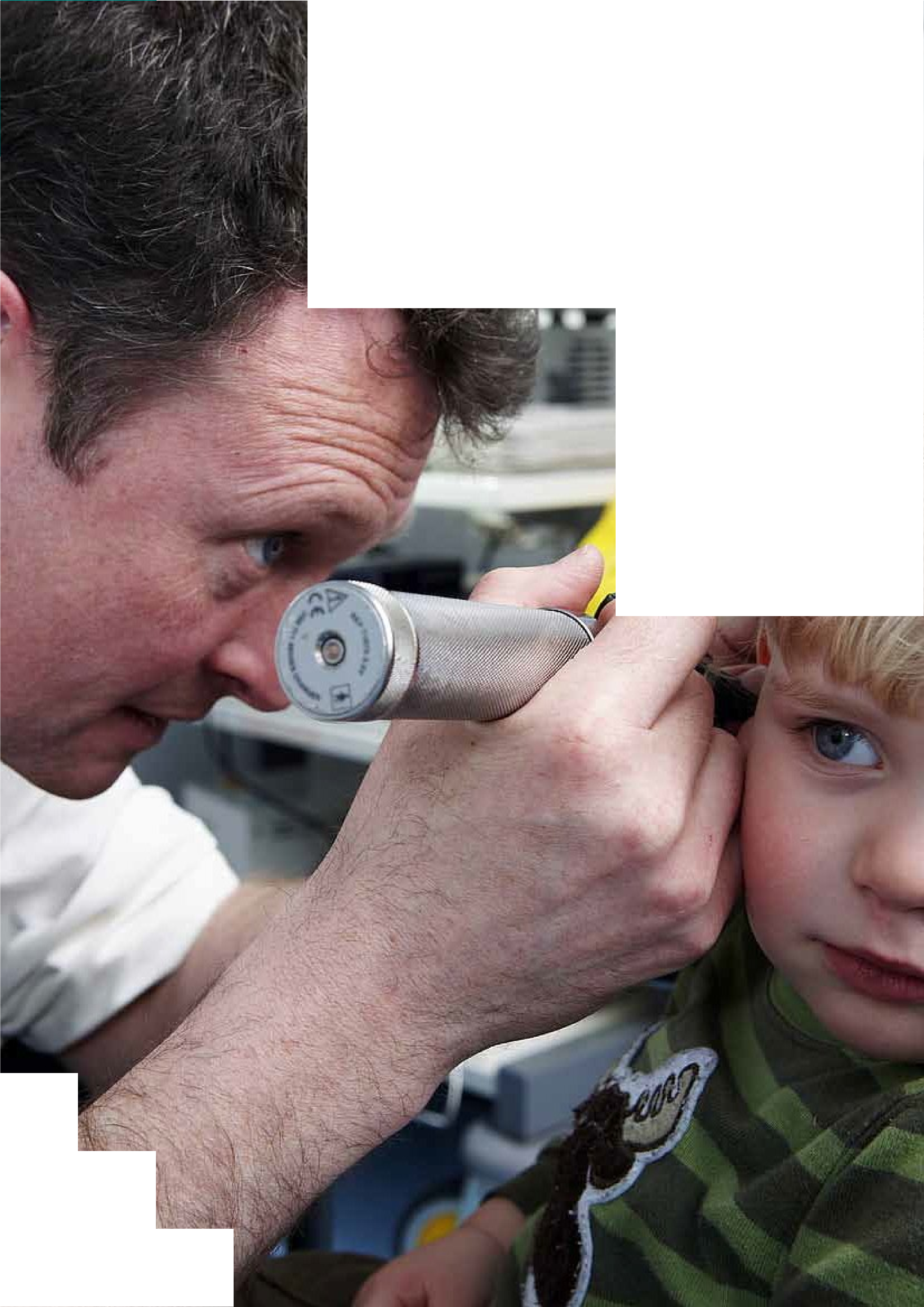
In 2012/13, no employees (2011/12 – 0) received remuneration in excess of the highest paid director.

Remuneration ranged from £14,153 to £153,859 (2011/12 - £13,903 to £148,319).

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. Real Increase in Cash Equivalent used to take into account the recommended inflation rate of 5.2%.

NHS Telford and Wrekin - Annual Report



Summary of financial statements 2012/13

Introduction

The 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

NHS Telford and Wrekin is the everyday name for Telford and Wrekin Primary Care Trust (PCT). Until the Government's changes to the NHS take place on 31 March 2013, the PCT continues to be the NHS organisation which purchases NHS funded services for the population of the borough. It also carries out Public Health initiatives to improve health and reduce inequalities while developing GP and other primary care services in the region. From 1 April 2013, the functions of NHS Telford and Wrekin will transfer to the local clinician-led Clinical Commissioning Group (CCG), Telford and Wrekin Council and the National Commissioning Board (NCB).

During 2012/13, NHS Telford and Wrekin received an uplift to its funding of 3%, increasing the available recurring resource to £279m. The uplift is provided to cover increases in all the PCT's costs including inflation. This is in line with the uplift received in 2011/12 which was 2.2%. The CCG has been notified that its uplift in 2013/14 will be 2.3%.

Of central importance to all NHS organisations over the coming years will be the successful implementation of the Government's Quality, Innovation, Productivity and Prevention (QIPP) initiative. This seeks to improve the delivery of healthcare by reviewing the way in which services are provided. During 2012/13 NHS Telford and Wrekin identified and achieved reductions in its expenditure of approximately £3.9m through QIPP related schemes. Examples of such schemes include savings in drug expenditure through co-ordinated purchasing and improved treatment of patients through revised care pathways. Additional savings on a similar scale are planned for 2013/14

Further information on the National Commissioning Board, Telford and Wrekin Council (for Public Health Services) and NHS Telford and Wrekin CCG's plans for 2013/14 may be found on the websites of those organisations. The CCG website is www.telford.nhs.uk/telford-and-wrekin-ccg/

A copy of the Final Accounts of Telford and Wrekin PCT can also be found on this website.

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 £1,157,000 (representing about 0.04% of the allocation) and a capital underspend of £430,000

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 £1,157,000 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 its full notified cash limit.

The Statement of Comprehensive Net Expenditure

The Statement of Comprehensive Net Expenditure shows the net operating costs of the PCT (£277.4m) 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 £000	2011-12 £000
Administration Costs and Programme Expenditure		
Gross employee benefits	**4,799**	4,797
Other costs	**278,065**	268,781
Income	**(5,478)**	(5,801)
Net operating costs before interest	**277,386**	267,777
Other (Gains)/Losses	**26**	50
Finance costs	**9**	11
Net operating costs for the financial year	**277,421**	267,838
Of which:		
Administration Costs		
Gross employee benefits	**3,525**	4,236
Other costs	**5,160**	4,178
Income	**(939)**	(623)
Net administration costs before interest	**7,746**	7,791
Finance costs	**0**	11
Net administration costs for the financial year	**7,746**	7,802
Programme Expenditure		
Gross employee benefits	**1,274**	561
Other costs	**272,905**	264,603
Income	**(4,539)**	(5,178)
Net programme expenditure before interest	**269,640**	259,986
Other (Gains)/Losses	**26**	50
Finance costs	**9**	0
Net programme expenditure for the financial year	**269,675**	260,036

	2012-13 £000	2011-12 £000
Other Comprehensive Net Expenditure		
Impairments and reversals put to the Revaluation Reserve	**71**	0
Net (gain) on revaluation of property, plant & equipment	**(45)**	(232)
Total comprehensive net expenditure for the year*	**277,447**	267,606

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

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.

Statement of Financial Position

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

The non-current assets section mainly shows the value of Property, Plant and equipment (£6.2m). This is a reduction compared to the previous years due to technical adjustments to the valuation relating to impairments and charges.

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 £1.2m. This is due to improved cash collection and prompt invoice issuing.

Trade and other payables (i.e. amounts owed by the PCT) have reduced by £2.6m compared to the previous year. This was the impact of a concerted effort by the PCT to clear as many old invoices as possible in year to leave a 'cleaner' Balance Sheet for the new NHS to move forward with.

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

£112k. Taxpayers equity shows the distribution of the financing of the PCT's net assets.

	31 March 2013	31 March 2012
	£000	£000
Non-current assets:		
Property, plant and equipment	**6,225**	7,775
Total non-current assets	**6,225**	7,775
Current assets:		
Trade and other receivables	**1,265**	2,053
Cash and cash equivalents	**15**	51
Total current assets	**1,280**	2,104
Total assets	**7,505**	9,879
Current liabilities		
Trade and other payables	**(17,466)**	(19,624)
Provisions	**(72)**	(1,199)
Borrowings	**0**	(51)
Total current liabilities	**(17,538)**	(20,874)
Non-current assets plus/less net current assets/liabilities	**(10,033)**	(10,995)
Non-current liabilities		
Provisions	**(303)**	(415)
Total non-current liabilities	**(303)**	(415)
Total Assets Employed:	**(10,336)**	(11,410)
Financed by taxpayers' equity:		
General fund	**(11,308)**	(12,933)
Revaluation reserve	**972**	1,523
Total taxpayers' equity:	**(10,336)**	(11,410)

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 [date] and signed on its behalf by

Chief Executive: **Date:**

ment of Changes in Taxpayers Equity

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	**(12,933)**	**1,523 0**	**0 0**	**(11,410)**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(277,421)			(277,421)
Net gain on revaluation of property, plant, equipment		45		45
Impairments and reversals		(71)		(71)
Transfers between reserves*	525	(525)		0
Reclassification Adjustments				
Total recognised income and expense for 2012-13	**(276,896)**	**(551)**	**0**	**(277,447)**
Net Parliamentary funding	278,521			278,521
Balance at 31 March 2013	**(11,308)**	**972**	**0**	**(10,336)**
Balance at 1 April 2011	(15,562)	1,308	0	(14,254)
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(267,838)			(267,838)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment		232		232
Transfers between reserves*	17	(17)		0
Total recognised income and expense for 2011-12	**(267,821)**	**215**	**0**	**(267,606)**
Net Parliamentary funding	270,450			270,450
Balance at 31 March 2012	**(12,933)**	**1,523**	**0**	**(11,410)**

Statement of Cash Flows

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 (£278.9m) were financed mainly by cash drawings from the Department of Health £278.5m.

	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities		
Net Operating Cost Before Interest	**(277,386)**	(267,777)
Depreciation and Amortisation	**482**	427
Impairments and Reversals	**440**	0
(Increase)/Decrease in Trade and Other Receivables	**788**	(1,569)
Increase/(Decrease) in Trade and Other Payables	**(2,175)**	80
Provisions Utilised	**(596)**	(953)
Increase/(Decrease) in Provisions	**(652)**	84
Net Cash Inflow/(Outflow) from Operating Activities	**(279,099)**	(269,708)
Cash flows from investing activities		
(Payments) for Property, Plant and Equipment	**(372)**	(739)
Proceeds of disposal of assets held for sale (PPE)	**965**	0
Net Cash Inflow/(Outflow) from Investing Activities	**593**	(739)
Net cash inflow/(outflow) before financing	**(278,506)**	(270,447)
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and	**0**	(3)
Net Parliamentary Funding	**278,521**	270,450
Net Cash Inflow/(Outflow) from Financing Activities	**278,521**	270,447
Net increase/(decrease) in cash and cash equivalents	**15**	0
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**0**	0
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign	0	0
Cash and Cash Equivalents (and Bank Overdraft) at year end	15	0

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. 92.5% of invoices were paid within the 30 day target and 83% of the total value paid. The number within target improved from 86% to 92.5% during the year. 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.

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	6,179	41,403	5,829	29,591
Total Non-NHS Trade Invoices Paid Within Target	5,717	34,388	5,382	26,613
Percentage of NHS Trade Invoices Paid Within Target	**92.5%**	**83.1%**	**92.3%**	**89.9%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,057	198,206	2,491	179,393
Total NHS Trade Invoices Paid Within Target	2,052	189,211	1,586	174,158
Percentage of NHS Trade Invoices Paid Within Target	**67.1%**	**95.5%**	**63.7%**	**97.1%**

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.

Audit

The PCT's external auditors are Grant Thornton. Fees for audit services during the year were £73,000 and £22,000 relates to an under accrual in 2011/12 payable to the Audit Commission. The other auditors remuneration of £25,000 relates to other specific pieces of work such as on Payment by Results (PBR).

Capital

The PCT receives it's Capital funding from the Department of Health and is given a limit beyond which it cannot spend. Capital spending includes expenditure on improving buildings and purchasing equipment that has a useful life of more than one year.

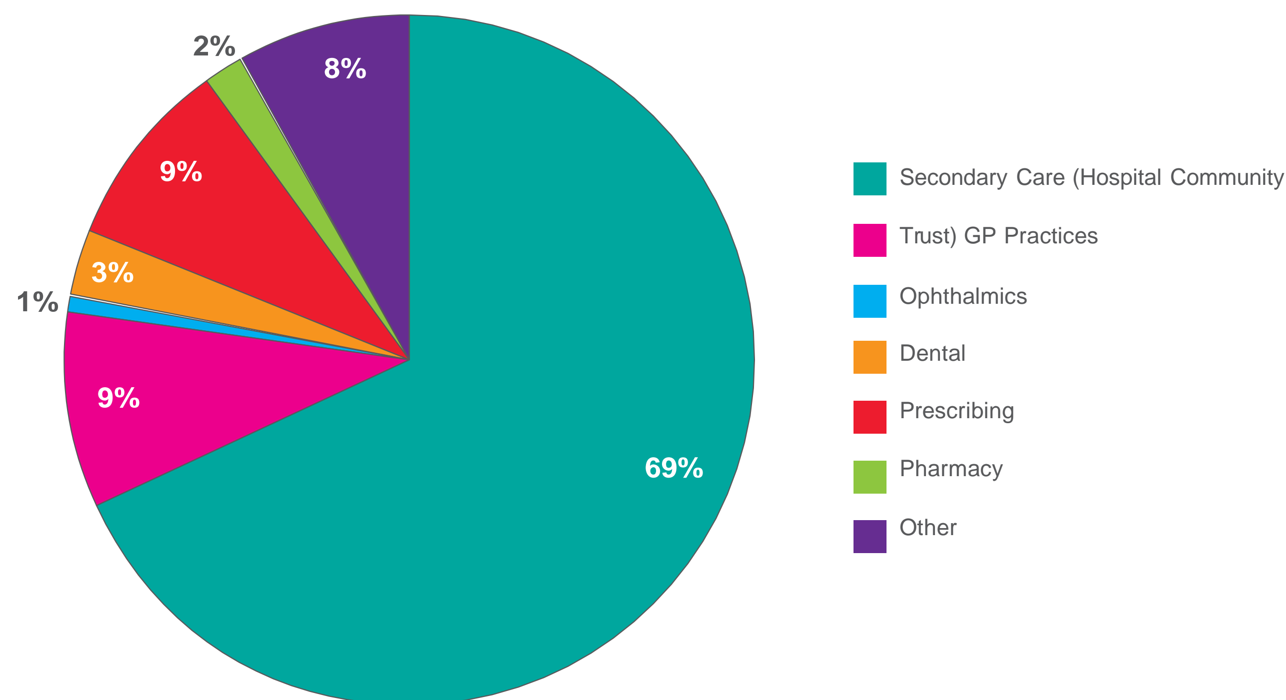
The main items of Capital Expenditure in year were;

General Practice/clinic developments and maintenance	£248k
Halesfield Offices refurbishment and maintenance	£43k

Revenue Expenditure

The PCT also receives it's revenue funding from the Department of Health. This is in the form of a revenue funding limit imposed on it as to the amount of revenue expenditure the PCT can incur. Revenue spending includes items such as commissioning of Acute, Primary, Community and Mental Health services on behalf of its population.

How the money was spent



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 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 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
comprehensive income at the time the Trust commits
itself to the retirement, regardless of the method

the additional costs is charged to the statement of

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.

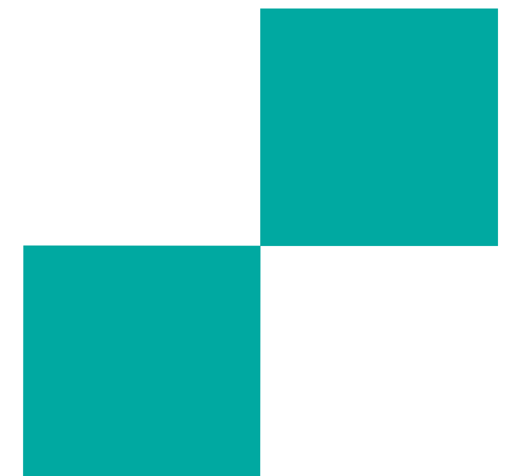
The latest assessment of the liabilities of the scheme is

contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England

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

comprehensive income at the time the Trust commits

itself to the retirement, regardless of the method



Financial Performance Targets

Revenue Resource Limit

	2012-13	2011-12
	£000	£000
The PCTs' performance for the year ended 2012-13 is as follows:		
Total Net Operating Cost for the Financial Year		267,838
Net operating cost plus (gain)/loss on transfers by absorption	**277,421**	
Adjusted for prior period adjustments in respect of errors	**0**	0
Revenue Resource Limit	**278,578**	268,936
Under/(Over)spend Against Revenue Resource Limit (RRL)	**1,157**	**1,098**

Capital Resource Limit

	2012-13	2011-12
	£000	£000
The PCT is required to keep within its Capital Resource Limit.		
Capital Resource Limit	**(172)**	786
Charge to Capital Resource Limit	**(602)**	526
(Over)/Underspend Against CRL	**430**	**260**

Running Costs

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	7,746	7,208	538
Weighted population (number in units)*	164,027	164,027	164,027
Running costs per head of population (£ per head)	**47**	**44**	**3**
PCT Running Costs 2011-12			
Running costs (£000s)	7,802	7,039	763
Weighted population (number in units)	161,390	161,390	161,390
Running costs per head of population (£ per head)	**48**	**44**	**5**

Staff Sickness absence and ill health retirements

	2012-13	2011-12
	Number	Number
Total Days Lost	1,559	2,833
Total Staff Years	183	407
Average working Days	**8.50**	**7.0**

There were no early retirements on ill-health grounds.

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	0	1	1	1	0	1
£10,001-£25,000	0	0	0	2	0	2
£25,001-£50,000	1	0	1	2	0	2
£50,001-£100,000	0	0	0	1	0	1
£100,001 - £150,000	0	0	0	4	0	4
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	1	0	1
Total number of exit packages by type (total cost)	**1**	**1**	**2**	**11**	**0**	**11**
	£000s	£000s	£000s	£000s	£000s	£000s
	46	**2**	**48**	**919**	**0**	**919**

Total resource cost

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.

This annual report contains a summary of the PCT's financial accounts for 2011/12.

Related Party Transactions for Year Ended 31 March 2013

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
Donnington	Jim Hudson	2,143
Newport (Linden Hall)	Stefan Waldendorf	1,333
Oakengates (Limes Walk)	Karen Stringer	1,853
Stirchley	Mike Innes	1,549
Sutton Hill	Andy Inglis	1,029

In addition, Donnington Health Centre was sold to the GP practice for £400,000.

Some GPs that are on the PCT Board, CCG Board or CAP members are also involved with Shropshire doctors cooperative Ltd, payments of £2,272,852 were made to Shropshire doctors cooperative Ltd in 2012/13.

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 Telford & Wrekin 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 Telford & Wrekin PCT's charitable funds.

Obtaining a copy of the PCT's full accounts

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

Date:

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.

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

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 Telford and Wrekin 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 39 to 52.

This report is made solely to the accountable officer of Telford and Wrekin 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 Telford and Wrekin 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

NHS Telford and Wrekin Board Members

Mrs Joanna Newton	PCT Chair	1. Chair of Governors, Weobley Primary School 2. Shareholder, Glaxo Smith Kline (GSK)
Mr Eamonn Kelly To 30/09/12	PCT Chief Executive	None declared
Mr Brian Hanford To 30/09/12	Director of Finance	1. Trustee and Treasurer of HALO (non pecuniary) 2. Spouse employed by Hoople (contractor to Herefordshire PCT)
Mr Andrew Mason	Chair Non Executive Director	1. Trustee, Wyldwoods Charity
Mrs Louise Lomax	Non Executive Director	1. Director, Severn Gorge countryside trust 2. Consultant trainer, Citizens' Advice
Dr Helen Herritty	Non Executive Director	1. Husband employed by company supplying pumps to public sector building refurbishments 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 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 From 17/01/12 To 31/05/12	Non Executive Director	None declared
Mrs Margaret Jackson From 01/06/12	Non Executive Director	None declared
Mrs Susan Doheney To 30/09/12	Director of Nursing	None declared
Dr Kiran Patel To 30/09/12	Medical Director	1. Consultant Cardiologist and Honarary Senior Lecturer, Sandwell and West Birmingham NHS
Dr Catherine Woodward	Director of Public Health/ Director of Infection Prevention Control	1. Member of the BMA 2. Member, West Midlands BMA Regional Council Executive 3. Member, BMA Public Health Committee

NHS Telford and Wrekin Board Members Continued

Dr Mike Innes	PEC Chair/Clinical Commissioning Chair	1. GP Partner, Stirchley Medical Practice
Dr Leigh Griffin To 31/10/12	Managing Director Deputy Chief Executive	1. Director, Sefton for Africa
Mr Paul Clifford	Corporate Director Telford and Wrekin Council	1. Director, Telford and Wrekin Council 2. PCT/LA Pooled budgets
Mrs Lin Jonsberg	Trust Board Secretary	1. Tribunal judge, mental health tribunals service 2. Trustee, Deaf Direct, Worcester (non-pecuniary)
Mr Paul Maubach To 30/09/12	Director of Commissioning Development	None declared
Mrs Suzanne Penny To 30/09/12	Interim Head of HR	1. Director, Dinedor Associates Ltd
Mr Graham Urwin From 01/10/12	PCT Chief Executive	None declared
Mr Andrew Nash From 01/10/12 To 31/01/13	Director of Finance	None declared
Mrs Ros Francke From 14/01/13	Director of Finance	1. Member of the Healthcare Financial Management Association Commissioning Faculty. 2. Husband is Managing Director of Claritas Consulting who provides services to the NHS in England and Wales.
Mrs Brigid Stacey From 01/10/12	Director of Nursing	None declared
Dr Ken Deacon From 01/10/12	Medical Director	1. NHS General Practice Principal, Greenridge Surgery, Birmingham 2. Company Director, Greenridge Healthcare Ltd

Declared Interests

NHS Telford and Wrekin PEC Members

Dr Mike Innes	PEC Chair	1. Partner at Stirchley Medical Practice, Telford
Dr Andy Inglis	PEC GP	1. Partner at Sutton Hill Medical Practice 2. Member of Shropshire Doctors Co-operative 3. Research with Keele University with Sutton Hill Medical Practice 4. Board Member and member of the Clinical Commissioning Group
Dr Karen Stringer	PEC GP	1. Partner at Oakengates Medical Practice 2. Husband is a GP in Shropshire County PCT and partner of Riverside Medical Practice, Shrewsbury 3. Board member and member of the Telford and Wrekin Clinical Commissioning Group
Dr Jim Hudson	PEC GP	1. Partner at Donnington Medical Practice 2. Director and part owner of Doctors in Donnington Ltd 3. Director and part owner of Donnington Healthcare Ltd. 4. Member of Shropshire Doctors Co-operative 5. Member of Shropshire and Telford Federation 6. Keele University, grant for medical students circa 2010, primary care research at DMP 7. Board member and member of the Telford and Wrekin Clinical Commissioning Group
Mrs Carolyn Fenton West	PEC Nurse	1. Nurse Practioner at Madeley Medical Centre, Telford and Holliwell Practice
Dr Jo Leahy	Medical Director	1. Sole Trader: Luminessence Coaching providing locum cover for general practice
Dr Catherine Woodward	Director of Public Health	1. Member of the BMA 2. Member, West Midlands BMA Regional Council Executive 3. Member, BMA Public Health Committee
Dr Leigh Griffin	PCT Managing Director	Director of "Sefton for Africa"
Mrs Karen Kalinowski	Local Authority representative on	Officer of Telford and Wrekin Council – pooled budgets

NHS Telford and Wrekin Clinical Commissioning Board Members

Dr Mike Innes	Chair	1. Partner at Stirchley Medical Practice, Telford
Dr Andy Inglis	GP Member	1. Partner at Sutton Hill Medical Practice 2. Member of Shropshire Doctors Co-operative 3. Research with Keele University with Sutton Hill Medical Practice 4. Board Member and member of the Clinical Commissioning Group
Dr Karen Stringer	GP Member	1. Partner at Oakengates Medical Practice 2. Husband is a GP in Shropshire County PCT and partner of Riverside Medical Practice, Shrewsbury 3. Board member and member of the Telford and Wrekin Clinical Commissioning Group
Dr Jim Hudson	GP Member	1. Partner at Donnington Medical Practice 2. Director and part owner of Doctors in Donnington Ltd 3. Director and part owner of Donnington Healthcare Ltd. 4. Member of Shropshire Doctors Co-operative 5. Member of Shropshire and Telford Federation. 6. Keele University, grant for medical students circa 2010, primary care research at DMP 7. Board member and member of the Telford and Wrekin Clinical Commissioning Group
Dr Stefan Waldendorf To June 2012	GP Member	1. Partner at Linden hall Surgery 2. Member of Shropshire Doctors Co-operative 3. Member of Telford and Wrekin Clinical Commissioning Group
Dr Jo Leahy From July 2012	GP Member	1. Sole Trader: Luminessence Coaching providing locum cover for general practice
Dr Catherine Woodward	Director of Public Health	1. Member of the BMA 2. Member, West Midlands BMA Regional Council Executive 3. Member, BMA Public Health Committee

Declared Interests

NHS Telford and Wrekin Clinical Commissioning Board Members Continued

Name	Role	Declared interest
Mr Andrew Mason To November 2012	Non Executive Director of the PCT	1. Trustee of Wyldwoods (Registered Charity no. 1128886) offering creative arts for wellbeing
Mrs Louise Lomax From December 2012	Non Executive Director of the PCT	1. Director, Severn Gorge countryside trust 2. Consultant trainer, Citizens' Advice
Mr Geoff Braden	Local Support Member of the PCT	None declared
Mr Dylan Harrison	Local Support Member of the PCT	1. Director of Children's Centre and Childcare Consultancy Limited 2. Executive head fo Childcare and Family Support at
Mr Paul Clifford	Local Authority representative on CCB	1. Officer of the Local Authority
Mr Dave Evans From May 2012	CCG Chief Officer	1. Owner of PSPC, a private health care consultancy, which does contract with NHS 2. Wife is a partner in Realising Solutions LLP, a consultancy that contracts with NHS and is an employee of Tribal Education Ltd which contracts with NHS
Mrs Fran Beck From June 2012	CCG Executive Lead Commissioning	1. Exec Lead responsible for CCG/LA pooled budgets e.g. Sec 256 reablement
Miss Alison Smith From June 2012	CCG Executive Lead Governance and Performance	None declared
Mr Andrew Nash From July 2012	CCG Chief Finance Officer	None declared
Mrs Christine Morris From August 2012	CCG Executive Lead Quality and Safety	1. Husband is a partner in an online pharmacy in Oswestry Shropshire
Mrs Zena Young From August 2012	Secondary Nurse	1. Divisional Head of Nursing, The Royal Wolverhampton Hospitals NHS Trust
Dr Martin Allen From August 2012	Secondary Consultant	1. Consultant Physician, University Hospital of North Staffordshire 2. Shine Health Foundation to facilitate early discharge from AMU (pecuniary)
Mrs Kate Ballinger From September 2012	Patient Representative	None declared
Mrs Julie Ellis From July 2012	Practice Manager Representative	None declared

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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 ብኻልእ ቋንቋታት እውን ይርከብ ኢዩ: ወይ ኣዕቢዩ ዝተጻሕፈ ማሕተም ወይ ድማ ብዝስማዕ (ድምጺ) እንተሓቲኩም::

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

Telford and Wrekin Primary Care Trust

2012-13 Accounts

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Telford and Wrekin Primary Care Trust

2012-13 Accounts

2012-13 Annual Accounts of Telford & Wrekin 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 Telford & Wrekin 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

NHS
Telford and Wrekin

ANNUAL GOVERNANCE STATEMENT 2012/13

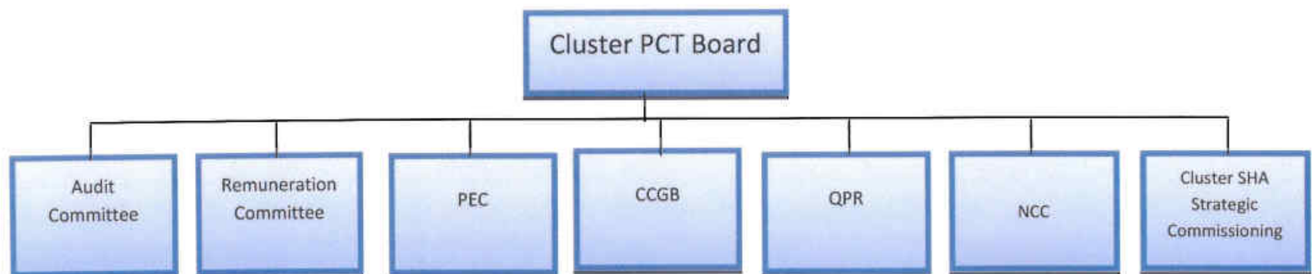
1. Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Telford and Wrekin'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. NHS Telford and Wrekin 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 NHS Telford and Wrekin coming under the remit of the former. The revised governance arrangements came into effect in October 2012. NHS Telford and Wrekin 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 Telford and Wrekin. 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).
- Under 18 conception rate in Telford and Wrekin

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 SHA in July 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 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 facilitiates 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 NHS Telford and Wrekin. 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 NHS Telford and Wrekin'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:
Focus on change management detracts from planning for health care commissioning and provision. This may lead to failure to progress reconfiguration, to provide integrated care pathways that facilitate care closer to home, at the acute and community trusts.	• Existing organisations • Transition arrangements including public contact activity • Current service provision arrangements • Existing demographic and health inequalities data • Public opinion and patient experience data • Legacy document • Public Health Transition Plan	The CEO in collaboration with the CCG to develop a vision for health and healthcare Develop robust communication strategy
Failure to develop sustainable systems for delivery of care across the health economy and identify opportunities for investment for change, in the context of financial and resource constraints could increasingly be detrimental to the provision of healthcare and may lead to unmet need and failure to address health inequalities.	• CEO to CEO review and discussion • outline business case • PCT, CCG and cluster board reports • cluster support for foundation trust status applicants • Health Overview and Scrutiny Committee forward plan • commissioner led pathway development for stroke, urgent care and community outpatient clinics, with clinician involvement • investment in community services • local authority service redesign and T&W co-operative council projects including the Health Hub developed in partnership with the PCT business continuity plans.	- Forward plan for LHE Clinical Assurance Group - Robust arrangements for on going financial review and assurance established - Engagement of the CCGs - Continued public engagement and media briefings to maintain openness and address issues as they are raised - Close financial, resource and timescale monitoring - Action plan to be signed off by LHE Health Systems Improvement Board Graham Urwin, David Evans and Mike Innes (31/03/13)
Failure to maintain effective business continuity or significant delay in the development of the CCGs and cluster will increase the chance that corporate risks may not be managed effectively and may result in loss of engagement with clinicians.	• Meetings between the CCG and PCT and cluster leads. • CCG and cluster board and governance arrangements. • Cluster Director of Commissioning Development working with CCGs. • Organisational memory.	Close working between the CCG, PCT and cluster. Cluster agreement on the shape of commissioning support. Maintain robust governance mechanisms for ensuring the transfer of legal and regulatory responsibility, organisational memory and maintenance of leadership and

	• Business continuity and emergency planning.	ownership through transition. March 2013
Uncertainly about the future may result in a poor staff morale and staff leaving the local healthcare organisations because of uncertainty about their continued employment. This may lead to exacerbation of risks and skills gaps in future organisations. Long term absences may exacerbate this risk.	• Current and transitional structures. • HR department / monitoring data. • TUPE arrangements. • Business continuity plans. • Occupational health services. • Staff counselling, HR and H&S processes including stress management arrangements. • HR presence at Halesfield. • It is acknowledged that there are a number of very capable specialist staff. • NED with responsibility for staff well being throughout transition. • NEDs with responsibility for whistleblowing.	Intergrated working with Shropshire County PCT. Staff briefings. March 2013
New risks added to the Strategic Risk Register during 2012/13:		
Failure to develop sustainable systems of delivery of care across the health economy and identify opportunities for investment for change, in the context of financial and resource constraints could increasingly become detrimental to the provision of healthcare	• Financial governance: arrangements to oversee development and delivery of annual financial plan (budget) through: • Board (monthly report) • CCG PPQ and Governance Board (monthly report) • Budgetary control: through accountable budget holders (executive directors) and budget managers (senior managers) with monthly budget statements. Performance is discussed with accountants at routine monthly meetings. • Local Authority representation on PCT Board: provides an outlet to highlight our current issues. Regular liaison meetings to oversee and manage issues arising. • Health Outcome reports: routinely (monthly) provided to PPQ assurance statement to boards outlining progress. Included within these reports is an impact assessment against health inequalities. Additionally any deterioration against relevant service performance targets highlighted, with action plans produced as required. • Cluster governance arrangements.	Workforce capacity: monitoring thorugh change to ensure key roles are covered. Delivery of QIPP: QIPP action plan. Local Authority financial pressures: impact assessment of proposed budget reductions and mitigating plan produced. Financial governance arrangements: - Formal reporting through established committees to oversee delivery of financial targets - Dedicated programme officer to prepare detailed reports - Monthly reporting to the CCG and cluster board and detailed monitoring by PPQ and QIPP committee. CCG Engagement: Planning and Prioritising Group, chaired by a CCG representative, to provide support and leadership as we move to a clinically led planning process.
Poor quality information or untimely information streams from providers or internally generated sources and lack of capability to effectively analyse these will exacerbate the risk of bad decision making and performance monitoring.	• Existing informatics and monitoring mechanisms	Information: Robust review of the quality and timeliness of data streams from providers and the capabity of PCT staff to effectively use information provided.

		Continued review via the internal audit plan. TRAQS implementation will act as an information resource. Andy Inglis (on going)
Significant pending list at the acute trust and the Trust have reported that it did not have capacity to meet the 18 weeks target within deadlines	• Arrangements, including additional funding of £9m, have been implemented to enable the trust to meet a deadline of 7 weeks from 05/11/11, which are now non-negotiable.	Weekly review meetings with telephone monitoring of progress by the SHA and cluster. Continued monitoring by the LHE Board to ensure targets are met and the backlog reduced. Fran Beck (31/03/13)
Failure to establish effective mechanisms for monitoring and providers activity, or to work effectively with them, may lead to poor quality care and outcomes for patients.	• Contract monitoring • CQR • Joint working arrangements	Review contract and quality monitoring processes to ensure they are effective in identifying quality, outcomes and patient experience poor practice by all providers. Discussions with CSU re: future operation of CQR Consideration of the use of implementation of the 5Cs and patient stories in the cluster and CCGs. Christine Morris (31/03/13)
Governance structures within existing organisations may not maintain robust quality and risk management through the transition period and these services may not be fit for purpose in the new organisations.	• Newly defined governance arrangements, including quality, clinical governance and risk management • Governance planning for future organisations (cluster and CCGs) • CQC and NHSLA • Audit Committee • CQR • Legislation, DH requirements, specialist staff	Continued monitoring of compliance with safety and quality standards and legislation via quality meetings with providers. Multi-agency implementation of actions to address lessons to be learnt identified by RCA activity including those for acute mental health admission and concerns re: Winterbourne View. Christine Morris Shared risk reporting with emerging organisations. David Evans Develop policy to acheive full compliance with the Equality Act. Alison Smith Mapping of areas for the future attention of the CCG. Karen Stringer (Mandy Gatt) (all on going)
Shropshire Community Health Trust There is the potential for the community trust to fail to establish a viable business model, leading to failure to deliver services, reduction in quality and ultimately business collapse. This risk will be exacerbated by a lack of effective business continuity plans in the community and acute trusts and the local CCGs that ensure that failing services are identified and supported or decommissioned and replaced by another suitable provider.	• Community trust business planning processes • CCG business and commissioning plans • Contract monitoring • CQR meetings and monitoring	The community trust will be required to demonstrate the effectivenss of its future business plans and provide detailed evidence of the continuing management of the risks on its BAF. Revise business continuity plans for various scenarios of failure to deliver services by the community trust (this will need to include a risk appetite for the levels of tolerable failure). David Evans(31/03/13)

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 Telford and Wrekin CCG Audit committees.

6.2 Breaches of data security

NHS Telford and Wrekin has reported one data security incident during 2012/13. The incident took place at PCT premises during March 2013, when a copy of a GP performers meeting agenda was circulated to GPs in a training session erroneously. The agenda did not contain any patient identifiable information, and although it did include the names of GPs, the agenda was in relation to admittance to the PCTs performers list and did not contain any other information, and consequently this incident was not required to be reported to the Information Commissioner. An internal investigation is taking place and a serious incident reported.

6.3 Serious incidents (SIs):

NHS Telford and Wrekin reported no other serious incidents during 2012/13.

6.4. Arrangements for Annual Statement of Accounts Production

The arrangements for producing its annual statement of accounts did not work as effectively as intended. As a consequence, the Trust did not submit a set of auditable accounts for audit until 30 April 2013. This is after the deadline of by the Department of Health of 22 April 2013.

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

NHS Telford and Wrekin

Signature:

Date: 7.6.13

INDEPENDENT AUDITOR'S REPORT TO THE ACCOUNTABLE OFFICER OF TELFORD AND WREKIN PRIMARY CARE TRUST

We have audited the financial statements of Telford and Wrekin 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 34-35;
- the table of pension benefits of senior managers and related narrative notes on page 36; and
- the pay multiples narrative on page 37.

This report is made solely to the accountable officer of Telford and Wrekin 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 Telford and Wrekin 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 Telford and Wrekin 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
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	**4,799**	4,797
Other costs	5.1	**278,065**	268,781
Income	4	**(5,478)**	(5,801)
Net operating costs before interest		**277,386**	267,777
Other (Gains)/Losses	10	**26**	50
Finance costs	11	**9**	11
Net operating costs for the financial year		**277,421**	267,838
Of which:			
Administration Costs			
Gross employee benefits	7.1	**3,525**	4,236
Other costs	5.1	**5,160**	4,178
Income	4	**(939)**	(623)
Net administration costs before interest		**7,746**	7,791
Finance costs	11	**0**	11
Net administration costs for the financial year		**7,746**	7,802
Programme Expenditure			
Gross employee benefits	7.1	**1,274**	561
Other costs	5.1	**272,905**	264,603
Income	4	**(4,539)**	(5,178)
Net programme expenditure before interest		**269,640**	259,986
Other (Gains)/Losses	10	**26**	50
Finance costs	11	**9**	0
Net programme expenditure for the financial year		**269,675**	260,036

Other Comprehensive Net Expenditure	**2012-13 £000**	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**71**	0
Net (gain) on revaluation of property, plant & equipment	**(45)**	(232)
Total comprehensive net expenditure for the year*	**277,447**	267,606

The notes on pages 5 to 39 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	12	**6,225**	7,775
Total non-current assets		**6,225**	7,775
Current assets:			
Trade and other receivables	15	**1,265**	2,053
Cash and cash equivalents	16	**15**	51
Total current assets		**1,280**	2,104
Total assets		**7,505**	9,879
Current liabilities			
Trade and other payables	18	**(17,466)**	(19,624)
Provisions	20	**(72)**	(1,199)
Borrowings	19	**0**	(51)
Total current liabilities		**(17,538)**	(20,874)
Non-current assets plus/less net current assets/liabilities		**(10,033)**	(10,995)
Non-current liabilities			
Provisions	20	**(303)**	(415)
Total non-current liabilities		**(303)**	(415)
Total Assets Employed:		**(10,336)**	(11,410)
Financed by taxpayers' equity:			
General fund		**(11,308)**	(12,933)
Revaluation reserve		**972**	1,523
Total taxpayers' equity:		**(10,336)**	(11,410)

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	**(12,933)**	**1,523**	**0**	**(11,410)**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	**(277,421)**			**(277,421)**
Net gain on revaluation of property, plant, equipment		**45**		**45**
Impairments and reversals		**(71)**		**(71)**
Transfers between reserves*	**525**	**(525)**		**0**
Reclassification Adjustments				
Total recognised income and expense for 2012-13	**(276,896)**	**(551)**	**0**	**(277,447)**
Net Parliamentary funding	**278,521**			**278,521**
Balance at 31 March 2013	**(11,308)**	**972**	**0**	**(10,336)**
Balance at 1 April 2011	(15,562)	1,308	0	(14,254)
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(267,838)			(267,838)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment		232		232
Transfers between reserves*	17	(17)		0
Total recognised income and expense for 2011-12	(267,821)	215	0	(267,606)
Net Parliamentary funding	270,450			270,450
Balance at 31 March 2012	(12,933)	1,523	0	(11,410)

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		**(277,386)**	(267,777)
Depreciation and Amortisation		**482**	427
Impairments and Reversals		**440**	0
(Increase)/Decrease in Trade and Other Receivables		**788**	(1,569)
Increase/(Decrease) in Trade and Other Payables		**(2,175)**	80
Provisions Utilised		**(596)**	(953)
Increase/(Decrease) in Provisions		**(652)**	84
Net Cash Inflow/(Outflow) from Operating Activities		**(279,099)**	(269,708)
Cash flows from investing activities			
(Payments) for Property, Plant and Equipment		**(372)**	(739)
Proceeds of disposal of assets held for sale (PPE)		**965**	0
Net Cash Inflow/(Outflow) from Investing Activities		**593**	(739)
Net cash inflow/(outflow) before financing		**(278,506)**	(270,447)
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		**278,521**	270,450
Net Cash Inflow/(Outflow) from Financing Activities		**278,521**	270,447
Net increase/(decrease) in cash and cash equivalents		**15**	0
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**0**	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		**15**	0

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

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

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 £3,331,000 - 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. Land and buildings (£5,894,000) 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 Telford & Wrekin 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

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

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

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

1. Accounting policies (continued)

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

1.7 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

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

1.8 Non-current assets held for sale

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

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive 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. Accounting policies (continued)

1.9 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.

1.10 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).

1.11 Clinical negligence costs

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

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

1.12 Employee benefits

Short-term employee benefits

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

Retirement benefit costs

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

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

1. Accounting policies (continued)

1.13 Research and development

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

1.14 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

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

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

1. Accounting policies (continued)

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

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

The PCT as lessor

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

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.

Financial assets at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Statement of Comprehensive Net Expenditure. The net gain or loss incorporates any interest earned on the financial asset.

Held to maturity investments
Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

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

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

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

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

1. Accounting policies (continued)

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

Financial liabilities at fair value through profit and loss
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Statement of Comprehensive Net Expenditure. The net gain or loss incorporates any interest earned on the financial asset.

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, Telford & Wrekin PCT was dissolved on 1st April 2013. The PCT’s functions, assets and liabilities transferred to other public sector entities as outlined in Note 41 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 2012-13 £000	**Total 2012-13 £000**
Gross operating costs	194,628	73,917	4,896	9,423	**282,864**
Miscellaneous revenue	(1,180)	(3,665)	(40)	(593)	**(5,478)**
Net operating costs before interest	193,448	70,252	4,856	8,830	**277,386**
Gains/losses & finance costs				35	**35**
Net operating costs	193,448	70,252	4,856	8,865	**277,421**
Revenue resource limit	194,236	69,979	5,223	9,140	**278,578**
Surplus/(deficit)	**788**	**(273)**	**367**	**275**	**1,157**

	Clinical Commissioning Consortia 2011-12 £000	National Commissioning Board 2011-12 £000	Public Health Service 2011-12 £000	Corporate Functions 2011-12 £000	**Total 2011-12 £000**
Gross operating costs	193,026	67,571	5,294	7,687	**273,578**
Miscellaneous revenue	(1,132)	(3,909)	(195)	(565)	**(5,801)**
Net operating costs before interest	191,894	63,662	5,099	7,122	**267,777**
Gains/losses & finance costs				61	**61**
Net operating costs	191,894	63,662	5,099	7,183	**267,838**
Revenue resource limit	191,977	64,007	5,734	7,218	**268,936**
Surplus/(deficit)	**83**	**345**	**635**	**35**	**1,098**

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		267,838
Net operating cost plus (gain)/loss on transfers by absorption	**277,421**	
Revenue Resource Limit	**278,578**	268,936
Under/(Over)spend Against Revenue Resource Limit (RRL)	**1,157**	1,098

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	**(172)**	786
Charge to Capital Resource Limit	**(602)**	526
(Over)/Underspend Against CRL	**430**	260

3.3 Under/(Over)Spend Against Cash Limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**278,521**	270,450
Cash Limit	**278,521**	270,450
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)	**240,050**
Less: Trade Income from DH	**(2)**
Sub total: net advances	**240,048**
Plus: cost of Dentistry Schemes (central charge to cash limits)	**9,092**
Plus: drugs reimbursement (central charge to cash limits)	**29,381**
Parliamentary funding credited to General Fund	**278,521**

4. Miscellaneous Revenue

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Dental Charge income from Contractor-Led GDS & PDS	**2,002**		**2,002**	2,058
Prescription Charge income	**1,313**		**1,313**	1,279
NHS Trusts	**620**	**620**	**0**	710
NHS Foundation Trusts	**15**	**15**	**0**	0
Primary Care Trusts - Other	**60**	**56**	**4**	100
Department of Health - Other	**2**	**0**	**2**	1
Local Authorities	**0**	**0**	**0**	303
Education, Training and Research	**1,037**	**1**	**1,036**	859
Rental revenue from operating leases	**237**	**237**	**0**	135
Other revenue	**192**	**10**	**182**	356
Total miscellaneous revenue	**5,478**	**939**	**4,539**	5,801

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	**23,789**		**23,789**	26,016
Non-Healthcare	**1,077**	**1,040**	**37**	626
Total	**24,866**	**1,040**	**23,826**	26,642
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	**127,414**	**1,003**	**126,411**	125,086
Goods and services (other, excl Trusts, FT and PCT)	**9**	**0**	**9**	343
Total	**127,423**	**1,003**	**126,420**	125,429
Goods and Services from Foundation Trusts	**26,706**	**272**	**26,434**	25,421
Purchase of Healthcare from Non-NHS bodies	**13,348**		**13,348**	10,167
Expenditure on Drugs Action Teams	**1,277**		**1,277**	1,288
Non-GMS Services from GPs	**1,134**	**0**	**1,134**	581
Contractor Led GDS & PDS (excluding employee benefits)	**11,621**		**11,621**	10,797
Chair, Non-executive Directors & PEC remuneration	**72**	**72**	**0**	93
Executive committee members costs	**196**	**196**	**0**	178
Consultancy Services	**271**	**219**	**52**	277
Prescribing Costs	**25,332**		**25,332**	26,170
G/PMS, APMS and PCTMS (excluding employee benefits)	**23,670**	**0**	**23,670**	22,694
Pharmaceutical Services	**222**		**222**	190
Local Pharmaceutical Services Pilots	**64**		**64**	48
New Pharmacy Contract	**5,710**		**5,710**	5,545
General Ophthalmic Services	**1,769**		**1,769**	1,783
Supplies and Services - Clinical	**1,310**	**0**	**1,310**	1,048
Supplies and Services - General	**47**	**41**	**6**	27
Establishment	**1,028**	**860**	**168**	797
Premises	**886**	**713**	**173**	576
Impairments & Reversals of Property, plant and equipment	**440**	**0**	**440**	0
Depreciation	**482**	**347**	**135**	427
Impairment of Receivables	**0**	**0**	**0**	1
Research and Development Expenditure	**18**	**0**	**18**	(88)
Audit Fees	**95**	**95**	**0**	84
Other Auditors Remuneration	**25**	**25**	**0**	36
Clinical Negligence Costs	**0**	**0**	**0**	13
Education and Training	**96**	**42**	**54**	203
Grants for capital purposes	**2,349**	**0**	**2,349**	284
Grants for revenue purposes	**7,145**	**0**	**7,145**	7,482
Other	**463**	**235**	**228**	588
Total Operating costs charged to Statement of Comprehensive Net Expenditure	**278,065**	**5,160**	**272,905**	268,781
Employee Benefits (excluding capitalised costs)				
PCT Officer Board Members	**344**	**344**	**0**	509
Other Employee Benefits	**4,455**	**3,181**	**1,274**	4,288
Total Employee Benefits charged to SOCNE	**4,799**	**3,525**	**1,274**	4,797
Total Operating Costs	**282,864**	**8,685**	**274,179**	273,578
Analysis of grants reported in total operating costs				
For capital purposes				
Grants to fund Capital Projects - GMS	**2,349**	**0**	**2,349**	284
Total Capital Grants	**2,349**	**0**	**2,349**	284
Grants to fund revenue expenditure				
To Local Authorities	**6,262**	**0**	**6,262**	6,352
To Private Sector	**883**	**0**	**883**	0
To Other	**0**	**0**	**0**	1,130
Total Revenue Grants	**7,145**	**0**	**7,145**	7,482
Total Grants	**9,494**	**0**	**9,494**	7,766

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**7,746**	**7,208**	**538**
Weighted population (number in units)*	**164,027**	**164,027**	**164,027**
Running costs per head of population (£ per head)	**47**	**44**	**3**
PCT Running Costs 2011-12			
Running costs (£000s)	7,802	7,039	763
Weighted population (number in units)	161,390	161,390	161,390
Running costs per head of population (£ per head)	48	44	5

5.2 Analysis of Operating Expenditure by Expenditure Classification

	2012-13 £000	2011-12 £000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	**23,670**	22,694
Prescribing costs	**25,332**	26,170
Contractor led GDS & PDS	**11,621**	10,797
General Ophthalmic Services	**1,769**	1,783
Pharmaceutical services	**222**	190
Local Pharmaceutical Services Pilots	**64**	48
New Pharmacy Contract	**5,710**	5,545
Non-GMS Services from GPs	**1,134**	581
Total Primary Healthcare purchased	**69,522**	67,808
Purchase of Secondary Healthcare		
Learning Difficulties	**1,955**	2,890
Mental Illness	**23,075**	23,519
Maternity	**7,778**	7,676
General and Acute	**112,338**	106,741
Accident and emergency	**4,605**	4,316
Community Health Services	**26,038**	27,581
Other Contractual	**14,387**	12,751
Total Secondary Healthcare Purchased	**190,176**	185,474
Grant Funding		
Grants for capital purposes	**2,349**	284
Grants for revenue purposes	**7,145**	7,482
Total Healthcare Purchased by PCT	**269,192**	261,048
Healthcare from NHS FTs included above	**26,375**	23,832

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. The most significant property lease is for the PCT's headquarters, which has 16 years remaining and total future rentals of £2,580,000.

	Land	Buildings	Other	2012-13 Total	2011-12
	£000	£000	£000	£000	£000
Payments recognised as an expense					
Minimum lease payments				**295**	281
Total				**295**	281
Payable:					
No later than one year	**0**	**258**	**11**	**269**	293
Between one and five years	**0**	**1,031**	**11**	**1,042**	1,043
After five years	**0**	**2,064**	**0**	**2,064**	2,320
Total	**0**	**3,353**	**22**	**3,375**	3,656
Total future sublease payments expected to be received				0	0

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	2011-12
	£000	£000
Recognised as income		
Rental Revenue	**237**	135
Total	**237**	135

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	3,947	2,894	1,053	3,774	2,766	1,008	173	128	45
Social security costs	320	237	83	320	237	83	0	0	0
Employer Contributions to NHS BSA - Pensions Division	474	351	123	474	351	123	0	0	0
Other pension costs	10	7	3	10	7	3	0	0	0
Termination benefits	48	36	12	48	36	12	0	0	0
Total employee benefits	4,799	3,525	1,274	4,626	3,397	1,229	173	128	45
Less recoveries in respect of employee benefits	0	0	0	0	0	0	0	0	0
Total - Net Employee Benefits including capitalised costs	4,799	3,525	1,274	4,626	3,397	1,229	173	128	45
Employee costs capitalised	0	0	0	0	0	0	0	0	0
Gross Employee Benefits excluding capitalised costs	4,799	3,525	1,274	4,626	3,397	1,229	173	128	45
Recognised as:									
Commissioning employee benefits	4,799			4,626			173		
Gross Employee Benefits excluding capitalised costs	4,799			4,626			173		

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	2,575	2,339	236
Social security costs	725	725	0
Employer Contributions to NHS BSA - Pensions Division	1,133	1,133	0
Other pension costs	10	10	0
Termination benefits	354	354	0
Total gross employee benefits	4,797	4,561	236
Less recoveries in respect of employee benefits	0	0	0
Total - Net Employee Benefits including capitalised costs	4,797	4,561	236
Employee costs capitalised	0	0	0
Gross Employee Benefits excluding capitalised costs	4,797	4,561	236
Recognised as:			
Commissioning employee benefits	4,797		
Gross Employee Benefits excluding capitalised costs	4,797		

The 11/12 figures for social security costs & employer pension contributions were overstated by a total of £936K 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	3	3	0	3	3	0
Administration and estates	47	38	9	43	39	4
Nursing, midwifery and health visiting staff	7	7	0	7	7	0
Scientific, therapeutic and technical staff	3	3	0	3	3	0
Social Care Staff	1	0	1	4	0	4
Other	38	36	2	35	35	0
TOTAL	99	87	12	95	87	8
Of the above - staff engaged on capital projects	0	0	0	1	1	0

7.3 Staff Sickness Absence and Ill Health Retirements

	2012-13 Number	2011-12 Number
Total days lost	**1,559**	2,833
Total staff years	**183**	407
Average working days lost	**8.5**	7.0

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	*Number of other departures agreed Number	Total number of exit packages by cost band Number	*Number of compulsory redundancies Number	*Number of other departures agreed Number	Total number of exit packages by cost band Number
Lees than £10,000	**0**	**1**	**1**	1	0	**1**
£10,001-£25,000	**0**	**0**	**0**	2	0	**2**
£25,001-£50,000	**1**	**0**	**1**	2	0	**2**
£50,001-£100,000	**0**	**0**	**0**	1	0	**1**
£100,001 - £150,000	**0**	**0**	**0**	4	0	**4**
£150,001 - £200,000	**0**	**0**	**0**	0	0	**0**
>£200,000	**0**	**0**	**0**	1	0	**1**
Total number of exit packages by type (total cost	**1**	**1**	**2**	**11**	**0**	**11**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Total resource cost	**46**	**2**	**48**	919	0	919

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.

8.0 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

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

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.

9. Better Payment Practice Code

9.1 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	**6,179**	**41,403**	5,829	29,591
Total Non-NHS Trade Invoices Paid Within Target	**5,717**	**34,388**	5,382	26,613
Percentage of NHS Trade Invoices Paid Within Target	**92.5%**	**83.1%**	92.3%	89.9%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3,057**	**198,206**	2,491	179,393
Total NHS Trade Invoices Paid Within Target	**2,052**	**189,211**	1,586	174,158
Percentage of NHS Trade Invoices Paid Within Target	**67.1%**	**95.5%**	63.7%	97.1%

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.

10. 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)	**(30)**	**0**	**(30)**	(50)
Gain/(Loss) on disposal of assets held for sale	**4**	**0**	**4**	0
Total	**(26)**	**0**	**(26)**	(50)

11. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest				
Total interest expense	**0**	**0**	**0**	0
Other finance costs	**0**	**0**	**0**	0
Provisions - unwinding of discount	**9**		**9**	11
Total	**9**	**0**	**9**	11

12.1 Property, Plant and Equipment

2012-13	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:									
At 1 April 2012	**2,067**	**5,296**	**0**	**0**	**106**	**0**	**491**	**160**	**8,120**
Additions of Assets Under Construction				0					**0**
Additions Purchased	0	382	0		0	0	7	0	**389**
Reclassifications as Held for Sale	(851)	(110)	0	0	0	0	0	0	**(961)**
Disposals other than for sale	0	(30)	0	0	0	0	(132)	0	**(162)**
Upward revaluation/positive indexation	0	38	0	0	7	0	0	0	**45**
Impairments/negative indexation	(40)	(31)	0	0	0	0	0	0	**(71)**
At 31 March 2013	**1,176**	**5,545**	**0**	**0**	**113**	**0**	**366**	**160**	**7,360**
Depreciation									
At 1 April 2012	**0**	**0**	**0**	**0**	**6**	**0**	**293**	**46**	**345**
Disposals other than for sale	0	0	0		0	0	(132)	0	**(132)**
Impairments	0	440	0	0	0	0	0	0	**440**
Charged During the Year	0	387	0		8	0	71	16	**482**
At 31 March 2013	**0**	**827**	**0**	**0**	**14**	**0**	**232**	**62**	**1,135**
Net Book Value at 31 March 2013	**1,176**	**4,718**	**0**	**0**	**99**	**0**	**134**	**98**	**6,225**
Purchased	1,176	4,718	0	0	99	0	134	98	**6,225**
Total at 31 March 2013	**1,176**	**4,718**	**0**	**0**	**99**	**0**	**134**	**98**	**6,225**
Asset financing:									
Owned	1,176	4,718	0	0	99	0	134	98	**6,225**
Total at 31 March 2013	**1,176**	**4,718**	**0**	**0**	**99**	**0**	**134**	**98**	**6,225**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	**670**	**843**	**0**	**0**	**10**	**0**	**0**	**0**	**1,523**
Movements (DV revaluation & indexation)	(396)	(162)	0	0	7	0	0	0	**(551)**
At 31 March 2013	**274**	**681**	**0**	**0**	**17**	**0**	**0**	**0**	**972**

12.2 Property, Plant and Equipment

2011-12	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	**£000**
Cost or valuation:									
At 1 April 2011	**2,605**	**6,085**	**0**	**343**	**96**	**0**	**465**	**160**	**9,754**
Additions - purchased	0	550	0	0	0	0	26	0	**576**
Reclassifications	0	343	0	(343)	0	0	0	0	**0**
Disposals other than by sale	0	(50)	0	0	0	0	0	0	**(50)**
Revaluation & indexation gains	5	217	0	0	10	0	0	0	**232**
Cumulative dep netted off cost following revaluatio	(543)	(1,849)	0	0	0	0	0	0	**(2,392)**
At 31 March 2012	**2,067**	**5,296**	**0**	**0**	**106**	**0**	**491**	**160**	**8,120**
Depreciation									
At 1 April 2011	**543**	**1,530**	**0**		**0**	**0**	**208**	**29**	**2,310**
Charged During the Year	0	319	0		6	0	85	17	**427**
Cumulative dep netted off cost following revaluatio	(543)	(1,849)	0	0	0	0	0	0	**(2,392)**
At 31 March 2012	**0**	**0**	**0**	**0**	**6**	**0**	**293**	**46**	**345**
Net Book Value at 31 March 2012	**2,067**	**5,296**	**0**	**0**	**100**	**0**	**198**	**114**	**7,775**
Purchased	2,067	5,296	0	0	100	0	198	114	**7,775**
At 31 March 2012	**2,067**	**5,296**	**0**	**0**	**100**	**0**	**198**	**114**	**7,775**
Asset financing:									
Owned	2,067	5,296	0	0	100	0	198	114	**7,775**
At 31 March 2012	**2,067**	**5,296**	**0**	**0**	**100**	**0**	**198**	**114**	**7,775**

12.3 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 the Valuation Office agency with an effective date of 30th September 2009.

Each year since then, desk-top revaluations of the same assets are undertaken. 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.

All valuations were undertaken by Jon Jones MRICS

Asset lives for each class of asset fall into the following ranges :-
- Buildings : 5 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.

13. 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	0	0	0
Over-specification of assets	0	0	0
Abandonment of assets in the course of construction	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen obsolescence	0		0
Loss as a result of catastrophe	0		0
Other	433		433
Changes in market price	7		7
Total charged to Annually Managed Expenditure	**440**		**440**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Changes in market price	71		
Total impairments for PPE charged to reserves	**71**		
Total Impairments of Property, Plant and Equipment	**511**	**0**	**440**

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.

The main impairment loss is £355,000 and relates to Donnington Health Centre which became surplus to requirements and was sold to the GPs.

14. Intra-Government and Other Balances

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with other Central Government Bodies	**91**	**0**	**937**	**0**
Balances with Local Authorities	**224**	**0**	**2,012**	**0**
Balances with NHS Trusts and Foundation Trusts	**708**	**0**	**3,438**	**0**
Balances with bodies external to government	**242**	**0**	**11,079**	**0**
At 31 March 2013	**1,265**	**0**	**17,466**	**0**
Prior period:				
Balances with other Central Government Bodies	189	0	479	0
Balances with Local Authorities	682	0	3,635	0
Balances with NHS Trusts and Foundation Trusts	669	0	6,603	0
Balances with Public Corporations and Trading Funds	60	0	178	0
Balances with bodies external to government	453	0	8,729	0
At 31 March 2012	2,053	0	19,624	0

15.1 Trade and Other Receivables

	Current		Non-current	
	31 Mar 2013	31 Mar 2012	**31 Mar 2013**	31 Mar 2012
	£000	£000	**£000**	£000
NHS receivables - revenue	**751**	858	**0**	0
NHS prepayments and accrued income	**27**	0	**0**	0
Non-NHS receivables - revenue	**471**	925	**0**	0
Non-NHS prepayments and accrued income	**0**	210	**0**	0
VAT	**16**	60	**0**	0
Total	**1,265**	2,053	**0**	0
Total current and non current	**1,265**	2,053		
Included above:				
Prepaid pensions contributions	**0**	0		

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	**54**	695
By three to six months	**103**	10
By more than six months	**193**	0
Total	**350**	705

16. Cash and Cash Equivalents

	31 Mar 2013 £000	31 Mar 2012 £000
Opening balance	**51**	0
Net change in year	**(36)**	51
Closing balance	**15**	51
Made up of		
Cash with Government Banking Service	**15**	0
Commercial banks	**0**	51
Cash and cash equivalents as in statement of financial position	**15**	51
Bank overdraft - Government Banking Service	**0**	(51)
Cash and cash equivalents as in statement of cash flows	**15**	0
Patients' money held by the PCT, not included above	**0**	0

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	0	0	0	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	851	110	0	0	0	0	0	0	0	**961**
Less assets sold in the year	(851)	(110)	0	0	0	0	0	0	0	**(961)**
Balance at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
										0
Balance at 1 April 2011	0	0	0	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2012	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2012	0	0	0	0	0	0	0	0	0	**0**

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

At 31 March 2012	0
At 31 March 2013	0

There were 2 significant assets held for sale and disposed of in the year:

1. Land at the Princess Royal Hospital valued at £530,000 which was sold to the local acute Trust.
2. Donnington Health Centre valued at £400,000 which was sold to the GPs.

18 Trade and other payables

	Current		Non-current	
	31 Mar 2013	31 Mar 2012	**31 Mar 2013**	31 Mar 2012
	£000	£000	**£000**	£000
NHS payables - revenue	**4,233**	7,082	**0**	0
Family Health Services (FHS) payables	**3,331**	3,671		
Non-NHS payables - revenue	**2,062**	3,839	**0**	0
Non-NHS payables - capital	**138**	121	**0**	0
Non_NHS accruals and deferred income	**5,695**	2,823	**0**	0
Social security costs	**0**	51		
Tax	**1**	59		
Other	**2,006**	1,978	**0**	0
Total	**17,466**	19,624	**0**	0
Total payables (current and non-current)	**17,466**	19,624		

19. Borrowings

	Current		Non-current	
	31 Mar 2013	31 Mar 2012	**31 Mar 2013**	31 Mar 2012
	£000	£000	**£000**	£000
Bank overdraft - Government Banking Service	**0**	51		
Bank overdraft - commercial banks	**0**	0		
PFI liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
LIFT liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**0**	0	**0**	0
Other (describe)	**0**	0	**0**	0
Total	**0**	51	**0**	0

20. Provisions

	Total £000s	Pensions to Former Directors £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Restructuring £000s	Continuing Care £000s	Equal Pay £000s	Agenda for Change £000s	Other £000s	Redundancy £000s
Balance at 1 April 2012	**1,614**	34	302	55	0	151	0	0	797	275
Arising During the Year	**44**	3	39	2	0	0	0	0	0	0
Utilised During the Year	**(596)**	(4)	(38)	(55)	0	0	0	0	(224)	(275)
Reversed Unused	**(696)**	0	0	0	0	(151)	0	0	(545)	0
Unwinding of Discount	**9**	1	8	0	0	0	0	0	0	0
Balance at 31 March 2013	**375**	**34**	**311**	**2**	**0**	**0**	**0**	**0**	**28**	**0**
Expected Timing of Cash Flows:										
No Later than One Year	**72**	**4**	**38**	**2**	**0**	**0**	**0**	**0**	**28**	**0**
Later than One Year and not later than Five Years	**167**	**16**	**151**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Later than Five Years	**136**	**14**	**122**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

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

As at 31 March 2013	90
As at 31 March 2012	0

"Other" provisons are made up of:
Prescribing Incentive Scheme £28k

21. Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities		
Equal Pay	**0**	0
Other (employers/public liability claims)	**(1)**	0
Amounts Recoverable Against Contingent Liabilities	**0**	0
Net Value of Contingent Liabilities	**(1)**	0
Contingent Assets		
Contingent Assets	**0**	0
Net Value of Contingent Assets	**0**	0

22. 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.

23.1 Financial Assets

	At 'fair value through profit and loss' £000	Loans and receivables £000	Available for sale £000	Total £000
Receivables - NHS		**778**		**778**
Receivables - non-NHS		**471**		**471**
Cash at bank and in hand		**15**		**15**
Total at 31 March 2013	**0**	**1,264**	**0**	**1,264**
Receivables - NHS		858		858
Receivables - non-NHS		926		926
Cash at bank and in hand		51		51
Total at 31 March 2012	0	1,835	0	1,835

23.2 Financial Liabilities

	At 'fair value through profit and loss' £000	Other £000	Total £000
NHS payables		**4,233**	**4,233**
Non-NHS payables		**7,895**	**7,895**
Total at 31 March 2013	**0**	**12,128**	**12,128**
NHS payables		7,082	7,082
Non-NHS payables		6,711	6,711
Other borrowings		51	51
Total at 31 March 2012	**0**	13,844	13,844

24. 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. Payments include creditors at the year end.

GP Practice	Board/PEC/CCG Member	2012/13 Payments £000
Donnington	Jim Hudson	2,143
Newport (Linden Hall)	Stefan Waldendorf	1,333
Oakengates (Limes Walk)	Karen Stringer	1,853
Stirchley	Mike Innes	1,549
Sutton Hill	Andy Inglis	1,029

In addition, Donnington Health Centre was sold to the GP Practice for £400,000.

Some GPs that are on the PCT Board, CCG Board or CAP members are also involved with Shropshire Doctors Cooperative Ltd, payments of £2,272,852 were made to Shropshire Doctors Cooperative Ltd in 2012/13.

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 Telford & Wrekin 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 Telford & Wrekin PCT's charitable funds.

25. Losses and Special Payments

There were no losses and special payments in 2012-13.

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	7,461	2
Special payments - PCT management costs	72,455	6
Losses in respect of the provision of family practitioner services	0	0
Special payments in respect of the provision of family practitioner services	0	0
Total losses	7,461	2
Total special payments	72,455	6
Total losses and special payments	79,916	8

26. 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.

Telford & Wrekin CCG (£202.2m)
NHS England (£67.7m)
NHS Property Services (£0.3m)
Telford & Wrekin Council (£10.4m)
Public Health England (£0.6m)

(*Figures are based on the baseline return completed by the PCT and may not reflect the final allocations)

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

Shropshire Community Health NHS Trust (assets £1.6m)
NHS Property Services (assets £4.4m)
Department of Health (liabilities £11.2m)
Telford & Wrekin CCG (liabilities £5.1m)