Department of Health

NHS

Yorkshire and the Humber Strategic Health Authority

2012-13 Annual Report and Accounts

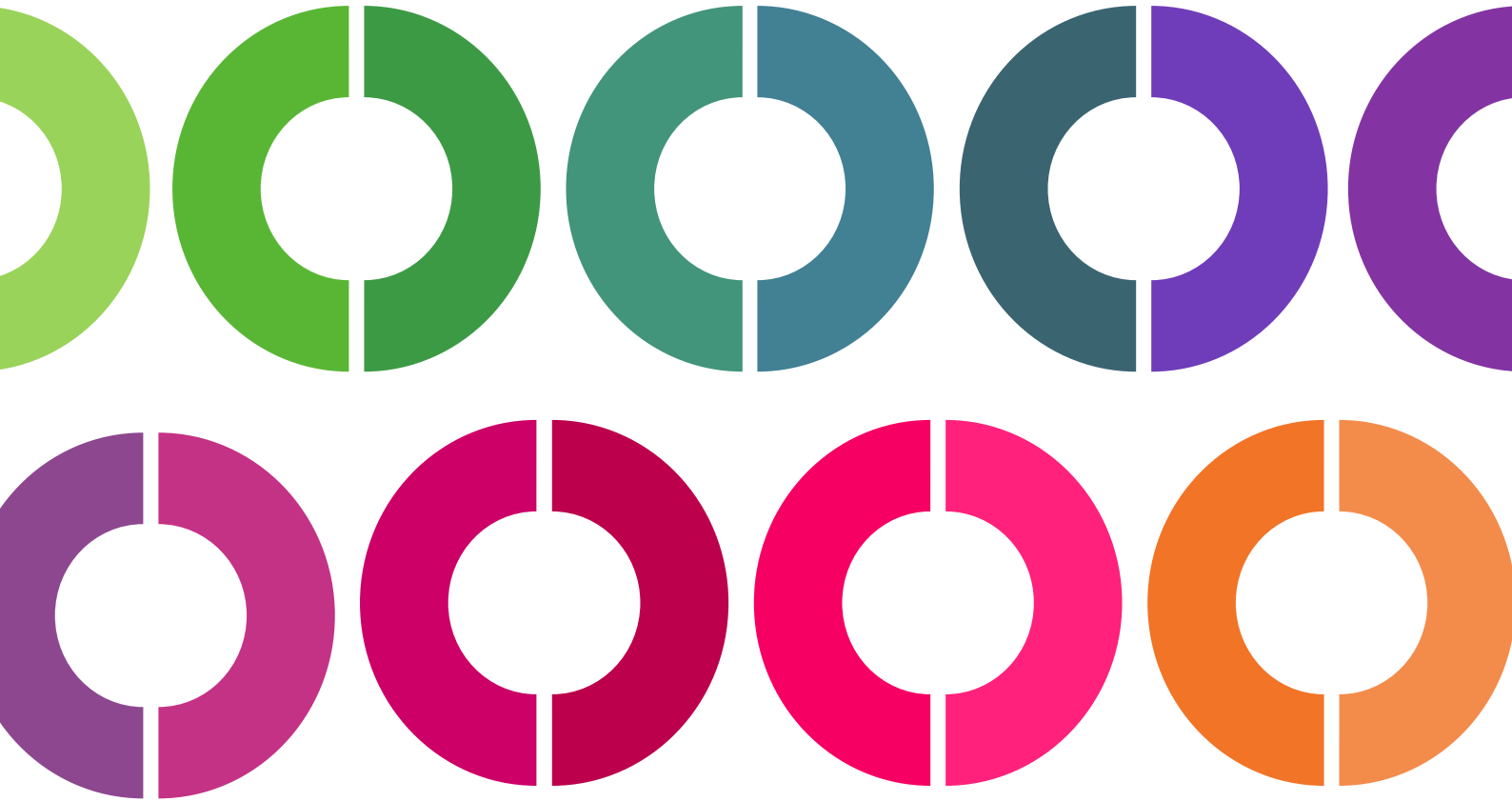
Published to gov.uk, in PDF format only.

www.gov.uk/dh

Yorkshire and the Humber Strategic Health Authority

2012-13 Annual Report

NHS
Yorkshire and the Humber



ANNUAL REPORT
AND FINANCIAL STATEMENTS

2012/ 2013

Yorkshire and the Humber Strategic Health Authority
Part of NHS North of England

1. Joint foreword from the Chair and Chief Executive

This final annual report of the three strategic health authorities (SHAs) that make up NHS North of England is an opportunity to reflect – not just over the past year, but over the whole period of the SHAs – and acknowledge the contribution we have made towards improving health and healthcare for people who live in the North of England.

NHS North East, NHS North West and NHS Yorkshire and the Humber came into being in 2006 as a result of mergers of eight smaller SHAs established in 2002. During this time we have taken the NHS through a period of growth and development in the earlier years, but also through more financial and service pressures in the last three years.

Our stewardship of the NHS through the years of our tenure has hopefully lived up to the expectations of a good farmer – another generation of caring for land! Our land was the NHS and we weathered most of the storms and tried not to let the thistles grow under our feet. We have worked it hard and sought to get the best value we could. We have also grown ideas, encouraged innovation and introduced new technology to increase productivity and efficiency. We have overseen the governance and professional standards that continuously improved the environment for our patients and endeavour to protect them from avoidable harm.

Now we hand over to the new organisations that will manage the future NHS.

Our successor bodies will continue to face the challenges of ensuring the NHS stays relevant and trusted so it is able to serve an ageing population against the rising costs of treatments and constant increases in the number of people with long-term conditions.

We hand over during the most radical period of transition the NHS has seen since its inception in 1948. A transition to a new NHS that will be ever more patient-focused and clinically-led, with its success measured by outcomes.

We feel we have achieved so much it would be invidious to pick out too many examples. Put simply, what we have done is put the people first and work with the resources given to us to create as much health and as many good health services as we could:

- We have supported the development of our providers to be amongst the best hospitals, mental health services, community teams and general practices in the country.
- We have driven health improvement and tackled health inequalities – including world class innovations like Fresh, the North East Office for Tobacco Control, the Our Life public engagement social enterprise in the North West and the award-winning Altogether Better community health champions model in Yorkshire and the Humber.
- We have encouraged the research and delivery of technical innovations across the North from telemedicine in prisons to early adoption of new cancer drugs…

…and so much more.

All this success is due to the hard work and commitment of our staff. We are genuinely grateful to everyone who has worked in the SHAs and in the NHS organisations across the North in a particularly challenging time. Staff who, despite great uncertainties in their own futures, have unfailingly shown their dedication to delivering excellence to patients and health improvements for our population.

This year has very much been a year of transition, preparing to move from old structures to the new organisations that will continue to implement the changes to the NHS set out in the Health and Social Care bill 2010.

We wish our successors all the best for the future and pass the baton to them to take the NHS in the North of England forward for the benefit of those who use it.

Kathryn Riddle
Chair
NHS North of England

Professor Stephen Singleton OBE
Interim Chief Executive
NHS North of England

2. The area we serve

Set up in July 2006, NHS Yorkshire and the Humber was the regional headquarters of the NHS until 31 March 2013. During that time the organisation acted as a key link between the Department of Health (DH) and local NHS organisations such as hospitals and primary care trusts (PCTs).

There are 15 PCTs, 22 NHS trusts, 32 general hospitals and 34 community hospitals in the Yorkshire and the Humber region, which covers an area of some 15,000 square kilometres and has a population of more than five million. The community we served includes large urban settlements such as Hull, Leeds and Sheffield as well as rural areas, often with scattered populations, such as the East Riding of Yorkshire and North Yorkshire.

Different sections of the community have different health needs and differences in the make up of populations can be seen within the region. Urban areas tend to have higher numbers of younger people, with older populations found more in coastal and rural areas. Urban areas also tend to have larger proportions of ethnic minorities, such as Bradford's Asian community. These groups may have specific health needs, such as a greater risk from diabetes or coronary heart disease, and may be at greater risk from health inequalities.

Health inequalities remain a significant issue in our region, with people in most of our PCT areas experiencing poorer health and having greater likelihood of premature death than the average for England. During our tenure we continued to focus on reducing health inequalities, especially the main causes of ill health and premature death such as cancer, coronary heart disease, diabetes, and chronic obstructive pulmonary disease. In some areas this also included stroke, mental and behavioural disorders and accidents.

Health profiles for both local authority areas and individual GP practices are available from the Association of Public Health Observatories website **www.apho.org.uk.**

The Yorkshire and the Humber Public Health Observatory website **www.yhpho.org.uk** provides a good source for further analysis.

In preparation for the transition to GP commissioning and the establishment of clinical commissioning groups (CCGs) in 2013, which is now underway, primary care trusts (PCTs) during 2011/12 formed cluster PCTs to ensure capacity and capability is maintained throughout the period of change.

The PCT clusters are:

Cluster	Comprising:
Airedale, Bradford and Leeds	• NHS Bradford and Airedale • NHS Leeds
Calderdale, Kirklees and Wakefield	• NHS Calderdale • NHS Kirklees • NHS Wakefield District
Humber	• NHS East Riding of Yorkshire • NHS Hull • NHS North Lincolnshire • North East Lincolnshire Care Trust Plus
North Yorkshire and York	• NHS North Yorkshire and York
South Yorkshire and Bassetlaw	• NHS Barnsley • NHS Bassetlaw • NHS Doncaster • NHS Rotherham • NHS Sheffield

NHS organisations in Yorkshire and the Humber

Primary Care Trusts

- NHS Barnsley
- NHS Bassetlaw
- NHS Bradford and Airedale
- NHS Calderdale
- NHS Doncaster
- NHS East Riding of Yorkshire
- NHS Hull
- NHS Kirklees
- NHS Leeds
- North East Lincolnshire Care Trust Plus
- NHS North Lincolnshire
- NHS North Yorkshire and York
- NHS Rotherham
- NHS Sheffield
- NHS Wakefield District

NHS Trusts

- Hull and East Yorkshire Hospitals NHS Trust
- Leeds Teaching Hospitals NHS Trust
- The Mid Yorkshire Hospitals NHS Trust
- Leeds Community Healthcare NHS Trust

Ambulance Services

- Yorkshire Ambulance Service NHS Trust

Care Trusts

- Bradford District Care Trust

Foundation Trusts

- Airedale NHS Foundation Trust
- Barnsley Hospital NHS Foundation Trust
- Bradford Teaching Hospitals NHS Foundation Trust
- Calderdale and Huddersfield NHS Foundation Trust
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust
- Harrogate and District NHS Foundation Trust
- Humber NHS Foundation Trust
- Leeds and York Partnership NHS Foundation Trust
- Northern Lincolnshire and Goole Hospitals NHS Foundation Trust
- Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust
- The Rotherham NHS Foundation Trust
- Sheffield Children's NHS Foundation Trust
- Sheffield Health and Social Care NHS Foundation Trust
- Sheffield Teaching Hospitals NHS Foundation Trust
- South West Yorkshire Partnership NHS Foundation Trust
- York Hospitals NHS Foundation Trust

3. Business model: transition

About NHS North of England

On 3 October 2011, the three strategic health authorities (SHAs) across the North of England – NHS North East, NHS North West and NHS Yorkshire and the Humber – were placed under a single management framework and began to work together as NHS North of England – one of four SHA 'clusters' across England.

NHS North of England's area covers 126 NHS organisations and 50 local authorities, with over 380,000 NHS staff providing health and social care to over 14.7 million people,and a NHS budget of £26 billion.

Our collective aim has been to ensure the delivery of safe, high quality services, providing excellent patient experience and with strong clinical outcomes during organisational changes within the NHS.

As part of NHS North of England, the three statutory SHA bodies remained in place until the end of March 2013 and, during that time, continued to be responsible for the performance and development of the NHS across the region.

NHS North of England was led by one single executive management team – details of the team are available within the North of England SHA cluster board section on page 44.

This annual report outlines the progress of NHS Yorkshire and the Humber, as part of NHS North of England, during 2012/13.

NHS changes under the Health and Social Care Act 2012

The SHA has continued to lead a huge amount of work under the transition programme, which began in March 2011, to co-ordinate the implementation of NHS changes taking place under the Health and Social Care Act 2012

Working together with chief executives from primary care trusts, NHS foundation trusts, local authorities, clinical commissioning groups and the NHS Commissioning Board, a lot of our work this year has focussed on a detailed transition plan for Yorkshire and the Humber, to ensure smooth and effective handover of functions and work to successor organisations.

This work has covered the functions below, as well as the corporate transition of the SHA and primary care trust clusters:

- Maintaining and improving the quality of health outcomes.
- Developing the NHS workforce.
- Provider development.
- Public health services.
- Commissioning arrangements.
- Support for local authorities to establish health and wellbeing boards.

Governance of the transition programme – which was a shared programme across the three SHAs in the NHS North of England cluster – was through the transition programme board, which provided ongoing assurance to the NHS North of England chief executive that transition was on track, with all risks and issues actively managed.

The transition programme board

The detailed work of the transition programme was to ensure that functions, information and assets which were the responsibility of the three SHAs making up NHS North of England, were either transferred successfully to the appropriate new organisation, or brought to satisfactory conclusion by 31 March 2013. The transition board co-ordinated and oversaw, on behalf of NHS North of England, the development and implementation of transition and closedown plans, to ensure the appropriate systems, processes and assurances were in place to support the SHA cluster through the final year of its operation to successful organisational closure.

The SHAs also continued to exercise oversight and assurance over the handover and closure programmes of primary care trusts (PCTs) across the North of England up until the 31 March 2013. The transition programme board which oversaw this work consisted of senior representatives from eleven specialist work streams:

- Workforce, education and training.
- Corporate affairs.
- Operations and performance.
- Estates.
- Human resources.
- Chief Nurse and quality and safety.
- Informatics.
- Finance.
- Public health.
- Commissioning development.
- Provider development

Programme assurance was provided through a monthly report, completed by PCT transition leads and SHA cluster work stream leads and reviewed by the programme board. This allowed the programme board to identify emerging risks and issues and plan mitigating actions at a regional and local level. The transition director reported on the overall progress of the programme to the SHA cluster board.

4. Our staff

Throughout the period of transition we continued to focus on providing help and support to our staff.

The human resources teams within NHS North of England worked together and actively engaged with receiver organisations to promote good working relationships and a smooth transition.

A job matching process was completed at the end of November 2012, and staff were informed of the outcomes. In addition, a large number of staff successfully secured roles in one of the new receiver organisations via the ring fenced recruitment process. The majority of SHA staff transferred to one of the new receiver organisations under the “lift and shift” process.

The number of staff employed by NHS Yorkshire and the Humber in 2012/13 was 464, including staff employed by organisations hosted by the SHA. Staff turnover for the year was 13 per cent, a decrease on last year which was 15 per cent. Sickness has risen compared to last year which was 1.8 per cent and now stands at 2 per cent.

Staff involvement

In 2011/12 a decision was taken not to participate in further national annual staff surveys as the timescales would provide limited opportunities to respond to the feedback from staff. Instead, it was agreed that an NHS North of England ‘Pulse’ survey - to monitor the attitudes and mood of staff - would be conducted. This provided staff with more frequent opportunities to give feedback at intervals throughout 2012/13, and for more immediate responses to be formulated and implemented to address any issues arising from the survey.

The NHS North of England interim chief executive established a programme of monthly staff briefings via video conference and these were supplemented by executive director briefings throughout the year. In addition, the SHA maintained bi-monthly Staff Partnership Forum meetings which were well attended by representatives from each directorate and provided an opportunity for regular exchange of information and updates.

A joint SHA/Trade Union Partnership Forum with representatives of the four main trade unions recognised by the SHA met on a monthly basis. This was an opportunity to work in partnership to ensure that the best interests of our staff were taken into account in the planning process leading up to March 2013, and it provided a forum for formal consultation on the organisational change process.

Information regarding the transition was also communicated to staff regularly via the interim chief executive’s weekly newsletter, the SHA intranet and the HR transition website.

Staff health and wellbeing

During 2012/13, the SHA continued to invest in the health and wellbeing of its staff. A dedicated health and wellbeing group was promoted across the organisation via screensavers, the intranet and the staff weekly bulletin. Topics covered this year included the Global Corporate Challenge, smoking cessation, gym membership and flu vaccines.

The HR team further developed the staff wellbeing section on the intranet and this provided information and details of wellbeing support and services.

In addition, an area dedicated to health and wellbeing was established in the staff restaurant, Cafe Blenheim.

Education, training and development

One of the SHA's aims has been to support staff and ensure they were equipped with the skills and knowledge they will need in the future, as well as in the jobs they do today. Throughout 2012/13 an outplacement support service delivered a number of staff training workshops including career planning, CV and application form preparation, job hunting and interview skills.

In partnership with the Job Centre Plus, we were also able to offer staff who had not yet secured a job role, the opportunity to take up training to support them in future career searches.

5. Equality and diversity

The SHA continued to provide leadership on equality and diversity (E&D) to NHS commissioner and provider organisations across the region during the transition period.

The SHA co-ordinated and facilitated the Regional Equality and Diversity Leads (REDL) network which provided E&D leads in NHS organisations with a platform for sharing best practice and learning throughout the year.

In 2012/13 the REDL network produced and published a protocol in support of the provision of high quality care to transgender people who may access NHS services in the region. The protocol is based largely on guidance issued by the Equality and Human Rights Commission. It reflects changes associated with enactment of the Equality Act 2010 and can be used both to inform good practice and as a template to develop local policies.

The NHS Equality Delivery System

The NHS Equality Delivery System (EDS), which was introduced in the spring of 2012, provided a framework to help NHS organisations deliver the Government's commitment to fairness and personalisation including the equality pledges of the NHS Constitution. It has also helped NHS organisations to respond more readily to the public sector equality duties within the Equality Act 2010.

Whilst use of the EDS is voluntary, uptake in the region has been extensive and the SHA has organised and delivered training for managers and clinicians to support ongoing implementation of the system within local NHS organisations.

The SHA has also encouraged NHS commissioners and providers to participate in a national review of the EDS. The review highlighted widespread support as well as identifying some areas for improvement.

Conference for clinicians and service users to explore transgender issues in care

In 2012, the SHA held a conference exploring transgender issues in care. The event, which received over 160 applications for 80 places, received very positive feedback from clinicians and service users. As result of the event, and the high level of interest it generated, NHS organisations developed local awareness raising sessions for NHS staff, some of which were sponsored by the SHA.

Diversity research project

In 2012/13 the SHA initiated a research project into the issues facing E&D leads in progressing equality and diversity in their organisations. The project involved conducting a series of interviews with E&D leads and senior leaders in regional provider and commissioner organisations.

The project identified areas for further development such as:

- Encouraging commissioners and providers of NHS services to progress beyond a compliance culture.
- Ensuring executive teams understand why equality and diversity should be regarded as a priority and part of the core business.
- Developing a narrative for managers and clinicians that sets out why equality and diversity is important in service delivery.

A report detailing the research and its results is being prepared and will be shared across the region.

Training programme for E&D leads

The SHA arranged for a cohort of seven E&D leads from regional NHS organisations to take part in a national training and development programme. Feedback from the participants has been very positive and they are continuing their development by participating in a self-facilitated learning set.

6. Environmental issues and sustainability

During 2012/13 NHS Yorkshire and the Humber continued to provide leadership on sustainability and climate change across the region, working closely with the NHS Sustainable Development Unit (SDU) and regional sustainability leads in NHS North West and NHS North East.

Further improvement was made to the proportion of NHS organisations in Yorkshire and the Humber that have board-approved sustainable development management plans, which rose to 87.5 per cent. There was also steady progress in tackling carbon emissions across the region.

The SHA-hosted Climate Change Management Group continued to operate as an effective network for the exchange of information and dissemination of good practice. There have been numerous local examples of initiatives in sustainability and carbon management which further the sustainability agenda, support modern models of care and deliver significant cost savings.

The SHA regional sustainability lead focused on developing and strengthening local sustainability networks to enable them to become self-supporting when the SHA no longer exists. This has included actively forging links with local government sustainability networks.

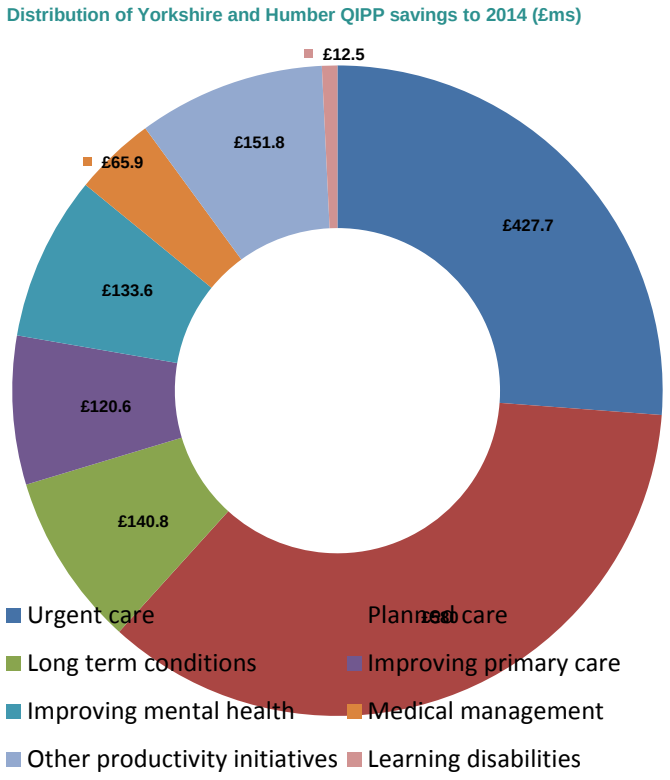
In 2012/13 the SHA continued its work to reduce overall energy consumption and keep staff engaged and informed of environmental issues and sustainability. During the transition process the reuse of furniture, IT equipment and software licenses has been a key consideration. As a sender organisation, the SHA has already made available SharePoint servers and other IT equipment to other NHS organisations.

The SHA's five year sustainable development implementation plan (SDIP), adopted in 2010, remained within its targets for the SHA's final year. As a clustered SHA the board level lead for NHS North of England was Paul Johnstone, Regional Director of Public Health.

7. Quality, innovation, productivity and prevention (QIPP) report 2012/13

2012/ 13 marks the end of the third year of the national challenge to improve quality and productivity of services and at the same time, achieve efficiency savings of approximately £20 billion in the NHS by April 2014.

In Yorkshire and the Humber, QIPP programmes aim to achieve efficiencies which will save around £1.6 billion by 2014. The chart below shows how the planned savings are distributed against eight main categories. For each category, NHS organisations have programmes of work that are aimed at making the best use of technology, innovative approaches, IT, workforce skills and clinicians' time. In addition to making savings, the QIPP challenge has set out to achieve sustainable improvements to the quality and safety of hospital and community care and also provide more support to patients and families for managing chronic illness closer to home.



Both NHS trusts and commissioning organisations undertake rigorous QIPP planning and implementation. During this year of commissioning transition, primary care trusts (PCTs) have worked closely with emerging clinical commissioning groups (CCGs) and local area teams to ensure effective QIPP strategy and management. Collaboration between providers and commissioners has been key to successful transformation and this kind of partnership was a central theme of QIPP management work streams across Yorkshire and the Humber in 2012/13.

In 2011/12, Yorkshire and Humber QIPP schemes by NHS trusts, PCT clusters and CCGs achieved productivity savings of £482m, 99 per cent of the target for the year. The reported position for March 2013 demonstrates productivity savings to the end of 2012/13 as £434m, 102 per cent of the target for the year.

The table below demonstrates the progress to date of Yorkshire and Humber health economies in achieving their four year QIPP savings targets.

PCT Cluster	Four year total planned target £000	Savings to date (11/12 + 12/13) %
Total Airedale, Bradford and Leeds	**379,137**	**56%**
NHS Bradford and Airedale	145,800	59%
NHS Leeds	233,337	54%
Total Calderdale, Kirklees and Wakefield	**296,055**	**52%**
NHS Calderdale	60,277	51%
NHS Kirklees	123,548	52%
NHS Wakefield District	112,230	52%
Total Humber	**310,587**	**56%**
NHS East Riding of Yorkshire	100,692	54%
NHS Hull	104,597	59%
NHS North Lincolnshire	49,441	53%
North East Lincolnshire Care Trust Plus	55,857	57%
Total North Yorkshire and York	**268,239**	**53%**
Total South Yorkshire and Bassetlaw	**439,513**	**57%**
NHS Barnsley	72,644	59%
NHS Bassetlaw	36,956	59%
NHS Doncaster	99,003	56%
NHS Rotherham	74,857	63%
NHS Sheffield	156,053	54%
Total PCT Cluster savings in Yorkshire and the Humber	**1,693,530**	**55%**

The SHA tracked the progress and delivery of QIPP initiatives in each of the five PCT clusters in Yorkshire and the Humber and their constituent PCTs during 2012/13. Over the final months of this transition year, the SHA has handed over understanding and responsibility for assurance of QIPP in Yorkshire and the Humber to NHS England.

8. Performance review for the Yorkshire and the Humber health economy

Across Yorkshire and the Humber our communities continued to focus on the delivery of all NHS performance targets with particular attention being given to the priorities (domains) identified in the NHS Operating Framework 2012/13 outlined below.

Domain 1: Preventing people from dying prematurely

Ambulance quality (category A response times)

Purpose: responsive ambulance services are critical for emergency patients. We expect a minimum of 75 per cent of category A calls to result in the arrival of an emergency response within eight minutes, and 95 per cent to result in the arrival of an emergency response within 19 minutes.

Indicator	Period	Planned performance	Actual performance	Data source
Category A Red 1 & Red 2, 8 minute response times	March 2013	75% of calls to result in the arrival of a vehicle at scene within 8 minutes.	75.73%	YAS published data
Category A Red 1, 8 minute response times	March 2013	75% of calls to result in the arrival of a vehicle at scene within 8 minutes.	74.38%	YAS published data
Category A Red 2, 8 minute response times	March 2013	75% of calls to result in the arrival of a vehicle at scene within 8 minutes.	95.61%	YAS published data
Category A Red 1 & Red 2, 19 minute response times	March 2013	95% of calls to result in the arrival of a vehicle at scene within 19 minutes.	96.68%	YAS published data

Progress Red 1, eight minute response times: the target for Red 1 in 2012/ 2013 remained at 75 per cent, with an aspiration to reach 80 per cent by April 2013. The achievement of the Red 1 standard remained a significant challenge for all ambulance services, but the Yorkshire Ambulance Service NHS Trust remained on track to achieve improvement in Q4 after implementing the key actions detailed within its Red 1 project plan and consistent with the trajectory submitted to the Department of Health.

Progress Red 2, 19 minute response times: stable and performing well.

Cancer 31 day and 62 day waits

Purpose: implementation of the Cancer Reform Strategy including cancer access targets for treatment within 31 days and 62 days.

Indicator	Period	Planned performance	Actual performance	Data source
Cancer waits – referral to treatment (62 days)	Oct to Dec 2012-13	90%	89.85%	Cancer waiting times database
Cancer waits – diagnosis to treatment (31 days)	Oct to Dec 2012-13	96%	98.76%	Cancer waiting times database

Progress: progress continued to be made to ensure communities sustained waiting times for access to cancer treatments.

Domain 4: Ensuring that people have a positive experience of care

Referral to treatment

Purpose: to ensure that no-one waited more than 18 weeks from referral to hospital treatment.

Indicator	Period	Planned performance	Actual performance	Data source
Referral to treatment (RTT) % admitted	February 2013	90% of patients to begin treatment within 18 weeks of referral	91.5%	DH published data
RTT % non-admitted	February 2013	95% of patients to begin treatment within 18 weeks of referral	96.34%	DH published data
RTT % incomplete	February 2013	92% of patients to begin treatment within 18 weeks of referral	93.85%	DH published data

Progress: all acute trusts and commissioners continued to strive to deliver these operational standards as per their contractual commitments and the pledges in the NHS Constitution. Much progress was made on reducing the number of long waits this year and the SHA worked actively with these organisations to ensure that patients were seen in the timeliest manner possible and that backlogs were eradicated.

A & E

Purpose: to ensure all patients were seen and treated within four hours of presentation.

Indicator	Period	Planned performance	Actual performance	Data source
% patients seen within four hours	Full year 12-13	95%	95.04%%	Unify weekly A&E report

Progress: all acute trusts and commissioners continued to strive to deliver minimum A&E waiting times within four hours and progress continues to be made.

Cancer two week wait

Purpose: implementation of the Cancer Reform Strategy including cancer access targets for treatment within two weeks, 31 days and 62 days.

Indicator	Period	Planned performance	Actual performance	Data source
Two week target	Oct to Dec 2012-13	93%	95.74%	Cancer waiting times database

Progress: progress continued to be made to ensure communities sustained waiting times for access to cancer treatments.

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

Healthcare associated infections (HCAIs)

Purpose: to achieve a zero tolerance for all avoidable HCAIs in line with national objectives: MRSA and Clostridium Difficile (C. Diff).

Indicator	Period	Planned performance	Actual performance	Data source
MRSA blood stream infections	April 2012 to February 2013	97	99	Unify 2
MRSA blood stream infections (monthly) average	April 2012 to February 2013	8.8	9	Unify 2
C. Difficile - hospital acquired infections only	April 2012 to February 2013	686	635	Unify 2
C: Difficile – all PCT	April 2012 to February 2013	1512	1590	Unify 2

Progress: progress has been made to improve infection control within healthcare and to ensure that the number of HCAI cases are minimised. MRSA cases in Yorkshire and the Humber fell by more than 20% in 12-13 when compared to 11-12 and the number of C.Diff cases fell by 20% in 12-13 when compared to 11-12.

9. Performance, finance and assurance

The finance and performance teams continued to work closely together in line with the SHA's business model to improve health services and the health of the population across the region. Both teams held local NHS organisations to account for any underperformance against national performance standards.

Performance

The performance team was responsible for ensuring the delivery of key NHS programmes across NHS organisations in Yorkshire and the Humber.

Key achievements in 2012/2013:

Cancer

NHS Yorkshire and the Humber continued to successfully deliver all eight of the operational standards set out as part of the Cancer Reform Strategy.

Stroke

Each hospital trust in Yorkshire and the Humber has been through an external peer review process for accreditation of their stroke services. This process has been over three years in the making following on from the publication of *Healthy Ambitions* (the SHA's clinically-led vision for improving healthcare in the region) which highlighted Yorkshire and the Humber as an outlier in the delivery of stroke care. The accreditation process assessed how trusts delivered the core elements highlighted within *Healthy Ambitions* and the National Stroke Strategy. Only one of our trusts has not yet been accredited.

Mixed Sex Accommodation

NHS Yorkshire and the Humber continued to make progress in eliminating Mixed Sex Accommodation breaches. In 2012-13 there were 41 breaches which represents an 87% reduction on the previous year where there were 308.

10. Nursing and quality

The main strategic objectives of the directorate included quality, professional nursing practice, the safeguarding of children and vulnerable adults and the delivery of the health visitor programme. A key activity in the second half of the year was the preparation and validation of the key patient safety and quality information to be handed over to successor bodies.

Key achievements in 2012/ 13

Quality

Safety and governance

- Continuous monitoring of quality within the region including serious incidents, never events, Hospital Standard Mortality Rates (HSMR and SHMI), themes and trends.
- Supporting the development and implementation of national and regional quality dashboards.
- Working to develop the regional approach to the implementation of the national initiatives such as the Safety Thermometer and Energise for Excellence, as well as the transparency work taking place across the North of England.
- Assessment of quality of potential foundation trusts.

Safeguarding adults and children

- Supporting improvements in safeguarding reviews. (NHS Yorkshire and the Humber also carried out this piece of work for NHS North East)
- Ensuring capacity and corporate memory were maintained during transition.
- Improving share and spread of learning from safeguarding investigations for the health service.
- Supporting frontline staff by improving opportunities to share information and knowledge with colleagues by setting up a forum for child safeguarding leads, having recognised this as one of our high risk areas.
- Ensuring that safeguarding expertise and capacity was maintained and transferred to new organisations.

Healthcare acquired infections

- Continuing to make significant reductions in the number of MRSA and Clostridium Difficile cases throughout 2011/12 and 2012/13.
- Working to share and spread best practice across the North of England.

Eliminating mixed-sex accommodation

- We have achieved significant improvements across the region on this key priority and have set up mechanisms to report, publish and audit data for mixed-sex accommodation in NHS-funded care.

Service and patient impact

Stroke

- Continuing to make improvements in performance against the two stroke vital signs (percentage of patients who spend 90 per cent of time on a stroke unit; percentage of patients with a high risk of transient ischemic attack (TIA) who are seen and commence treatment within 24 hours). Similar achievements were made against a much broader range of indicators such as patients receiving a scan within four hours of admission, being seen and assessed by a speech and language specialist within 24 hours and receiving a comprehensive package of rehabilitation and after care.
- Continuing to utilise the region-wide stroke assurance framework – a programme of external peer review. Accreditation of stroke services was undertaken in collaboration with the three stroke networks.
- Ensuring the vast majority of organisations are now either fully or provisionally accredited to provide hyper-acute, acute and rehabilitation services.
- Working to complete the handover of the accreditation process to the successor bodies.

Patient experience and engagement

- Ensuring all primary care trusts in the region successfully comply with their legal duty to engage with patients, carers and the public in designing and implementing service changes.
- Working with the performance team to improve ways that patient experience is tracked and reported.
- Sharing innovation and learning through a regional network, regular briefings and a series of master classes to support and develop all NHS organisations in the region.

NHS continuing healthcare

- Playing an active role nationally with the Department of Health and Association of Directors of Adult Social Services to support the NHS Commissioning Board in delivering its responsibilities for NHS continuing healthcare.

Healthy Ambitions

- The pathways identified in *Healthy Ambitions* remained important vehicles in achieving the directorate's objectives.

Children's services and maternity

- Developing a number of resources and services to improve the on-going care of children with asthma and diabetes.
- Launching *Competence in Teams – Caring for Children*. This framework aims to help improve children's physical and mental wellbeing by identifying the competencies needed to provide proactive services that respond to children and young people with acute, continuing and complex needs. This will benefit commissioners, providers and the workforce.
- Developing initiatives to support breast feeding and neonatal care, women accessing services and reduce unnecessary interventions.
- On-going delivery of the Nursing and Midwifery Council standards for local supervisory authority (LSA) practice.
- Seeing three of the region's maternity services win awards for best practice - Doncaster and Bassetlaw NHS Foundation Trust, Calderdale and Huddersfield NHS Foundation Trust and Hull and East Yorkshire Hospitals NHS Trust.

Learning disabilities

- Ensuring all localities completed the enhanced commissioning assurance framework.
- The learning disabilities health panel has contributed to the NHS Future Forum review.

Mental health/ Improving Access to Psychological Therapies (IAPT) / dementia

- Establishing IAPT pathfinder sites in Hull and Sheffield for long term conditions and medically unexplained symptoms.
- Launching national dementia commissioning packs across all localities in Yorkshire and Humber
- Establishing a call to action programme on reducing inappropriate prescribing of low dose anti-psychotics.
- Undertaking a state of readiness review prior to implementation on mental health payment by results.

Priorities for 2012/13

Systems assurance

- Ensuring a safe and effective handover of all safety and quality assurance functions to new organisations through the transition period.
- Improving the timeliness and quality of serious incident reporting, investigation and management, as assessed by commissioners.
- Ensuring the continuation of effective and appropriate patient, public, service user and carer engagement across Yorkshire and the Humber.

Improved quality and safety

- Continuing to strengthen partnerships with local safeguarding children boards and local safeguarding adults' boards to enable coherent, streamlined safeguarding work programmes and accountabilities.
- Improving outcomes in pregnancy and childbirth, including breast-feeding rates.
- Ensuring quality outcomes for people with dementia by auditing the use of low dose anti-psychotic prescribing and developing an integrated approach to commissioning dementia services.
- Reducing health inequalities for people with learning disabilities.
- Improving key aspects of nursing and midwifery care, e.g. reducing pressure ulcers, falls and infections through the energising for excellence and transparency approach.
- Ensuring the implementation of the NHS Safety Thermometer – a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care.
- Ensuring aspirant foundation trusts meet the requirements of Monitor's quality governance framework.

Improved quality and experience

- Supporting improvements in patient experience during the transition period.
- Improving the privacy and dignity of patients and service users in the region through eliminating mixed sex accommodation.
- Reducing the number of out-of-area placements in mental health.
- Implementing the four-year plan for talking therapies.

11. Commissioning development

The commissioning development directorate worked closely with primary care trust cluster chief executives and directors of commissioning development to arrange implementation of the new commissioning arrangements described in the white paper *Equity and Excellence: Liberating the NHS* and contained in the Health and Social Care Act 2012.

This work covered three elements:

- The development of clinical commissioning groups (CCGs) ready to take on their full responsibilities from April 2013.
- The establishment of commissioning support arrangements that can provide CCGs with the services that they will require to carry out their commissioning role.
- The transfer of the direct commissioning responsibilities for primary care services, offender and prison health, military health and some aspects of public health services to the new NHS Commissioning Board.

An important part of this work was the engagement by the emerging CCGs (and the NHS Commissioning Board) with local authorities to prepare them for new responsibilities including:

- The creation of Health and Wellbeing Boards.
- The transfer of public health responsibilities to local authorities.
- The need for NHS commissioners to work with local authorities to develop joint strategies and integrated approaches to commissioning services.

The directorate also continued to take forward work on strategic service issues that cut across individual organisational boundaries, including work on major trauma and stroke services.

Supporting the commissioning transition

From 1 April 2013 there have been 23 CCGs within Yorkshire and the Humber. All 23 have progressed through the authorisation process and have received site visits organised by the NHS Commissioning Board. CCGs have been authorised in four waves. The six CCGs in wave one were authorised in December 2012 with the 10 in wave two authorised in January 2012. The four CCGs in wave three received their authorisation decision in February 2013 with the three remaining CCGs being authorised in March 2013.

Throughout 2012/13 primary care trust (PCT) clusters established CCGs as sub-committees of their boards and there was increasing delegation of day-to-day responsibility for planning and commissioning decisions to these sub-committees, with all budgets now successfully delegated to the CCGs.

Key achievements and priorities in 2012/13

- The 23 CCGs were supported by organisation and development plans to make their submissions to the NHS Commissioning Board's (NHS CB) authorisation process and are now operating in shadow form, ready for full operation from April 2013.
- Joint working with PCT cluster directors of commissioning development to support delivery of the new commissioning arrangements through a shared commissioning development and contingency programme.
- Designate leadership roles in CCGs identified with a programme of leadership development support available for clinicians taking on these new roles, with designates successfully authorised via the NHS CB's assessment centres.
- A weekly transition newsletter was produced, in partnership with Local Government Yorkshire and the Humber that communicated guidance, events and information of interest to local authorities and NHS organisations.
- PCT clusters and emerging CCGs identified new commissioning support arrangements based on three areas (North Yorkshire and Humber, South Yorkshire and Bassetlaw and West Yorkshire) with dedicated leadership, and whose viability had been confirmed by the NHS CB following successful submissions for checkpoints one to four.
- A Memorandum of Understanding was agreed between all CCGs and the relevant commissioning support service to cover the services to be provided in 2012/13.
- CCGs produced clear plans setting out the approach to commissioning services in 2012/13 and meeting the quality improvement productivity and prevention (QIPP) challenge, as an integral part of the PCT cluster single integrated plan process.
- CCGs were involved in all shadow Health and Wellbeing Boards and linking to local authorities on the development of joint strategic needs assessments and health and wellbeing strategies.
- Work was carried out with the Department of Health on the design of the new arrangements for the direct commissioning of primary care services by the NHS CB, including the approach to joint NHSCB-CCG work on improving the quality of primary care.
- CCGs played a full role in the development of Health and Wellbeing Boards.
- Successful transfer of primary care commissioning to the NHS CB and delivery of the NHSCB's operational model.

- Implementation of the single operating model for specialised commissioning, offender and prison health and military health.
- Recruitment to new organisations continued to proceed at pace.
- Preparation for the transfer of PCT contracts to the new bodies along with arrangements for services commissioned collaboratively by CCGs.
- Continuing to promote engagement with local authority and other strategic partners at a regional level to support local engagement activity.
- Developing and sharing understanding of how the new system will operate including clinical networks, clinical senates and connections with public health at national and local level.
- The NHS CB regional and local area teams are in place with senior teams recruited and new working arrangements starting to be implemented.

Strategy and partnerships

Key achievements and priorities in 2012/13

- Continued to develop the new Yorkshire and the Humber major trauma network and implement region-wide major trauma standards with the aim of saving up to 100 lives per year. This has been successfully transferred into regional specialised commissioning arrangements. This aims to reduce disability and increase NHS productivity through shorter stays and better co-ordination for major trauma patients.
- Continued to provide leadership on service change and reconfiguration work within the region, supporting more than 20 reconfiguration proposals ranging from information advice and guidance to formal assurance.
- Produced *Better for Less* briefings identifying practical and evidenced-based guides to delivering better care for patients at reduced costs.
- Produced *Getting Ready* briefings to pass on key experience and information to new CCGs and ensure effective handover to the new NHS system being implemented from April 2013.
- Continued the strategic focus on the improvement of stroke services, with an accreditation programme to assure standards in hospitals across Yorkshire and the Humber and the implementation of a telemedicine system to facilitate round-the-clock stroke care including thrombolysis.

Priorities for 2012/13

- The development and successful implementation of new clinical senate arrangements to support the new commissioning system and work with existing networks.
- The transition of reconfiguration and service planning priorities into the new NHS architecture.
- Work with local authority colleagues to provide regional leadership and support to NHS and local government colleagues through the transition.

12. Provider development

As part of the overall reform programme for the NHS, all NHS trusts are required to have achieved foundation trust (FT) status or submitted their application for assessment by Monitor. From April 2013, the NHS Trust Development Authority (NTDA) will formally take over responsibility for delivering this objective.

The provider development team worked with providers of NHS healthcare to support their development as robust, clinically and cost-effective organisations, ensuring they had good governance and the resilience to deliver the healthcare required by our communities. Over the last year, the SHA's provider development team has worked closely with the NTDA to ensure a smooth transition and handover for the remaining NHS trusts in Yorkshire and Humber.

In July 2012, Scarborough and North East Yorkshire Healthcare NHS Trust merged with York Teaching Hospitals NHS Foundation Trust. The successful acquisition by York Teaching Hospitals was considered the best solution for the people and communities within the local health economy, enabling the viability of clinical services in Scarborough to be protected and strengthened through merging with clinical teams at York.

Bradford District Care NHS Trust, Hull and East Yorkshire Hospitals NHS Trust and the Yorkshire Ambulance Service NHS Trust all successfully completed the SHA assurance process, demonstrating its readiness for Monitor assessment. Our expectation is that they will be formally authorised as foundation trusts during 2013.

Newly created as a standalone trust in 2011, Leeds Community Healthcare NHS Trust is making good progress with its FT preparations and whilst there have been some delays, their progression to Monitor is also expected to take place during 2013.

As one of the largest and most complex trusts in the country, the progression of Leeds Teaching Hospitals NHS Trust was more challenging. The trust was successful in 2011 in delivering a major reconfiguration of clinical services across the General Infirmary and St. James's sites. Further internal changes are required to enable the trust to complete a successful application and following discussion between the trust, the SHA and the NTDA a timescale will be agreed as part of the NTDA Annual Planning process.

Early in 2011, The Mid Yorkshire Hospitals NHS Trust successfully commissioned two new Private Finance Initiative (PFI) hospitals at Pinderfields and Pontefract. However, there are still significant challenges for this organisation in clinical configuration and finance. During 2012, the management of the trust changed, and a new board was appointed. Performance significantly improved through the year, with service standards being consistently met and the successful delivery of in-year financial targets. The future viability of the trust is closely linked to a reconfiguration of clinical services across the trust's three sites. It is expected that the commissioners will launch a public consultation during 2013 on the proposed changes. It is within this context, that the trust board announced during 2012 that it would not be making an application for foundation trust status by April 2014 and discussions continue with the NTDA on future plans.

Aspirant trusts*	Initial Planned DH submission date
Yorkshire Ambulance Service NHS Trust	1 December 2012
Leeds Teaching Hospital NHS Trust	TBC
Leeds Community Healthcare NHS Trust	April 2013
Hull and East Yorkshire Hospitals NHS Trust	January 2013
Bradford District Care Trust	1 November 2012
The Mid Yorkshire Hospitals NHS Trust	TBC

* In July 2012 Scarborough and North East Yorkshire Healthcare NHS Trust was acquired by the York Teaching Hospitals NHS Foundation Trust.

13. Public health

The public health directorate was part of the wider regional public health and social care group, which also encompassed colleagues from the Department of Health and the Yorkshire and the Humber Public Health Observatory (YHPHO). We also worked with the regional Health Protection Agency team.

The group supported local organisations in their activities to improve health and wellbeing and reduce health inequalities, and supported health protection, emergency planning and NHS commissioners.

Key achievements in 2012/13:

Public health transition

- The public health transition assurance process operated throughout the year, offering support and advice to the local directors of public health network.
- A Yorkshire and Humber-wide risk register was developed and refreshed on a regular basis.
- In December 2012 the SHA was assured that all local areas were well placed to make a successful public health transition at the end of March 2013.
- The SHA successfully supported the Yorkshire and Humber Public Health Transition Steering Group – a multi-agency group which operated throughout the year to guide the transition.
- Regular reports to the Public Health England transition team and to the SHA board on public health transition were produced on issues regarding the transition process.

Directors of Public Health Network

- The SHA supported directors of public health across the region via their regular network meetings. This covered a wide range of business including health protection, health improvement and healthcare services.

Vaccination and immunisation

- Vaccine uptake rates for all the routine childhood vaccinations given by ages one, two and five were higher in 2011/12 than the previous year.
- Uptake of the first dose of vaccine against measles, mumps and rubella for children reaching their second birthday was 93 per cent in 2011/12 compared to 91 per cent in 2010/11.

Health inequalities

- Building on the report *The Big Opportunity Part Two* **http://www.yhpho.org.uk/resource/item.aspx?RID=106410** we continued to support local organisations to draw on the work of the Marmot review in order to tackle the wider determinants of inequalities in health and wellbeing. We continued to work with the Public Health Observatory on its programme to support joint strategic needs assessment (JSNA); and with Minding the Gap to build capacity in local authorities in designing workshops on JSNA and Marmot.
- We established pilot projects in nine hospitals to collect data from emergency departments (EDs) that the police, licensing authorities and other partners can use to stop violent attacks from happening. We also worked with the Yorkshire Ambulance Service to test whether routinely collected ambulance service data could supplement or even replace ED data in helping the police, local authorities and partners plan and act to stop violence happening.
- Work was initiated in two areas in Sheffield to harness the unique power of Altogether Better health champions. These champions support the development of communities and are seen by local people as a source of health and wellbeing advice.
- The SHA continued to support local leads for affordable warmth and extended the network to include local authorities as well as NHS staff. The public health team instigated a successful bid to the Warm Homes Healthy People fund which led to the production of the *Winter Warmth Toolkit*, a comprehensive set of communications tools which has received national recognition and widespread take up.

Oral health

- We ensured the safe transition of oral health improvement and dental commissioning functions to Public Health England and the NHS Commissioning Board local area teams in Yorkshire and the Humber.
- The SHA continued to support national dental pilots in Yorkshire and the Humber; these pilot contracts are based on registration, capitation and quality and aim to improve the quality of patient care, increase access to NHS dental services and to improve oral health, especially the oral health of children.

Screening

- We worked with the incipient NHS Commissioning Board and Public Health England to design the new commissioning model for screening programmes and to ensure safe transition into the new system.
- A series of workshops and training events were organised to cover new developments in screening programmes, serious incident management and the new commissioning model.
- Audit visits to maternity units in 14 trusts were carried out to examine two fail-safe points in antenatal and newborn screening programmes. The purpose of the audit was to strengthen and improve processes to ensure the eligible population is correctly identified and all positive results are dealt with appropriately. Individual trust-based reports were completed to assist organisations to identify development areas and action plans.

Workforce

- The Liberating Public Health Development Programme – a bespoke programme for directors of public health and teams across primary care trust, health protection agency, public health observatory and local authorities to support individuals and teams – was very successful. The programme was a mix of development sessions and master classes which addressed the critical issues in public health.
- The SHA public health team worked with partners in the north to commission a leadership programme for band six to eight public health practitioners.
- The SHA and DH public health teams worked with the PHE transition team through the year to prepare for the establishment of Public Health England Region and Yorkshire and Humber Centre. This was a complex process but the new region and centre teams are beginning to work in their new roles.
- Making Every Contact Count (MECC) and the use of the Prevention and Lifestyle Behaviour Change: a competence framework in Yorkshire and the Humber and wider continued at pace. Recent evaluation described the 'viral' impact of MECC and illustrated the diverse adoption across local authority, various health settings including mental health and acute care, fire services, probation services, pharmacy and others. A conference in October 2012 embedded the ‘evidence into legacy’ theme. Innovative e-learning packages, SROI tools, evaluations and other materials are available on the website **www.makingeverycontactcount.co.uk**

NHS healthcare professional alert notices

The issue of an alert is a method by which NHS bodies and others can be made aware of a registered healthcare professional whose performance gives rise to concern that patients or staff may, in future, be at risk of harm either from inadequate or unsafe clinical practise or from inappropriate behaviour. The alert system is not a part of the NHS disciplinary process or statutory regulatory framework; it is an integral part of the system for pre-employment checks.

The public health team successfully managed a system across Yorkshire and the Humber, allowing alerts to be processed, distributed and monitored in a highly confidential manner. A national database is maintained containing all active alerts across England.

14. Informatics

Yorkshire and the Humber programme for information technology

The key aim of Yorkshire and the Humber's programme for information technology (Y&HPfIT) was to deliver personalised, convenient, safe and supportive care, enabled by innovative use of technology. In addition the programme aimed to support the delivery of the White Paper *Equity and Excellence: Liberating the NHS*, and the information revolution by putting patients first and giving people more information**,** control and greater choice about their care.

Key achievements:

Delivering the building blocks for integrated care – electronic patient record

Roll out of the information-sharing infrastructure based on a single primary/ community care system in our region continued in 2012/2013. 100 per cent of the region's community services, child health and prison services, custody suites (West Yorkshire) and 71 per cent of GP practices plan to use TPP SystmOne.

NHS Yorkshire and the Humber worked with NHS trusts providing secondary care to help them achieve system interoperability – a key requirement for patient centred, integrated, care pathways. The Summary Care Record (SCR) has been proven to benefit patients and healthcare professionals alike, speeding up the process of medicines reconciliation. The process is more efficient and safer for patients who need to take specific medications at specific times. It also reduces workload at GP surgeries, which, without the SCR, often need to provide information to hospitals about their patients' medication. The Care Record Viewer allows trusts to view the patient's full SystmOne primary/ community record for the first time thereby increasing patient safety and improving the quality of care.

The Electronic Prescribing Service (EPS) has also continued its roll out. Among other benefits, the EPS improves patient convenience and helps GPs understand actual usage.

The new data sharing model now puts patients in control of who is permitted to see their medical record.

Innovative technology and delivering QIPP

The telehealth hub:

During the year, the Yorkshire and Humber Telehealth Hub enabled healthcare providers to access and deliver telehealth solutions to over two thousand patients. A positive evaluation of the hub is about to be published confirming the benefits of using this technology.

Building on last year's infrastructural developments, a number of telehealth applications benefiting patients and clinicians were undertaken:

- Hull and East Yorkshire Hospitals NHS Trust used telecoaching, telemedicine and telemonitoring to improve the care for patients with chronic heart failure.
- Barnsley Hospital NHS Foundation Trust deployed telehealth to many more NHS patients integrated with social care.
- Airedale NHS Foundation Trust built on their experiences of deploying telehealth in prisons and now use it to improve the experiences of patients in nursing and care homes.
- Leeds Teaching Hospitals NHS Trust recently began a major telehealth procurement.

Delivering personalised care to people with long term conditions

In the last 12 months, further care planning templates were developed, benefiting an increasing number of patients with long-term conditions. This helped increasing numbers of healthcare professionals to deliver best practice in shared patient/clinician decision making. It also allowed patients to increase their level of self-directed care which in turn has improved their experience and permitted more efficient and effective use of NHS resources.

15. Support services

Communications and corporate business

Communications

The communications team provided a supporting function, not only for the SHA, but also for NHS organisations across the region. The team delivered corporate communications and media management for the SHA. It also had a role in providing assurance, leadership and co-ordination for the wider NHS in Yorkshire and the Humber and acted as a key point of liaison between the Department of Health media and marketing teams and NHS communicators across Yorkshire and the Humber.

Key achievements in 2012/13:

- Maintained positive media coverage.
- Worked with communications colleagues in the North West and North East SHAs in order to form one single NHS North team.
- Continued to support the SHA staff and business functions during the transition period.
- Provided support and guidance to the region's primary care trusts during their move to cluster arrangements.
- Developed an NHS Choose Well "app" which iPhone and Android phone users can download to access up-to-date information on their nearest NHS services.
- Implemented a communications strategy to support the development of clinical commissioning groups (CCGs).
- Coordinated a weekly communication between NHS, CCGs and local authorities in order to support the transition.
- Gave media support to the NHS Commissioning Board's Special Health Authority.
- Supported the region's remaining NHS trusts in working towards foundation trust status.
- Maintained a campaign to boost health visitor recruitment in Yorkshire and the Humber, encouraging them to return to practice as well as attracting new entrants to the profession.
- Delivered a 'flu vaccination awareness-raising campaign aimed at the public focusing on at-risk groups, with a social media campaign aimed specifically at pregnant women.

Corporate Business 2012/13

The corporate business team ensured the effective operation and governance of the SHA. This included supporting the SHA board and its committees, ensuring up-to-date and relevant business continuity plans were in place, and overseeing the smooth running of the organisation and its infrastructure including IT and facilities management.

The team responded to requests under the Freedom of Information Act, handling around 150 requests in 2012/13, as well as correspondence from members of the public, MPs and other stakeholders.

Key achievements 2012/13

During its final year, the corporate business team played a key role in ensuring the effective operation of the SHA. This included managing the discharge of all statutory duties and working towards organisational closure with transition plans to hand over the SHA's functions and associated knowledge to successor bodies safely and efficiently.

The team also facilitated and oversaw the governance and business processes of the single board for the North of England SHA cluster.

Emergency preparedness 2012/13

2012/13 was an exceptionally busy year for the emergency preparedness team. Throughout the transition period the team continued to ensure that the regional NHS was prepared to respond to major incidents, a mass casualty incident and influenza pandemic.

In 2012/13 our key activities included:

- Organising a number of workshops throughout the year on the implications of the new emergency preparedness resilience system that will be in place from April 2013 both for the NHS and for partner organisations.
- Ensuring that the NHS had its own plans as well as joint plans with partners for the Diamond Jubilee, 2012 Olympic Torch Relay and 2012 Olympic and Paralympics.
- Opening a new NHS Gold Command Suite at Yorkshire Ambulance Service Headquarters in June.
- Working with partners in response to industrial action and to a number of flooding incidents that have happened across the North of England throughout the year.

16. Workforce and education

The quality of patient care depends on the skills, competencies, behaviours and attitudes of our staff. With this in mind, over 60 per cent of NHS funding in the region is dedicated to staffing.

The main objective of the workforce and education directorate was to develop the region's existing and future NHS workforce through effective planning, education and commissioning.

Key achievements in 2012/13

- Supporting the transition process to new structural and managerial arrangements for workforce and education.
- Developing leadership and organisational capacity in the new NHS.
- Developing the new workforce arrangements, particularly the development of the Yorkshire and the Humber Local Education and Training Board, in partnership with key stakeholders.
- Actively contributing to the Quality, Innovation, Productivity and Prevention (QIPP) and Single Assurance and Accountability Process (SAAP) programmes.
- Developing and implementing a sustainable commissioning and investment plan for undergraduate, postgraduate and support staff education and training.
- Ensuring that there was a sustainable clinical skills investment programme across Yorkshire and the Humber.
- Ensuring that there was a stable financial platform throughout the transition and in readiness for taking forward the recommendations of the Multi-Professional Education and Training (MPET) review.
- Ensuring continued attention to all workforce development activity in line with the SHA business plan and Department of Health service level agreement.

Priorities for 2013/14

- To support and develop the Yorkshire and the Humber Local Education and Training Board (YHLETB) in a way that delivers patient and service needs.
- To maintain and develop strong partnerships with all stakeholders around the new workforce arrangements.
- To identify and agree local priorities for education and training to ensure security of supply of the skills and people providing healthcare across Yorkshire and the Humber.
- To plan, commission and quality assure excellent education and training on behalf of the local health community, taking a multi-disciplinary approach that delivers whole system solutions.
- To ensure value for money and sound financial governance throughout the commissioning and evaluation of education and training and for running costs of the YHLETB.

- To implement the MPET review and ensure that there is a stable financial platform.
- To develop leadership and organisational development capability in the new NHS.
- To support and promote the values and ethos of the NHS Constitution in every aspect of the work of the YHLETB.
- To work in partnership with universities, clinical academics and the Yorkshire and the Humber Academic Health Science Network (AHSN) to support innovation and research.
- To be a forum for developing the whole healthcare workforce around patient needs.

17. Hosted programmes

The SHA hosted two national programmes on behalf of SHAs in England; the NHS National Cancer Screening Programme and the Electronic Staff Record.

National Cancer Screening Programme

The national team is responsible for the NHS breast screening, cervical screening and bowel cancer screening programmes, along with the prostate risk management initiative.

The role of the team is to:

- Achieve the *Improving Outcomes – a Strategy for Cancer* objective to improve and expand cancer screening.
- Minimise harm caused by cancer screening.
- Ensure screening is available to all eligible people.
- Contribute to the development, implementation and improvement of NHS cancer screening programmes.
- Ensure standards are maintained and that there is a continuous drive for excellence.
- Carry out work at a national level to enable cost-effective local implementation.
- Provide specialist expertise on the delivery of cancer screening programmes.

Electronic staff record

Electronic Staff Record (ESR) is a national, integrated workforce solution used by all but two NHS organisations throughout England and Wales. ESR is central to the NHS workforce strategy and provides a complete workforce solution for the NHS. ESR supports evidence-based workforce planning at local, regional and national levels and empowers managers and employees to undertake staff development. This leads to safer, more effective patient care whilst securing greater value for taxpayers' money. The ongoing aim of the NHS ESR Central Team is to maximise benefits through the uptake of all ESR functionality across the NHS, to help realise efficiency gains and improve quality and productivity.

On 1 January 2013 the ESR Central Team transferred to its new host provider, NHS Business Services Authority.

18. The North of England SHA Cluster Board

From 3 October 2011, Yorkshire and the Humber Strategic Health Authority, North East Strategic Health Authority, and North West Strategic Health Authority came together under a single management framework, working together as NHS North of England.

This section introduces the members of the North of England SHA cluster board and lists their declared interests.

From 1 April 2012 to 31 March 2013, the North of England SHA cluster board met on six occasions in both public and private sessions. Private board sessions ensured information of a confidential nature, within the terms of the exemptions permitted by the Freedom of Information Act 2000, could be discussed without compromising the proper and effective operation of the organisation.

Agendas and minutes of the public sessions of the board meetings can be found on our website:
http://www.yorksandhumber.nhs.uk/who_we_are/board_information/board_meetings/

Non-executive directors

Kathryn Riddle – Chairman
Kathryn is Pro Vice Chancellor and Chairman of the Council of the University of Sheffield. She is also a Justice of the Peace, a Deputy Lieutenant of South Yorkshire and an Honorary Colonel.

Sir Peter Carr CBE – Vice Chairman (to 31 May 2012)
Sir Peter is the Chair and Director of Premier Waste Management Ltd, Company Secretary and Director of Corchester Towers Ltd and, until early 2012, was Chair and Director of Durham County Waste Management Ltd.

Sally Cheshire – Vice Chairman
Sally is an authority member and Audit Chair of the Human Fertilisation and Embryology Authority (HFEA, a non-departmental body of the DH). She is also the Audit Chair of the Health Research Authority (from July 2012).

Prof. Peter Fidler CBE
Prof. Fidler is a non-executive director of Codeworks and Chief Executive / Vice Chancellor of the University of Sunderland.

Alan Foster
Alan has no declared interests.

Sarah Harkness
Sarah is Chair of the SHA's Independent Investigations Committee (a standing committee of the SHA Board) and is a member of the Council and Audit Committee of the University of Sheffield. She is also a non-executive director and chair of the Audit Committee of the NHS Trust Development Authority (from 28 September 2012) and a non-executive director of JRI Orthopaedics Ltd (from 28 September 2012).

Prof. Oliver James
Prof. James is a non-executive chair of e-Therapeutics PLC and Chair of Samoures Investment Trust, Jersey. He is also Chair of the Sir James Knott Trust.

Ian Walker
Ian is the Managing Director of Rotary Electrical Services and Chairman of Rotary Engineering UK Ltd. He is also a member of the Court of the University of Sheffield and is Chairman of the SHA's Audit Committee.

Executive Directors

Ian Dalton CBE – Chief Executive (to September 2012)
Ian has no declared interests.

Richard Barker – Chief Operating Officer
Richard has no declared interests.

Jane Cummings – Director of Nursing / Chief Nurse (to May 2012)
Jane is a trustee of 'Over the Wall' charity.

Gill Harris – Chief Nurse (from May 2012)
Gill has no declared interests.

Mark Ogden – Deputy Chief Executive / Director of Finance (to June 2012)
Mark is a member of the Financial Skills Partnership Advisory Group.

Jane Tomkinson – Director of Finance (from June 2012)
Jane has no declared interests.

Prof. Stephen Singleton OBE – Medical Director and Interim Chief Executive (from October 2012)
Prof. Singleton is the Chair of Trustees, Children's Foundation and a group member of Slaters' Bridge Group

Directors

Elaine Darbyshire – Director of Communications and Corporate Affairs
Elaine is a trustee of St. Ann's Hospice, Manchester and trustee of 'Greatsport', Manchester. She is also director of Our Life.

Tim Gilpin – Director of Workforce and Education
Tim is a non-executive director of After Adoption Yorkshire

Prof. Paul Johnstone – Cluster Director of Public Health
Paul's post is a joint position spanning the Department of Health and strategic health authority. He is a trustee of a charity called North-to-North Partnership. Paul's wife is a part-time partner for a small consultancy which provides management and leadership support for GPs and primary care professionals.

19. Committees of the Board

Audit Committee

The Audit Committee was responsible for making sure that the SHA was run in a clear and open way and that significant risks across the NHS were identified and managed. It also made sure that the SHA acted in line with relevant regulations, codes of conduct or any other relevant guidance.

The committee members were:

Chairman

- Mr Ian Walker

Non-executive directors

- Prof. Peter Fidler CBE
- Mr Alan Foster
- Mrs Sarah Harkness

Remuneration and Terms of Service Committee

Details of this committee are contained in the remuneration report.

Provider Development Board

On behalf of the SHA board, the provider development board was established to ensure that NHS trusts yet to achieve authorisation as a foundation trust (FT) either did so, or reached an appropriate alternative solution. The provider development board was charged with providing the SHA board with assurance on aspirant FT applicants and other provider development proposals as required until March 2013.

The Provider Development Board oversaw the transition of this work to the National Trust Development Authority which became operational on 1 April 2013.

Patient Safety Committee

The Patient Safety Committee had oversight of the SHA's functions in relation to patient safety, with specific reference to:

- The commissioning and publication of independent investigations under HSG(94)27.
- Oversight of other serious incidents.
- Section 12 accountabilities.
- Local Supervising Authority for Midwives.

Local Education and Training Board (LETB)

The purpose of the Yorkshire and the Humber LETB is to:

- Identify and agree local priorities for education and training to ensure security of supply of the skills and people providing health and public health services across Yorkshire and the Humber.
- Plan and commission education and training on behalf of Yorkshire and the Humber in the interests of sustainable, high-quality provision and health improvement.
- Improve the quality of education and training for the future and current NHS workforce.
- Develop effective partnerships and facilitate collaboration between key stakeholders.
- Be a forum for developing the whole health and public health workforce.
- Implement local financial governance assurance and delegated responsibility for the LETB Multi-Professional Education and Training (MPET) budget within the agreed HEE financial framework.
- Drive improvements in service quality and safety.

20. Complaints

The NHS (complaints) regulations outline the process for complaints about NHS services. There are two stages to the complaints procedure; local resolution, followed by an independent review.

Complaints should first be made to the complaints manager at the hospital, GP or dental practice where the care or treatment took place. The complaint will be investigated and a full written response provided. If the complaint cannot be resolved locally, it can be taken to the second stage by contacting the Parliamentary and Health Service Ombudsman on 0345 015 4033.

When looking into complaints raised by individuals, NHS organisations should be committed to the P*rinciples of Good Complaint Handling* published by the Parliamentary and Health Service Ombudsman.

A full set of the principles, together with supporting information, can be accessed via the following link:

http://www.ombudsman.org.uk/improving-public-service/ombudsmansprinciples/principles-of-good-complaint-handling-full

Free, independent help, advice and support, including interpreter services are available from the Independent Complaints Advocacy Service (ICAS) on 0808 802 3000 (for ICAS in Yorkshire) or by visiting their website at **www.carersfederation.co.uk**

Serious Untoward Incidents involving data loss or confidentiality breach reported to the Information Commissioner's office in 2012/ 2013

No serious untoward incidents involving data loss or confidentiality breach relating to NHS Yorkshire and the Humber were reported to the Information Commissioner's Office during 2012/2013.

21. Director of Finance's report

2012-13 was the final year of the NHS Yorkshire and the Humber Strategic Health Authority ("NHSYH".) Since October 2011 NHS North West, NHS North East and NHS Yorkshire and the Humber, the three strategic health authorities in the North of England, have been working together under a single management framework as NHS North of England.

2012-13 was therefore a year with focus on financial transition. I am grateful to Finance Director colleagues and the SHA finance team for ensuring that the NHS Yorkshire and the Humber health economy as a whole, and the SHA in particular delivered its financial targets, during a time of significant change. The NHS North of England Board was able to be assured about the operation of controls to manage risks, and hence to have confidence in governance and reporting arrangements.

The final account summary statements of NHS Yorkshire and the Humber are set out in the pages that follow. All assets and liabilities have been fully identified, and all balances have an identified destination. Balance sheet disaggregation and transfer of balances will be actioned through the Department of Health's legacy management team in liaison with successor bodies in the 2013-14 financial year.

In 2012/13 the accounts have been produced in line with requirements of International Financial Reporting Standards (IFRS).

The summary statements also include the management costs of the SHA and details of our performance relating to the Confederation of British Industry's (CBI) better payment practice code. The full accounts, available on request from the Department of Health, provide further details of the amount spent on each area of SHA activity and include the Annual Governance Statement. The remuneration report provides full details of senior managers' remuneration.

Letter of representation

The directors of NHS Yorkshire and the Humber have provided a written declaration to their external auditors stating that as far as they are aware there is no relevant audit information that has not been disclosed. This is set out in a letter of representation in a format determined by the external auditors.

The independent auditors to NHS Yorkshire and the Humber were:

Audit Commission (From 1 April 2012 – 30 September 2012)
3 Leeds City Office Park,
Holbeck
Leeds LS11 5BD

KPMG (From 1 October 2012 – 31 March 2013)
1 The Embankment
Neville Street
Leeds LS1 4DW

Cost of audit:
Audit work: £96k
Further assurance work: £0k
Other services: £0k

22. Independent auditor's report

INDEPENDENT AUDITOR'S REPORT TO THE SIGNING OFFICER OF YORKSHIRE AND THE HUMBER SHA ON THE SUMMARY FINANCIAL STATEMENT

We have examined the summary financial statement for the year ended 31 March 2013.

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

Respective responsibilities of directors and auditor

The Signing 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.

Basis of opinion

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 Yorkshire and the Humber SHA for the year ended 31 March 2013 on which we have issued an unqualified opinion.

Paul Lundy for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
1 The Embankment
Neville Street
Leeds
LS1 4DW.

June 2013

23. Summary of financial statements

The summary financial statements shown here are the primary statements of the accounts plus additional key extracts from our full annual accounts which are available on request by contacting the Department of Health

In each statement, 2012/2013 performance is compared to 2011/2012.

The statement of comprehensive net expenditure summarises the total spend by the SHA over the 12 month period, showing total (gross) spend and income, and deducting income from gross spend to give net operating costs.

The SHA has a statutory duty to keep net operating costs within an approved spending limit, known as the resource limit.

The statement of financial position shows the financial position of the SHA on 31 March 2013. The top half of the balance sheet shows the assets and liabilities of the SHA. The bottom half shows the amount owed to, or due from the Department of Health, as SHA assets are owned by, and liabilities underwritten by, the Secretary of State for Health.

The statement of changes in taxpayers' equity shows the changes to the taxpayers' investment in the SHA and reconciles the income and expenditure shown in the statement of comprehensive expenditure with the taxpayers' equity shown in the statement of financial position.

The cash flow statement shows the total cash received and paid out, along with changes to working capital (debtors and creditors).

In addition to the primary statements there is a further analysis of training and education spend and hosted programme spend.

Summary financial statements for 2012/ 2013
Statement of comprehensive net expenditure for the year ended 31 March 2013

	2012-13 £000	2011-12 £000
Administration costs and programme expenditure		
Gross employee benefits	27,092	29,262
Other costs	556,445	544,370
Income	(10,026)	(7,862)
Net operating costs before interest	**573,511**	**565,770**
Investment income	0	0
Other (gains)/ losses	0	0
Finance costs	0	0
Net operating costs for the financial year	**573,511**	**565,770**

Summary financial statements for 2012/ 2013
Statement of financial position as at 31 March 2013

	31 March 2013 £000	31 March 2012 £000
Non-current assets		
Property, plant and equipment	0	363
Total non-current assets	**0**	**363**
Current assets		
Trade and other receivables	1,053	3,610
Cash and cash equivalents	22	7
Total	**1,075**	**3,617**
Total current assets	**1,075**	**3,617**
Total assets	**1,075**	**3,980**
Current liabilities		
Trade and other payables	(12,073)	(20,557)
Provisions	(244)	(4,116)
Total current liabilities	**(12,317)**	**(24,673)**
Net current assets/ (liabilities)	**(11,242)**	**(21,056)**
Non-current assets plus/ less current assets/ liabilities	**(11,242)**	**(20,693)**
Non-current liabilities		
Trade and other payables	0	0
Provisions	0	(1,988)
Total non-current liabilities	**0**	**(1,988)**
Total assets employed	**(11,242)**	**(22,681)**
Financed by:		
Taxpayers' equity		
General fund	(11,242)	(22,816)
Revaluation reserve	0	135
Total taxpayers' equity	**(11,242)**	**(22,681)**

Summary of financial statements for 2012/ 2013
Statement of changes in taxpayers' equity for the year ended 31 March 2013

	General fund £000	Revaluation reserve £000	Total reserves £000
Balance at 1 April 2012	**(22,816)**	**135**	**(22,681)**
Changes in taxpayers' equity for 2012-13			
Net operating costs for the year	(573,511)	0	(573,511)
Transfers between reserves	135	(135)	0
Total recognised income and expense for 2012-2013	**(573,376)**	**(135)**	**(573,511)**
Net parliamentary funding	584,950	0	584,950
Balance at 31 March 2013	**(11,242)**	**0**	**(11,242)**

Summary financial statements for 2012/ 2013
Statement of cash flows for the year ended 31 March 2013

	2012-2013 £000	2011-2012 £000
Cash flows from operating activities		
Net operating costs	(573,511)	(565,770)
Depreciation and amortisation	363	380
(Increase)/ decrease in trade and other receivables	2,557	679
(Increase)/ decrease in trade and other payables	(8,484)	564
Provisions utilised	(3,654)	(484)
(Increase)/ decrease in provisions	(2,206)	46
Net cash inflow/ (outflow) from operating activities	**(584,935)**	**(564,585)**
Cash flows from investing activities		
(Payments) for purchase of property, plant and equipment	0	(51)
Net cash inflow/ (outflow) from investing activities	**0**	**(51)**
Net cash (outflow) before financing	(584,935)	(564,636)
Cash flows from financing activities		
Net parliamentary funding	584,950	564,642
Net cash inflow/ (outflow) from financing	**584,950**	**564,642**
Net increase/ (decrease) in cash and cash equivalents	**15**	**6**
Cash (and) cash equivalents (and bank overdrafts) at the beginning of the period	**7**	**1**
Cash and cash equivalents (and bank overdraft) at year end	**22**	**7**

Workforce, training and education costs

	2012-2013 £000	2011-2012 £000
NHS bodies	370,196	364,124
Educational Institutions	108,742	109,604
Other	19,895	18,783
Total	**498,833**	**492,511**

Hosted programmes

	2012-2013 £000	2011-2012 £000
National cancer screening	47,765	30,514
National programme for information technology	2,580	3,328
Other	3,350	15,728
Total hosted programme costs	**53,695**	**49,570**

Better payment practice code – measure of compliance

	Number	£000
Non-NHS payables		
Total non-NHS trade invoices paid in the year	19,309	143,119
Total non-NHS trade invoices paid within target	18,537	141,178
Percentage of non-NHS trade invoices paid within target	**96.0%**	**98.6%**
NHS payables		
Total NHS trade invoices paid in the year	**4,863**	**432,660**
Total NHS trade invoices paid within target	**4,582**	**425,895**
Percentage of NHS trade invoices paid within target	**94.2%**	**98.4%**

Remuneration report

Membership of the remuneration and terms of service committee

For the period 1 April 2012 to 31 March 2013 membership of the committee comprised three non-executive directors. The Chief Executive and the Director of Workforce and Education also usually attend.

Policy on the remuneration of senior managers for current and future financial years

Since January 2006, Her Majesty's Treasury (HM Treasury) has required that all public sector pay proposals must be subject to approval through the new HM Treasury/Cabinet Office gateway, the Public Sector Pay Committee (PSPC). The Department of Health (DH) and HM Treasury have therefore produced a framework for senior managers in the NHS – very senior managers pay framework (VSM).

The framework is based on setting "spot rates" for Chief Executive (CE) salaries of strategic health authorities (SHAs) and primary care trusts (PCTs) within four bands determined by the size of the weighted population of the SHA. Yorkshire and the Humber SHA is categorised as band 2. In addition to the spot rate, there is local discretion to increase salaries to reflect either additional duties and/or to aid recruitment and retention, the latter being called recruitment and retention premia (RRP's). Salaries under this framework are first approved by the SHA's remuneration committee and subject to final approval by the Department of Health.

Performance assessment and performance related pay

Yorkshire and the Humber SHA has agreed to follow the national pay framework for VSM which includes the possibility for an annual non-pensionable, non-consolidated one-off payment, dependant on performance.

Contract duration, notice periods and termination payments.

All directors of the SHA are on a permanent contract with either the SHA or their substantive employer. All directors with the exception of the Regional Director of Public Health are subject to the terms and conditions of service set out in the very senior managers pay policy. The Regional Director of Public Health is subject to arrangements determined by the Department of Health. There are no specific conditions relating to termination payments except that any decisions about termination payments are reserved to the Remuneration and Terms of Service Committee.

Service contracts

Details of the service contract for each senior manager who has served NHS North of England from 1 April 2012 to 31 March 2013:

Name	Start date	Notice period
Executive directors and directors		
Ian Dalton CBE	28/08/2007	6 months
Richard Barker	01/05/2009	6 months
Jane Cummings	01/11/2007	6 months
Mark Ogden	01/07/2006	6 months
Prof. Stephen Singleton OBE	01/07/2006	6 months
Tim Gilpin	02/10/2006	6 months
Prof. Paul Johnstone	Joint appointment with DH 01/07/2006	6 months
Elaine Darbyshire	02/03/2009	6 months
Jane Tomkinson	11/05/2011	6 months
Gill Harris	01/05/2012	6 months
Non-executive directors		
Kathryn Riddle OBE*	01/07/2006	31/03/2013
Sir Peter Carr CBE*	01/07/2006	31/06/2012
Sally Cheshire*	01/09/2006	31/03/2013
Prof. Peter Fidler CBE*	01/07/2006	31/03/2013
Sarah Harkness*	01/12/2007	31/03/2013
Alan Foster*	01/07/2006	31/03/2013
Prof. Oliver James*	01/08/2007	31/03/2013
Ian Walker*	01/10/2006	31/03/2013

Notes:

* Appointed by the Appointments Commission

Provision of compensation for early termination

Not applicable.

Other details sufficient to determine the entity's liability in the event of early termination

Not applicable.

Any other significant awards made to past senior managers

Not applicable.

Salary and pension entitlements of senior managers

Salaries and allowances 1 April 2012 – 31 March 2013

	2012/2013 (share of cluster costs to Yorkshire and the Humber SHA)			Gross costs for 2012/2013			Gross costs for 2011/2012		
	Salary (bands of £5,000)	Other remuneration (bands of £5K)	Benefits in kind (rounded to the nearest £00)	Salary (bands of £5,000)	Other remuneration (bands of £5K)	Benefits in kind (rounded to the nearest £00)	Salary (bands of £5,000)	Other remuneration (bands of £5K)	Benefits in kind (rounded to the nearest £00)
Name and title	£000	£000	£00	£000	£000	£00	£000	£000	£00
Executive directors and directors of NHS North of England									
Ian Dalton CBE[1] Chief Executive	20-25	5-10	0	60-65	15-20	0	75-80	0	0
Richard Barker Chief Operating Officer	45-50	0-5	0	140-145	10-15	0	140-145	5-10	0
Mark Ogden[2] Deputy Chief Exec/ Director of Finance	15-20	0-5	10	40-45	5-10	20	175-180	5-10	60
Jane Cummings[3] Director of Nursing/ Chief Nurse	0-5	0	0	10-15	0	0	135-140	5-10	0
Prof. Stephen Singleton OBE[4] Medical Director/ Interim Chief Executive	45-50	0	0	140-145	360-365	15-20	190-195	0	40

Notes

[1] Ian Dalton was part-time in the role of Chief Executive at NHS North of England and on a part-time IMAS placement at the NHS Commissioning Board. He left NHS North of England on 30 September 2012.

[2] Mark Ogden left NHS North of England on 30 June 2012.

[3] Jane Cummings left NHS North of England 30 April 2012.

[4] Prof. Stephen Singleton became Interim Chief Executive at NHS North of England on 30 September 2012 in addition to his role as Cluster Medical Director. His other remuneration includes a redundancy payment of £300-305k and a Clinical Excellence Award.

Salaries and allowances 1 April 2012 – 31 March 2013 contd.

	2012/2013 (share of cluster costs to Yorkshire and the Humber SHA)			Gross costs for 2012/2013			Gross costs for 2011/2012		
	Salary (bands of £5,000)	Other remuneration (bands of £5K)	Benefits in kind (rounded to the nearest £00)	Salary (bands of £5,000)	Other remuneration (bands of £5K)	Benefits in kind (rounded to the nearest £00)	Salary (bands of £5,000)	Other remuneration (bands of £5K)	Benefits in kind (rounded to the nearest £00)
Name and title	**£000**	**£000**	**£00**	**£000**	**£000**	**£00**	**£000**	**£000**	**£00**
Executive directors and directors of NHS North of England contd.									
Tim Gilpin[5] Director of Workforce and Education	45-50	0	0	145-150	280-285	86	130-135	0	84
Prof. Paul Johnstone[6] Cluster Director of Public Health	30-35	25-30	0	90-95	80-85	0	85-90	80-85	0
Elaine Darbyshire Director of Communications and Corporate Affairs	35-40	0	10	115-120	0	20	115-120	0	20
Jane Tomkinson[7] Director of Finance	45-50	0	20	145-150	0	50	N/A	N/A	N/A
Gill Harris[8] Director of Nursing/ Chief Nurse	45-50	0	0	140-145	0	0	N/A	N/A	N/A
Hosted Programmes (Yorkshire and the Humber SHA)									
Julietta Pattnick National Cancer Screening Director	0	0	0	105-110	0	39	105-110	0	40

Notes:

[5] Tim Gilpin other remuneration relates to redundancy payment.

[6] Prof Paul Johnstone is employed by the Department of Health and is a joint appointment between NHS North of England (Yorkshire and Humber SHA) and the Department of Health. Other remuneration relates to Clinical Excellence Award and payment relating to DH responsibilities.

[7] Jane Tomkinson took the position as Director of Finance for NHS North of England on 1 July 2012

[8] Gill Harris joined NHS North of England on 1 May 2012

Salaries and allowances 1 April 2012 – 31 March 2013 contd.

	2012/2013 (share of cluster costs to Yorkshire and the Humber SHA)			Gross costs for 2012/2013			Gross costs for 2011/2012		
	Salary (bands of £5,000)	Other remuneration (bands of £5K)	Benefits in kind (rounded to the nearest £00)	Salary (bands of £5,000)	Other remuneration (bands of £5K)	Benefits in kind (rounded to the nearest £00)	Salary (bands of £5,000)	Other remuneration (bands of £5K)	Benefits in kind (rounded to the nearest £00)
Name and title	£000	£000	£00	£000	£000	£00	£000	£000	£00
Non-executive directors of NHS North of England									
Kathryn Riddle OBE Chair	20-25	0	0	60-65	0	0	55-60	0	0
Sir Peter Carr CBE[9] Vice Chair	5-10	0	0	25-30	0	0	40-45	0	0
Sally Cheshire Vice Chair	15-20	0	0	50-55	0	0	40-45	0	0
Prof. Peter Fidler CBE Non-executive director	0-5	0	0	5-10	0	0	10-15	0	0
Alan Foster Non-executive director	0-5	0	0	5-10	0	0	10-15	0	0
Sarah Harkness Non-executive director	0-5	0	0	5-10	0	0	5-10	0	0
Prof. Oliver James Non-executive director	0-5	0	0	5-10	0	0	5-10	0	0
Ian Walker Non-executive director	0-5	0	0	10-15	0	0	10-15	0	0

Notes:

[9] Sir Peter Carr left NHS North of England on 30 June 2012

The 2012/13 share of salary cluster costs shown on the above table does not have an equivalent comparator (clustering of the three SHAs commenced midway through 2011/12 on 1st October 2011).

NHS pension benefits 2012/13 – executive directors and directors of NHS North of England

	Real increase in pension at age 60 (bands of £2,500)	Real increase 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 in cash equivalent transfer value
Name and title	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Ian Dalton CBE Chief Executive	2.5-5	7.5-10	20-25	60-65	362	293	54
Richard Barker Chief Operating Officer	0-2.5	2.5-5	50-55	155-160	961	866	50
Mark Ogden Deputy Chief Executive/ Director of Finance	0-2.5	2.5-5	40-45	120-125	814	685	23
Jane Cummings Director of Nursing/ Chief Nurse	0-2.5	2.5-5	65-70	205-210	1,260	965	20
Prof Stephen Singleton OBE[1] Medical Director/ Interim Chief Executive	0-2.5	2.5-5	65-70	200-205	142	1,326	-1,253
Tim Gilpin Director of Workforce and Education	2.5-5	12.5-15	55-60	175-180	1,274	1,107	77
Paul Johnstone[2] Cluster Director of Public Health	N/A refer to note 1						
Elaine Darbyshire Director of Communications and Corporate Affairs	0-2.5	0	5-10	0	95	70	22

NHS pension benefits 2012/13 – executive directors and directors of NHS North of England contd.

Name and title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in lump sum at age 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2013 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000) £000	Cash equivalent transfer value at 31 March 2013 £000	Cash equivalent transfer value at 31 March 2012 £000	Real increase in cash equivalent transfer value £000
Jane Tomkinson Director of Finance	2.5-5	7.5-10	50-55	150-155	929	812	75
Gill Harris Director of Nursing/ Chief Nurse	0-(2.5)	(2.5)-(5)	55-60	165-170	1,013	966	-3
Julietta Patnick National Cancer Screening Director	0-2.5	0-2.5	35-40	105-110	758	701	14

Notes

[1]Prof. Stephen Singleton retired on 31 March 2013

[2] Prof. Paul Johnstone is a member of the senior civil service pension scheme

Non-executive members do not receive pensionable remuneration, therefore their names are not listed

Salary and pension entitlements of senior managers of NHS North of England

The executive directors are members of the NHS pension scheme. The employer's contribution to the scheme was equivalent to 14% of their salary.

From 1 April 2012 Prof. Paul Johnstone was appointed as the cluster director for Public Health and is employed by the Department of Health. This is a joint appointment between NHS North of England (Yorkshire and the Humber SHA) and the Department of Health.

The benefits in kind for the senior managers relate to their lease cars and it is calculated on the taxable benefit of the lease car.

Contrary to the definition of the real increase in CETVs set out in the Manual for Accounts, common market valuation factors have not been used for the start and end of the period (as the most recent set of actuarial valuation factors, produced by the Government Actuary's Department (GAD) with effect from 8 December 2011, have been applied as at 31 March 2013).

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 midpoint of the remuneration band for the highest paid director at Yorkshire and the Humber Strategic Health Authority in the financial year 2012/13, based on the gross cost to the SHA (not the SHA's cluster share) was £177,500. This was 3.8 times the median remuneration of the Yorkshire and Humber SHA workforce in 2012/13 which was £47,319 (the increase from the 2011/12 reported figure of 2.5 reflects the use this year of gross cost rather than cluster share to identify the highest paid director employed by Yorkshire and the Humber SHA).

Review of Tax Arrangements of Public Sector Appointees

The SHA has employed two people on an off payroll engagement during 2012/13 at a cost of over £58,200 per annum. The SHA confirms that contractual clauses were in place at the beginning of the contract providing the employing department with the assurance as to the individual's tax obligations.

Total cost of exit packages agreed 2012 - 2013

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	*Number of other departure agreed	Total value of exit packages by cost band
Less than £10,000	2	0	17
£10,001 - £25,000	5	3	132
£25,001 - £50,000	3	1	125
£50,001 - £100,000	3	1	258
£100,001 - £150,000	6	0	724
£150,001 - £200,000	9	0	1,508
> £200,001	3	0	890
Total	31	5	3,654

Annual Governance Statement

1. Scope of responsibility

This section broadly describes my responsibilities as Accountable Officer of the Authority, including maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives, whilst safeguarding public funds.

1.1 During 2012/13 Yorkshire and the Humber Strategic Health Authority continued to operate as a statutory body within the NHS North of England cluster, which included North East and North West SHAs under a single management structure. This was the final year of 'clustering' prior to the structural changes in the NHS becoming operational on 1 April 2013, at which time Yorkshire and the Humber SHA will cease to exist. As Interim Chief Executive, appointed from October 2012, I have responsibility for the accounting and governance arrangements across the cluster including Yorkshire and the Humber SHA during this final year.

1.2 The accounting and governance arrangements in operation across the cluster have been in operation since the creation of the NHS North of England Board in October 2011. These arrangements were put in place to reflect the need for continuity and stability during a period of significant change, and also to reflect the continuing statutory nature and responsibilities of the three SHAs, whilst operating within a single common set of objectives and priorities.

1.3 The Board is accountable for internal control and as Accountable Officer and Chief Executive of the SHA, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum with the Department of Health.

1.4 In addition to my responsibility for the Strategic Health Authority, I am accountable for the performance of PCTs and non-Foundation NHS Trusts in Yorkshire and the Humber, including providing strategic leadership to the health community, ensuring that all parts of the NHS work together and with partner organisations such as Local Authorities, and driving the achievement of agreed targets for health improvement and service delivery.

1.5 During this period of significant change in the NHS, I am also responsible for ensuring that arrangements are in place to identify and manage risks associated with the transition of services and organisations within NHS North of England to their new successor bodies. 2012/13 has been a particularly challenging year as final arrangements have been put in place to ensure the smooth closedown of existing organisations, whilst ensuring the development of new organisations and their operational readiness from 1 April 2013. This included taking forward the structural changes to deliver Clinical Commissioning Groups (CCGs) which will succeed PCTs, together with their Commissioning Support Units (CSUs), and also supporting the development of new national bodies including NHS England, Public Health England and Health Education England.

1.6 As Interim Chief Executive, I have overall responsibility for risk management arrangements and I am supported in this role by a Senior Management Team made up of Executive and other Directors. The structure of the Senior Management Team means that all directors have a responsibility for risk management in their respective areas. These responsibilities are set out in the Authority's Risk Management Strategy and Responsibilities Statement.

1.7 Relationships with Chief Executives in all local health organisations in Yorkshire and the Humber are maintained via a forum which meets on a regular basis and this is mirrored by other Directors with their professional counterparts. The Authority performance manages Primary Care Trusts and NHS Trusts (but not Foundation Trusts) and in this context it seeks assurance that these organisations have also developed frameworks for the management of risk and Board assurance, which is of particular importance during this final year of transition.

2. The governance framework of the organisation

This section sets out the governance arrangements in place within the Authority and reflects the fact that the SHA continued to operate within a single management structure following the 'clustering' of Strategic Health Authorities in 2011.

2.1 The non-statutory NHS North of England cluster brings together the three Strategic Health Authorities of NHS North East, NHS North West and NHS Yorkshire and the Humber under a single Board and management structure, whilst recognising the three SHAs continued to function as statutory bodies to 31 March 2013.

2.2 There is a single committee structure across the three SHAs, including an Audit Committee which is the principal committee charged with governance arrangements. Other committees of the Board include Remuneration and Terms of Reference; Provider Development; Education and Training; and Patient Safety. Membership of these committees is drawn from the non-Executive Directors of the Board of NHS North of England.

During the year there were several changes to Board membership, some of which were as a result of the structural changes taking place in the NHS. Board membership and attendance is shown in Appendix 1.

2.3 The Board`s 2012/13 Business Plan includes the key deliverables set out in the NHS Operating Framework and these were reflected as strategic objectives in the Board`s Risk and Assurance Framework, which is the main vehicle for monitoring and reporting progress and associated risks. During the year the Board received quarterly updates on progress toward achieving its strategic objectives in a `traffic light` risk rated format. During the first half of the year a number of objectives turned from green to amber, largely due to uncertainties around the transition programme and the emergence of financial pressures in some NHS organisations. However, as the year progressed and guidance and clarification regarding processes and procedures became clearer, this allowed these issues to be managed more effectively.

In addition, regular performance reports and updates from relevant Directors on key business areas within its broader strategic objectives were reported to each meeting of the Board, highlighting performance, risks and actions in managing the effective implementation of the business agenda. These reporting mechanisms provided the Board with assurance on the progress and performance in achieving its key objectives

2.4 The key risks associated with the achievement of the Board`s strategic objectives are set out in the Risk and Assurance Framework, which continued to be reviewed and updated during the year to ensure it continued to meet operational needs and was being effectively implemented during this final year of transition. The risk and control framework associated with the Transition programme is referred to in sections 3 and 4 below.

2.5 The Board has ultimate responsibility for ensuring that effective governance arrangements are in place across all three SHAs and assures itself through a range of sources that effective governance, internal control and risk management arrangements are in place and operating effectively. The Board also has a responsibility to ensure

compliance with its **statutory functions** and receives regular compliance report. The Board's development session in January 2013 considered the latest report.

2.6 The Board operates within the Code of Conduct for NHS Boards which sets out the public service values that are at the heart of the National Health Service, and also the Code of Accountability for NHS Boards which sets out the basis on which NHS organisations should seek to fulfil the duties and responsibilities conferred upon them by the Secretary of State for Health. These Codes, together with the Department of Health requirement for all NHS organisations to have a Board Risk and Assurance Framework setting out strategic objectives and risks, form the code of governance within which the SHA conducts its business.

2.7 The **Audit Committee** plays a key role in ensuring the establishment and maintenance of an effective integrated system of governance, risk management and internal control that supports the achievement of the organisation`s objectives. The minutes of the Audit Committee are reported to the Board at which the Committee Chair highlights any significant issues.

The Audit Committee is supported in its work by internal and external auditors, who provide independent review of the systems and procedures and report regularly to Committee. In addition, each SHA has a Local Counter Fraud Specialist who undertakes an annual programme of work approved by Committee, which supports a zero tolerance approach to fraud and corruption.

The normal processes for **scrutinising and signing off the statutory accounts** which would normally be carried out by the Audit Committee of the SHA in May 2013 following the conclusion of work by the auditors, cannot be carried out by the existing Committee as the SHA will cease to be a statutory body on 31 March 2013. Alternative arrangements have therefore been put in place which include the continued responsibility of myself and the Director of Finance beyond 31 March 2013 to bring this process to a conclusion, together with the establishment of an Audit Committee which will meet specifically for this purpose as a sub-committee of the Department of Health`s Audit Committee, with membership drawn from the Non Executive Directors of the Board of NHS North of England to provide continuity.

As part of the closedown process, arrangements are in place for identifying financial balances to appropriate receiver organisations in accordance with Department of Health guidance and details of these will be included in the annual accounts.

There is also a formal **Transfer Scheme** in place which is a legal process coordinated by the Department of Health, which identifies everything (e.g. existing staff, assets, contracts, data etc) that is transferring to new receiving organisations.

Any ongoing risks or actions associated with functions transferring to new organisations are being identified and documented, and arrangements made for discussion and **handover** to successor bodies. An example of this is a Quality handover event held in February 2013, with attendees from SHAs and PCTs across the North of England meeting with Public Health England and the NHS Commissioning Board to discuss the handover of Quality issues and risks.

3. Risk assessment

This section describes the arrangements for assessing risk and how this is monitored and managed within the Authority.

3.1 The Board is engaged in the development and review of the risks associated with the Authority's strategic objectives included in the Risk and Assurance Framework and the relevant controls in place to manage those risks. Risks are initially formulated by the relevant lead Director and considered and approved by the Board.

3.2 All staff are encouraged to participate in risk management and familiarise themselves with the various policies, processes, procedures and training materials available through shared electronic files, including arrangements for raising risks on the risk register. Anti-fraud and corruption work is carried out by a dedicated Local Counter Fraud Specialist who reports regularly to the Audit Committee and communicates with all staff.

3.3 The Authority operates a 'traffic light' risk assessment process whereby risks are rated green (low), amber (medium) or red (high). Risk rating is the combined result of scoring for probability and impact and the value of risk scores is amended during the year as a consequence of actions taken to mitigate or manage risks. Strategic risks and their ratings are reviewed regularly by the Board through the review of the Risk and Assurance Framework.

3.4 A particular risk has been **staff capacity** during the latter part of the year as staff began to be appointed to new NHS organisations. Close attention has been paid to this with plans in place to manage the situation. Both old and new organisations recognised the importance of ensuring an accurate and timely financial closedown and handover and have cooperated on staffing issues to deliver a satisfactory outcome.

3.5 **Information governance** and data security continued to be an important area for the SHA during this final year of transition. The main focus of work during 2012/13 has been on preparing SHA information for appropriate handover and supporting the business needs of emerging organisations, ensuring capability and capacity to take on Information Governance functions moving forward, whilst minimising risk and maintaining data security. This focus has meant that less work has been able to be done on pursuing the Department of Health Information Governance Toolkit indicators, an approach which was agreed by both the Senior Management Team and Audit Committee.

There have been no reported serious lapses in data security during the year.

4. The risk and control framework

This section describes how the various risk control mechanisms work within the Authority and how these provide assurance to the Board that risks are being addressed and managed.

4.1 In accordance with the principles of good governance, the key focus for managing risk and assuring the Board that effective arrangements are in place, is the **Board Risk and Assurance Framework**, which identifies the strategic objectives of the Board, together with the associated risks to achieving those objectives and the control mechanisms in place to manage risk.

4.2 This is the main vehicle for managing risk associated with the delivery of the Board`s strategic objectives. This is a strategic management tool and is not designed to reflect every potential risk, but rather to focus on those risks which are most significant and could threaten the achievement of the Authority`s strategic objectives. In addition, a further element of the risk and assurance process are departmental **Operational Risk Registers**, which capture those lesser, transient or operational risks which, although not likely to impact on the achievement of the organisations` objectives, need to be addressed and managed as part of the ongoing evaluation and improvement of the risk and control environment.

The Framework continued to be reviewed and updated during the year to ensure it continued to reflect the key strategic objectives of the Board, and that actions were identified and agreed with the appropriate Directors to address any gaps in control or assurance processes. Strategic and operational risk registers operate a `traffic light` risk rating system which readily identifies the risk status and these ratings are reviewed regularly and amended as appropriate.

4.3 There has been particular focus in 2012/13 on the systems and risks surrounding the **Transition Programme,** including the financial closure programme in this final year, to ensure a smooth handover to successor organisations when the three cluster SHAs are abolished on 31 March 2013. The key governance and risk mechanisms associated with this are set out below.

The NHS North of England Board has a number of processes in place across the three cluster SHAs to successfully manage the Transition into the new NHS landscape.

A cluster **Transition Board** was established at the beginning of the year and has continued to provide leadership and management of the overall transition programme throughout the year, across the main business areas of the cluster SHAs. This reports to the NHS North of England Board on a regular basis and is supported by a number of **work stream groups,** dealing with key business areas, which link to both local and national mechanisms for identifying risks, seeking guidance and reporting actions. A North of England **transition risk register** has been developed which captures the key local risks identified through these various mechanisms, together with actions to manage these, and is monitored by the Transition Board.

The Transition Board is also supported through the **financial transition assurance framework** which links to one of the work stream groups. This is a 'traffic light' risk rated system which is both a local and national financial reporting mechanism. It captures the key financial work areas which need to be addressed, together with milestones, timeframes and risks, and provides monthly local intelligence on progress. The framework is monitored by the Transition Board and is reported at national level to the Department of Health. All North of England PCTs are also involved in this process.

In addition, to support financial closedown and the production of the annual accounts and effective handover to successor organisations, the three cluster SHAs have detailed local financial **closedown plans** which are embedded within the broader transition assurance framework and provide a check list of the detailed tasks, responsible persons and timeframes for successful closedown.

4.4 The various mechanisms set out above with regard to the management of the Transition process and associated risks are embedded within NHS North of England risk management arrangements. The importance of the Transition process to the successful delivery of the structural changes in the NHS is reflected in the well defined and documented processes for identifying, monitoring, reporting and managing risk in this regard. The reporting mechanisms include the cluster Transition Board, the NHS North of England Board and the Department of Health.

The NHS North of England Board received monthly reports on the progress of transition arrangements, which provided assurance that appropriate systems were in place to manage the process.

4.5 The practice of inviting Directors to attend Audit Committee during the year to discuss the key risks associated with their objectives has been continued during 2012/13 and helped to inform the overall risk management process and provide assurance.

4.6 Risks are operationally managed through the **Senior Management Team** and the **Assurance Group** and monitored by the Audit Committee. The Assurance Group, which comprised senior managers across the broad spread of business of the three cluster SHA`s in the North of England, supported the Senior Management Team and Audit Committee in monitoring risk management arrangements, providing regular review and monitoring of the risk environment, including development, monitoring and review of the Risk and Assurance Framework and Operational Risk Registers.

4.7 Risks are identified in a number of ways, including:

- Risk assessment of policies and procedures
- Risk assessment of operational procedures
- Risk scanning by the Senior Management Team
- Board reports
- Strategic risk register
- Operational risk registers
- Assurance Group (with cross cutting membership on Transition and IT groups)
- Internal and External Audit reports.
- Information issued by the Department of Health on risks affecting the whole NHS.
- Local Counter Fraud Specialist reports.
- Plans and processes supporting the Transition programme including the risk register.

4.8 The prevention of risk is addressed through policies, procedures, guidance documents and manuals which are designed to assist and support staff and which govern the routine operational business processes of the SHA. These together form the internal control environment within which risks are managed.

4.9 **Internal and External Audit** also play a key role in reviewing risk, assurance and control systems and reporting on their effectiveness to Audit Committee on a regular basis. The Audit Committee is involved in determining the SHA`s internal audit plan, based on a risk assessment which reflects the key objectives set out in the Risk and Assurance Framework and aimed at providing the Board with assurance on various aspects of the risk and control environment. For 2012/13, the Committee agreed that the plan should remain flexible, based on a rolling assessment of the SHA`s core processes, to reflect the increased potential for risk arising during this final year of transition. The SHA also had an **anti-fraud** plan in place throughout the year to detect and deter fraud. The plan was based on criteria set by NHS Protect (the national counter fraud service) plus a local risk based assessment and was approved and monitored by the Audit Committee.

5. Review of the effectiveness of risk management and internal control

This section talks about the effectiveness of the risk management processes in place within the Authority and the sources which provide evidence that the various mechanisms are operating effectively.

5.1 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.

5.2 The Head of Internal Audit provides me with a year-end `Opinion` statement on the overall arrangements for gaining assurance through the Board Risk and Assurance Framework and on the systems of internal control which are reviewed as part of the internal audit work programme. For 2012/13 the audit Opinion gave the Authority 'significant assurance' that there was a sound system of internal control in operation throughout the year.

5.3 External Auditors appointed by the Audit Commission also provide an independent review of the Authority's Financial Statements and overall control environment. Their Annual Audit Letter to the Board in respect of Yorkshire and the Humber SHA provided an 'Unqualified Opinion' for 2011/12. Their Opinion for the current year will be reported after the year-end accounts have been audited and is expected in June 2013. The auditors also provide a statutory Value for Money Conclusion on the SHA's arrangements for securing economy, efficiency and effectiveness and for 2011/12 the SHA received an 'Unqualified Conclusion' opinion. The Auditor`s report for 2012/13 will be reported after the financial year end.

5.4 The Department of Health carried out a 2012 mid-year Transition Assurance Review of all SHA clusters to assess preparedness to manage the transition programme through to its final conclusion. The outcome was very positive and provided the Board and the Department of Health with assurance that NHS North of England had appropriate arrangements in place which were being managed effectively.

5.5 Executive managers and Directors within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance, through monitoring and review of the risks and associated actions in respect of their areas of responsibility. Senior managers also represent their respective Directors on the Assurance Group which is responsible for the operational effectiveness of the risk and control environment.

The Risk and Assurance Framework itself, which is subject to regular review, provides me with evidence of the effectiveness of the control mechanisms that manage the risks to the organisation of achieving its principal objectives.

5.6 My review is also informed by:

(i) other sources of assurance as set out in the Risk and Assurance Framework.
(ii) Board agenda papers which are linked to the appropriate Board objective/s and carry a risk assessment and other control statements completed by the author provide the Board with assurance.
(iii) The Transition programme assurance processes that were in place.
(iv) The system of internal control within the SHA comprising a range of policies, procedures, codes of conduct, scheme of delegation etc. The key procedures are set out in the SHA cluster Corporate Governance Manual which was reviewed and amendments approved by the Board during the year and communicated to all staff. The SHA also has in place a Procurement Manual and a Budget Manual, designed to direct and guide staff in operational matters and improve internal control and risk arrangements.
(v) The Audit Committee has a key role in the oversight of the Authority`s risk and control environment which is reflected in the Committee`s Terms of Reference agreed by the Board.
(vi) NHS Protect (which leads nationally on work to identify and tackle fraud and corruption across the health service) provides the Authority with assurance regarding its anti-fraud and corruption arrangements. A Qualitative Assessment of all NHS bodies is carried out annually and for 2011/12 (the latest available) this showed that Yorkshire and the Humber SHA was performing well and was the highest scoring SHA.
(vii) The cross directorate Assurance Group which supports the Senior Management Team and Audit Committee.

6. Significant Issues

In this section I am required to declare if any significant issues have arisen during the year which could have impacted on the achievement of the Authority`s objectives or resulted in the annual accounts being misstated.

There were no significant issues to report in Yorkshire and the Humber SHA.

Signing Officer

24. Feedback

Department of Health Richmond House 79 Whitehall **London** SW1A 2NS

Department of Health

NHS

Yorkshire and the Humber Strategic Health Authority

2012-13 Accounts

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Yorkshire and the Humber Strategic Health Authority

2012-13 Accounts

INDEPENDENT AUDITOR'S REPORT TO THE SIGNING OFFICER OF YORKSHIRE AND THE HUMBER SHA

We have audited the financial statements of Yorkshire and the Humber SHA for the year ended 31 March 2013 on pages 1 to 45. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England. We have also audited the information in the Remuneration Report that is subject to audit.

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

Respective responsibilities of Signing Officer and auditor

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

Scope of the audit of the financial statements

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of Yorkshire and the Humber SHA as at 31 March 2013 and of its expenditure and income for the year then ended; and

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

Certificate

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

Paul Lundy for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
1 The Embankment
Neville Street
Leeds LS1 4DW.

4 June 2013

The Accounts of the Yorkshire and the Humber SHA

NATIONAL HEALTH SERVICE

ANNUAL ACCOUNTS 2012/2013

The Accounts of the Yorkshire and the Humber SHA

FOREWORD

These accounts have been prepared by the Yorkshire and the Humber Strategic Health Authority (NHS Yorkshire and the Humber) under section 98(2) of the National Health Service Act 1977 (as amended) in the form which the Secretary of State has, with the approval of the Treasury, directed.

Statutory background

The Yorkshire and Humber SHA is a public body and part of the National Health Service. It is a statutory body governed by Acts of Parliament and came into existence on the 1st July 2006 under Statutory Instrument 2006 No 1408. As a statutory body, the Yorkshire and Humber SHA has specific powers to act as a regulator, to contract in its own name, act as a corporate trustee, to fund projects jointly planned with and to make payments and grants to local authorities, voluntary organisations and other bodies.

On the 2nd October 2011 SHAs were organised under a clustering arrangement, where the Yorkshire and Humber SHA was clustered with the North West SHA and the North East SHA, and have been placed under a single management framework and work together as NHS North of England. Each SHA maintains its separate statutory responsibilities and reports on its own activities and resources.

Main functions of the Strategic Health Authority

The Yorkshire and Humber SHA secures the improvement in the physical and mental health of people in Yorkshire and Humber through resources available to it.

This is done by:

- Creating a strategic framework to deliver the NHS Plan in their area.
- Securing annual performance agreements and performance management of Primary Care Trusts and NHS Trusts.
- Building capacity and supporting performance improvement across all their local health agencies.

Review of activities and performance against targets

The Yorkshire and Humber SHA, in line with other NHS bodies, operates resource based accounting. This expenditure is measured against a Resource Limit set by the Department of Health. The Yorkshire and Humber SHA has a statutory duty to contain expenditure within the Resource Limit and an administrative duty to achieve "Operating Financial Balance".

Better Payment Practice Code

The Yorkshire and Humber SHA is required to pay its non-NHS creditors in accordance with the Better Payments Practice Code. The target is to pay 95% of non-NHS creditors within 30 days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed with the supplier. Of the total relevant non-NHS bills, 96% of bills, representing 99% by value, were paid within the target. The same target applies to NHS bodies. Of the total relevant NHS bills, 94% of bills representing 98% by value, were paid within target.

The Accounts of the Yorkshire and the Humber SHA

NHS North of England: Names of Board Members

CHAIRMAN:

Kathryn Riddle O.B.E

VICE CHAIRMAN:

Sir Peter Carr, C.B.E, DL (to 30.06.12)
Sally Cheshire

NON EXECUTIVE DIRECTORS:

Professor Peter Fidler, M.B.E, DL, DipTP, DipSoc, MRTPI
Alan Foster
Sarah Harkness
Professor Oliver James BA, MA, BM, BCh, FRCP, F.Acad.Med.Sci
Ian Walker

CHIEF EXECUTIVE:

Ian Dalton (01.04.12 - 30.09.12)
Professor Stephen Singleton (1.10.12 - 31.03.12)

EXECUTIVE DIRECTORS:

Richard Barker	Chief Operating Officer
Jane Cummings (01.04.12 - 30.04.12)	Chief Nurse
Gill Harris (01.05.12 - 30.03.13)	Chief Nurse
Mark Ogden (01.03.12 - 30.06.12)	Cluster Director of Finance / Deputy Chief Executive
Jane Tomkinson (01.07.12 -31.03.12)	Cluster Director of Finance / Deputy Chief Executive
Professor Stephen Singleton (01.03.12 - 31.03.13)	Cluster Medical Director

OTHER DIRECTORS:

Tim Gilpin	Cluster Director of Workforce and Education
Professor Paul Johnstone	Cluster Director of Public Health
Elaine Darbyshire	Director of Communications & Corporate Affairs

Details of salaries, allowances and pension benefits relating to Directors are contained in the governace and finance section of the Strategic Health Authority's 2012/13 Annual Report.

Policy in respect of employees with disabilities

The Yorkshire and Humber SHA is committed to challenging discrimination, promoting equality and diversity, and respecting human rights in all we do. The Yorkshire and Humber SHA is committed to employing people with disabilities and to retaining existing employees if they become disabled.

Policy in respect of equality and diversity

The Yorkshire and Humber SHA is committed to meet the Public Sector Equality Duty in the Equality Act 2010, by treating all its employees, applicants for employment, service users, patients and sub-contractors equally regardless of their gender, marriage or civil partnership status, sexual orientation, colour, race, nationality, ethnic origin, religion or belief, including lack of belief, age, disability, gender re-assignment, sex, pregnancy and maternity, age, disability, part time work status or carers' responsibilities.

KPMG are the auditors for the Yorkshire and the Humber Strategic Health Authority

The external auditor was Paul Lundy, KPMG, Public Sector Audit, 1 The Embankment, Leeds, LS1 4DW.
The summary of the auditors' remuneration is shown below:

	2012/13	2011/12
	£000	£000
Audit fees	96	156
Other fees	0	3
Total	96	159

Signed:  **Date:**

Signing Officer

Statement of the responsibilities of the signing officer of the Stategic Health Authority 2012-13 Accounts

The Department of Health's Accounting Officer has designated the role of Signing Officer for the final accounts of Yorkshire and Humber Strategic Health Authority to discharge the following responsibilities for the Department of Health:

- 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 Strategic Health Authority;

- the expenditure and income of the Strategic Health Authority 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, and from the assurances provided by the Accountable Officer until 31 March 2013, I am assured that the responsibilities have been properly discharged.

Signing Officer

Signed.....Janet.....

Date.....29/05/2013.....

Appendix 1

2012/13 ACCOUNTS CERTIFICATE OF ASSURANCE TO THE DEPARTMENT OF HEALTH DIRECTOR GENERAL, STRATEGY FINANCE AND NHS

I am aware that as Signing Officer designated by the Department of Health Accounting Officer, you are required to sign the accounts and supporting certificates of NHS Yorkshire and Humber Strategic Health Authority (SHA) in order to comply with the Department's 2012/13 accounts finalisation process.

To assist you in that process, I can confirm that for the year ended 31 March 2013 based on my own knowledge of internal control matters and through experience in my role as Accountable Officer until 31 March 2013, the SHA:

- had in place effective management systems to safeguard public funds and assets and assist in the implementation of corporate governance;
- kept proper accounting records which disclosed with reasonable accuracy at any time the financial position of the SHA;
- took reasonable steps for the prevention and detection of fraud and other irregularities;
- achieved value for money from the resources available to the SHA;
- applied income and expenditure to the purposes intended by Parliament and conformed to the authorities which governed and
- had effective and sound financial management systems in place.

I also confirm that in my role overseeing the preparation of the annual statutory accounts, the accounts were prepared in the 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. As required 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.

Name: Professor Stephen Singleton

Signed: 

Date: 29/05/13

Appendix 2

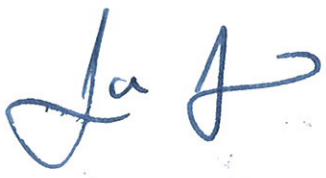
2012/13 ACCOUNTS CERTIFICATE OF FINANCIAL ASSURANCE TO THE DEPARTMENT OF HEALTH DIRECTOR GENERAL, STRATEGY FINANCE AND NHS

I am aware that as Signing Officer designated by the Department of Health Accounting Officer, you are required to sign the accounts and supporting certificates of NHS Yorkshire and Humber Strategic Health Authority (SHA) in order to comply with the Department's 2012/13 accounts finalisation process.

To assist you in that process, I can confirm that in my role managing the preparation of the annual statutory accounts, the accounts were prepared in the 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. As required 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.

Name: Jane Tomkinson

Signed: 

Date: 29/05/13

The Accounts of the Yorkshire and the Humber SHA

Annual Governance Statement

1. Scope of Responsibility

This section broadly describes my responsibilities as Accountable Officer of the Authority, including maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives, whilst safeguarding public funds.

1.1 During 2012/13 Yorkshire and the Humber Strategic Health Authority continued to operate as a statutory body within the NHS North of England cluster, which included North East and North West SHAs under a single management structure. This was the final year of 'clustering' prior to the structural changes in the NHS becoming operational on 1 April 2013, at which time Yorkshire and the Humber SHA ceased to exist. As Interim Chief Executive, appointed from October 2012, I have responsibility for the accounting and governance arrangements across the cluster including Yorkshire and the Humber SHA during this final year.

1.2 The accounting and governance arrangements in operation across the cluster have been in operation since the creation of the NHS North of England Board in October 2011. These arrangements were put in place to reflect the need for continuity and stability during a period of significant change, and also to reflect the continuing statutory nature and responsibilities of the three SHAs, whilst operating within a single common set of objectives and priorities.

1.3 The Board is accountable for internal control, and as Accountable Officer and Chief Executive of the SHA, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum with the Department of Health.

1.4 In addition to my responsibility for the Strategic Health Authority, I am accountable for the performance of PCTs and non-Foundation NHS Trusts in Yorkshire and the Humber, including providing strategic leadership to the health community, ensuring that all parts of the NHS work together and with partner organisations such as Local Authorities, and driving the achievement of agreed targets for health improvement and service delivery.

1.5 During this period of significant change in the NHS, I am also responsible for ensuring that arrangements are in place to identify and manage risks associated with the transition of services and organisations within NHS North of England to their new successor bodies. 2012/13 has been a particularly challenging year as final arrangements have been put in place to ensure the smooth closedown of existing organisations, whilst ensuring the development of new organisations and their operational readiness from 1 April 2013. This included taking forward the structural changes to deliver Clinical Commissioning Groups (CCGs) which will succeed PCTs, together with their Commissioning Support Units (CSUs), and also supporting the development of new national bodies including NHS England, Public Health England and Health Education England.

1.6 As Interim Chief Executive, I have overall responsibility for risk management arrangements and I am supported in this role by a Senior Management Team made up of Executive and other Directors. The structure of the Senior Management Team means that all directors have a responsibility for risk management in their respective areas. These responsibilities are set out in the Authority's Risk Management Strategy and Responsibilities Statement.

1.7 Relationships with Chief Executives in all local health organisations in Yorkshire and the Humber are maintained via a forum which meets on a regular basis and this is mirrored by other Directors with their professional counterparts. The Authority performance manages Primary Care Trusts and NHS Trusts (but not Foundation Trusts) and in this context it seeks assurance that these organisations have also developed frameworks for the management of risk and Board assurance, which is of particular importance during this final year of transition.

2. The Governance Framework of the Organisation

This section sets out the governance arrangements in place within the Authority and reflects the fact that the SHA continued to operate within a single management structure following the 'clustering' of Strategic Health Authorities in 2011.

2.1 The non statutory NHS North of England cluster brings together the three Strategic Health Authorities of NHS North East, NHS North West and NHS Yorkshire and the Humber under a single Board and management structure, whilst recognising the three SHAs continued to function as statutory bodies to 31 March 2013.

2.2 There is a single committee structure across the three SHAs, including an Audit Committee which is the principal committee charged with governance arrangements. Other committees of the Board include Remuneration and Terms of Reference; Provider Development; Education and Training; and Patient Safety. Membership of these committees is drawn from the non-Executive Directors of the Board of NHS North of England. During the year there were several changes to Board membership, some of which were as a result of the structural changes taking place in the NHS.

2.3 The Board's 2012/13 Business Plan includes the key deliverables set out in the NHS Operating Framework and these were reflected as strategic objectives in the Board's Risk and Assurance Framework, which is the main vehicle for monitoring and reporting progress and associated risks. During the year the Board received quarterly updates on progress toward achieving its strategic objectives in a 'traffic light' risk rated format. During the first half of the year a number of objectives turned from green to amber, largely due to uncertainties around the transition programme and the emergence of financial pressures in some NHS organisations. However, as the year progressed and guidance and clarification regarding processes and procedures became clearer, this allowed these issues to be managed more effectively.

In addition, regular performance reports and updates from relevant Directors on key business areas within its broader strategic objectives were reported to each meeting of the Board, highlighting performance, risks and actions in managing the effective implementation of the business agenda. These reporting mechanisms provided the Board with assurance on the progress and performance in achieving its key objectives.

2.4 The key risks associated with the achievement of the Board's strategic objectives are set out in the Risk and Assurance Framework, which continued to be reviewed and updated during the year to ensure it continued to meet operational needs and was being effectively implemented during this final year of transition. The risk and control framework associated with the Transition programme is referred to in sections 3 and 4.

2.5 The Board has ultimate responsibility for ensuring that effective governance arrangements are in place across all three SHAs and assures itself through a range of sources that effective governance, internal control and risk management arrangements are in place and operating effectively. The Board also has a responsibility to ensure compliance with its statutory functions and receives regular compliance reports. The Board's development session in January 2013 considered the latest report.

2.6 The Board operates within the Code of Conduct for NHS Boards which sets out the public service values that are at the heart of the National Health Service, and also the Code of Accountability for NHS Boards which sets out the basis on which NHS organisations should seek to fulfil the duties and responsibilities conferred upon them by the Secretary of State for Health. These Codes, together with the Department of Health requirement for all NHS organisations to have a Board Risk and Assurance Framework setting out strategic objectives and risks, form the code of governance within which the SHA conducts its business.

2.7 The **Audit Committee** plays a key role in ensuring the establishment and maintenance of an effective integrated system of governance, risk management and internal control that supports the achievement of the organisation's objectives. The minutes of the Audit Committee are reported to the Board at which the Committee Chair highlights any significant issues.

The Audit Committee is supported in its work by internal and external auditors, who provide independent review of the systems and procedures and report regularly to Committee. In addition, each SHA has a Local Counter Fraud Specialist who undertakes an annual programme of work approved by Committee, which supports a zero tolerance approach to fraud and corruption.

The normal processes for **scrutinising and signing off the statutory accounts** which would normally be carried out by the Audit Committee of the SHA in May 2013 following the conclusion of work by the auditors, cannot be carried out by the existing Committee as the SHA will cease to be a statutory body on 31 March 2013. Alternative arrangements have therefore been put in place which include the continued responsibility of myself and the Director of Finance beyond 31 March 2013 to bring this process to a conclusion, together with the establishment of an Audit Committee which will meet specifically for this purpose as a sub-committee of the Department of Health's Audit Committee, with membership drawn from the Non Executive Directors of the Board of NHS North of England to provide continuity.

As part of the closedown process, arrangements are in place for identifying financial balances to appropriate receiver organisations in accordance with Department of Health guidance and details of these will be included in the annual accounts.

There is also a formal **Transfer Scheme** in place which is a legal process coordinated by the Department of Health, which identifies everything (e.g. existing staff, assets, contracts, data etc) that is transferring to new receiving organisations.

Any ongoing risks or actions associated with functions transferring to new organisations are being identified and documented, and arrangements made for discussion and **handover** to successor bodies. An example of this is a Quality Handover Event held in February 2013, with attendees from SHAs and PCTs across the North of England meeting with Public Health England and the NHS Commissioning Board to discuss the handover of Quality issues and risks.

3. Risk Assessment

This section describes the arrangements for assessing risk and how this is monitored and managed within the Authority.

3.1 The Board is engaged in the development and review of the risks associated with the Authority's strategic objectives included in the Risk and Assurance Framework and the relevant controls in place to manage those risks. Risks are initially formulated by the relevant lead Director and considered and approved by the Board.

3.2 All staff are encouraged to participate in risk management and familiarise themselves with the various policies, processes, procedures and training materials available through shared electronic files, including arrangements for raising risks on the risk register. Anti-fraud and corruption work is carried out by a dedicated Local Counter Fraud Specialist who reports regularly to the Audit Committee and communicates with all staff.

3.3 The Authority operates a 'traffic light' risk assessment process whereby risks are rated green (low), amber (medium) or red (high). Risk rating is the combined result of scoring for probability and impact and the value of risk scores is amended during the year as a consequence of actions taken to mitigate or manage risks. Strategic risks and their ratings are reviewed regularly by the Board through the review of the Risk and Assurance Framework.

3.4 A particular risk has been **staff capacity** during the latter part of the year as staff began to be appointed to new NHS organisations. Close attention has been paid to this with plans in place to manage the situation. Both old and new organisations recognised the importance of ensuring an accurate and timely financial closedown and handover and have cooperated on staffing issues to deliver a satisfactory outcome.

3.5 **Information governance** and data security continued to be an important area for the SHA during this final year of transition. The main focus of work during 2012/13 has been on preparing SHA information for appropriate handover and supporting the business needs of emerging organisations, ensuring capability and capacity to take on Information Governance functions moving forward, whilst minimising risk and maintaining data security. This focus has meant that less work has been able to be done on pursuing the Department of Health Information Governance Toolkit indicators, an approach which was agreed by both the Senior Management Team and Audit Committee. There have been no reported serious lapses in data security during the year.

4. The Risk and Control Framework

This section describes how the various risk control mechanisms work within the Authority and how these provide assurance to the Board that risks are being addressed and managed.

4.1 In accordance with the principles of good governance, the key focus for managing risk and assuring the Board that effective arrangements are in place, is the **Board Risk and Assurance Framework**, which identifies the strategic objectives of the Board, together with the associated risks to achieving those objectives and the control mechanisms in place to manage risk.

4.2 This is the main vehicle for managing risk associated with the delivery of the Board's strategic objectives. This is a strategic management tool and is not designed to reflect every potential risk, but rather to focus on those risks which are most significant and could threaten the achievement of the Authority's strategic objectives. In addition, a further element of the risk and assurance process are departmental **Operational Risk Registers**, which capture those lesser, transient or operational risks which, although not likely to impact on the achievement of the organisations' objectives, need to be addressed and managed as part of the ongoing evaluation and improvement of the risk and control environment.

The Framework continued to be reviewed and updated during the year to ensure it continued to reflect the key strategic objectives of the Board, and that actions were identified and agreed with the appropriate Directors to address any gaps in control or assurance processes. Strategic and operational risk registers operate a 'traffic light' risk rating system which readily identifies the risk status and these ratings are reviewed regularly and amended as appropriate.

4.3 There has been particular focus in 2012/13 on the systems and risks surrounding the **Transition Programme,** including the financial closure programme in this final year, to ensure a smooth handover to successor organisations when the three cluster SHAs are abolished on 31 March 2013. The key governance and risk mechanisms associated with this are set out below.

The NHS North of England Board has a number of processes in place across the three cluster SHAs to successfully manage the Transition into the new NHS landscape.

A cluster **Transition Board** was established at the beginning of the year and has continued to provide leadership and management of the overall transition programme throughout the year, across the main business areas of the cluster SHAs. This reports to the NHS North of England Board on a regular basis and is supported by a number of **work stream groups,** dealing with key business areas, which link to both local and national mechanisms for identifying risks, seeking guidance and reporting actions. A North of England **transition risk register** has been developed which captures the key local risks identified through these various mechanisms, together with actions to manage these, and is monitored by the Transition Board.

The Transition Board is also supported through the **financial transition assurance framework** which links to one of the work stream groups. This is a 'traffic light' risk rated system which is both a local and national financial reporting mechanism. It captures the key financial work areas which need to be addressed, together with milestones, timeframes and risks, and provides monthly local intelligence on progress. The framework is monitored by the Transition Board and is reported at national level to the Department of Health. All North of England PCTs are also involved in this process.

In addition, to support financial closedown and the production of the annual accounts and effective handover to successor organisations, the three cluster SHAs have detailed local financial **closedown plans** which are embedded within the broader transition assurance framework and provide a check list of the detailed tasks, responsible persons and timeframes for successful closedown.

4.4 The various mechanisms set out above with regard to the management of the Transition process and associated risks are embedded within NHS North of England risk management arrangements. The importance of the Transition process to the successful delivery of the structural changes in the NHS is reflected in the well defined and documented processes for identifying, monitoring, reporting and managing risk in this regard. The reporting mechanisms include the cluster Transition Board, the NHS North of England Board and the Department of Health.

The NHS North of England Board received monthly reports on the progress of transition arrangements, which provided assurance that appropriate systems were in place to manage the process.

4.5 The practice of inviting Directors to attend Audit Committee during the year to discuss the key risks associated with their objectives has been continued during 2012/13 and helped to inform the overall risk management process and provide assurance.

4.6 Risks are operationally managed through the **Senior Management Team** and the **Assurance Group** and monitored by the Audit Committee. The Assurance Group, which comprised senior managers across the broad spread of business of the three cluster SHA's in the North of England, supported the Senior Management Team and Audit Committee in monitoring risk management arrangements, providing regular review and monitoring of the risk environment, including development, monitoring and review of the Risk and Assurance Framework and Operational Risk Registers.

4.7 Risks are identified in a number of ways, including: -

- Risk assessment of policies and procedures
- Risk assessment of operational procedures
- Risk scanning by the Senior Management Team+A31
- Board reports
- Strategic risk register
- Operational risk registers
- Assurance Group (with cross cutting membership on Transition and IT groups)
- Internal and External Audit reports
- Information issued by the Department of Health on risks affecting the whole NHS
- Local Counter Fraud Specialist reports
- Plans and processes supporting the Transition programme including the risk register

4.8 The prevention of risk is addressed through policies, procedures, guidance documents and manuals which are designed to assist and support staff and which govern the routine operational business processes of the SHA. These together form the internal control environment within which risks are managed.

4.9 **Internal and External Audit** also play a key role in reviewing risk, assurance and control systems and reporting on their effectiveness to Audit Committee on a regular basis. The Audit Committee is involved in determining the SHA's internal audit plan, based on a risk assessment which reflects the key objectives set out in the Risk and Assurance Framework and aimed at providing the Board with assurance on various aspects of the risk and control environment. For 2012/13, the Committee agreed that the plan should remain flexible, based on a rolling assessment of the SHA's core processes, to reflect the increased potential for risk arising during this final year of transition. The SHA also had an **anti-fraud** plan in place throughout the year to detect and deter fraud. The plan was based on criteria set by NHS Protect (the national counter fraud service) plus a local risk based assessment and was approved and monitored by the Audit Committee.

5. Review of the Effectiveness of Risk Management and Internal Control

This section talks about the effectiveness of the risk management processes in place within the Authority and the sources which provide evidence that the various mechanisms are operating effectively.

5.1 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.

5.2 The Head of Internal Audit provides me with a year-end 'Opinion' statement on the overall arrangements for gaining assurance through the Board Risk and Assurance Framework and on the systems of internal control which are reviewed as part of the internal audit work programme. For 2012/13 the audit Opinion gave the Authority 'significant assurance' that there was a sound system of internal control in operation throughout the year.

5.3 External Auditors appointed by the Audit Commission also provide an independent review of the Authority's Financial Statements and overall control environment. Their Annual Audit Letter to the Board in respect of Yorkshire and the Humber SHA provided an 'Unqualified Opinion' for 2011/12. Their Opinion for the current year will be reported after the year-end accounts have been audited and is expected in June 2013. The auditors also provide a statutory Value for Money Conclusion on the SHA's arrangements for securing economy, efficiency and effectiveness and for 2011/12 the SHA received an 'Unqualified Conclusion' opinion. The Auditor's report for 2012/13 will be reported after the financial year end.

5.4 The Department of Health carried out a 2012 mid-year Transition Assurance Review of all SHA clusters to assess preparedness to manage the transition programme through to its final conclusion. The outcome was very positive and provided the Board and the Department of Health with assurance that NHS North of England had appropriate arrangements in place which were being managed effectively.

5.5 Executive managers and Directors within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance, through monitoring and review of the risks and associated actions in respect of their areas of responsibility. Senior managers also represent their respective Directors on the Assurance Group which is responsible for the operational effectiveness of the risk and control environment. The Risk and Assurance Framework itself, which is subject to regular review, provides me with evidence of the effectiveness of the control mechanisms that manage the risks to the organisation of achieving its principal objectives.

5.6 My review is also informed by:

(i) other sources of assurance as set out in the Risk and Assurance Framework.
(ii) Board agenda papers which are linked to the appropriate Board objective/s and carry a risk assessment and other control statements completed by the author provide the Board with assurance.
(iii) The Transition programme assurance processes that were in place.
(iv) The system of internal control within the SHA comprising a range of policies, procedures, codes of conduct, scheme of delegation etc. The key procedures are set out in the SHA cluster Corporate Governance Manual which was reviewed and amendments approved by the Board during the year and communicated to all staff. The SHA also has in place a Procurement Manual and a Budget Manual, designed to direct and guide staff in operational matters and improve internal control and risk arrangements.
(v) The Audit Committee has a key role in the oversight of the Authority's risk and control environment which is reflected in the Committee's Terms of Reference agreed by the Board.
(vi) NHS Protect (which leads nationally on work to identify and tackle fraud and corruption across the health service) provides the Authority with assurance regarding its anti-fraud and corruption arrangements. A Qualitative Assessment of all NHS bodies is carried out annually and for 2011/12 (the latest available) this showed that Yorkshire and the Humber SHA was performing well and was the highest scoring SHA.
(vii) The cross directorate Assurance Group which supports the Senior Management Team and Audit Committee.

6. Significant Issues

In this section I am required to declare if any significant issues have arisen during the year which could have impacted on the achievement of the Authority's objectives or resulted in the annual accounts being misstated.

There were no significant issues to report in Yorkshire and the Humber SHA.

Signing Officer

Signed.....

Date.....29/05/2013.....

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	27,092	29,262
Other costs	5.1	556,445	544,370
Income	4	(10,026)	(7,862)
Net operating costs before interest		573,511	565,770
Investment income	9	0	0
Other (Gains)/Losses	10	0	0
Finance costs	11	0	0
Net operating costs for the financial year		573,511	565,770
Transfers by absorption -(gains)		0	
Transfers by absorption - losses		0	
Net (gain)/loss on transfers by absorption		0	
Net operating costs and transfer gains/losses for the financial year		573,511	565,770
Of which:			
Administration Costs			
Gross employee benefits	7.1	21,667	24,749
Other costs	5.1	12,051	14,820
Income	4	(8,417)	(5,925)
Net administration costs before interest		25,301	33,644
Investment income	9	0	0
Other (Gains)/Losses	10	0	0
Finance costs	11	0	0
Net administration costs for the financial year		25,301	33,644
Programme Expenditure			
Gross employee benefits	7.1	5,425	4,513
Other costs	5.1	544,394	529,550
Income	4	(1,609)	(1,937)
Net programme expenditure before interest		548,210	532,126
Investment income	9	0	0
Other (Gains)/Losses	10	0	0
Finance costs	11	0	0
Net programme expenditure for the financial year		548,210	532,126

Other Comprehensive Net Expenditure	**2012-13 £000**	2011-12 £000
Impairments and reversals	0	0
Net (gain) on revaluation of property, plant & equipment	0	0
Net (gain) on revaluation of intangibles	0	0
Net (gain) on revaluation of financial assets	0	0
Movement in other reserves	0	0
Net (gain)/loss on available for sale financial assets	0	0
Net Gain / (loss) on Assets Held for Sale	0	
Release of Reserves to Statement of Comprehensive Net Expenditure	0	
Net actuarial (gain)/loss on pension schemes	0	0
Reclassification Adjustments		
On Disposal of Available for Sale Financial Assets	0	0
Total comprehensive net expenditure for the year*	573,511	565,770

*This is the sum of the rows above plus net operating costs for the financial year after absorption accounting adjustments.
The notes on pages 17 to 45 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	**0**	363
Intangible assets	13	**0**	0
Investment property	15	**0**	0
Other financial assets	20	**0**	0
Trade and other receivables	19	**0**	0
Total non-current assets		**0**	363
Current assets:			
Inventories	18	**0**	0
Trade and other receivables	19	**1,053**	3,610
Other financial assets	20	**0**	0
Other current assets	21	**0**	0
Cash and cash equivalents	22	**22**	7
Sub Total current assets		**1,075**	3,617
Non-current assets held for sale	23	**0**	0
Total current assets		**1,075**	3,617
Total assets		**1,075**	3,980
Current liabilities			
Trade and other payables	24	**(12,073)**	(20,557)
Other liabilities	25	**0**	0
Provisions	31	**(244)**	(4,116)
Borrowings	26	**0**	0
Other financial liabilities	34.2	**0**	0
Total current liabilities		**(12,317)**	(24,673)
Non-current assets plus/less net current assets/liabilities		**(11,242)**	(20,693)
Non-current liabilities			
Trade and other payables	24	0	0
Other Liabilities	25	0	0
Provisions	31	0	(1,988)
Borrowings	26	0	0
Other financial liabilities	34.2	0	0
Total non-current liabilities		**0**	(1,988)
Total Assets Employed:		**(11,242)**	(22,681)
Financed by taxpayers' equity:			
General fund		(11,242)	(22,816)
Revaluation reserve		0	135
Other reserves		0	0
Total taxpayers' equity:		**(11,242)**	(22,681)

The notes on pages 17 to 45 form part of this account.

The financial statements on pages *13 to 16* were approved by the Department of Health Audit and Risk Sub-Committee (NHS North of England) *on 29th May 2013* and signed on its behalf by

Signing Officer  **Date:** 29/05/2013

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	(22,816)	135	0	(22,681)
Changes in taxpayers' equity for 2012-13				
Net operating cost plus (gain)/loss on transfers by absorption	(573,511)			(573,511)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment		0		0
Net Gain / (loss) on Revaluation of Intangible Assets		0		0
Net Gain / (loss) on Revaluation of Financial Assets		0		0
Net Gain / (loss) on Assets Held for Sale		0		0
Impairments and reversals		0		0
Movements in other reserves	0		0	0
Transfers between reserves	135	(135)		0
Release of Reserves to SOCNE		0		0
Transfers between Revaluation Reserve & General Fund in respect of assets transferred under absorption	0	0		0
Reclassification adjustment on disposal of available for sale financial assets		0		0
Net actuarial gain/(loss) on pensions	0		0	0
Total recognised income and expense for 2012-13	(573,376)	(135)	0	(573,511)
Net Parliamentary funding	584,950			584,950
Balance at 31 March 2013	(11,242)	0	0	(11,242)
Prior Year				
Changes in taxpayers' equity for 2011-12				
Balance at 1 April 2011	(21,688)	135	0	(21,553)
Adjustment for accounting policy changes (donations and grants)	0	0	0	0
Other adjustments	0	0	0	0
Restated balance at 1 April 2011	(21,688)	135	0	(21,553)
Net operating cost for the year	(565,770)			(565,770)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment		0		0
Net Gain / (loss) on Revaluation of Intangible Assets		0		0
Net Gain / (loss) on Revaluation of Financial Assets		0		0
Net Gain / (loss) on Assets Held for Sale		0		0
Impairments and reversals		0		0
Movements in other reserves	0		0	0
Transfers between reserves	0	0		0
Release of Reserves to SOCNE		0		
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets		0		0
Reserves Eliminated on Dissolution	0	0		
Net actuarial gain/(loss) on pensions	0		0	0
Total recognised income and expense for 2011-12	(565,770)	0	0	(565,770)
Net Parliamentary funding	564,642			564,642
Balance at 31 March 2012	(22,816)	135	0	(22,681)

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		(573,511)	(565,770)
Depreciation and Amortisation		363	380
Impairments and Reversals		0	0
Other Gains / (Losses) on foreign exchange		0	0
Interest Paid		0	0
(Increase)/Decrease in Inventories		0	0
(Increase)/Decrease in Trade and Other Receivables		2,557	679
(Increase)/Decrease in Other Current Assets		0	0
Increase/(Decrease) in Trade and Other Payables		(8,484)	564
(Increase)/Decrease in Other Current Liabilities		0	0
Provisions Utilised		(3,654)	(484)
Increase/(Decrease) in Provisions		(2,206)	46
Net Cash Inflow/(Outflow) from Operating Activities		(584,935)	(564,585)
Cash flows from investing activities			
Interest Received		0	0
(Payments) for Property, Plant and Equipment		0	(51)
(Payments) for Intangible Assets		0	0
(Payments) for Other Financial Assets		0	0
Proceeds of disposal of assets held for sale (PPE)		0	0
Proceeds of disposal of assets held for sale (Intangible)		0	0
Proceeds from Disposal of Other Financial Assets		0	0
Rental Revenue		0	0
Net Cash Inflow/(Outflow) from Investing Activities		0	(51)
Net cash inflow/(outflow) before financing		(584,935)	(564,636)
Cash flows from financing activities			
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		0	0
Net Parliamentary Funding		584,950	564,642
Capital Receipts Surrendered		0	0
Capital grants and other capital receipts		0	0
Cash Transferred (to)/from Other NHS Bodies		0	0
Net Cash Inflow/(Outflow) from Financing Activities		584,950	564,642
Net increase/(decrease) in cash and cash equivalents		15	6
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		7	1
Opening Balance Adjustment		0	0
Restated Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		7	1
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		22	7

1. Accounting Policies

Under the provisions of the Health and Social Care Act 2012, Yorkshire and the Humber SHA was dissolved on 31 March 2013. The SHA's functions, assets and liabilities transferred to other public sector entities as outlined in Note 40 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.

The Secretary of State for Health has directed that the financial statements of SHAs shall meet the accounting requirements of the SHA Manual for Accounts, which has been agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2012-13 SHAs 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 SHA 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 SHA for the purpose of giving a true and fair view has been selected. The particular policies adopted by the SHA are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

Yorkshire and the Humber Strategic Health Authority 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 SHA exercises in-year budgetary control over the other entity.

1.1 Accounting Conventions

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

Acquisitions and Discontinued Operations

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

Critical accounting judgements and key sources of estimation uncertainty

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

Critical judgements in applying accounting policies

The Yorkshire and the Humber Strategic Health Authority management has not made specific critical judgements, apart from those involving estimations in the process of applying the entity's accounting policies that have a significant effect on the amounts recognised in the financial statements.

Key sources of estimation uncertainty

At the Statement of Financial Position date assumptions have been made regarding asset valuations, asset lives and provisions. The capitalised fixed assets have been fully depreciated at 31st March 2013 in line with the life of the SHA. However at current levels these do not cause a significant risk of material adjustment to the carrying amounts of total assets and liabilities within the next financial year.

1.2 Revenue and Funding

The main source of funding for the Yorkshire and the Humber Strategic Health Authority is allocations (Parliamentary Funding) from the Department of Health within an approved cash limit, which is credited to the General Fund of the SHA. Parliamentary funding is recognised in the financial period in which the cash is received.

1. Accounting policies (continued)

1.2 Revenue and Funding (continued)

Revenue is accounted for applying the accruals convention. Operating revenue is revenue which relates directly to the operating activities of the authority including national programmes hosted by the Yorkshire and the Humber Strategic Health Authority. It comprises programme funding from organisations, fees and charges for services provided on a full-cost basis to external customers, other revenue from NHS organisations. 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 revenue. Where revenue is received for a specific activity which is to be delivered in the following financial year, that revenue is deferred.
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.

1.3 Taxation

The Yorkshire and the Humber Strategic Health Authority 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.

1.4 Administration and Programme Costs

Treasury has set performance targets in respect of non-frontline expenditure (administration expenditure).
SHAs therefore analyse and report revenue income and expenditure by "admin and programme".
For SHAs, the Treasury 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, including education and training of current and future NHS staff.

1.5 Property, Plant & Equipment

Recognition

Property, Plant & Equipment which is capable of being used for more than one year and they:

- individually have a cost equal to or greater than £5,000; or
- collectively have a cost of at least £5,000 and an individual cost of more than £250, where the assets are functionally interdependent, they have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single management control.

The Yorkshire and the Humber Strategic Health Authority does not capitalise the cost of refurbishments to office premises leased by the SHA

1.6 Intangible Assets

Yorkshire and the Humber Strategic Health Authority does not hold any intangible assets.

1.7 Depreciation, amortisation and impairments

Depreciation and amortisation are charged on a straight line basis to write off the costs or valuation of tangible non-current assets, less any residual value, over their estimated useful lives. The estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

At each Statement of Financial Position date, the SHA checks whether there is any indication that any of its tangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount.

If there has been an impairment loss, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to the Statement of Comprehensive Net 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 the Statement of Comprehensive Net Expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1. Accounting policies (continued)

1.8 Non-current assets held for sale
Yorkshire and the Humber Strategic Health Authority does not hold any non-current assets for sale.

1.9 Inventories
Yorkshire and the Humber Strategic Health Authority does not hold inventories.

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 SHAs 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 SHAs.

The NHSLA operates a risk pooling scheme under which the SHA pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The total value of clinical negligence provisions carried by the NHSLA on behalf of the SHA is disclosed at Note 31.

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, except for bonuses earned but not yet taken which, like leave earned but not yet taken is not accrued for at the year end, on the grounds of immateriality.

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 SHA commits itself to the retirement, regardless of the method of payment.

1.13 Research and Development
Yorkshire and the Humber Strategic Health Authority does not have any research and development expenditure.

1. Accounting policies (continued)

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 SHA 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 SHA has a present legal or constructive obligation which occurs when all of the conditions attached to the payment have been met.

1.16 EU Emissions Trading Scheme
EU Emission Trading Scheme allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amount are valued at fair value at the end of the reporting period.

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

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

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

1.18 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 SHA 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 SHA's net operating cost.

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

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

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases. This is a change in accounting policy from previous years where leased land was always treated as an operating lease.

The SHA as lessor
Amounts due from lessees under finance leases are recorded as receivables at the amount of the SHA'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 SHA'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. Accounting policies (continued)

1.19 Foreign exchange

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

1.20 Provisions

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

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 SHA has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

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

1.21 Financial Instruments

Financial assets

Financial assets are recognised when the SHA 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.

1. Accounting policies (continued)

1.21 Financial Instruments

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

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

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the Statement of Comprehensive Net Expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

Financial liabilities

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

Financial liabilities are initially recognised at fair value.

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

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. Accounting policies (continued)

1.22 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 - subject to consultation
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IPSAS 32 - Service Concession Arrangement - subject to consultation

2 Operating segments

The operating segments reported in 2012-13 reflect the format used for internal reporting following the clustering arrangements under NHS North of England. Expenditure is reported against four segments:

a) Core Activities (SHA Administration)
b) Hosted Activities
c) Multi-Professional Education & Training (MPET)
d) Economy

Yorkshire and the Humber Strategic Health Authority acts as a statutory host body to a wide range of National and Regional programmes. These hosted budgets have also been reported separately from its Core allocation for SHA Administration. Within the overall resource allocation issued by the Department of Health, Yorkshire and the Humber Strategic Health Authority receives a separate allocation for Multi-Professional Education & Training (MPET) for its activities in relation to planning and commissioning training and education on behalf of the NHS organisations in the region. The relative size and nature of this allocation means that expenditure relating to the MPET allocation is monitored separately from Yorkshire and the Humber Strategic Health Authority other budgets. Economy refers to funding held by the Yorkshire and the Humber Strategic Health Authority on behalf of the region wide health economy.

	Core Activities		Hosted Activities		MPET		Economy		Total	
	2012-13	2011-12	**2012-13**	2011-12	**2012-13**	2011-12	**2012-13**	2011-12	**2012-13**	2011-12
	£000	£000	**£000**	£000	**£000**	£000	**£000**	£000	**£000**	£000
Expenditure	**8,119**	9,025	**56,639**	54,949	**508,753**	501,796	**0**	0	**573,511**	565,770
Surplus/(Deficit)										
Segment surplus/(deficit)	**12**	1,223	**23,914**	51,392	9,817	14,243	**114,393**	51,319	**148,136**	118,177
Common costs	**0**	0	**0**	0	0	0	**0**	0	**0**	0
Surplus/(deficit) before interest	**12**	1,223	**23,914**	51,392	**9,817**	14,243	**114,393**	51,319	**148,136**	118,177
Net Assets:										
Segment net assets	**(240)**	(4,835)	**(3,659)**	(10,206)	**(7,343)**	(7,640)	**0**	0	**(11,242)**	(22,681)

See Note 41.4

The following providers receive more than 10% of Education and Training Expenditure (MPET); Leeds Teaching Hospitals NHS Trusts (£77m), Sheffield Hospitals NHS Foundation Trusts (£66m) and NHS Business Services Authority (£48m)

3. Financial Performance Targets

3.1 Revenue Resource Limit

	2012-13 £000	2011-12 £000
The SHA's performance for the year ended 2012-13 is as follows:		
Total Net Operating Cost for the Financial Year		565,770
Net operating costs plus (gain)/loss on transfers by absorption	573,511	
Adjust outturn for "local" PPAs	0	
Revenue Resource Limit	721,647	683,947
Under/(Over)spend Against Revenue Resource Limit (RRL)	148,136	118,177

3.2 Capital Resource Limit

	2012-13 £000	2011-12 £000
The SHA is required to keep within its Capital Resource Limit.		
Total Gross Capital Expenditure	0	51
less: Net Book Value of Non-Current Assets Disposed of to NHS Bodies	0	0
less: Net Book Value of Non-Current Assets Disposed of to non-NHS Bodies	0	0
less: Capital Grants Received	0	0
Charge Against the Capital Resource Limit (CRL)	0	51
Capital Resource Limit (CRL)	100	100
(Over)/Underspend Against CRL	100	49

4 Operating Revenue

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Fees & Charges	2,133	1,884	249	3,607
Rental Income from Finance Leases	0	0	0	0
Rental Income from Operating Leases	0	0	0	0
Recoveries in respect employee benefits	2,936	2,711	225	1,493
Other	4,957	3,822	1,135	2,762
Total operating revenue	10,026	8,417	1,609	7,862
Investment Revenue	0	0	0	0
Total Operating and Investment Revenue	10,026	8,417	1,609	7,862

5.1 Operating costs (excluding employee benefits)

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Chair and Non-executive directors remuneration	101	101	0	103
Consultancy Services	0	0	0	1
External contractors	0	0	0	0
Establishment expenses	2,669	2,669	0	1,144
Transport and moveable plant	73	73	0	66
Premises	1,152	1,152	0	1,740
Impairments & reversals for non current assets held for sale	0	0	0	0
Depreciation	363	363	0	380
Capital - Amortisation	0	0	0	0
Capital - Impairments and reversals - PPE	0	0	0	0
Capital - Impairments and reversals - Intangible Asset	0	0	0	0
Impairments and Reversals of Receivables	0	0	0	(4)
Impairment and Reversals of financial assets	0	0	0	0
Inventories Write Offs	0	0	0	0
Auditors remuneration - audit fee	96	96	0	156
Auditors remuneration - other fees (freetext note required)	0	0	0	3
MPET Education and Training	498,833	2,201	496,632	492,511
Hosted Activities/ Internal Recharges *	53,158	5,396	47,762	48,270
Total Operating Costs excl. Employee benefits	556,445	12,051	544,394	544,370

*Hosted Activities/Internal Recharges is made up of Hosted Activities of £53,695k (See Note 5.5), Internal Recharges of (£956k) and other of £420k. See Note 41.8

5.2 Gross Employee Benefits - excluding capitalised costs and income in respect of staff costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Employee Benefits (excluding officer board members)	26,875	21,450	5,425	28,795
SHA Officer Board members	217	217	0	467
Total Employee Benefits	27,092	21,667	5,425	29,262
TOTAL OPERATING COSTS	583,537	33,718	549,819	573,632

5.3 Running costs and public health expenditure

	2012-13 £000
Of the above: running costs for Pulic Health	2,095
Of "Total op costs excl employee benefits": Public Health	1,497
Of "Employee Benefits": Public Health	598
Total Public Health expenditure	2,095
Of Operating Revenue: amount relating to Public Health Income from Outside the NHS/DH	338

Running Costs 2012-13	SHA & MPET £000	Public Health £000	Total £000
Running costs (£000s) - net of income	23,816	1,757	25,573
Weighted population (number in units)	5,555,829	5,555,829	5,555,829
Running costs per head of population (£ per head)	4.3	0.3	4.6

5.4 MPET (Education & Training)

	2012/13 £000s	2011/12 £000s
NHS Bodies	370,196	364,124
Educational Institutions*	108,742	109,604
Other (incl GP Practices)	19,895	18,783
Total	498,833	492,511

*Note 41.10 provides further analysis of expenditure with Educational Institutions.

5.5 Hosted Activities

	2012/13 £000s	2011/12 £000s
National Cancer Screening	47,765	30,514
National Programme for IT	2,580	3,328
Other*	3,350	15,728
**Total Hosted Programme costs ** **	53,695	49,570

* Other no longer includes the Cancer Drugs Fund which ceased to be hosted by the SHA in 2012/13

** Non-Pay costs only. Total costs shown in segmental analysis on page 24 (Note 2).

6. Operating Leases

6.1 SHA as lessee

	Land £000	Buildings £000	Other £000	2012-13 Total £000	2011-12 £000
Payments recognised as an expense					
Minimum lease payments	0	621	105	726	901
Contingent rents	0	0	0	0	0
Sub-lease payments	0	0	0	0	0
Total	0	621	105	726	901
Payable:					
No later than one year	0	590	0	590	683
Between one and five years	0	2,494	0	2,494	2,574
After five years	0	1,059	0	1,059	1,061
Total	0	4,143	0	4,143	4,318

Total future sublease payments expected to be received:	0	0

6.2 SHA as lessor

The Yorkshire and the Humber Strategic Health Authority was not a lessor in 2012/13 (2011/12: nil).

7. Employee benefits and staff numbers

7.1 Employee benefits

				Permanently employed			Other		
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Employee Benefits 2012-13 - gross expenditure									
Salaries and wages	23,357	18,660	4,697	20,037	16,129	3,908	3,320	2,531	789
Social security costs	1,533	1,234	299	1,533	1,234	299	0	0	0
Employer Contributions to NHS BSA - Pensions Division	2,202	1,773	429	2,202	1,773	429	0	0	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Total employee benefits	27,092	21,667	5,425	23,772	19,136	4,636	3,320	2,531	789
Less recoveries in respect of employee benefits (table below)	(2,936)	(2,711)	(225)	(2,936)	(2,711)	(225)	0	0	0
Total - Net Employee Benefits including capitalised costs	24,156	18,956	5,200	20,836	16,425	4,411	3,320	2,531	789
Employee costs capitalised	0	0	0	0	0	0	0	0	0
Gross Employee Benefits excluding capitalised costs	27,092	21,667	5,425	23,772	19,136	4,636	3,320	2,531	789

In addition to the total employees benefits stated above, the SHA in 2012/13 has paid payments in termination benefits. These costs are a charge against a provision established in a previous period - See note 7.4 (Exit Packages)

Employee Benefits 2012-13 - income				Permanently employed			Other		
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Salaries and wages	2,936	2,711	225	2,936	2,711	225	0	0	0
Social Security costs	0	0	0	0	0	0	0	0	0
Employer Contributions to NHS BSA - Pensions Division	0	0	0	0	0	0	0	0	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other Post Employment Benefits	0	0	0	0	0	0	0	0	0
Other Employment Benefits	0	0	0	0	0	0	0	0	0
Termination Benefits	0	0	0	0	0	0	0	0	0
TOTAL excluding capitalised costs	2936	2,711	225	2,936	2,711	225	0	0	0

Employee Benefits Prior Year

Employee Benefits Gross expenditure 2011-12	Total £000	Permanently employed £000	Other £000
Salaries and wages	25,451	20,747	4,704
Social security costs	1,529	1,529	0
Employer Contributions to NHS BSA - Pensions Division	2,282	2,282	0
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Total employee benefits	29,262	24,558	4,704
Less recoveries in respect of employee benefits	(1,493)	(1,493)	0
Total - Net Employee Benefits including capitalised costs	27,769	23,065	4,704
Employee costs capitalised	0	0	0
Gross Employee Benefits excluding capitalised costs	29,262	24,558	4,704

7.2 Staff Numbers

	2012-13			2011-12		
	Total Number	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number
Average Staff Numbers						
Other	464	392	72	459	390	69
TOTAL	464	392	72	459	390	69

7.3 Staff Sickness absence and ill health retirements

	2012-13 Number	2011-12 Number
Total Days Lost	1,728	1,529
Total Staff Years	347	360
Average working Days Lost	4.98	4.25

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

7.4 Exit Packages agreed during 2012-13

	2012-13			2011-12		
Exit package cost band (including any special payment element)	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band
	Number	Number	Number	Number	Number	Number
Lees than £10,000	2	0	2	1	0	1
£10,001-£25,000	5	3	8	1	0	1
£25,001-£50,000	3	1	4	0	0	0
£50,001-£100,000	3	1	4	1	0	1
£100,001 - £150,000	6	0	6	0	0	0
£150,001 - £200,000	9	0	9	0	0	0
>£200,000	3	0	3	1	0	1
Total number of exit packages by type (total cost)	31	5	36	4	0	4
	£'s	£'s	£'s	£'s	£'s	£'s
Total resource cost	3,512,739	141,480	3,654,219	409,000	0	409,000

Rendundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme

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

7.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.
In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

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

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

b) Full actuarial (funding) valuation

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

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

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

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

c) Scheme provisions

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

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

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

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

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

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

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

8. Better Payment Practice Code

8.1 Measure of compliance

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	19,309	143,119	21,171	139,107
Total Non-NHS Trade Invoices Paid Within Target	18,537	141,178	20,645	135,350
Percentage of NHS Trade Invoices Paid Within Target	96.0%	98.6%	97.5%	97.3%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	4,863	432,660	4,570	410,333
Total NHS Trade Invoices Paid Within Target	4,582	425,895	4,368	404,596
Percentage of NHS Trade Invoices Paid Within Target	94.2%	98.4%	95.6%	98.6%

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

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

The Yorkshire and Humber Strategic Health Authority has not paid any interest charges in the financial year 2012/13 (2011/12: nil).

9. Investment Income

The Yorkshire and the Humber Strategic Health Authority had no investment income in 2012/13 (2011/12: nil).

10. Other Gains and Losses

The Yorkshire and the Humber Strategic Health Authority has had no gains or losses in 2012/13 (2011/12: nil).

11. Finance Costs

The Yorkshire and the Humber Strategic Health Authority has had no finance costs in 2012/13 (2011/12: nil).

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	0	468	0	0	0	0	1,434	146	2,048
Additions of Assets Under Construction				0					0
Additions Purchased	0	0	0		0	0	0	0	0
Additions Leased	0	0	0		0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassifications as Held for Sale and Reversals	0	0	0	0	0	0	0	0	0
Disposals other than for sale	0	0	0	0	0	0	0	0	0
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	0
Impairments/negative indexation charged to reserves	0	0	0	0	0	0	0	0	0
Reversal of Impairments charged to reserves	0	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	0
At 31 March 2013	0	468	0	0	0	0	1,434	146	2,048
Depreciation									
At 1 April 2012		310	0	0	0	0	1,239	136	1,685
Reclassifications	0	0	0		0	0	0	0	0
Reclassifications as Held for Sale	0	0	0		0	0	0	0	0
Disposals other than for sale	0	0	0		0	0	0	0	0
Upward revaluation/positive indexation	0	0	0		0	0	0	0	0
Impairments/negative indexation charged to operating	0	0	0	0	0	0	0	0	0
Reversal of Impairments charged to operating expense	0	0	0	0	0	0	0	0	0
Charged During the Year	0	158	0	0	0	0	195	10	363
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	0
At 31 March 2013	0	468	0	0	0	0	1,434	146	2,048
Net Book Value at 31 March 2013	0	0	0	0	0	0	0	0	0
Asset financing:									
Owned	0	0	0	0	0	0	0	0	0
Held on finance lease	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	0	0	0	0	0	0	0	0	0

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	0	133	0	0	0	0	0	2	135
Movements (transfer to General Fund)	0	(133)	0	0	0	0	0	(2)	(135)
At 31 March 2013	0	0	0	0	0	0	0	0	0

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	0	456	0	0	0	0	1,395	146	1,997
Additions - purchased	0	12	0	0	0	0	39	0	51
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	0
Impairments/negative indexation charged to reserves	0	0	0	0	0	0	0	0	0
Reversal of Impairments charged to reserves	0	0	0	0	0	0	0	0	0
Transfers (to)/form NHS Bodies	0	0	0	0	0	0	0	0	0
At 31 March 2012	0	468	0	0	0	0	1,434	146	2,048
Depreciation									
At 1 April 2011	0	125	0	0	0	0	1,054	126	1,305
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassifications as Held for Sale	0	0	0	0	0	0	0	0	0
Disposals other than for sale	0	0	0	0	0	0	0	0	0
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	0
Impairments/negative indexation charged to operating expenses	0	0	0	0	0	0	0	0	0
Reversal of Impairments charged to operating expenses	0	0	0	0	0	0	0	0	0
Charged During the Year	0	185	0	0	0	0	185	10	380
Transfers to NHS Bodies	0	0	0	0	0	0	0	0	0
At 31 March 2012	0	310	0	0	0	0	1,239	136	1,685
Net book value	0	158	0	0	0	0	195	10	363
Asset financing:									
Owned	0	158	0	0	0	0	195	10	363
Held on finance lease	0	0	0	0	0	0	0	0	0
Total at 31 March 2012	0	158	0	0	0	0	195	10	363

12.3 Property, plant and equipment

The Strategic Health Authority Plant, Property and Equipment has a nil Net Book Value at 31st March 2013. Previous capitalised engineering installation and refurbishment at Blenheim House (Leeds) and Don Valley House (Sheffield) and Information Technology equipment have been fully depreciated. Asset lives were reviewed in 2011/12 and were aligned with the remaining period of the SHA.

13 Intangible non-current assets

The Yorkshire and the Humber Strategic Health Authority does not have any intangible non-current assets in 2012/13 (2011/12: nil).

14.Analysis of impairments and reversals recognised in 2012-13

The Yorkshire and the Humber Strategic Health Authority does not have any impairments and reversals in 2012/13 (2011/12: nil).

15 Investment Property

The Yorkshire and the Humber Strategic Health Authority does not have any investment income in 2012/13 (2011/12: nil).

16 Commitments

The Yorkshire and the Humber Strategic Health Authority does not have any capital commitments in 2012/13 (2011/12: nil).

17 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	809	0	2,691	0
Balances with Local Authorities	0	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	32	0	4,849	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	212	0	4,533	0
At 31 March 2013	1,053	0	12,073	0
prior period:				
Balances with other Central Government Bodies	1,327	0	9,504	0
Balances with Local Authorities	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	976	0	5,261	0
Balances with Public Corporations and Trading Funds	2	0	22	0
Balances with bodies external to government	1,305	0	5,770	0
At 31 March 2012	3,610	0	20,557	0

18 Inventories

	Consumables £000	Other £000	Total £000
Balance at 1 April 2012	0	0	0
Additions	0	0	0
Inventories recognised as an expense in the period	0	0	0
Write-down of inventories (including losses)	0	0	0
Reversal of write-down previously taken to SoCNE	0	0	0
Transfers (to)/from other public sector bodies	0	0	0
Balance at 31 March 2013	0	0	0

19.1 Trade and Other Receivables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
NHS Receivables - Revenue	321	1,824	0	0
NHS Receivables - Capital	0	0	0	0
NHS Prepayments and Accrued Income	0	0	0	0
Non NHS Trade Receivables - Revenue	34	657	0	0
Non NHS Trade Receivables - Capital	0	0	0	0
Non-NHS Prepayments and Accrued Income	178	648	0	0
Provision for Impairments of Receivables	0	0	0	0
VAT	520	481	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables	0	0	0	0
Total	1,053	3,610	0	0
Total current and non current	1,053	3,610		

19.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	332	210
By three to six months	32	23
By more than six months	4	33
Total	368	266

19.3 Provision for impairment of receivables

The Yorkshire and the Humber Strategic Health Authority does not have any provisions for impairment of receivables in 2012/13 (2011/12: nil).

20 Other Financial Assets - Current

The Yorkshire and the Humber Strategic Health Authority does not have any other financial assets in 2012/13 (2011/12: nil).

21 Other Current Assets

The Yorkshire and the Humber Strategic Health Authority does not have any other current assets in 2012/13 (2011/12: nil).

22 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	7	1
Net change in year	15	6
Closing balance	22	7
Made up of		
Cash with Government Banking Service	22	7
Commercial banks	0	0
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	22	7
Bank overdraft - Government Banking Service	0	0
Bank overdraft - Commercial banks	0	0
Cash and cash equivalents as in statement of cash flows	22	7
Patients' money held by the SHA, not included above	0	0

23 Non-current Assets Held For Sale

The Yorkshire and the Humber Strategic Health Authority does not have any non-current assets for sale in 2012/13 (2011/12: nil).

24 Trade and Other Payables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
Interest Payable	0	0		
NHS Payables - Revenue	1,571	3,372	0	0
NHS Payables - Capital	0	0	0	0
NHS Accruals and Deferred Income*	5,969	11,415	0	0
Non-NHS Trade Payables - Revenue	1,573	1,812	0	0
Non-NHS Trade Payables - Capital	0	0	0	0
Non-NHS Accruals and Deferred Income	2,960	3,952	0	0
Social Security Costs	0	0		
VAT	0	0	0	0
Tax	0	0		
Payments received on account	0	6	0	0
Other	0	0	0	0
Total	12,073	20,557	0	0
Total payables (current and non-current)	**12,073**	**20,557**		

*NHS Accruals - 2011/12 included £6.8m relating to the Cancer Drugs Fund. The Cancer Drugs Fund programme ceased to hosted by the SHA in 2012/13.

25 Other Liabilities

The Yorkshire and the Humber Strategic Health Authority does not have any other liabilities in 2012/13 (2011/12: nil).

26 Borrowings

The Yorkshire and the Humber Strategic Health Authority does not have any borrowings in 2012/13 (2011/12: nil).

27 Other Financial Liabilities

The Yorkshire and the Humber Strategic Health Authority does not have any other financial liabilities in 2012/13 (2011/12: nil).

28 Deferred Income

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Opening balance at 1 April 2012	**179**	0	**0**	0
Deferred income addition	**0**	179	**0**	0
Transfer of deferred income	**(179)**	0	**0**	0
Deferred Income at 31 March 2013	**0**	179	**0**	0
Total other liabilities (current and non-current)	**0**	**179**		

29 Finance Lease Obligations

The Yorkshire and the Humber Strategic Health Authority does not have any finance lease obligations in 2012/13 (2011/12: nil).

30 Finance lease receivables as lessor

The Yorkshire and the Humber Strategic Health Authority does not have any finance lease receivables as lessor in 2012/13 (2011/12: nil).

31 Provisions

	Total £000s	Comprising: 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	6,104	0	0	0	730	0	0	0	50	5,324
Arising During the Year	87	0	0	0	0	0	0	0	0	87
Utilised During the Year	(3,654)	0	0	0	0	0	0	0	0	(3,654)
Reversed Unused	(2,293)	0	0	0	(730)	0	0	0	(50)	(1,513)
Unwinding of Discount	0	0	0	0	0	0	0	0	0	0
Change in Discount Rate	0	0	0	0	0	0	0	0	0	0
Transferred (to)/from other public sector bodies	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2013	244	0	0	0	0	0	0	0	0	244
Expected Timing of Cash Flows:										
No Later than One Year	244	0	0	0	0	0	0	0	0	244
Later than One Year and not later than Five Years	0	0	0	0	0	0	0	0	0	0
Later than Five Years	0	0	0	0	0	0	0	0	0	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities (£000s):

As at 31 March 2013	139,451
As at 31 March 2012	129,937

See Note 41.3 -Provisions

32 Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities		
Equal Pay	0	0
Other	(500)	(1,400)
Amounts Recoverable Against Contingent Liabilities	0	0
Net Value of Contingent Liabilities	(500)	(1,400)
Contingent Assets		
Contingent Assets	0	0
Net Value of Contingent Assets	0	0

The contingent liability relates to potential pension costs of former NHS Staff that transfered employment from the NHS Colleges of Health to the university sector in 1996 retaining NHS terms and conditions relating to retirement age. The reduction in the contingent liability from 2011/12 relates to reassignment of SHA leased office accomodation during 2012-13.

33 Impact of IFRS treatment 2012-13

There is no impact of IFRS treatment in the current period for Yorkshire and the Humber Strategic Health Authority.

34 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 SHA 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 SHA's expected purchase and usage requirements and the SHA is therefore exposed to little credit, liquidity or market risk.

Currency risk

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

Interest rate risk

SHAs are not permitted to borrow. The SHA therefore has low exposure to interest-rate fluctuations

Credit Risk

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

Liquidity Risk

The SHA 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 SHA is not, therefore, exposed to significant liquidity risks.

34.1 Financial Assets	At 'fair value through profit and loss' £000	Loans and receivables £000	Available for sale £000	Total £000
Embedded derivatives	0			0
Receivables - NHS		321		321
Receivables - non-NHS		34		34
Cash at bank and in hand		22		22
Other financial assets	0	0	0	0
Total at 31 March 2013	0	377	0	377
Embedded derivatives	0			0
Receivables - NHS		1,824		1,824
Receivables - non-NHS		657		657
Cash at bank and in hand		7		7
Other financial assets	0	0	0	0
Total at 31 March 2012	0	2,488	0	2,488

34.2 Financial Liabilities	At 'fair value through profit and loss' £000	Other £000	Total £000
Embedded derivatives	0		0
NHS payables		7,540	7,540
Non-NHS payables		4,533	4,533
Other borrowings		0	0
PFI & finance lease obligations		0	0
Other financial liabilities	0	0	0
Total at 31 March 2013	0	12,073	12,073
Embedded derivatives	0		0
NHS payables		14,787	14,787
Non-NHS payables		5,764	5,764
Other borrowings		0	0
PFI & finance lease obligations		0	0
Other financial liabilities	0	0	0
Total at 31 March 2012	0	20,551	20,551

35 Related party transactions

Yorkshire & the Humber Strategic Health Authority is a body corporate established by the order of the Secretary of the State for Health.

The Department of Health is regarded as a related party. During the year, Yorkshire and the Humber Strategic Health Authority 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 :

All Primary Care Trusts in Yorkshire and the Humber
All NHS Trusts and Foundation Trusts in Yorkshire and the Humber
NHS Pensions Agency
NHS Business Services Authority (Students Bursary Unit)
University Hospitals Coventry and Warwickshire NHS Trusts
Gateshead Health NHS Foundation Trusts
Connecting for Health (Health and Social Care Information Centre from 01/04/13)
Frimley Park Hospitals NHS Foundation Trust
North West London Hospitals NHS Trust
Nottingham University Hospitals NHS Trust

During the year the following Directors had related party interests (2012/13 expenditure with the relevant organisations is shown in brackets):

~ University of Sheffield (£6,433k): Kathryn Riddle (Pro-Vice Chancellor and Chairman of the Council); Ian Walker (Member of the Court); and Sarah Harkness (Member of the Council and Member of the Audit Committee)

The compensation paid to cluster officers is disclosed in Note 7 Employee Benefits on Page 27 and within the Remuneration Report within the Annual Report.

36 Losses and special payments

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

	Total Value of Cases £s	Total Number of Cases
Losses	410	3
Special payments	0	0
Total losses and special payments	410	3

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

	Total Value of Cases £s	Total Number of Cases
Losses	14,884	2
Special payments	0	0
Total losses and special payments	14,884	2

37 Third Party Assets

The Yorkshire and the Humber Strategic Health Authority does not hold any third party assets in 2012/13 (2011/12: nil).

38 Pooled Budget

The Yorkshire and the Humber Strategic Health Authority does not have pooled budgets 2012/13 (2011/12: nil).

39 Cashflows relating to exceptional items

The Yorkshire and the Humber Strategic Health Authority does not have any cashflows relating to exceptional items in 2012/13 (2011/12: nil).

40 Events after the end of the reporting period

Following the Heath and Social Care Act (2012), the SHA was dissolved on the 31 March 2013. The main functions carried out by Yorkshire and the Humber SHA in 2012/13 are to be carried out in 2013/14 by the following public sector bodies:

- Health Education England
- NHS England
- NHS Trust Development Authority
- Public Health England
- Health & Social Care Information Centre

The SHA has put processes in place throughout 2012/13 to ensure the safe discharge of services and ensure a smooth transition. This will ensure that the SHAs duty to commission high quality education services across the NHS, provide support and leadership to Trusts which have yet to obtain Foundation status and all other statutory duties will continue to be discharged by the successor organisations.

The SHA has been actively involved in the national process in arranging the transfer of balances post 31 March 2013. All short term balances will be discharged during the first quarter of 2013/14 and any long term balances will adhere to national policy and be transferred to the successor organisation.

In addition to the transfer of functions, the lease for Blenheim House, as the principal place of business of the SHA, has transferred to the Department of Health on 31 March 2013 and any related balance sheet items will also transfer on the same date.

41.1 Taxpayers Equity and the General Fund

The balance sheet position of net liabilities and corresponding negative taxpayers equity and general fund reflect the government's resource accounting regime within which the SHA's accounts are prepared, rather than a weakness in the SHA's financial standing. Within 'resource accounting' it is normal for an organisation such as the SHA, without significant fixed assets, to have net liabilities.

Due to the way the NHS is funded net current liabilities can be sustained. The overwhelming majority of the Strategic Health Authority's cash funding comes via the cash limit and this cash is readily available to be drawn upon. Only a very small proportion of cash income arrives via debtors raised with other organisations. The cash limit is readily available allowing the creditors to be discharged.

41.2 Income

Income refers to funding received in addition to the cash limit used. In 2012/13 the £10m received as income was made up of salary recharges, fees and charges levied on PCT and Trusts by programmes hosted by the SHA and income received from Non-NHS organisations. See Note 4

41.3 Changes to Provisions

The 2012-13 accounts include a provision for redundancy costs for staff being retained by the Department of Health to assist in residual transition tasks during 2013/14. The majority of the provision held at the beginning of year was utlised for redundancy payments during 2012-13 and the balance not required was reversed and credited to the operating cost.

41.4 Segmental Analysis

The segmental analysis provides a breakdown of expenditure, resources and net assets/liabilities across distinct areas (segments) of SHA activity:

1.Core Activites (SHA Administration) - this relates to running the SHA

2. Hosted Activites - this includes national and regional programmes hosted by the SHA, including the National Cancer Screening Programme. The reduction in the surplus relates to increased spend by the National Cancer Screening Programme and the transfer of the regional Cancer Drugs Fund.

3. Multi-Professional Education and Training - this relates to the SHA role as commissioner for training and education for the NHS, commissioning from both the University sector and the NHS itself. Expenditure increased in 2012/13 compared to 2011/12, funded from use of part of the prior year underspends brought forward by the SHA and added to the Education and Training budget. This allowed additional non-recurrent investment, including a Dignity and Care programme. As part of the closure of the Strategic Health Authority on 31/3/2013 the accounts address a legacy accounting issue in relation to General Practice trainees employed by GP practices and reimbursed by the Postgraduate Medical Deanery. The accounts include an accrual for the cost of GP trainees employed by GP practices in March 2013 to align the period in which costs are accounted for by the Deanery with the period of training undertaken.

4. Economy - this refers to resource limit held by the SHA on behalf of the wider health economy of Yorkshire and the Humber or national programmes, including the PCT Strategic Investment Fund, This fund forms part of a strategy for planned healthcare development and management of the overall financial position of the Yorkshire and the Humber health economy.

41.5 Big Lottery Fund Project Payment

In 2012-13 £50,000 was received from the Big Lottery Fund for the regional Altogether Better project.

41.6 Resource Limit Underspend

The resource limit underspend of £148.1m comprises:

£114.4m of resource limit held by the SHA on behalf of the wider health economy and Department of Health.

£23.9m as the sum of all underspends generated by programmes and projects hosted by the SHA. Each programme has a specific allocation, usually made up of non-recurrent project funding and the level and rate of spending is determined by each programme according to the programme needs.

£9.8m of the underspend is the balance of prior year underspends for workforce education and training.

41.7 Resource Adjustments

Most of the aggregate revenue resource limit in the NHS is directly allocated to PCTs by the DH. As part of routine business, the SHA and local PCTs jointly request transfers of resource limit between the SHA and PCTs in Yorkshire and the Humber. These allocation movements are a combination of resources routed via the SHA for the local health economy by the DH and those relating to the overall strategy to manage the overall financial position of the Yorkshire and the Humber health economy.

41.8 Operating Costs (Note 5.1)

The increase in establishment expenses is due to the inclusion of legal charges incurred by the SHA and recharged to PCTs which were previously netted off. Hosted Activities/Internal recharges is made up of Hosted Activites of £53,695k, Internal recharges of (£956k) and other costs of £420k. The MPET Education and Training line and the Hosted Activities have been shown separately to enable year on year comparisons. The Internal Recharge line records the recharge of costs to MPET Education and Training and Hosted Activities.

41.9 The Authority's Capital Resource Limit and Capital Expenditure

In 2012-13 none of the Authority's final capital resource limit (£100k) was utlised.

41.10 Education & Training Expenditure with Educational Institutions funded through MPET (Multi - Professional Education & Training allocation)

	£'000
University of Leeds	18,615
Sheffield Hallam University	23,944
University of Huddersfield	12,610
University of Hull	13,276
University of Bradford	11,600
Leeds Metropolitan University	9,252
University of Sheffield	6,398
University of York	7,691
York St John University	4,015
Other	1,341
Total	**108,742**

41.11 Running Costs

The Accounts analyse SHA spend into Programme Costs and Running Costs (Admin). Programme Costs comprise the majority of Education and Training spend and the National Cancer Screening Programme. Running Costs comprise the cost of administration for the SHA including Education and Training and those hosted projects not classified as Programme Costs. Running Costs is based on total administration costs plus the services provided by North West SHA Estates services (£272k). The population figure refers to the population of Yorkshire and the Humber, adjusted by weightings used by the Department of Health for resource allocation purposes.