Department of Health

NHS

Doncaster Primary Care Trust

2012-13 Annual Report and Accounts

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Doncaster Primary Care Trust

2012-13 Annual Report

NHS Doncaster

Annual Review 2012/13

Doncaster Primary Care Trust

We are Doncaster's local leader for health, guardian of public health and custodian of the borough's multi-million pound NHS budget.

In 2012/13 we operated with a resource allocation of £590 million. Our role, alongside the newly emerging Clinical Commissioning Group, is to make sure health services are available to our patients when and where they are needed.

The Trust had 221 employees at the end of 2012/13. Our role was to organise and fund health services for the 300,000 patients registered with a GP practice based in the PCT area and to make sure those services are of high quality and perform well.

Doncaster Clinical Commissioning Group

During the 2012/13 year, Doncaster Clinical Commissioning Group (DCCG) was a committee of the NHS South Yorkshire and Bassetlaw Board. It is a clinically led committee that worked alongside the PCT to commission health services.

NHS South Yorkshire and Bassetlaw

In April 2011 NHS Sheffield, NHS Rotherham, NHS Barnsley, NHS Doncaster and NHS Bassetlaw formed the South Yorkshire and Bassetlaw Cluster.

Clusters are designed to ensure that individual primary care trusts continue to meet their legal, financial and performance responsibilities and obligations throughout the NHS reforms until Clinical Commissioning Groups assume full responsibility for budgets in April 2013.

NHS Doncaster remained a statutory organisation in its own right, however the five PCTs shared a Chief Executive and a number of director posts.

In July 2011 following the Department of Health publishing the single operating model for clusters, NHS Yorkshire and the Humber asked all its clusters to adopt the "single board" model. The model requires the membership of the boards of each PCT in a cluster to be identical, thereby enabling the boards to operate as if they were one board. NHS South Yorkshire and Bassetlaw began operating in this way from October 2011.

NHS South Yorkshire and Bassetlaw Cluster Board includes members are from each of the constituent PCTs and the meetings are held monthly, in public.

Welcome

This annual report for NHS Doncaster covers the 12 months from 1st April 2012 to 31st March 2013.

It was a year of further transition for health services as the national NHS started to implement new organisational changes determined by the Health and Social Care Act. The foundations were laid for the formal creation of Doncaster Clinical Commissioning Group (CCG) – the successor to Doncaster Primary Care Trust – from 1 April 2013, though the organisation had been running in shadow form prior to that.

I am delighted to say that Bassetlaw was one of the first areas in the country to be given the 'green light' to become a clinical commissioning group and our authorisation was agreed with no conditions attached. This is testimony to the hard work of our local GPs and managers, who were united in their determination to get the organisation off to a flying start and have successfully achieved their objective.

During the year, NHS Doncaster staff who were directly involved in providing public health services transferred to their new employer, Doncaster Council. This has provided a further opportunity to strengthen our ties with a key local authority partner, which is all the more important following the formation of the new Health and Wellbeing Boards, which are bringing health and social care closer together.

At local level 'designate' appointments were made to the CCG senior team, ahead of becoming substantive posts on 1 April 2103.

Looking back, 2012/13 was a year of substantial change as we played our local part in helping to implement the biggest NHS reorganisation for decades. Over the past six and a half years, Doncaster PCT has helped create effective and efficient health services that are greatly valued by local people, a legacy it has now handed on to Doncaster CCG to continue the journey.

How we are organised - NHS South Yorkshire and Bassetlaw Cluster

NHS South Yorkshire and Bassetlaw Cluster is made up of NHS Sheffield, NHS Rotherham, NHS Barnsley, NHS Doncaster and NHS Bassetlaw.

The South Yorkshire and Bassetlaw Board has continued to ensure that our primary care trusts continued to meet their legal, financial and performance responsibilities and obligations throughout 2012/13, until Clinical Commissioning Groups assume full responsibility for budgets in April 2013.

Whilst each PCT remained the statutory organisation, thefive PCTs shared a Chief Executive and a number of director posts. During this year we continued to operate as a single trust board which meant that the boards of each PCT in a cluster met jointly on a monthly basis.

NHS South Yorkshire and Bassetlaw Cluster Board members are from each of the constituent PCTs and the meetings were held monthly, in public, throughout the year.

As well as ensuring the continuation of statutory responsibilities by each of the constituent PCTs, the cluster has supported the transition to the new commissioning and public health arrangements set out in the Health and Social Care Act 2012.

All five Clinical Commissioning Groups (CCGs) in South Yorkshire and Bassetlaw have been established in shadow form as committees of the Cluster Board during the year. Under a scheme of delegation, the CCGs have managed delegated budgets and functions. The CCGs are accountable to the Cluster Board until 1 April 2013 when that accountability transfers to the NHS Commissioning Board. It is at this stage that CCGs will have to be authorised to function fully.

NHS South Yorkshire and Bassetlaw Cluster Board and Senior Officers Register of Interests

Name	Title	Declaration
Alan Tolhurst	Chairman	• Director of ACT Consultancy • Chairman of Robin Hood Airport Consultative Committee • Chairman St Leger Homes, Doncaster • Member Rotherham Health and Wellbeing Board • Member of Sheffield Teaching Hospitals FT, Rotherham FT and Nottinghamshire Healthcare FT • Deputy Lieutenant of South Yorkshire
Andy Buck	Chief Executive	• Director of Medipex NHS Innovation company
David Liggins	Vice Chair and Locality Chair	• Director and 50 per cent shareholder of S and L Properties, 30-34 Watson Road, Worksop – main tenant is Nottinghamshire Police who sublet to NHS Drugs and Alcohol Team (DAT) • Member of the Steering Group of Rural Bassetlaw Befriending

		• Chair of Doncaster Community Solutions Ltd (Doncaster LiftCo) • Member of Doncaster Strategic Partnering Board • Volunteer Tutor, Expert Patient Programme, Retford Action Centre • Partner Governor, Nottinghamshire Healthcare Trust
Tom Sheard	Vice Chair and Locality Chair	• Company Secretary, Barnsley TUC Training Ltd • Chairman, Unite Barnsley No 1 Branch; Elected Member of Barnsley Chamber of Commerce • Elected Member of Barnsley MBC Kingstone Ward (Labour Party) • Member of the Labour Party • Trustee Shawlands Charitable Trust, Barnsley
Roger Greenwood	Vice Chair and Locality Chair	• Chairman Braithwell with Micklebring Parish Council
Pat Wade	Non- Executive Director	• Parish Councillor of Aston-cum-Aughton
Les Ranson	Associate Non- Executive Director	• Chairman of Governors at Wadworth Primary School
Mel Morris	Associate Non- Executive Director	• MAA Associates
Melvyn Lunn	Audit Committee Chair	• Co-opted Member, Barnsley Metropolitan Borough Council Audit Committee; • Non-Executive Director of Berneslai Homes Ltd and Chair of Audit Committee; • Non-Executive Director/Trustee, Barnsley Community Build; • Director/Trustee of Priory Campus.
Robert Bailey	Audit Committee Vice Chair	• Financial Director Emmaus Sheffield Ltd • Director of Muir Wood Properties • Chairman of ACCEA Advisory Committee for Clinical Excellence Awards for Y&H

		• Panel Member for ACCEA National Review Panel for Platinum Awards
Steve Hackett	Executive Director of Finance	• Public Sector Director Barnsley Community Service Ltd (Barnsley LIFTco) • Public Sector Director Doncaster Community Solutions Ltd (Doncaster LiFTco) • Public Sector Director Community First Sheffield Ltd
Dr Phil Foster	Medical Director (until December 2012)	• Shareholder, Retford Health • Medical Director Bassetlaw Hospice • Medical Director, NHS Bassetlaw • Parish Councillor, Babworth Parish Council
Dr David Black	Medical Director (From December 2012)	• Awaiting detail
Margaret Kitching	Executive Nurse Director	• None
Debbie Hilditch	Executive Director of HR and Governance	• None
Brian Hughes	Director of Performance and Accountability	• None
Tony Baxter	Director of Public Health, NHS Doncaster	• Parent Governor and Vice Chair of Board of Governors at Doncaster School for the Deaf
Jeremy Wight	Director of Public Health, NHS Sheffield	• None
John Radford	Director of Public Health, NHS Rotherham	• Unpaid GP for 1 session per week
Elizabeth Shassere	Director of Public Health, NHS Barnsley (until November 2012)	• None

Chris Kenny	Director of Public Health, NHS Bassetlaw	• Chair of Trustees Nottinghamshire Hospice

Audit Committee

As a committee of the NHS South Yorkshire and Bassetlaw Board the committee is responsible for:

- Reviewing the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the organisation's activities that supports the achievement of the organisation's objectives.
- Monitoring the implementation of agreed control improvements, largely through the work of external and internal audit, both of which are represented at committee meetings.
- Ensuring there is an effective internal and external audit function.
- Reviewing the accounting policies and the draft annual financial statements prior to submission to the Board. Monitoring compliance with Standing Orders and Standing Financial Instructions

The audit committee members are:

Mr M Lunn	Audit Committee Chairman
Dr L Ranson	Associate Non-Executive Director
Mr M Morris	Associate Non-Executive Director
Mrs P Wade	Non-Executive Director
Mr R Bailey	Audit Committee Vice Chairman

Remuneration and Terms of Service Committee

As a committee of the NHS South Yorkshire and Bassetlaw Board the committee is responsible for advising about the appropriate remuneration and terms of service for the Chief Executive, executive directors and other senior managers, as well as monitoring and evaluating their performance.
For the purpose of this report senior managers are defined as:
'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Trust. This means those who influence the decisions of the organisation as a whole rather than the decisions of individual directorates or departments.'
The salaries and relevant pension details of the most senior managers, and the Non-Executive members of the Board, who had control over the major activities of the Primary Care Trust in 20012/13 can be found in the Summary Financial

Statement. There were no early termination issues for senior officers to report in the year.

The committee members consist of:

Mr Alan Tolhurst *Chairman*
Mr Andy Buck *Chief Executive*
Mr Roger Greenwood *Non-Executive Director, Vice Chair & Locality Chair*
Mr Steve Hackett *Director of Finance*
Mrs Debbie Hilditch *Director of Human Resources & Governance*
Mr David Liggins *Non-Executive Director, Vice Chair & Locality Chair*
Mr Tom Sheard *Non-Executive Director, Vice Chair & Locality Chair*

The changing face of the NHS

Different organisations came into being as a result of the reforms embodied in the Health and Social Care Act 2012. These include clinical commissioning groups, NHS England and Health and Wellbeing Boards, as well as the transition of public health responsibilities to local authorities.

Here you will find a guide to the key elements of these changes:

GP practices have come together into **clinical commissioning groups** (CCGs) and from April 2013 they took over the majority of the commissioning responsibilities which have been carried out by Doncaster PCT. Other health professionals and lay members are included on the boards of the CCGs.

Strategic health authorities (SHAs) were created to manage the local NHS on behalf of the Secretary of State for Health. They were abolished in March 2013.

Primary care trusts (PCTs), including NHS Doncaster, were abolished at the end of March 2013.

Commissioning support units (CSUs): These new NHS organisations provide specialist commissioning support which is available to CCGs if required. The PCT's approach to developing commissioning support has been to work in partnership with our CCGs to understand what they will need and whether they will want to build their own capacity, buy it in or share with other organisations. A key decision has been to develop a CSU across West and South Yorkshire and Bassetlaw.

Local Involvement Networks (LINks) have transformed into **HealthWatch** and aim to ensure that the views and feedback from patients and carers are an integral part of local commissioning across health and social care.

Health and Wellbeing Boards bring together key decision makers to set a clear direction for the commissioning of healthcare, social care and public health, and

to drive the integration of services across communities. CCG representatives are members of these boards, and each has already been working in shadow form, building on existing relationships and developing their joint agenda.

Doncaster Clinical Commissioning Group Governing Body members 2012/13

Name	Appointment	Declaration
Dr Nick Tupper	Committee Member (Chair)	Shareholder in Hallcross Medical Group GP at Kingthorne Group Practice Part owner of The Rutland Medical & Education Centre Co-Clinical Director for the Doncaster 8-8 Health Centre Shareholder in Glenthorpe
Dr Niki Seddon	Locality Lead North West Locality	GP at Carcroft Health Centre Carcroft Governor at RDaSH
Dr Marco Pieri	Locality Lead North West Locality	GP at Petersgate Medical Centre, Scawthorpe
Dr Andy Oakford	Locality Lead North East Locality	GP at Field Road Surgery Stainforth
Dr Jeremy Bradley	Locality Lead North East Locality	GP at The Heathfield Centre Hatfield
Dr Alastair Graves	Locality Lead Central Locality	St Vincent's Medical Practice Glenthorne Medical Director at Hallcross
Dr Sam Feeney	Locality Lead Central Locality	GP at The Mount Group Practice at Thorne Road Shareholder in Hallcross Medical Group

Name	Appointment	Declaration
Dr Gill Harding	Locality Lead South West Locality	GP at Church View Surgery Denaby Main Share Option in DMSL
Dr Lindsey Britten	Locality Lead South West Locality	GP at The Scott Practice Balby
Dr Pat Barbour	Locality Lead South East Locality	GP at Frances Street Medical GP at the 8-8 Health Centre
Dr Ayesha Zafar	Locality Lead South East Locality	GP at West End Clinic, Rossington
Mr Albert Schofield	Lay Member	None
Miss Anthea Morris	Lay Member	Better2Know Ltd Hagen Moresby Ltd The Old Rectory Trading Company Ltd Biopoint Ltd (registered in Ireland)
Mr Chris Stainforth	Chief Officer (Designate)	None
Mrs Hayley Tingle	Chief Finance Officer (Designate)	None
Mrs Mary Shepherd	Chief Nurse (Designate)	None
Dr Emyr Jones	Secondary Care Doctor Member	None

Engaging with Our Community

All Primary Care Trusts (PCTs) have a duty to produce an annual report on consultations about commissioning and other relevant decisions, as set out in section 242A (1) of the NHS Act 2006. This is where consultations have informed the commissioning of or changes to services. These are 'commissioning decisions', and include decisions about primary care, secondary care and community health services.

During the year we started a consultation on Patient Choice which was still ongoing as this report was being compiled.

Our approach and commitment to consultation, engagement and involvement

We are committed to engaging all individual residents and representatives of communities and groups who have an interest in, or are directly affected by, health services in Doncaster.

Sustainability Report

Our facilities management team lead have this year led on energy efficiency within the trust, taking over this role from the public health directorate. We have a Vital Sign to reduce our carbon footprint with our baseline for energy usage reported through our annual ERIC (Estates Return Information Collection) Return, which is available on request. We are always looking for ways to reduce the use of natural resources. Where water meters are fitted, we have systems in place to monitor the use of water and reduce its usage. Water saving measures are incorporated into the design of all our LIFT buildings and into the refurbishments of existing buildings.

Throughout the year we have continued to work with the local voluntary sector and Doncaster Council to promote Fuel Poverty, Health and Wellbeing promotions and the expert patient programme to encourage self care in the community.

Workforce

Staff were able to access the majority of mandatory and statutory training via e-learning with the exception of training where an element of 'face to face' training or assessment is required. The use of the Electronic Staff Record (ESR) system has enabled successful monitoring of completion of mandatory and statutory training thus ensuring staff are up to date with their training requirements.

Health and wellbeing of staff continued to be high on our agenda and this is an area embedded within regular one to one meetings between manager and staff member and as part of the annual appraisal. Support continues to be available from Occupational Health, the Staff Counselling Scheme and the Physiotherapy Service. The online NHS Life Check tool is available for staff to use either at their own workstation, or at a dedicated workstation. The tool provides an assessment of health and wellbeing and suggests an action plan to improve this.

Staff Sickness Absence	**2012 figures**
Total days lost	**1291**
Total staff years	**233**
Average working days lost	**5.54**

The above figures were provided by the Department of Health and represent the period January to December 2012.

Equal opportunities

We are committed to ensuring equal opportunities in employment and have appropriate policies in place to provide guidance, including in specific areas such as Maternity Leave and Retirement, and via our Equality Strategy and Single Equality Scheme which covers six equality strands.

Positive about disabled people

All job applicants who meet the minimum criteria for a post are shortlisted for interview in accordance with our commitment to the disability symbol.

We continue to improve the premises we own, including new LIFT buildings to ensure they comply with the current disability legislation.

Equality and Diversity

NHS Doncaster is committed to promoting the equality and diversity agenda both for staff within the organisation and for the patients and the public for whom we commission care as evidenced in our Equality Strategy, in the equality information which we published in January 2012 and in our corporate commitment to our Equality Objectives.

Being prepared for an emergency

We have a Major Incident Plan that is fully compliant with the requirement of the NHS Emergency Planning Guidance 2005 and all associated guidance. During

the year, our emergency planning staff attended major incident training exercises.

Significant Issues

NHS South Yorkshire & Bassetlaw significant issues are those captured in Section 3.1. Significant issues which faced NHS Doncaster / Doncaster Clinical Commissioning Group in 2012/13 related to:

- Transition to the new NHS architecture including authorisation of the NHS Doncaster Clinical Commissioning Group.

- Management of the impact associated with local Safeguarding Children partnerships.

Full Assurance Framework action plans relating to these significant issues were put into place, monitored and reported via the Assurance Framework.

Transition: In addition to regular updating of the Assurance Framework and reporting on associated Assurance Framework action plans, assurance and activity on transition to the new NHS architecture has also been reported monthly to the NHS Doncaster CCG Committee through the monthly Chief Officer and Chair reports. Actions have included:

- The development of the governance structure and Assurance Framework as described above alongside terms of reference and a Constitution.
- The production of a clear and credible Single Integrated Plan aligned to the priorities of the Doncaster Shadow Health & Wellbeing Board.
- Holding CCG Committee meetings in public from January 2012.
- Organisational Development planning and implementation.
- Development of relevant strategies and procedural documents including Communication, Engagement & Equality, Choice, Risk and Standards of Business Conduct and Declarations of Interest.
- Preparation for Authorisation resulting in NHS Doncaster CCG being authorised with only 1 condition relating to the partnership safeguarding of Looked After Children.

Safeguarding: In addition to regular updating of the Assurance Framework and reporting on associated Assurance Framework action plans, assurance and activity on safeguarding children and vulnerable adults has also been reported to the CCG Committee through the Quality & Patient Safety Report. Actions have included:

- Maintaining an overview of Safeguarding issues through the minutes of the Safeguarding Assurance Forum and the Safeguarding Assurance

Reports received by the Quality & Patient Safety Group, with exception reporting to the Cluster Quality & Patient Safety Committee.
- Active membership of the Doncaster Safeguarding Children Board and Doncaster Safeguarding Adults Partnership Board with active involvement in Serious Case Reviews, Lessons Learned Reviews and the implementation plan following a local partnership Care Quality Commission inspection.
- Working in partnership to improve services for Looked After Children.
- Participating in Domestic Homicide Reviews in partnership with the Safer Doncaster Partnership.
- Working with our local Acute Trust to develop a monitored action plan to ensure that the full range of commissioned Designated Doctor functions in relation to child safeguarding are in place and effective.

Looking after personal information

We have a clear Information Governance Strategy and Policy, and this is supported by a Cluster Information Governance Strategy. We have a Senior Information Risk Owner and Caldicott Guardian both locally and at Board level.

We have undertaken various initiatives to ensure good information governance within the organisation and in our work with out partners, including:

- A full review and update of the information asset register and patient identifiable dataflows in and out of the organisation.
- Reviewing incidents that relate to information governance issues and ensuring that where applicable remedial action is completed.
- Undertaking IG risk assessments on NHS Doncaster premises to ensure compliance with the Data Protection Act and Confidentiality Code of Conduct.
- Ensuring safe records management arrangements continue to be in place.
- Providing support for staff in their completion of annual Information Governance training.

My review confirms that NHS Doncaster / NHS Doncaster Clinical Commissioning Group has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

Financial Statements

It is with great pleasure that I present the 2012/13 Annual Financial Accounts for NHS Doncaster. Full copies of the Annual Accounts are available upon request. As the Health and Social Care Bill became and Act of Parliament in March 2012, these Annual Accounts will be the last ones produced for NHS Doncaster as Primary Care Trusts will no longer exist beyond 31 March 2013. With effect from

1 April 2013 the new NHS infrastructure of NHS England, Public Health England and Clinical Commissioning Groups will take on the commissioning responsibilities that Primary Care Trusts had. In addition some responsibilities for Public Health have transferred to Local Authorities. These Annual Accounts therefore show the final close down financial position for NHS Doncaster.

The financial statements that follow are a summary of the financial performance of the PCT during 2012/13. The figures in the financial statements, including the remuneration report, are subject to audit.

Financial Performance

I am very pleased to be able to report that at the end of the 2012/13 financial year NHS Doncaster has once again met all of its statutory financial duties.

The financial performance of the PCT is summarised below

- A revenue surplus of £2,239,000 against a resource limit of £589,845,000
- A capital surplus of £582,000 against a resource limit of £1,163,000
- Cash drawings within a combined revenue and capital cash limit of £586,462,000
- Achieved all the four Better Practice Payment Code Targets

Within its plan for the year, the PCT highlighted a number of risks to its financial position. These mainly centred around the cost of care for patients with continuing health needs including retrospective claims relating to previous years, over-performance on contracts with acute hospitals, particularly in respect of unplanned care and the cost of prescribed drugs,. In order to mitigate the risks, the PCT set aside resources to cover these possible outcomes. We also worked closely with GPs to try to constrain the increasing trends in these areas and I am pleased to be able to report that this work has delivered reduced growth in some of these areas.

2012/13 also saw the continuation of the requirement for the NHS to reduce the cost of performing its duties referred to as its management/running costs. The PCT reduced these costs by 12.4% compared to 2011/12.

In summary, the PCT has had a challenging but ultimately successful year in managing its resources whilst continuing to invest and provide for the current and future healthcare needs of Doncaster residents.

Hayley Tingle
Chief Finance Officer

Doncaster NHS
Primary Care Trust

Annual Governance Statement 2012/13
NHS Doncaster – 5N5

1. Scope of responsibility

The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, 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 the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

2. The governance framework of the organisation

2.1. Overview

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

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

2012/13 has been a year of transition towards the new NHS architecture as set out in the government's vision. This Annual Governance Statement therefore reflects the changing assurance processes during the year.

NHS Doncaster (legally known as Doncaster Primary Care Trust) has remained as the statutory body throughout the period and remained so until its abolition on 31st March 2013. Primary Care Trusts (PCTs) were "clustered" in line with government guidance. NHS South Yorkshire & Bassetlaw operated as a Cluster of 5 constituent PCTs:

- NHS Barnsley
- NHS Bassetlaw
- NHS Doncaster
- NHS Rotherham
- NHS Sheffield

During 2012/13 all constituent PCTs shared an Accountable Officer (Chief Executive), a Director of Finance and a team of Executive Directors and Non Executive Directors. The Directors of Public Health for each PCT also remained individual members of the Trust Board.

The emerging Clinical Commissioning Groups were established as Sub Committees of the Trust Board under a Scheme of Delegation and managerial letter of delegation to Chief Operating Officers.

NHS Doncaster Clinical Commissioning Group (CCG) has a Chief Officer, a Chief Finance Officer and an underpinning management, governance and Committee structure. Formal delegation of responsibilities to NHS Doncaster CCG by the Board related to the future work of Clinical Commissioning Groups such as Acute, Mental Health and Community healthcare commissioning (whilst accountability was retained by the Trust Board).

The system of internal control was in place through the above mechanisms in Doncaster for the year ended 31st March 2013

2.2. Structure, performance and highlights of corporate governance

2.2.1. Overview

Handover and Closedown: During 2012/13 the NHS South Yorkshire & Bassetlaw Board and the NHS Doncaster CCG Committee have prepared for transition to the new NHS architecture in line with Department of Health guidelines for closedown of PCTs. A Transfer Scheme was developed by the Board for both Assets and Liabilities and for Staffing, and this was in place by 31st March when the formal transfer took place. In addition, a Quality Legacy Handover Document with the “softer” intelligence regarding quality and performance was developed by the PCT and passed to receiving organisations. A Handover Assembly was held on 13th March between the PCT as sender and all local receiving organisations including the Clinical Commissioning Group to ensure an effective legacy handover to receiving organisations.

Annual Accounts: In terms of annual accounts, for 2012/13 a clear process was identified which mirrored arrangements in 2011/12 and which ensured that PCT accounts were effectively closed down and accounts produced. Accounts scrutiny and sign-off is planned via the Cluster Audit Committee (which will

remain for a short period to June 2013), with the accounts having first been reviewed in detail by the Clinical Commissioning Group's Audit Committee to which much of the corporate memory on the accounts will have transferred.

Discharge of statutory duties: Arrangements are in place to ensure effective discharge of statutory duties and this is documented through routine Cluster reporting arrangements, and in NHS Doncaster CCG via Quarterly Governance Reports received by the Audit & Risk Group and the NHS Doncaster CCG Committee.

Corporate Governance Code: The NHS South Yorkshire & Bassetlaw Board and the NHS Doncaster CCG Committee have complied at all times with the UK Corporate Governance Code in respect of:

- *Leadership:* Headed by an effective board comprised of Executive and Non Executive Directors with a clear division of responsibilities, a clear process for decision-making and a Chair responsible for leadership of the Board.

- *Effectiveness:* Comprised of individuals with a range of skills, experience and knowledge. A formal process for appointments. Provided with a range of strategic information covering quality, finance, performance, strategy, policy and risk. Subject to annual evaluation via the Annual Governance Statement.

- *Accountability:* Effective management of conflicts of interest and a robust process for risk management and internal control corporate through regular reporting. Interaction with Internal and External Audit.

- *Remuneration:* Set by the Remuneration and Terms of Service Committee.

- *Relations with Stakeholders:* Effective partnership arrangements and sharing of information via an Annual Report.

2.2.2. NHS South Yorkshire & Bassetlaw

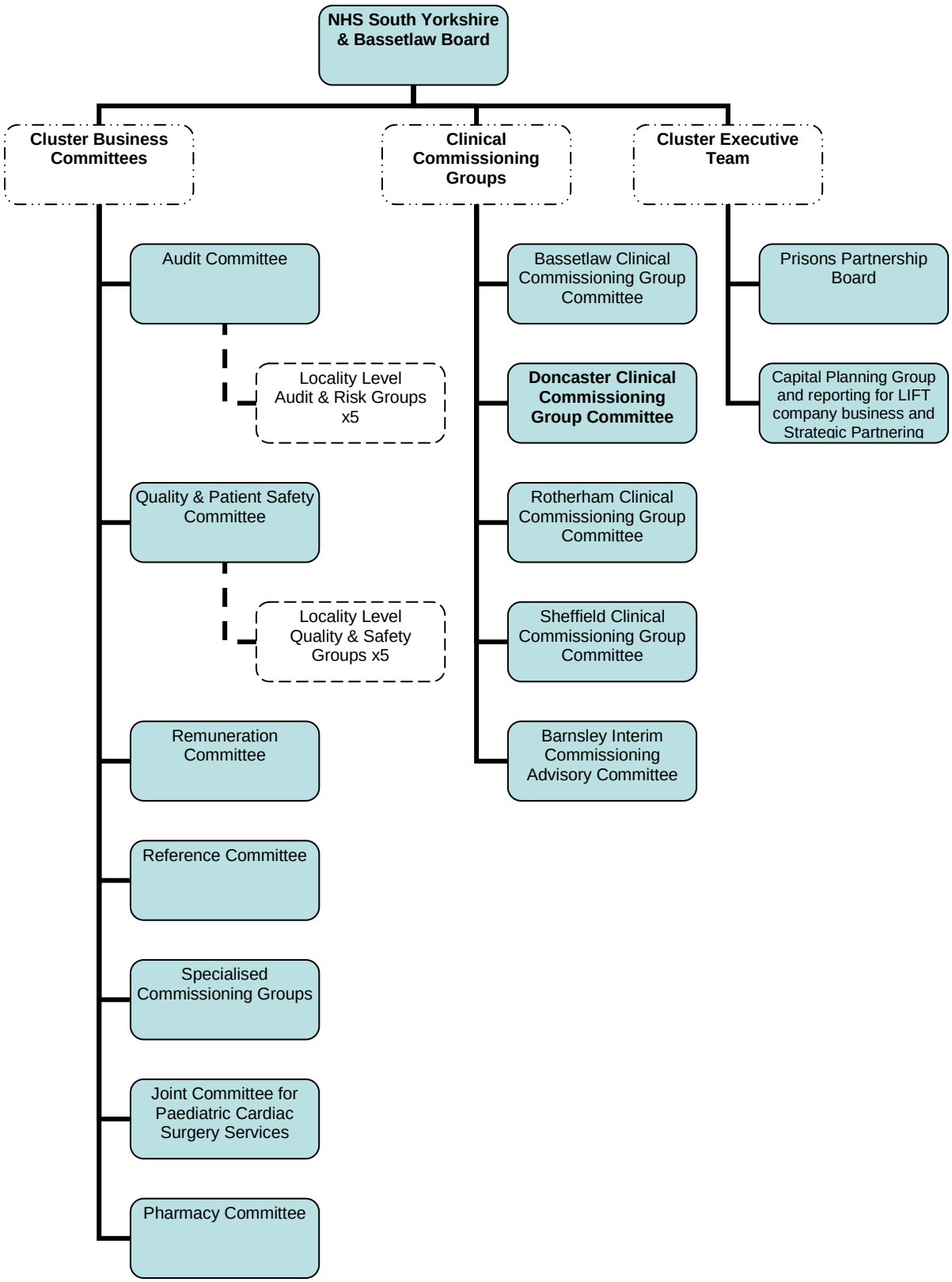
Structure: NHS South Yorkshire & Bassetlaw had a Trust Board in place throughout 2012/13 which was quorate at each meeting. The Board considered a range of governance documents, strategies and quality / financial / performance assurance reports. The Board also received both the public and private minutes of the formal NHS Doncaster CCG Committee to which responsibility for commissioning the majority of local healthcare was delegated (whilst accountability was retained by the Board). The Board was supported in its assurance responsibilities by a formal sub-structure of meetings including an

Audit Committee receiving reports on internal and external audit and assurance, a Quality and Patient Safety Committee receiving reports on provider quality, safeguarding and infection control, and a Reference Committee. The high-level governance meeting structure is shown on page 5.

Effectiveness: The effectiveness of the Board was last reviewed at a Timeout session on 22nd February 2012 which concluded that the Board was functioning effectively and focusing on the right issues. Due to the abolition of the Board from 31st March 2013, its effectiveness has not been reviewed during 2012/13. A Governance paper was received and approved by the first Trust Board meeting in October 2011 in which:

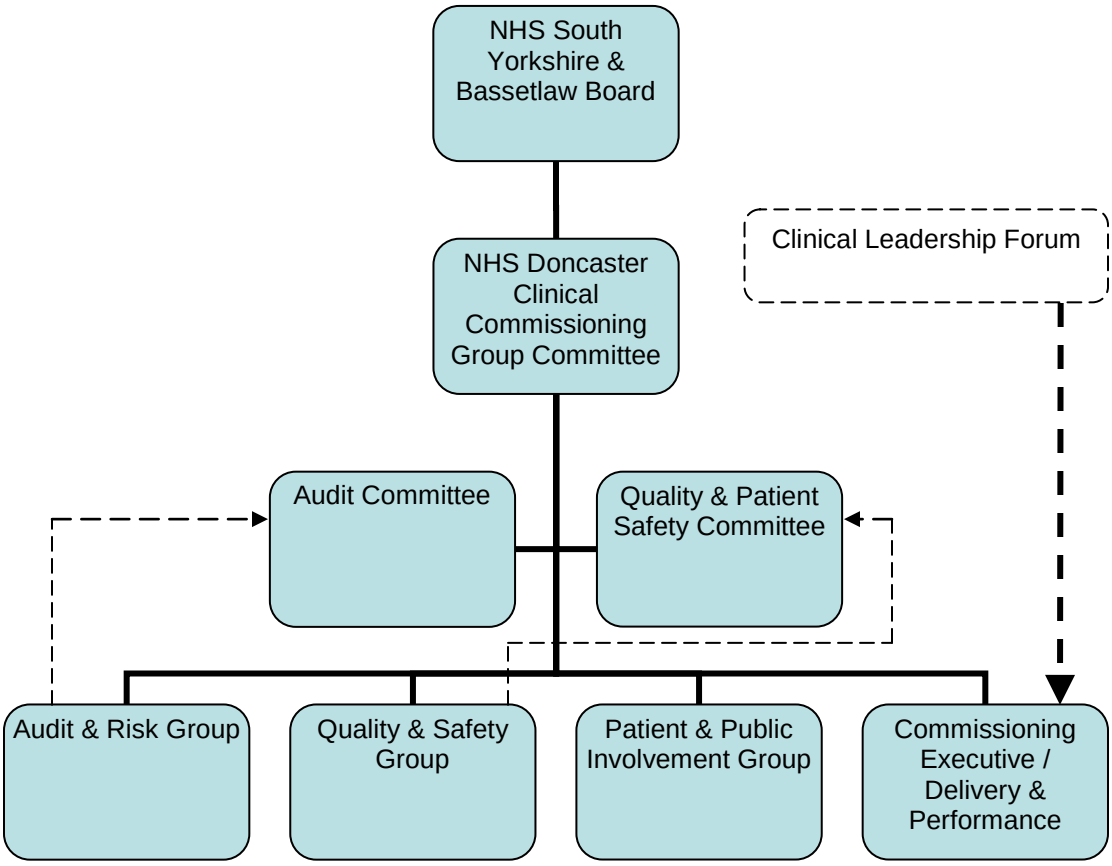
- The Board was advised on the governance structure to support the Single Trust Board of NHS Barnsley, NHS Bassetlaw, NHS Doncaster, NHS Rotherham and NHS Sheffield.
- Approval was given for the terms of reference for the committees of the Trust Board which covered Audit, Quality and Patient Safety, Remuneration, Maintaining High Professional Standards, Pharmacy applications and Clinical Commissioning Groups. These reflected the movement to a single Trust Board.
- Revised Standing Orders / Standing Financial Instructions and Scheme of Delegation were agreed.
- It was identified where the Chief Executive and Director of Finance sought to delegate further functions to the Chief Officer and Chief Finance Officer of the CCGs. These were then covered in Letters of Delegation to each CCG.
- The Board membership (including Directors) and the accountability arrangements at Board level were noted.

Risk Management: A Board Assurance Framework and Risk Register have been maintained throughout the period, coordinated by the Governance Leads of the constituent PCTs. The Assurance Framework was received by the Board in January 2012 and by the Cluster Audit Committee as a closing position in March 2013. The Risk Register was received by the Board in January 2012 and updated outside of the Board thereafter. The Information Governance Strategy was last received in February 2012. Monthly reports were received on Finance, Quality and Performance.


NHS South Yorkshire & Bassetlaw Board
Cluster Business Committees
Clinical Commissioning Groups
Cluster Executive Team
Audit Committee
Locality Level Audit & Risk Groups x5
Quality & Patient Safety Committee
Locality Level Quality & Safety Groups x5
Remuneration Committee
Reference Committee
Specialised Commissioning Groups
Joint Committee for Paediatric Cardiac Surgery Services
Pharmacy Committee
Bassetlaw Clinical Commissioning Group Committee
Doncaster Clinical Commissioning Group Committee
Rotherham Clinical Commissioning Group Committee
Sheffield Clinical Commissioning Group Committee
Barnsley Interim Commissioning Advisory Committee
Prisons Partnership Board
Capital Planning Group and reporting for LIFT company business and Strategic Partnering

2.2.3. NHS Doncaster Clinical Commissioning Group

Structure: The establishment of the NHS Doncaster Clinical Commissioning Group Committee was formally approved by the NHS South Yorkshire & Bassetlaw Trust Board in October 2011. The Committee was in place throughout the period 2012/13 and was quorate at each meeting with the exception of September 2012 – all recommendations from the September meeting were subsequently ratified at the October meeting. A letter of delegation from the single Trust Board in October 2011 confirmed that the NHS Doncaster CCG Committee had been formally established as a Committee of the Board with delegated commissioning responsibility and approved the NHS Doncaster CCG Committee Terms of Reference. The budget for which the Committee received delegated responsibility included the resources for community health services, maternity care, elective hospital services, urgent care, ambulance services, emergency and non-elective hospital services, older people's healthcare, children and young people's healthcare, rehabilitation services, healthcare for people with mental health and learning disabilities, and continuing healthcare. It did not include primary care services, prison health services, public health services or specialised health services. The high-level governance model was developed in consultation with NHS Doncaster CCG members and Chair, local Governance Leads, the Local Medical Committee and the Governance Lead for NHS South Yorkshire & Bassetlaw and is shown below.



As part of the CCG Authorisation process, this structure was reviewed and a new structure was agreed for implementation from 1st April 2013 and captured in the Group's Constitution.

Effectiveness: The delegation confirmed that the Chief Officer and Chief Finance Officer would continue to hold responsibility for managerial, operational and financial matters. The delegation of additional budgetary control to the Chief Finance Officer was covered in a separate letter of delegation from the Director of Finance covering both pay and non-pay elements. Monitoring of the effectiveness of the delegated arrangements was undertaken by the Chief Executive and Director of Finance respectively. As part of this delegation, NHS Doncaster CCG was required to ensure that they met all financial statutory and administrative duties. The Audit & Risk Group also undertook a self-assessment based on the Audit Handbook in-year.

Risk Management: An Assurance Framework and Risk Register have been maintained throughout the period. The Assurance Framework was received quarterly by the NHS Doncaster CCG Committee. NHS Doncaster CCG maintained throughout the period:

- A formally approved governance structure comprising Audit & Risk Group, Quality & Safety Group, Patient & Public Involvement Group, Commissioning Executive / Delivery & Performance and Clinical Leadership Forum. There was continuity of the meetings aligned underneath the formal groups.

- The 5x5 risk matrix with the risk tolerance/appetite under which risks can be tolerated as a score of 11 or below, and the escalation to the Cluster Assurance Framework of risks which were scored at or in excess of a score of 16.

- An NHS Doncaster CCG Assurance Framework.

3. Risk assessment

3.1. NHS South Yorkshire & Bassetlaw

To support the work of the Board and its Committees and to provide assurance that the risks across the Cluster were known and understood, a single Assurance

Framework covering all constituent PCT areas was in place throughout 2012/13. The Assurance Framework took into account the accountabilities and responsibilities referenced in the following:

- Objectives from the *Cluster Implementation Guidance* (January 2011) and the *Shared Operating Model for PCT Clusters* (July 2011);
- NHS Commissioning Board duties (e.g. offender healthcare military healthcare, primary care contracting, emergency planning);
- Escalating Clinical Commissioning Group issues based on *Functions of GP Commissioning Consortia: A Working Document* (March 2011).

In developing the NHS South Yorkshire & Bassetlaw Assurance Framework all existing PCT Assurance Framework risks and any new/emerging risks in light of the changing NHS architecture were captured. The Assurance Framework was developed in accordance with guidelines provided by the Department of Health, Internal Audit and the Strategic Health Authority and comprised risks which affected the achievement of Cluster objectives.

A standard 5x5 risk matrix as detailed in Section 3.2 below was agreed to assess risk which incorporated both consequence and likelihood. The Cluster risk tolerance (appetite under which risks can be tolerated) is a score of 11 or below where the assessment has been undertaken following the implementation of controls and assurances. This is the same for both the Cluster Assurance Framework and the Clinical Commissioning Group Assurance Frameworks. Local Clinical Commissioning Group Assurance Framework risks which scored at or in excess of a score of 16 were escalated to the Cluster Assurance Framework. All new risks scoring 16-20 were notified to the Board as part of the integrated performance report.

The objectives for PCT Clusters as detailed in the Department of Health *Shared Operating Model for PCT Clusters* (July 2011) were taken as those against which the Cluster Assurance Framework risks were mapped:

- Integrated Finance, Operations and Delivery
- Commissioning Development
- Ensuring Quality (Effectiveness, Experience & Safety)
- Emergency Planning & Resilience
- Commissioning Elements of Provider Development
- Communication and Engagement

All existing risks from the 5 PCT Assurance Frameworks were mapped to the principal risks of the Cluster. There was full alignment of the 5 PCTs' principal risks with the Cluster principal risks. All PCT Assurance Framework risks which were not expected to carry forward to the Clinical Commissioning Group Assurance Frameworks were captured on the Cluster Assurance Framework.

The ownership of the risks was linked to the Scheme of Delegation with Director / Chief Executive accountability identified.

The format of the Assurance Framework was designed and populated based on the existing Assurance Frameworks in existence across the Cluster and in consideration of Internal Audit feedback on best practice.

The Cluster Assurance Framework was presented to the Audit Committee and the Board in November 2011. An update to the Board was provided in January 2012 and a closing Assurance Framework was received by the Audit Committee in March 2013.

Until the NHS Commissioning Board formally took over responsibility for the commissioning of FHS/Primary Care, Offender Healthcare, Military Healthcare and Specialised Commissioning, a Risk Register co-produced by the Executive Team and Governance/Commissioning Leads captured risks associated with these directly commissioned services. The Risk Register was presented to the January 2012 Board alongside the Assurance Framework Action Plan and continued to be updated outside of the Board. Specialised Commissioning Groups held their own Assurance Frameworks which continued during transition.

All the risks on the Assurance Framework were newly added from October 2011 as this was the first Assurance Framework of the NHS South Yorkshire & Bassetlaw Cluster. At the close of the year as of 31st March 2013 there were 20 risks on the Cluster Assurance Framework. 5 of these risks were scored in excess of 11 and all 5 were being treated, with 1 risk scored below 11 also being treated.

During the period, gaps in control and assurance were identified, action plans put into place and monitored. There were no lapses of data security reported to the Information Commissioner. The 6 risks being treated at year-end comprised:

Ref	Principal Risk	Current Risk			Action Plan
		C	L	CxL	
1.2	Failure to deliver the financial aspects of the QIPP agenda.	5	3	**15**	Continue to monitor QIPP delivery across the localities
2.2	Failure to directly commission for specialised services during transition: • Specialised Commissioning • FHS and Primary Care Contracting • Offender Health and Military Health Commissioning	5	2	**10**	Complete the prison healthcare action plan to mitigate against any potential risks identified in the HM Inspectorate of Prisons report.

Ref	Principal Risk	Current Risk			Action Plan
		C	L	CxL	
2.4	Recent national publication of a call for retrospective Continuing Healthcare claims is expected to lead to a significant increase in claims – impacting on both staffing capacity to review the claims and on finance. The time limits for the process are very short – September 2012.	4	3	**12**	Develop a coordinated approach to Continuing Care retrospective claims reviews
3.5	Failure to effectively safeguard children and vulnerable people in line with statutory requirements leading to potential harm.	5	3	**15**	Monitor through Cluster Risk Register and local arrangements
3.6	Failure to ensure effective workforce planning and capability leading to de-motivation of staff.	4	3	**12**	Undertaken a gap analysis / skills audit to ensure capacity and capability for CSS functions
6.1	Failure to effectively engage staff systematically during transition, resulting in potential de-motivation, lack of productivity and poor staff experience and including potential industrial action	4	3	**12**	Work to align workforce systems and processes across the localities

3.2. NHS Doncaster Clinical Commissioning Group

The standard 5x5 risk matrix below adopted by the NHS South Yorkshire & Bassetlaw to assess risk was also adopted by NHS Doncaster Clinical Commissioning Group.

Risk Matrix		Likelihood				
		(1) Rare	(2) Unlikely	(3) Possible	(4) Likely	(5) Almost certain
Consequence	(1) Negligible	**1**	**2**	**3**	**4**	**5**
	(2) Minor	**2**	**4**	**6**	**8**	**10**
	(3)	**3**	**6**	**9**	**12**	**15**

	Moderate					
	(4) Major	4	8	12	16	20
	(5) Extreme	5	10	15	20	25

1-5	Low
6-11	Medium
12-15	High
16-20	Very High
25	Extreme

The NHS South Yorkshire & Bassetlaw risk tolerance/appetite under which risks can be tolerated is a score of 11 or below where the assessment has been undertaken following the implementation of controls and assurances. The same risk appetite was adopted by the NHS Doncaster Clinical Commissioning Group.

The transferring Assurance Framework was first received by the NHS Doncaster CCG Committee in November 2011 and a refreshed framework was received in January 2012. Thereafter, the Committee received an updated copy of the Assurance Framework on a quarterly basis for review, assurance and approval. As at the close of the year 31st March 2013 there were 19 risks on the Assurance Framework, 2 of which were in excess of the risk toleration level and both of which were being treated. 1 additional risk below the toleration threshold was also being treated as shown below.

Ref	Principal Risk	Current Risk			Action Plan
		C	L	CxL	
2.2	Failure to commission services which adequately safeguard children and vulnerable adults, potentially resulting in increased harm to vulnerable groups.	5	3	**15**	Work in partnership with the Local Authority to ensure referrals with the accompanying documentation are received in a timely manner for the medicals of Looked After Children.
2.4	Failure to performance manage contracts to ensure that Providers deliver against local and national performance targets, potentially resulting in organisational non-achievement of required targets.	4	3	**12**	Continue to take all contractual and partnership measures available to the CCG to bring A&E performance back on track.

Ref	Principal Risk	Current Risk			Action Plan
		C	L	CxL	
3.1	Failure to have a clear Financial Strategy matched to commissioning priorities in the Strategic Plan, potentially resulting in available funding not being matched to prioritised commissioning areas.	4	2	**8**	Review financial allocation in-year in light of transitional arrangements

The NHS Doncaster CCG inherited the strategic objectives of Doncaster Primary Care Trust. Although the Assurance Framework risks associated with these objectives were refreshed during early 2012 based on CCG responsibilities, the Assurance Framework was still mapped to the PCT strategic objectives. New CCG strategic objectives were developed and approved at the October CCG Committee meeting. The Assurance Framework was therefore revised to match these strategic objectives, and new risks were identified under each strategic objective.

The CCG strategic objectives are:

- Commission innovative healthcare and pathways to improve patient experience, outcomes and cost effectiveness.
- Contract and performance manage for continuous quality improvement.
- Achieve economic efficiency and effectiveness within the allocated resource limit.
- Develop transparent and accountable relationships with stakeholders.
- Ensure all our Corporate Governance systems and processes are robust and transparent.
- Foster effective organisational development and leadership.

All risks were therefore new during 2012/13, but there was a clear mapping exercise from the PCT assurance framework to ensure continuity and this mapping was approved by the CCG Committee. Gaps in control and assurance were identified throughout the year and action plans put into place and monitored. There were no lapses of data security reported to the Information Commissioner.

4. The risk and control framework

NHS Doncaster's Risk Management Strategy, Policy & Procedure was in place in 2012/13, having been adopted by NHS Doncaster Clinical Commissioning Group. The document was updated for the CCG and approved by the CCG Committee in October 2012. The strategic aim is to control risks to patients, to staff and to the organisation as far as is reasonably practicable and in

accordance with current guidance, legislation and best practice. NHS Doncaster CCG recognises and accepts its duty and legal responsibility to provide a safe and healthy working environment for all its employees, patients, visitors and all others who may be affected by the working activities of the organisation. The organisation has a proactive approach aiming to identify, assess, evaluate, record and review risks, so as to reduce the likelihood of them causing harm to patients or staff or loss to NHS Doncaster CCG and to reduce the impact of such harm or losses should they occur. The Risk Management Strategy, Policy and Procedure covers risk identification, evaluation, control, review and assurance. The Strategy, Policy & Procedure:

- Has been endorsed by the CCG Committee.
- Sets out the organisational attitude to and appetite for risk – a risk may be tolerated where the score is 11 or below.
- Clearly defines the structures for the management and ownership of risk.
- Clearly identifies how to manage situations in which a potential risk develops into an actual risk.
- Specifies the way in which risk issues are considered at each level of business planning - ranging from the capture of strategic risks on the Assurance Framework to the capture of operational team risks on team Risk Registers and the capture of project risks on project risk logs.
- Specifies how new and existing activities are assessed for risk and dependent on the level of risk are then incorporated into either the Assurance Framework, the Risk Register or into a project risk log.
- Uses common terminology and scoring in relation to risk issues which is replicated across the Assurance Framework and Risk Register.
- Defines the structures for gaining assurance about the management of risk – including quarterly reporting via the Governance Report to Governing Body.
- Defines the criteria which inform assessment of risk and the definition of specific risks as “key” i.e. those risks which threaten the achievement of the principal objectives are captured on the Assurance Framework, and the more operational team level risks are captured on the Risk Register.
- Defines the way in which the risk register and risk evaluation criteria will be regularly reviewed.
- Is set out in a single document and is easily available to all staff on the organisation’s website and in Policy Manuals.

Risk identification, assessment and monitoring is a continuous structured process in ensuring that NHS Doncaster CCG works within the legal and regulatory framework, identifying and assessing possible risks facing the organisation, and planning to prevent and respond to these. The process of risk management covers the following 5 steps to risk assessment:

- Step 1 – Identify the Risk
- Step 2 – Assess the Risk

- Step 3 – Evaluate the Risk
- Step 4 – Record the Risk
- Step 5 – Review the Risk

Risk management is embedded in the activity of the organisation through the above measures and also through assessments of specific risks e.g. information governance, equality impact assessment, business continuity.

We have a clear process for the reporting, management, investigation and learning from incidents. We have in place a Senior Information Risk Owner both locally (Chief of Corporate Services) and through Cluster arrangements (Director of HR & Governance) to support our arrangements for managing and controlling risks relating to information / data security.

A Counter Fraud report is received at each Audit Committee / Audit & Risk Group. The report aims to apprise the Audit & Risk Group of the proactive and reactive activity carried out by the Local Counter Fraud Specialist (LCFS). The content of the report is formatted to accord with the requirements of the NHS Counter Fraud Manual outlining where relevant activity has taken place across the 7 generic areas of counter fraud work:

- Anti-Fraud Culture (including mandatory 3-yearly staff training)
- Deterrence (including policy reviews and patient fraud checks)
- Prevention (including NHS Protect fraud prevention instructions, alerts and intelligence bulletins and local counter fraud alerts)
- Detection (including Local Proactive Exercises, the Local Intelligence Network to support the Accountable Officer for Controlled Drugs and the National Fraud Initiative)
- Investigations
- Sanctions
- Redress

Contracts are set at beginning of year with relevant performance standards included as Key Performance Indicators (KPIs). Monitoring of the KPIs is reported monthly and action is taken if any KPIs are under-achieving. Performance is reported to the CCG Committee monthly against the full range of Operating Framework requirements. A performance report is also submitted to Cluster Board which includes high-level Operating Framework issues and an overview of all requirements. For example, the Operating Framework target for Clostridium Difficile was breached in-year and mitigation plans were reported monthly to the CCG Committee through the Quality & Safety Report.

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

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of Internal Audit's work which resulted in an overall opinion that:

> **Significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives and that controls are generally being applied consistently.**

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

- External Audit providing progress reports to the Audit Committee, the Annual Management Letter and overview of cost effectiveness within NHS Doncaster.
- Internal Audit reviews of systems of internal control and progress reports to the Audit Committee, especially the annual Assurance Framework Internal Audit Report.
- Assurance reports on risk and governance received from the Audit Committee and Audit & Risk Group.
- Performance management systems.
- Internal Committee structure with delegated responsibility for risk identification, evaluation, control, review and assurance.
- Review of the Assurance Framework.
- Risk Register.
- Quarterly Governance Report capturing key risks across the spectrum of corporate governance.
- Self-assessment undertaken by the Audit Committee to ensure adherence to the principles contained within the NHS Audit Committee Handbook.
- The Single Integrated Plan which captures 5 clear clinical priorities and QIPP (Quality, Innovation, Productivity & Prevention) priorities and key risks.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the NHS Doncaster Clinical Commissioning Group Committee and Audit & Risk Group and by managers within NHS Doncaster. Action plans to address any identified weaknesses and ensure continuous improvement of the system are in place via the Assurance Framework action plan and also via action plans embedded within the Risk Register.

In maintaining and reviewing the effectiveness of the system of internal control:

- Any need to change priorities or controls is clearly recorded and either actioned, or reported to those with authority to take action.
- Lessons which can be learned from both successes and failures are identified and disseminated to those who can gain from them.
- An appropriate level of independent assurance is provided on the whole process of risk identification, evaluation and control.
- Each level of management, including the Board, reviews the risks and controls for which they are responsible.
- An embedded and fully operational governance and risk management structure is in place which clearly defines the roles and responsibilities of the Board and Sub Committees.

The following Committees and Officers have played a significant part in maintaining and reviewing the effectiveness of the system of internal control in 2012/13 and have managed risks assigned to them.

Trust Board: Responsible for providing clear commitment and direction for Risk Management within the Cluster. The Trust Board delegates responsibility for non-clinical risk management to the Audit Committee and clinical risk management to the Quality & Patient Safety Committee.

Audit Committee: Responsible for providing an independent overview of the arrangements for risk management within the Cluster, with specific responsibilities for financial risk management. It undertakes its own annual self-assessment of its effectiveness and reviews Internal and External Audits, the Assurance Framework and financial governance reports. The Cluster Audit Committee is mirrored in the NHS Doncaster Clinical Commissioning Group structure by an Audit & Risk Group which considers the same range of reports and the Probity Register. Local assurance flows up from the Audit & Risk Group to the Cluster Audit Committee.

Quality & Patient Safety Committee: The Committee with overarching responsibility for clinical risk management. It provides assurance to the Cluster Board that appropriate Clinical Governance and clinical risk management arrangements are in place across the organisations. The Quality & Patient Safety Committee is underpinned by various Sub Groups. The Cluster Quality & Patient Safety Committee is mirrored in the NHS Doncaster Clinical Commissioning Group structure by a Quality & Safety Group receiving reports across a range of topics including safeguarding, infection control, quality in contracts, incidents and medicines management. Local assurance flows up from the Quality & Safety Group to the Cluster Quality & Patient Safety Committee.

NHS Doncaster CCG Committee: The Committee with overarching responsibility for commissioning delegated services for the population of

Doncaster from October 2011. It has also functioned as our Professional Executive Committee.

Chief Officer: As Senior Responsible Officer for the whole of NHS Doncaster and NHS Doncaster Clinical Commissioning Group, the Chief Officer is responsible for achieving the objectives in the context of sound and appropriate business processes and reporting risks to the Cluster Chief Executive as Accountable Officer.

Chief Finance Officer: As Senior Responsible Officer for NHS finances across NHS Doncaster and NHS Doncaster Clinical Commissioning Group, the Chief Finance Officer is responsible for ensuring that the organisation complies with the Standing Financial Instructions to achieve financial balance and reports financial risks to the Cluster Director of Finance.

Executive Directors: Each Director is responsible for ensuring that risks have been properly identified and assessed across all their work areas, paying particular attention to cross-cutting risks. They are responsible for agreeing the risk register entries for their work areas and for ensuring that each departmental/team lead is actively addressing the risks in their area and escalating risks up to Director-level for their attention as appropriate. Each Director has the expectation of owning some of the main risks in their Directorate and personally addressing them, thus setting the tone for risk management in their areas of responsibility. Directors also play a crucial role in ensuring that risk-related issues are adequately dealt with when policies are being prepared or revised in their work areas.

Head of Internal Audit: The Head of Internal Audit has a central role in the process of securing this Annual Governance Statement, and in advising the Chief Executive and the Audit Committee on the “health” of NHS Doncaster’s risk management processes. As part of Internal Audit work, reviews are carried out to assess the robustness of the implementation of the Risk Management Strategy across the organisation. They provide information on the various strengths and weaknesses of the approach adopted by NHS Doncaster, and advise on where improvements are necessary and desirable for the good governance of the organisation.

Significant Issues

NHS South Yorkshire & Bassetlaw significant issues are those captured in Section 3.1. Significant issues which faced NHS Doncaster / Doncaster Clinical Commissioning Group in 2012/13 related to:

- Transition to the new NHS architecture including authorisation of the NHS Doncaster Clinical Commissioning Group.

- Management of the impact associated with local Safeguarding Children partnerships.

Full Assurance Framework action plans relating to these significant issues were put into place, monitored and reported via the Assurance Framework.

Transition: In addition to regular updating of the Assurance Framework and reporting on associated Assurance Framework action plans, assurance and activity on transition to the new NHS architecture has also been reported monthly to the NHS Doncaster CCG Committee through the monthly Chief Officer and Chair reports. Actions have included:

- The development of the governance structure and Assurance Framework as described above alongside terms of reference and a Constitution.
- The production of a clear and credible Single Integrated Plan aligned to the priorities of the Doncaster Shadow Health & Wellbeing Board.
- Holding CCG Committee meetings in public from January 2012.
- Organisational Development planning and implementation.
- Development of relevant strategies and procedural documents including Communication, Engagement & Equality, Choice, Risk and Standards of Business Conduct and Declarations of Interest.
- Preparation for Authorisation resulting in NHS Doncaster CCG being authorised with only 1 condition relating to the partnership safeguarding of Looked After Children.

Safeguarding: In addition to regular updating of the Assurance Framework and reporting on associated Assurance Framework action plans, assurance and activity on safeguarding children and vulnerable adults has also been reported to the CCG Committee through the Quality & Patient Safety Report. Actions have included:

- Active membership of the Doncaster Safeguarding Children Board and Doncaster Safeguarding Adults Partnership Board with active involvement in Serious Case Reviews, Lessons Learned Reviews and the implementation plan following a local partnership Care Quality Commission inspection.
- Working in partnership to improve services for Looked After Children.
- Participating in Domestic Homicide Reviews in partnership with the Safer Doncaster Partnership.
- Working with our local Acute Trust to develop a monitored action plan to ensure that the full range of commissioned Designated Doctor functions in relation to child safeguarding are in place and effective.
- Maintaining an overview of Safeguarding issues through the minutes of the Safeguarding Assurance Forum and the Safeguarding Assurance

Reports received by the Quality & Patient Safety Group, with exception reporting to the Cluster Quality & Patient Safety Committee.

6. Conclusion

My review confirms that NHS Doncaster / NHS Doncaster Clinical Commissioning Group has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

Accountable Officer: Ms Eleri de Gilbert

Accountable organisation: NHS Doncaster (5N5)

Signature: _____

Date: _____

Salary and Pension Entitlements of Senior Managers

	2012-13 Total Salary (bands of £5k) £000	**Organisation share (bands of £5k) £000**	**Other remuneration (bands of £5k) £000**	**Benefits in kind (bands of £100 £00**	2011-12 Total Salary (bands of £5k) £000	Organisation share (bands of £5k) £000	Other remuneration (bands of £5k) £000	Benefits in kind (bands of £100 £00
Directors Remunerations for South Yorkshire and Bassetlaw Cluster								
Name and title								
A Buck Chief Executive South Yorkshire and Bassetlaw Cluster	**145 - 150**	**25 - 30**	**0**	**22-23**	145 - 150	25 - 30	0	21 - 22
P. Foster (to Jan' 13) Medical Director South Yorkshire and Bassetlaw Cluster	**75 - 80**	**15 -20**	**0**	**0**	20 - 25	0 - 5	0	0
D Black (Commenced Nov' 12) Medical Director South Yorkshire and Bassetlaw Cluster	**50 - 55**	**10 - 15**	**0**	**0**	N/A	N/A	N/A	N/A
S.Hackett Director of Finance South Yorkshire and Bassetlaw Cluster	**110 - 115**	**20 - 25**	**0**	**0**	100 - 105	20 - 25	0	0
M.Kitching Nurse Director South Yorkshire and Bassetlaw Cluster	**95 - 100**	**15 -20**	**0**	**0**	45 - 50	5 - 10	0	0
D Hilditch	**85 - 90**	**15-20**	**0**	**0**	40 - 45	5-10	0	0

Director of Human Resources and Governance South Yorkshire and Bassetlaw Cluster								
A Baxter Director of Public Health (Doncaster Primary Care Trust) South Yorkshire and Bassetlaw Cluster	**125-130**	**125-130**	**0**	**20-21**	60-65	60-65	0	26-27
A Tolhurst Chairman for South Yorkshire and Bassetlaw Cluster	**40 - 45**	**5 - 10**	**0**	**0**	10 - 15	0 - 5	0	0
R. Greenwood Non Executive & Vice Chair for South Yorkshire and Bassetlaw Cluster	**35-40**	**5 - 10**	**0**	**0**	15-20	0 - 5	0	0
P. Wade Non Executive for South Yorkshire and Bassetlaw Cluster	**5 - 10**	**0 - 5**	**0**	**0**	0 - 5	0 - 5	0	0
R.Bailey Non Executive for South Yorkshire and Bassetlaw Cluster	**10 - 15**	**0 - 5**	**0**	**0**	5 - 10	0 - 5	0	0
Dr. L Ranson Associate Non Executive for South Yorkshire and Bassetlaw Cluster	**5 - 10**	**0 - 5**	**0**	**0**	0 - 5	0 - 5	0	0
M Morris Associate Non Executive for South Yorkshire and Bassetlaw Cluster	**5 - 10**	**0 - 5**	**0**	**0**	0 - 5	0 - 5	0	0
D Liggins Non Executive & Vice Chair for South Yorkshire and Bassetlaw Cluster	**30 - 35**	**5 - 10**	**0**	**0**	15 - 20	0 - 5	0	0

T.Sheard Non Executive & Vice Chair for South Yorkshire and Bassetlaw Cluster	**30 - 35**	**5 - 10**	**0**	**0**	15 - 20	0 - 5	0	0
M.Lunn Non Executive for South Yorkshire and Bassetlaw Cluster	**10 - 15**	**0 - 5**	**0**	**0**	5 - 10	0 - 5	0	0
Annette Laban Director of Commissioning Development (01/05/11-31/10/11)	**0**	**0**	**0**	**0**	65-70	10 - 15	0	43-44
Penny Brooks Nurse Director (01/05/11-30/09/11)	**0**	**0**	**0**	**0**	30-35	5 - 10	0	0
Tony Pedder Chairman (01/10/11-31/12/11)	**0**	**0**	**0**	**0**	5 - 10	0-5	0	0
NHS Doncaster								
Ann Gilbert Non Exec Director	**0**	**0**	**0**	**0**	0-5	0-5	0	0
Pamela Horner Non Exec Director	**0**	**0**	**0**	**0**	0-5	0-5	0	0
Anthony Humphries Non Exec Director	**0**	**0**	**0**	**0**	0-5	0-5	0	0
Jill Morris Non Exec Director	**0**	**0**	**0**	**0**	0-5	0-5	0	0
Albert Schofield Non Exec Director & Chair of Audit Committee	**0**	**0**	**0**	**0**	5 - 10	5 - 10	0	0
Tony Baxter Executive Director	**0**	**0**	**0**	**0**	60-65	60-65	0	26-27

Helen Beard Executive Director	**0**	**0**	**0**	**0**	15-20	15-20	0	0
Julie Bolus Executive Director	**0**	**0**	**0**	**0**	35-40	35-40	0	0
Heather Marsh Acting Director of Quality and Clinical Insurance	**0**	**0**	**0**	**0**	5 - 10	5 - 10	0	0
Jackie Pederson Associate Director Of Commissioning & Strategic Development	**0**	**0**	**0**	**0**	40-45	40-45	0	0
Chris Stainforth Director of Finance & Commissioning/Chief Operating Officer	**0**	**0**	**0**	**0**	50-55	50-55	0	0
Dr. Alastair Graves PEC Chair/Medical Director	**0**	**0**	**0**	**0**	10 - 15	10 - 15	0	0
Dr Eric Kelly PEC Member/Shadow Doncaster Health Consortium Chairman	**0**	**0**	**0**	**0**	10 - 15	10 - 15	0	0

* Consent Withheld

'- Information Not Provided

Pay Multiples

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

The midpoint of the banded remuneration of the highest paid director in Doncaster Primary Care Trust in the financial year 2012-13 was £127,500 (2011-12 £127,500). This was 4.80 times (2011-12, 5 times) the median remuneration of the workforce, which was £26,556. (2011-12, £25,528)

In 2012-13, 0 employees received remuneration in excess of the highest-paid director.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The Chief Executive and Directors of Doncaster PCT no longer represent the highest-paid Directors of the PCT due to these posts being shared across all PCTs within the South Yorkshire and Bassetlaw Cluster. Doncaster PCT reports expenditure for its share of these individuals only.

Highest Paid Director 2012/13	**2012-13**	2011-12
Midpoint of band of Highest Paid Director's Total Remuneration (£'000)	127,500	127,500*
Median Pay per Employee (see staff list)	26,556	25,528
Salary of highest employee to Median	4.80	5.00

*Restated for 2011-12

Salary and Pension Entitlements of Senior Managers For the South Yorkshire and Bassetlaw Cluster

Pension entitlements Name and title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at aged 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2013 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2013 £000	Cash Equivalent Transfer Value at 31 March 2012 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension (rounded to nearest £00) £'00
A Buck Chief Executive South Yorkshire and Bassetlaw Cluster	0 - 2.5	0 - 2.5	50 - 55	155 - 160	1,051	969	32	0
S Hackett Director of Finance South Yorkshire and Bassetlaw Cluster	5 - 7.5	17.5 - 20	30 - 35	95 - 100	448	415	90	0
M.Kitching Nurse Director South Yorkshire and Bassetlaw Cluster	12.5 - 15	42.5 - 45	35 - 40	105 - 110	751	645	226	0
D Hilditch Director of Human Resources and Governance South Yorkshire and Bassetlaw Cluster	0 - 2.5	5 - 7.5	30 - 35	100 - 105	612	560	52	0
Tony Baxter Director of Public Health (Doncaster Primary Care Trust) South Yorkshire and Bassetlaw Cluster	0-2.5	0-2.5	40-45	130-135	888	808	80	0

As Non-Executive members do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive members.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the members' accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefit accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figure, and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

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

Department of Health

NHS

Doncaster Primary Care Trust

2012-13 Accounts

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Doncaster Primary Care Trust

2012-13 Accounts

2012-13 Annual Accounts of Doncaster Primary Care Trust (non-london)

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

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

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

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

Signed.....Designated Signing Officer

Name: Clare Gilbert

Date.....6.6.13

2012-13 Annual Accounts of Doncaster Primary Care Trust (non-london)

STATEMENT OF RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

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

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

- make judgements and estimates which are reasonable and prudent;

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

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

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

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

By order of the Permanent Secretary.

6.6.13 Date ..... Signing Officer

6.6.13 Date ..... Finance Signing Officer

Doncaster NHS
Primary Care Trust

Annual Governance Statement 2012/13
NHS Doncaster – 5N5

1. Scope of responsibility

The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, 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 the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

2. The governance framework of the organisation

2.1. Overview

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

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

2012/13 has been a year of transition towards the new NHS architecture as set out in the government's vision. This Annual Governance Statement therefore reflects the changing assurance processes during the year.

NHS Doncaster (legally known as Doncaster Primary Care Trust) has remained as the statutory body throughout the period and remained so until its abolition on 31st March 2013. Primary Care Trusts (PCTs) were "clustered" in line with government guidance. NHS South Yorkshire & Bassetlaw operated as a Cluster of 5 constituent PCTs:

- NHS Barnsley
- NHS Bassetlaw
- NHS Doncaster
- NHS Rotherham
- NHS Sheffield

During 2012/13 all constituent PCTs shared an Accountable Officer (Chief Executive), a Director of Finance and a team of Executive Directors and Non Executive Directors. The Directors of Public Health for each PCT also remained individual members of the Trust Board.

The emerging Clinical Commissioning Groups were established as Sub Committees of the Trust Board under a Scheme of Delegation and managerial letter of delegation to Chief Operating Officers.

NHS Doncaster Clinical Commissioning Group (CCG) has a Chief Officer, a Chief Finance Officer and an underpinning management, governance and Committee structure. Formal delegation of responsibilities to NHS Doncaster CCG by the Board related to the future work of Clinical Commissioning Groups such as Acute, Mental Health and Community healthcare commissioning (whilst accountability was retained by the Trust Board).

The system of internal control was in place through the above mechanisms in Doncaster for the year ended 31st March 2013

2.2. Structure, performance and highlights of corporate governance

2.2.1. Overview

Handover and Closedown: During 2012/13 the NHS South Yorkshire & Bassetlaw Board and the NHS Doncaster CCG Committee have prepared for transition to the new NHS architecture in line with Department of Health guidelines for closedown of PCTs. A Transfer Scheme was developed by the Board for both Assets and Liabilities and for Staffing, and this was in place by 31st March when the formal transfer took place. In addition, a Quality Legacy Handover Document with the "softer" intelligence regarding quality and performance was developed by the PCT and passed to receiving organisations. A Handover Assembly was held on 13th March between the PCT as sender and all local receiving organisations including the Clinical Commissioning Group to ensure an effective legacy handover to receiving organisations.

Annual Accounts: In terms of annual accounts, for 2012/13 a clear process was identified which mirrored arrangements in 2011/12 and which ensured that PCT accounts were effectively closed down and accounts produced. Accounts scrutiny and sign-off is planned via the Cluster Audit Committee (which will remain for a short period to June 2013), with the accounts having first been reviewed in detail by the Clinical Commissioning Group's Audit Committee to which much of the corporate memory on the accounts will have transferred.

Discharge of statutory duties: Arrangements are in place to ensure effective discharge of statutory duties and this is documented through routine Cluster reporting arrangements, and in NHS Doncaster CCG via Quarterly

Governance Reports received by the Audit & Risk Group and the NHS Doncaster CCG Committee.

Corporate Governance Code: The NHS South Yorkshire & Bassetlaw Board and the NHS Doncaster CCG Committee have complied at all times with the UK Corporate Governance Code in respect of:

- *Leadership:* Headed by an effective board comprised of Executive and Non Executive Directors with a clear division of responsibilities, a clear process for decision-making and a Chair responsible for leadership of the Board.

- *Effectiveness:* Comprised of individuals with a range of skills, experience and knowledge. A formal process for appointments. Provided with a range of strategic information covering quality, finance, performance, strategy, policy and risk. Subject to annual evaluation via the Annual Governance Statement.

- *Accountability:* Effective management of conflicts of interest and a robust process for risk management and internal control corporate through regular reporting. Interaction with Internal and External Audit.

- *Remuneration:* Set by the Remuneration and Terms of Service Committee.

- *Relations with Stakeholders:* Effective partnership arrangements and sharing of information via an Annual Report.

2.2.2. NHS South Yorkshire & Bassetlaw

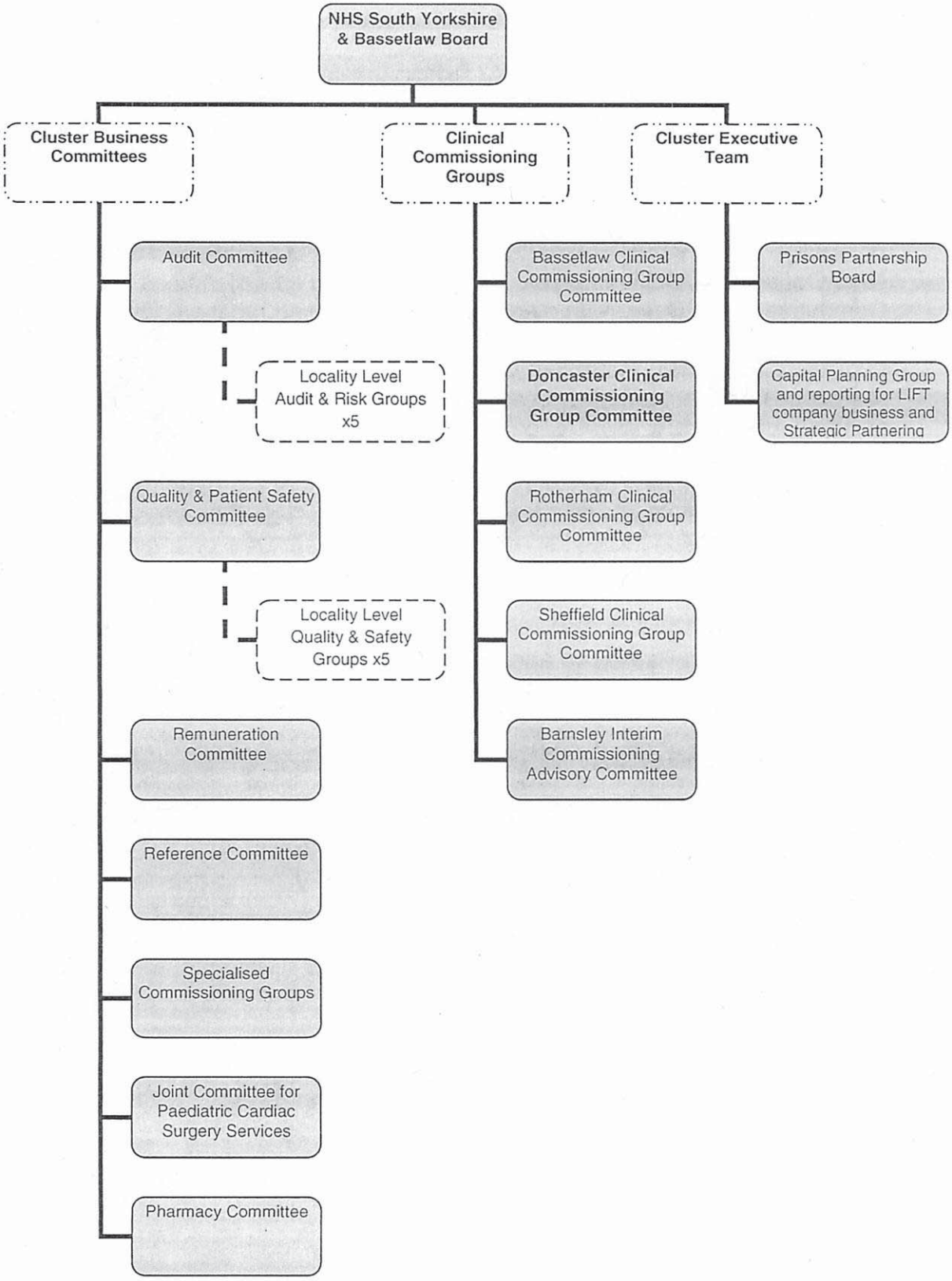
Structure: NHS South Yorkshire & Bassetlaw had a Trust Board in place throughout 2012/13 which was quorate at each meeting. The Board considered a range of governance documents, strategies and quality / financial / performance assurance reports. The Board also received both the public and private minutes of the formal NHS Doncaster CCG Committee to which responsibility for commissioning the majority of local healthcare was delegated (whilst accountability was retained by the Board). The Board was supported in its assurance responsibilities by a formal sub-structure of meetings including an Audit Committee receiving reports on internal and external audit and assurance, a Quality and Patient Safety Committee receiving reports on provider quality, safeguarding and infection control, and a Reference Committee. The high-level governance meeting structure is shown on page 5.

Effectiveness: The effectiveness of the Board was last reviewed at a Timeout session on 22nd February 2012 which concluded that the Board was functioning effectively and focusing on the right issues. Due to the abolition of the Board from 31st March 2013, its effectiveness has not been reviewed

during 2012/13. A Governance paper was received and approved by the first Trust Board meeting in October 2011 in which:

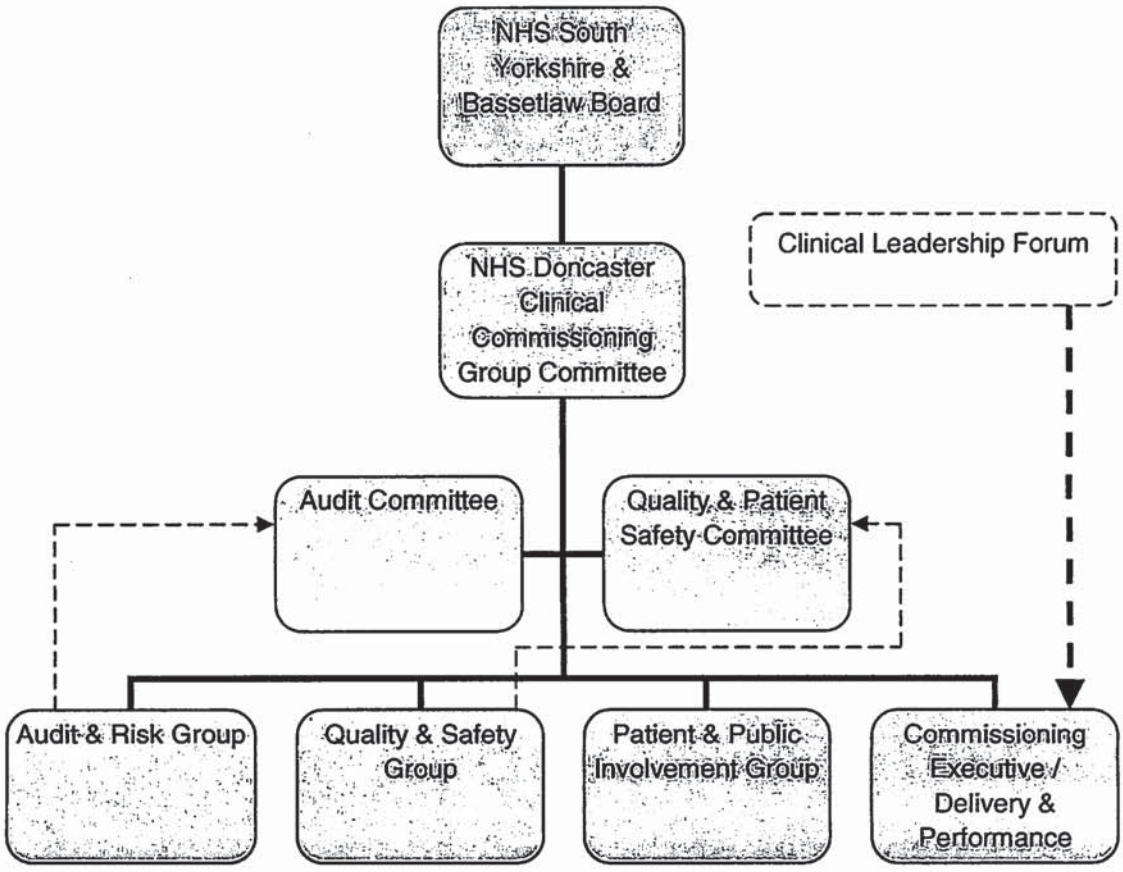
- The Board was advised on the governance structure to support the Single Trust Board of NHS Barnsley, NHS Bassetlaw, NHS Doncaster, NHS Rotherham and NHS Sheffield.
- Approval was given for the terms of reference for the committees of the Trust Board which covered Audit, Quality and Patient Safety, Remuneration, Maintaining High Professional Standards, Pharmacy applications and Clinical Commissioning Groups. These reflected the movement to a single Trust Board.
- Revised Standing Orders / Standing Financial Instructions and Scheme of Delegation were agreed.
- It was identified where the Chief Executive and Director of Finance sought to delegate further functions to the Chief Officer and Chief Finance Officer of the CCGs. These were then covered in Letters of Delegation to each CCG.
- The Board membership (including Directors) and the accountability arrangements at Board level were noted.

Risk Management: A Board Assurance Framework and Risk Register have been maintained throughout the period, coordinated by the Governance Leads of the constituent PCTs. The Assurance Framework was received by the Board in January 2012 and by the Cluster Audit Committee as a closing position in March 2013. The Risk Register was received by the Board in January 2012 and updated outside of the Board thereafter. The Information Governance Strategy was last received in February 2012. Monthly reports were received on Finance, Quality and Performance.


NHS South Yorkshire & Bassetlaw Board
Cluster Business Committees
Clinical Commissioning Groups
Cluster Executive Team
Audit Committee
Locality Level Audit & Risk Groups x5
Quality & Patient Safety Committee
Locality Level Quality & Safety Groups x5
Remuneration Committee
Reference Committee
Specialised Commissioning Groups
Joint Committee for Paediatric Cardiac Surgery Services
Pharmacy Committee
Bassetlaw Clinical Commissioning Group Committee
Doncaster Clinical Commissioning Group Committee
Rotherham Clinical Commissioning Group Committee
Sheffield Clinical Commissioning Group Committee
Barnsley Interim Commissioning Advisory Committee
Prisons Partnership Board
Capital Planning Group and reporting for LIFT company business and Strategic Partnering

2.2.3. NHS Doncaster Clinical Commissioning Group

Structure: The establishment of the NHS Doncaster Clinical Commissioning Group Committee was formally approved by the NHS South Yorkshire & Bassetlaw Trust Board in October 2011. The Committee was in place throughout the period 2012/13 and was quorate at each meeting with the exception of September 2012 – all recommendations from the September meeting were subsequently ratified at the October meeting. A letter of delegation from the single Trust Board in October 2011 confirmed that the NHS Doncaster CCG Committee had been formally established as a Committee of the Board with delegated commissioning responsibility and approved the NHS Doncaster CCG Committee Terms of Reference. The budget for which the Committee received delegated responsibility included the resources for community health services, maternity care, elective hospital services, urgent care, ambulance services, emergency and non-elective hospital services, older people's healthcare, children and young people's healthcare, rehabilitation services, healthcare for people with mental health and learning disabilities, and continuing healthcare. It did not include primary care services, prison health services, public health services or specialised health services. The high-level governance model was developed in consultation with NHS Doncaster CCG members and Chair, local Governance Leads, the Local Medical Committee and the Governance Lead for NHS South Yorkshire & Bassetlaw and is shown below.



As part of the CCG Authorisation process, this structure was reviewed and a new structure was agreed for implementation from 1st April 2013 and captured in the Group's Constitution.

Effectiveness: The delegation confirmed that the Chief Officer and Chief Finance Officer would continue to hold responsibility for managerial, operational and financial matters. The delegation of additional budgetary control to the Chief Finance Officer was covered in a separate letter of delegation from the Director of Finance covering both pay and non-pay elements. Monitoring of the effectiveness of the delegated arrangements was undertaken by the Chief Executive and Director of Finance respectively. As part of this delegation, NHS Doncaster CCG was required to ensure that they met all financial statutory and administrative duties. The Audit & Risk Group also undertook a self-assessment based on the Audit Handbook in-year.

Risk Management: An Assurance Framework and Risk Register have been maintained throughout the period. The Assurance Framework was received quarterly by the NHS Doncaster CCG Committee. NHS Doncaster CCG maintained throughout the period:

- A formally approved governance structure comprising Audit & Risk Group, Quality & Safety Group, Patient & Public Involvement Group, Commissioning Executive / Delivery & Performance and Clinical Leadership Forum. There was continuity of the meetings aligned underneath the formal groups.

- The 5x5 risk matrix with the risk tolerance/appetite under which risks can be tolerated as a score of 11 or below, and the escalation to the Cluster Assurance Framework of risks which were scored at or in excess of a score of 16.

- An NHS Doncaster CCG Assurance Framework.

3. Risk assessment

3.1. NHS South Yorkshire & Bassetlaw

To support the work of the Board and its Committees and to provide assurance that the risks across the Cluster were known and understood, a single Assurance Framework covering all constituent PCT areas was in place throughout 2012/13. The Assurance Framework took into account the accountabilities and responsibilities referenced in the following:

- Objectives from the *Cluster Implementation Guidance* (January 2011) and the *Shared Operating Model for PCT Clusters* (July 2011);
- NHS Commissioning Board duties (e.g. offender healthcare military healthcare, primary care contracting, emergency planning);
- Escalating Clinical Commissioning Group issues based on *Functions of GP Commissioning Consortia: A Working Document* (March 2011).

In developing the NHS South Yorkshire & Bassetlaw Assurance Framework all existing PCT Assurance Framework risks and any new/emerging risks in light of the changing NHS architecture were captured. The Assurance Framework was developed in accordance with guidelines provided by the Department of Health, Internal Audit and the Strategic Health Authority and comprised risks which affected the achievement of Cluster objectives.

A standard 5x5 risk matrix as detailed in Section 3.2 below was agreed to assess risk which incorporated both consequence and likelihood. The Cluster risk tolerance (appetite under which risks can be tolerated) is a score of 11 or below where the assessment has been undertaken following the implementation of controls and assurances. This is the same for both the Cluster Assurance Framework and the Clinical Commissioning Group Assurance Frameworks. Local Clinical Commissioning Group Assurance Framework risks which scored at or in excess of a score of 16 were escalated to the Cluster Assurance Framework. All new risks scoring 16-20 were notified to the Board as part of the integrated performance report.

The objectives for PCT Clusters as detailed in the Department of Health *Shared Operating Model for PCT Clusters* (July 2011) were taken as those against which the Cluster Assurance Framework risks were mapped:

- Integrated Finance, Operations and Delivery
- Commissioning Development
- Ensuring Quality (Effectiveness, Experience & Safety)
- Emergency Planning & Resilience
- Commissioning Elements of Provider Development
- Communication and Engagement

All existing risks from the 5 PCT Assurance Frameworks were mapped to the principal risks of the Cluster. There was full alignment of the 5 PCTs' principal risks with the Cluster principal risks. All PCT Assurance Framework risks which were not expected to carry forward to the Clinical Commissioning Group Assurance Frameworks were captured on the Cluster Assurance Framework. The ownership of the risks was linked to the Scheme of Delegation with Director / Chief Executive accountability identified.

The format of the Assurance Framework was designed and populated based on the existing Assurance Frameworks in existence across the Cluster and in consideration of Internal Audit feedback on best practice.

The Cluster Assurance Framework was presented to the Audit Committee and the Board in November 2011. An update to the Board was provided in January 2012 and a closing Assurance Framework was received by the Audit Committee in March 2013.

Until the NHS Commissioning Board formally took over responsibility for the commissioning of FHS/Primary Care, Offender Healthcare, Military Healthcare and Specialised Commissioning, a Risk Register co-produced by the

Executive Team and Governance/Commissioning Leads captured risks associated with these directly commissioned services. The Risk Register was presented to the January 2012 Board alongside the Assurance Framework Action Plan and continued to be updated outside of the Board. Specialised Commissioning Groups held their own Assurance Frameworks which continued during transition.

All the risks on the Assurance Framework were newly added from October 2011 as this was the first Assurance Framework of the NHS South Yorkshire & Bassetlaw Cluster. At the close of the year as of 31st March 2013 there were 20 risks on the Cluster Assurance Framework. 5 of these risks were scored in excess of 11 and all 5 were being treated, with 1 risk scored below 11 also being treated.

During the period, gaps in control and assurance were identified, action plans put into place and monitored. There were no lapses of data security reported to the Information Commissioner. The 6 risks being treated at year-end comprised:

Ref	Principal Risk	Current Risk			Action Plan
		C	L	CxL	
1.2	Failure to deliver the financial aspects of the QIPP agenda.	5	3	15	Continue to monitor QIPP delivery across the localities
2.2	Failure to directly commission for specialised services during transition: • Specialised Commissioning • FHS and Primary Care Contracting • Offender Health and Military Health Commissioning	5	2	10	Complete the prison healthcare action plan to mitigate against any potential risks identified in the HM Inspectorate of Prisons report.
2.4	Recent national publication of a call for retrospective Continuing Healthcare claims is expected to lead to a significant increase in claims – impacting on both staffing capacity to review the claims and on finance. The time limits for the process are very short – September 2012.	4	3	12	Develop a coordinated approach to Continuing Care retrospective claims reviews
3.5	Failure to effectively safeguard children and vulnerable people in line with statutory requirements leading to potential harm.	5	3	15	Monitor through Cluster Risk Register and local arrangements
3.6	Failure to ensure effective workforce planning and capability leading to de-motivation of staff.	4	3	12	Undertaken a gap analysis / skills audit to ensure capacity and capability for CSS functions

Ref	Principal Risk	Current Risk			Action Plan
		C	L	CxL	
6.1	Failure to effectively engage staff systematically during transition, resulting in potential de-motivation, lack of productivity and poor staff experience and including potential industrial action	4	3	12	Work to align workforce systems and processes across the localities

3.2. NHS Doncaster Clinical Commissioning Group

The standard 5x5 risk matrix below adopted by the NHS South Yorkshire & Bassetlaw to assess risk was also adopted by NHS Doncaster Clinical Commissioning Group.

Risk Matrix		Likelihood				
		(1) Rare	(2) Unlikely	(3) Possible	(4) Likely	(5) Almost certain
Consequence	(1) Negligible	1	2	3	4	5
	(2) Minor	2	4	6	8	10
	(3) Moderate	3	6	9	12	15
	(4) Major	4	8	12	16	20
	(5) Extreme	5	10	15	20	25

1-5	Low
6-11	Medium
12-15	High
16-20	Very High
25	Extreme

The NHS South Yorkshire & Bassetlaw risk tolerance/appetite under which risks can be tolerated is a score of 11 or below where the assessment has been undertaken following the implementation of controls and assurances. The same risk appetite was adopted by the NHS Doncaster Clinical Commissioning Group.

The transferring Assurance Framework was first received by the NHS Doncaster CCG Committee in November 2011 and a refreshed framework was received in January 2012. Thereafter, the Committee received an updated copy of the Assurance Framework on a quarterly basis for review, assurance and approval. As at the close of the year 31st March 2013 there

were 19 risks on the Assurance Framework, 2 of which were in excess of the risk toleration level and both of which were being treated. 1 additional risk below the toleration threshold was also being treated as shown below.

Ref	Principal Risk	Current Risk			Action Plan
		C	L	CxL	
2.2	Failure to commission services which adequately safeguard children and vulnerable adults, potentially resulting in increased harm to vulnerable groups.	5	3	15	Work in partnership with the Local Authority to ensure referrals with the accompanying documentation are received in a timely manner for the medicals of Looked After Children.
2.4	Failure to performance manage contracts to ensure that Providers deliver against local and national performance targets, potentially resulting in organisational non-achievement of required targets.	4	3	12	Continue to take all contractual and partnership measures available to the CCG to bring A&E performance back on track.
3.1	Failure to have a clear Financial Strategy matched to commissioning priorities in the Strategic Plan, potentially resulting in available funding not being matched to prioritised commissioning areas.	4	2	8	Review financial allocation in-year in light of transitional arrangements

The NHS Doncaster CCG inherited the strategic objectives of Doncaster Primary Care Trust. Although the Assurance Framework risks associated with these objectives were refreshed during early 2012 based on CCG responsibilities, the Assurance Framework was still mapped to the PCT strategic objectives. New CCG strategic objectives were developed and approved at the October CCG Committee meeting. The Assurance Framework was therefore revised to match these strategic objectives, and new risks were identified under each strategic objective.

The CCG strategic objectives are:

- Commission innovative healthcare and pathways to improve patient experience, outcomes and cost effectiveness.
- Contract and performance manage for continuous quality improvement.
- Achieve economic efficiency and effectiveness within the allocated resource limit.
- Develop transparent and accountable relationships with stakeholders.
- Ensure all our Corporate Governance systems and processes are robust and transparent.
- Foster effective organisational development and leadership.

All risks were therefore new during 2012/13, but there was a clear mapping exercise from the PCT assurance framework to ensure continuity and this mapping was approved by the CCG Committee. Gaps in control and assurance were identified throughout the year and action plans put into place and monitored. There were no lapses of data security reported to the Information Commissioner.

4. The risk and control framework

NHS Doncaster's Risk Management Strategy, Policy & Procedure was in place in 2012/13, having been adopted by NHS Doncaster Clinical Commissioning Group. The document was updated for the CCG and approved by the CCG Committee in October 2012. The strategic aim is to control risks to patients, to staff and to the organisation as far as is reasonably practicable and in accordance with current guidance, legislation and best practice. NHS Doncaster CCG recognises and accepts its duty and legal responsibility to provide a safe and healthy working environment for all its employees, patients, visitors and all others who may be affected by the working activities of the organisation. The organisation has a proactive approach aiming to identify, assess, evaluate, record and review risks, so as to reduce the likelihood of them causing harm to patients or staff or loss to NHS Doncaster CCG and to reduce the impact of such harm or losses should they occur. The Risk Management Strategy, Policy and Procedure covers risk identification, evaluation, control, review and assurance. The Strategy, Policy & Procedure:

- Has been endorsed by the CCG Committee.
- Sets out the organisational attitude to and appetite for risk – a risk may be tolerated where the score is 11 or below.
- Clearly defines the structures for the management and ownership of risk.
- Clearly identifies how to manage situations in which a potential risk develops into an actual risk.
- Specifies the way in which risk issues are considered at each level of business planning - ranging from the capture of strategic risks on the Assurance Framework to the capture of operational team risks on team Risk Registers and the capture of project risks on project risk logs.
- Specifies how new and existing activities are assessed for risk and dependent on the level of risk are then incorporated into either the Assurance Framework, the Risk Register or into a project risk log.
- Uses common terminology and scoring in relation to risk issues which is replicated across the Assurance Framework and Risk Register.
- Defines the structures for gaining assurance about the management of risk – including quarterly reporting via the Governance Report to Governing Body.
- Defines the criteria which inform assessment of risk and the definition of specific risks as "key" i.e. those risks which threaten the achievement of the principal objectives are captured on the Assurance

Framework, and the more operational team level risks are captured on the Risk Register.
- Defines the way in which the risk register and risk evaluation criteria will be regularly reviewed.
- Is set out in a single document and is easily available to all staff on the organisation's website and in Policy Manuals.

Risk identification, assessment and monitoring is a continuous structured process in ensuring that NHS Doncaster CCG works within the legal and regulatory framework, identifying and assessing possible risks facing the organisation, and planning to prevent and respond to these. The process of risk management covers the following 5 steps to risk assessment:

- Step 1 – Identify the Risk
- Step 2 – Assess the Risk
- Step 3 – Evaluate the Risk
- Step 4 – Record the Risk
- Step 5 – Review the Risk

Risk management is embedded in the activity of the organisation through the above measures and also through assessments of specific risks e.g. information governance, equality impact assessment, business continuity.

We have a clear process for the reporting, management, investigation and learning from incidents. We have in place a Senior Information Risk Owner both locally (Chief of Corporate Services) and through Cluster arrangements (Director of HR & Governance) to support our arrangements for managing and controlling risks relating to information / data security.

A Counter Fraud report is received at each Audit Committee / Audit & Risk Group. The report aims to apprise the Audit & Risk Group of the proactive and reactive activity carried out by the Local Counter Fraud Specialist (LCFS). The content of the report is formatted to accord with the requirements of the NHS Counter Fraud Manual outlining where relevant activity has taken place across the 7 generic areas of counter fraud work:

- Anti-Fraud Culture (including mandatory 3-yearly staff training)
- Deterrence (including policy reviews and patient fraud checks)
- Prevention (including NHS Protect fraud prevention instructions, alerts and intelligence bulletins and local counter fraud alerts)
- Detection (including Local Proactive Exercises, the Local Intelligence Network to support the Accountable Officer for Controlled Drugs and the National Fraud Initiative)
- Investigations
- Sanctions
- Redress

Contracts are set at beginning of year with relevant performance standards included as Key Performance Indicators (KPIs). Monitoring of the KPIs is

reported monthly and action is taken if any KPIs are under-achieving. Performance is reported to the CCG Committee monthly against the full range of Operating Framework requirements. A performance report is also submitted to Cluster Board which includes high-level Operating Framework issues and an overview of all requirements. For example, the Operating Framework target for Clostridium Difficile was breached in-year and mitigation plans were reported monthly to the CCG Committee through the Quality & Safety Report.

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

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of Internal Audit's work which resulted in an overall opinion that:

> **Significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives and that controls are generally being applied consistently.**

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

- External Audit providing progress reports to the Audit Committee, the Annual Management Letter and overview of cost effectiveness within NHS Doncaster.
- Internal Audit reviews of systems of internal control and progress reports to the Audit Committee, especially the annual Assurance Framework Internal Audit Report.
- Assurance reports on risk and governance received from the Audit Committee and Audit & Risk Group.
- Performance management systems.
- Internal Committee structure with delegated responsibility for risk identification, evaluation, control, review and assurance.
- Review of the Assurance Framework.
- Risk Register.
- Quarterly Governance Report capturing key risks across the spectrum of corporate governance.

- Self-assessment undertaken by the Audit Committee to ensure adherence to the principles contained within the NHS Audit Committee Handbook.
- The Single Integrated Plan which captures 5 clear clinical priorities and QIPP (Quality, Innovation, Productivity & Prevention) priorities and key risks.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the NHS Doncaster Clinical Commissioning Group Committee and Audit & Risk Group and by managers within NHS Doncaster. Action plans to address any identified weaknesses and ensure continuous improvement of the system are in place via the Assurance Framework action plan and also via action plans embedded within the Risk Register.

In maintaining and reviewing the effectiveness of the system of internal control:

- Any need to change priorities or controls is clearly recorded and either actioned, or reported to those with authority to take action.
- Lessons which can be learned from both successes and failures are identified and disseminated to those who can gain from them.
- An appropriate level of independent assurance is provided on the whole process of risk identification, evaluation and control.
- Each level of management, including the Board, reviews the risks and controls for which they are responsible.
- An embedded and fully operational governance and risk management structure is in place which clearly defines the roles and responsibilities of the Board and Sub Committees.

The following Committees and Officers have played a significant part in maintaining and reviewing the effectiveness of the system of internal control in 2012/13 and have managed risks assigned to them.

Trust Board: Responsible for providing clear commitment and direction for Risk Management within the Cluster. The Trust Board delegates responsibility for non-clinical risk management to the Audit Committee and clinical risk management to the Quality & Patient Safety Committee.

Audit Committee: Responsible for providing an independent overview of the arrangements for risk management within the Cluster, with specific responsibilities for financial risk management. It undertakes its own annual self-assessment of its effectiveness and reviews Internal and External Audits, the Assurance Framework and financial governance reports. The Cluster Audit Committee is mirrored in the NHS Doncaster Clinical Commissioning Group structure by an Audit & Risk Group which considers the same range of reports and the Probity Register. Local assurance flows up from the Audit & Risk Group to the Cluster Audit Committee.

Quality & Patient Safety Committee: The Committee with overarching responsibility for clinical risk management. It provides assurance to the Cluster Board that appropriate Clinical Governance and clinical risk management arrangements are in place across the organisations. The Quality & Patient Safety Committee is underpinned by various Sub Groups. The Cluster Quality & Patient Safety Committee is mirrored in the NHS Doncaster Clinical Commissioning Group structure by a Quality & Safety Group receiving reports across a range of topics including safeguarding, infection control, quality in contracts, incidents and medicines management. Local assurance flows up from the Quality & Safety Group to the Cluster Quality & Patient Safety Committee.

NHS Doncaster CCG Committee: The Committee with overarching responsibility for commissioning delegated services for the population of Doncaster from October 2011. It has also functioned as our Professional Executive Committee.

Chief Officer: As Senior Responsible Officer for the whole of NHS Doncaster and NHS Doncaster Clinical Commissioning Group, the Chief Officer is responsible for achieving the objectives in the context of sound and appropriate business processes and reporting risks to the Cluster Chief Executive as Accountable Officer.

Chief Finance Officer: As Senior Responsible Officer for NHS finances across NHS Doncaster and NHS Doncaster Clinical Commissioning Group, the Chief Finance Officer is responsible for ensuring that the organisation complies with the Standing Financial Instructions to achieve financial balance and reports financial risks to the Cluster Director of Finance.

Executive Directors: Each Director is responsible for ensuring that risks have been properly identified and assessed across all their work areas, paying particular attention to cross-cutting risks. They are responsible for agreeing the risk register entries for their work areas and for ensuring that each departmental/team lead is actively addressing the risks in their area and escalating risks up to Director-level for their attention as appropriate. Each Director has the expectation of owning some of the main risks in their Directorate and personally addressing them, thus setting the tone for risk management in their areas of responsibility. Directors also play a crucial role in ensuring that risk-related issues are adequately dealt with when policies are being prepared or revised in their work areas.

Head of Internal Audit: The Head of Internal Audit has a central role in the process of securing this Annual Governance Statement, and in advising the Chief Executive and the Audit Committee on the "health" of NHS Doncaster's risk management processes. As part of Internal Audit work, reviews are carried out to assess the robustness of the implementation of the Risk Management Strategy across the organisation. They provide information on the various strengths and weaknesses of the approach adopted by NHS Doncaster, and advise on where improvements are necessary and desirable for the good governance of the organisation.

Significant Issues

NHS South Yorkshire & Bassetlaw significant issues are those captured in Section 3.1. Significant issues which faced NHS Doncaster / Doncaster Clinical Commissioning Group in 2012/13 related to:

- Transition to the new NHS architecture including authorisation of the NHS Doncaster Clinical Commissioning Group.

- Management of the impact associated with local Safeguarding Children partnerships.

Full Assurance Framework action plans relating to these significant issues were put into place, monitored and reported via the Assurance Framework.

Transition: In addition to regular updating of the Assurance Framework and reporting on associated Assurance Framework action plans, assurance and activity on transition to the new NHS architecture has also been reported monthly to the NHS Doncaster CCG Committee through the monthly Chief Officer and Chair reports. Actions have included:

- The development of the governance structure and Assurance Framework as described above alongside terms of reference and a Constitution.
- The production of a clear and credible Single Integrated Plan aligned to the priorities of the Doncaster Shadow Health & Wellbeing Board.
- Holding CCG Committee meetings in public from January 2012.
- Organisational Development planning and implementation.
- Development of relevant strategies and procedural documents including Communication, Engagement & Equality, Choice, Risk and Standards of Business Conduct and Declarations of Interest.
- Preparation for Authorisation resulting in NHS Doncaster CCG being authorised with only 1 condition relating to the partnership safeguarding of Looked After Children.

Safeguarding: In addition to regular updating of the Assurance Framework and reporting on associated Assurance Framework action plans, assurance and activity on safeguarding children and vulnerable adults has also been reported to the CCG Committee through the Quality & Patient Safety Report. Actions have included:

- Active membership of the Doncaster Safeguarding Children Board and Doncaster Safeguarding Adults Partnership Board with active involvement in Serious Case Reviews, Lessons Learned Reviews and the implementation plan following a local partnership Care Quality Commission inspection.
- Working in partnership to improve services for Looked After Children.

- Participating in Domestic Homicide Reviews in partnership with the Safer Doncaster Partnership.
- Working with our local Acute Trust to develop a monitored action plan to ensure that the full range of commissioned Designated Doctor functions in relation to child safeguarding are in place and effective.
- Maintaining an overview of Safeguarding issues through the minutes of the Safeguarding Assurance Forum and the Safeguarding Assurance Reports received by the Quality & Patient Safety Group, with exception reporting to the Cluster Quality & Patient Safety Committee.

6. Conclusion

My review confirms that NHS Doncaster / NHS Doncaster Clinical Commissioning Group has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

Accountable Officer: Ms Eleri de Gilbert

Accountable organisation: NHS Doncaster (5N5)

Signature: Eleri de Gilbert

Date: 6.6.13

INDEPENDENT AUDITOR'S REPORT TO THE OFFICERS RESPONSIBLE FOR PREPARING THE ACCOUNTS OF DEVON PRIMARY CARE TRUST

We have audited the financial statements of Devon Primary Care Trust for the year ended 31 March 2013 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

We have also audited the information in the Remuneration Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes;
- the table of pension benefits of senior managers and related narrative notes; and
- the pay multiples narrative.

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

Respective responsibilities of responsible officers and auditor

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

Scope of the audit of the financial statements

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

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

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of Devon Primary Care Trust as at 31 March 2013 and of its net operating costs for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters

In our opinion:

- the part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and
- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we report by exception

We report to you if:

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

We have nothing to report in these respects.

Other matters on which we are required to conclude

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Trust has made proper arrangements for securing economy,

efficiency and effectiveness in its use of resources. We are also required by the Audit Commission's Code of Audit Practice to report any matters that prevent us being satisfied that the audited body has put in place such arrangements.

We have undertaken our audit in accordance with the Code of Audit Practice and, having regard to the guidance issued by the Audit Commission, we have considered the results of the following:

· our review of the annual governance statement;

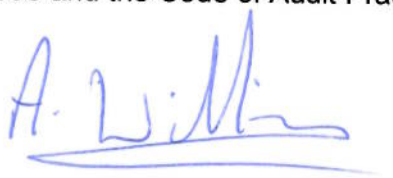
· the work of other relevant regulatory bodies or inspectorates, to the extent the results of the work have an impact on our responsibilities; and

· our locally determined risk-based work.

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

Certificate

We certify that we have completed the audit of the financial statements of Devon Primary Care Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.



Alun Williams
Senior Statutory Auditor, for and on behalf of Grant Thornton UK LLP

Hartwell House
55-61 Victoria Street,
Bristol
BS1 6FT

7 June 2013

Data entered below will be used throughout the workbook:

Entity name:	Doncaster PCT
This year	2012-13
Last year	2011-12
This year ended	31 March 2013
Last year ended	31 March 2012
This year commencing:	1 April 2012
Last year commencing:	1 April 2011

Manual for Accounts 2012-13

FOREWORD TO THE ACCOUNTS

Doncaster Primary Care Trust

These accounts for the year ended 31 March 2013 have been prepared by the Doncaster Primary Care Trust under section 3 (1) of schedule 15 of the National Health Service Act 2006 in the form which the Secretary of State has, with the approval of the Treasury, directed.

Statement of Comprehensive Net Expenditure for year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure			
Gross employee benefits	7.1	**9,567**	12,371
Other costs	5.1	**596,601**	590,868
Income	4	**(21,353)**	(21,449)
Net operating costs before interest		**584,815**	581,790
Investment income	9	**(171)**	(59)
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**2,962**	2,354
Net operating costs for the financial year		**587,606**	584,085
Transfers by absorption -(gains)		**0**	
Transfers by absorption - losses		**0**	
Net (gain)/loss on transfers by absorption		**0**	
Net Operating Costs for the Financial Year including absorption transfers		**587,606**	584,085
Of which:			
Administration Costs			
Gross employee benefits	7.1	**8,370**	10,259
Other costs	5.1	**5,961**	5,410
Income	4	**(2,411)**	(2,083)
Net administration costs before interest		**11,920**	13,586
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**0**	20
Net administration costs for the financial year		**11,920**	13,606
Programme Expenditure			
Gross employee benefits	7.1	**1,197**	2,112
Other costs	5.1	**590,640**	585,458
Income	4	**(18,942)**	(19,366)
Net programme expenditure before interest		**572,895**	568,204
Investment income	9	**(171)**	(59)
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**2,962**	2,334
Net programme expenditure for the financial year		**575,686**	570,479

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**(259)**	370
Net (gain) on revaluation of property, plant & equipment	**0**	(2,117)
Total comprehensive net expenditure for the year*	**587,347**	582,338

*This is the sum of the rows above plus net operating costs for the financial year after absorption accounting adjustments.
The notes on pages 5 to 43 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	**39,679**	41,621
Intangible assets	13	**0**	1
Investment property	15	**0**	0
Other financial assets	21	**901**	901
Trade and other receivables	19	**0**	0
Total non-current assets		**40,580**	42,523
Current assets:			
Inventories	18	**0**	0
Trade and other receivables	19	**3,361**	4,850
Other financial assets	36	**0**	0
Other current assets	22	**0**	0
Cash and cash equivalents	23	**98**	1
Total current assets		**3,459**	4,851
Non-current assets held for sale	24	**0**	0
Total current assets		**3,459**	4,851
Total assets		**44,039**	47,374
Current liabilities			
Trade and other payables	25	**(32,858)**	(35,561)
Other liabilities	26,28	**0**	0
Provisions	32	**(4,807)**	(5,864)
Borrowings	27	**(875)**	(741)
Other financial liabilities	36.2	**0**	0
Total current liabilities		**(38,540)**	(42,166)
Non-current assets plus/less net current assets/liabilities		**5,499**	5,208
Non-current liabilities			
Trade and other payables	25	(21)	(2)
Other liabilities	28	0	0
Provisions	32	(8,174)	(917)
Borrowings	27	(27,598)	(29,610)
Other financial liabilities	36.2	0	0
Total non-current liabilities		**(35,793)**	(30,529)
Total Assets Employed:		**(30,294)**	(25,321)
Financed by taxpayers' equity:			
General fund		(35,274)	(30,042)
Revaluation reserve		4,980	4,721
Other reserves		0	0
Total taxpayers' equity:		**(30,294)**	(25,321)

The notes on pages 5 to 43 form part of this account.

The financial statements on pages 1 to 43 were approved by the Designated Signing Officer on 6th June 2013 and are signed below:

Designated Signing Officer : Eun On

6.6.13

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

	General fund	Revaluation reserve	Other reserves	Total reserves
	£000	£000	£000	£000
Balance at 1 April 2012	**(30,042)**	**4,721**	**0**	**(25,321)**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(587,606)	0	0	**(587,606)**
Impairments and reversals	0	259	0	**259**
Total recognised income and expense for 2012-13	**(587,606)**	**259**	**0**	**(587,347)**
Net Parliamentary funding	582,374			**582,374**
Balance at 31 March 2013	**(35,274)**	**4,980**	**0**	**(30,294)**
Balance at 1 April 2011	**(22,722)**	**2,974**	**0**	**(19,748)**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(584,085)	0	0	(584,085)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment	0	2,117	0	2,117
Impairments and Reversals	0	(370)	0	(370)
Total recognised income and expense for 2011-12	(584,085)	1,747	0	(582,338)
Net Parliamentary funding	576,765	0	0	576,765
Balance at 31 March 2012	**(30,042)**	**4,721**	**0**	**(25,321)**

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		**(584,815)**	(581,790)
Depreciation and Amortisation		**2,339**	2,266
Impairments and Reversals		**444**	4,291
Interest Paid		**(2,941)**	(2,330)
(Increase)/Decrease in Inventories		**0**	37
(Increase)/Decrease in Trade and Other Receivables		**1,489**	716
Increase/(Decrease) in Trade and Other Payables		**(2,585)**	(3,711)
Provisions Utilised		**(308)**	(643)
Increase/(Decrease) in Provisions		**6,487**	5,576
Net Cash Inflow/(Outflow) from Operating Activities		**(579,890)**	(575,588)
Cash flows from investing activities			
Interest Received		**171**	59
(Payments) for Property, Plant and Equipment		**(680)**	(916)
Proceeds of disposal of assets held for sale (PPE)		**0**	332
Net Cash Inflow/(Outflow) from Investing Activities		**(509)**	(525)
Net cash inflow/(outflow) before financing		**(580,399)**	(576,113)
Cash flows from financing activities			
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**(1,878)**	(654)
Net Parliamentary Funding		**582,374**	576,765
Net Cash Inflow/(Outflow) from Financing Activities		**580,496**	576,111
Net increase/(decrease) in cash and cash equivalents		**97**	(2)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**1**	3
Cash and Cash Equivalents (and Bank Overdraft) at year end		**98**	1

1. Accounting policies

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

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

1.1 Accounting Conventions

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

Transforming Community Services (TCS) transactions

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

Acquisitions and Discontinued Operations

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

Critical accounting judgements and key sources of estimation uncertainty

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

Critical judgements in applying accounting policies

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

- The financial statements have been prepared on a going concern basis as the activities of Doncaster PCT will continue elsewhere in the public sector.The transfers of operations and assets within the public sector do not fall within the scope of IFRS 5 Non-current Assets Held for Sale and Discontinued Operations.

Key sources of estimation uncertainty

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

a) Property valuations

The valuations will be undertaken by an independent external valuer. Valuations will be based on "Fair Value."

Where the buildings are specialised in terms of fit-out and use the valuation basis will generally be based upon a Depreciated Replacement Cost with this cost based on a Modern Equivalent Building. As a consequence these values may vary as the costs of the costs of the replacement vary, i.e. as build costs (material prices etc.) and labour costs change. The values will also reflect changes in land prices which will be stated separately.

For non specialised buildings will be valued to "Fair Value." However for those non specialised assets, valuations will be based on their Market Values within their existing use. For example an office building would be valued as an office with reference to prevailing market values, but on the assumption that it will continue to be used as an office. These values will therefore be subject to changes in market conditions and market values.

b) Asset lives

Estimated asset lives and residual values are reviewed each year.

c) Accruals

Accruals included within the accounts are based on the best available information. This is applied in conjunction with historical experience and based on individual circumstances.

d) Provisions

Provisions for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation (often using the views of a third party ie NHSLA). Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the Treasury's appropriate real terms discount rates.

Provisions for Continuing Healthcare Retrospective Claims are calculated using a methodology which has been developed for estimating the level of financial liability from the claims submitted. The methodology utilises three main variables : the period of the claim, an estimated amount paid per week and an estimate of the likelihood of success, in order to derive the provision. The experience of clinical staff is taken account of to determine the variables used in the development of the methodology.

1. Accounting policies (continued)

1.2 Revenue and Funding

The main source of funding for the Primary Care Trust is allocations (Parliamentary Funding) from the Department of Health within an approved cash limit, which is credited to the General Fund of the Primary Care Trust. Parliamentary funding is recognised in the financial period in which the cash is received.

Miscellaneous revenue is income which relates directly to the operating activities of the Primary Care Trust. It principally comprises fees and charges for services provided on a full cost basis to external customers, as well as public repayment work. It includes both income appropriated-in-aid of the Vote and income to the Consolidated Fund which HM Treasury has agreed should be treated as operating income.

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Where revenue has been received for a specific activity to be delivered in the following financial year, that income will be deferred.

1.3 Care Trust Designation

This note is not applicable.

1.4 Pooled budgets

This note is not applicable as the PCT has not entered into any pooled budget arrangements.

1.5 Taxation

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

1.6 Administration and Programme Costs

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

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

1. Accounting policies (continued)

1.7 Property, Plant & Equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation

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

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

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

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

The PCT has obtained a valuation of all its properties as at 31st March 2013 (on a Modern Equivalent Asset basis). The PCT will carry out an impairment review on an annual basis and have a full professional revaluation on an MEA basis every 3 years.

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

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

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

1. Accounting policies (continued)

1.8 Intangible Assets

Doncaster Primary Care Trust had no intangible assets at 31 March 2013.

1.9 Depreciation, amortisation and impairments

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

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

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

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

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME) from 2011-12. This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.

AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1. Accounting policies (continued)

1.10 Donated assets

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

1.11 Government grants

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

1.12 Non-current assets held for sale

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

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

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

1.13 Inventories

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

1.14 Cash and cash equivalents

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

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

1.15 Losses and Special Payments

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

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

1.16 Clinical Negligence Costs

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

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

1. Accounting policies (continued)

1.17 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.

Retirement benefit costs

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

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

1.18 Research and Development

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

1.19 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.

1.20 Grant making

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

1.21 EU Emissions Trading Scheme

Doncaster Primary Care Trust did not have any EU Trading Scheme Allowances in 2012-13.

1. Accounting policies (continued)

1.22 Contingencies

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

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

1.23 Leases

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

The PCT as lessee

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

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

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

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

The PCT as lessor

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

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.

1.24 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.

1.25 Provisions

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

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

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

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

1. Accounting policies (continued)

1.26 Financial Instruments

Financial assets

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

Financial assets are initially recognised at fair value.

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

Financial assets at fair value through profit and loss

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

Held to maturity investments

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

Available for sale financial assets

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

Loans and receivables

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

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

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

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

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

1. Accounting policies (continued)

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

Financial liabilities are initially recognised at fair value.

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

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.

1.27 NHS LIFT transactions

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

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:
a) Payment for the fair value of services received;
b) Payment for the LIFT asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

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

b) LIFT assets, liabilities, and finance costs

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

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

1. Accounting policies (continued)

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

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

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

c) Lifecycle replacement

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

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.
Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the PCT to the operator for use in the scheme

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

Other assets contributed by the PCT to the operator

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

1.28 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

1.29 Events after the end of the reporting period

Under the provisions of the Health and Social Care Act 2012, Doncaster Primary Care Trust was dissolved on 31 March 2013. The PCT's functions, assets and liabilities transferred to other public sector entities as outlined in Note 42 Events after the Reporting Period. Where reconfigurations of this nature take place within the public sector, Government accounting requires that the activities concerned are to be considered as continuing operations, and so the closing entity prepares accounts on a "going concern" basis.

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

2 Operating segments

Doncaster Primary Care Trust operated one segment in 2011-12 and 2012-13, commissioning of healthcare.

3. Financial Performance Targets

3.1 Revenue Resource Limit

	2012-13 £000	2011-12 £000
The PCTs' performance for the year ended 2012-13 is as follows:		
Total Net Operating Cost for the Financial Year		584,085
Net operating cost plus (gain)/loss on transfers by absorption	587,606	
Adjusted for prior period adjustments in respect of errors	0	0
Revenue Resource Limit	589,845	586,773
Under/(Over)spend Against Revenue Resource Limit (RRL)	2,239	2,688

3.2 Capital Resource Limit

	2012-13 £000	2011-12 £000
The PCT is required to keep within its Capital Resource Limit.		
Capital Resource Limit	1,163	14,154
Charge to Capital Resource Limit	581	13,864
(Over)/Underspend Against CRL	582	290

3.3 Provider full cost recovery duty

Doncaster Primary Care Trust did not have a provider function in 2012-13 or 2011-12.

3.4 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	582,374	576,765
Cash Limit	586,462	576,765
Under/(Over)spend Against Cash Limit	4,088	0

3.5 Reconciliation of Cash Drawings to Parliamentary Funding

	2012-13 £000	2011-12 £000
Total cash received from DH (Gross)	497,703	492,177
Less: Trade Income from DH	0	0
Less/(Plus): movement in DH working balances	0	0
Sub total: net advances	497,703	492,177
(Less)/plus: transfers (to)/from other resource account bodies	0	0
Plus: cost of Dentistry Schemes (central charge to cash limits)	18,470	18,136
Plus: drugs reimbursement (central charge to cash limits)	66,201	66,452
Parliamentary funding credited to General Fund	582,374	576,765

4 Miscellaneous Revenue

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
Fees and Charges	0	0	0	0
Dental Charge income from Contractor-Led GDS & PDS	4,733	0	4,733	4,910
Dental Charge income from Trust-Led GDS & PDS	101	0	101	69
Prescription Charge income	3,429	0	3,429	3,377
Strategic Health Authorities	19	18	1	97
NHS Trusts	1	1	0	5
NHS Foundation Trusts	248	21	227	1,003
Primary Care Trusts Contributions to DATs	0	0	0	0
Primary Care Trusts - Other	1,611	1,493	118	1,384
Primary Care Trusts - Lead Commissioning	4	0	4	72
English RAB Special Health Authorities	0	0	0	0
NDPBs and Others (CGA)	0	0	0	0
Department of Health - SMPTB	0	0	0	0
Department of Health - Other	0	0	0	0
Recoveries in respect of employee benefits	789	746	43	785
Local Authorities	2,801	1	2,800	3,277
Patient Transport Services	0	0	0	0
Education, Training and Research	2,199	0	2,199	2,057
Non-NHS: Private Patients	0	0	0	0
Non-NHS: Overseas Patients (Non-Reciprocal)	0	0	0	0
NHS Injury Costs Recovery	0	0	0	0
Other Non-NHS Patient Care Services	353	0	353	450
Charitable and Other Contributions to Expenditure	0	0	0	0
Receipt of donated assets	0	0	0	0
Receipt of Government granted assets	0	0	0	0
Rental revenue from finance leases	0	0	0	0
Rental revenue from operating leases	4,919	0	4,919	3,854
Other revenue	146	131	15	109
Total miscellaneous revenue	**21,353**	**2,411**	**18,942**	**21,449**

5. Operating Costs

5.1 Analysis of operating costs:

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
Goods and Services from Other PCTs				
Healthcare	46,895	0	46,895	42,053
Non-Healthcare	358	358	0	879
Total	47,253	358	46,895	42,932
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	23,633	0	23,633	23,518
Goods and services (other, excl Trusts, FT and PCT))	0	0	0	0
Total	23,633	0	23,633	23,518
Goods and Services from Foundation Trusts	303,789	394	303,395	302,254
Purchase of Healthcare from Non-NHS bodies	66,614	0	66,614	63,218
Social Care from Independent Providers	0	0	0	0
Expenditure on Drugs Action Teams	3,724	0	3,724	3,705
Non-GMS Services from GPs	0	0	0	0
Contractor Led GDS & PDS (excluding employee benefits)	21,513	0	21,513	21,433
Salaried Trust-Led PDS & PCT DS (excluding employee benefits)	1,875	0	1,875	1,961
Chair, Non-executive Directors & PEC remuneration	49	49	0	76
Executive committee members costs	0	0	0	0
Consultancy Services	266	262	4	243
Prescribing Costs	54,113	0	54,113	55,001
G/PMS, APMS and PCTMS (excluding employee benefits)	41,940	0	41,940	41,275
Pharmaceutical Services	682	0	682	571
Local Pharmaceutical Services Pilots	0	0	0	0
New Pharmacy Contract	15,603	0	15,603	15,658
General Ophthalmic Services	3,154	0	3,154	2,952
Supplies and Services - Clinical	122	55	67	48
Supplies and Services - General	2,201	983	1,218	1,627
Establishment	693	538	155	659
Transport	25	25	0	8
Premises	3,556	2,052	1,504	3,457
Impairments & Reversals of Property, plant and equipment	444	0	444	4,291
Impairments and Reversals of non-current assets held for sale	0	0	0	0
Depreciation	2,338	164	2,174	2,263
Amortisation	1	0	1	3
Impairment & Reversals Intangible non-current assets	0	0	0	0
Impairment and Reversals of Financial Assets	0	0	0	0
Impairment of Receivables	0	0	0	0
Inventory write offs	0	0	0	0
Research and Development Expenditure	23	23	0	6
Audit Fees	138	138	0	204
Other Auditors Remuneration	0	0	0	0
Clinical Negligence Costs	0	0	0	0
Education and Training	1,878	24	1,854	1,729
Grants for capital purposes	0	0	0	0
Grants for revenue purposes	0	0	0	0
Impairments and reversals for investment properties	0	0	0	0
Other	974	896	78	1,776
Total Operating costs charged to Statement of Comprehensive Net Expenditure	596,601	5,961	590,640	590,868
Employee Benefits (excluding capitalised costs)				
Employee Benefits associated with PCTMS	0	0	0	0
Trust led PDS and PCT DS	0	0	0	0
PCT Officer Board Members	287	287	0	415
Other Employee Benefits	9,280	8,083	1,197	11,956
Total Employee Benefits charged to SOCNE	9,567	8,370	1,197	12,371
Total Operating Costs	606,168	14,331	591,837	603,239
Analysis of grants reported in total operating costs				
For capital purposes				
Grants to fund Capital Projects - GMS	0	0	0	0
Grants to Local Authorities to Fund Capital Projects	0	0	0	0
Grants to Private Sector to Fund Capital Projects	0	0	0	0
Grants to Fund Capital Projects - Dental	0	0	0	0
Grants to Fund Capital Projects - Other	0	0	0	0
Total Capital Grants	0	0	0	0
Grants to fund revenue expenditure				
To Local Authorities	0	0	0	0
To Private Sector	0	0	0	0
To Other	0	0	0	0
Total Revenue Grants	0	0	0	0
Total Grants	0	0	0	0

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	11,920	9,887	2,033
Weighted population (number in units)*	338,436	338,436	338,436
Running costs per head of population (£ per head)	35	29	6
PCT Running Costs 2011-12			
Running costs (£000s)	13,609	11,249	2,360
Weighted population (number in units)	338,436	338,436	338,436
Running costs per head of population (£ per head)	40	33	7

* Weighted population figures are not available for 2012-13 as the weighted capitation formula for PCT allocations was not updated for 2012-13. This was because it was decided to give all PCTs the same percentage growth in their allocations in this transitional year rather than differential growth based on a weighted capitation formula

Therefore, 2011-12 weighted population has been used to calculate the Running Costs per head of population in 2012-13

5.2 Analysis of operating expenditure by expenditure classification	2012-13 £000	2011-12 £000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	41,940	41,275
Prescribing costs	54,113	55,001
Contractor led GDS & PDS	21,513	21,433
Trust led GDS & PDS	1,875	1,961
General Ophthalmic Services	3,154	2,952
Department of Health Initiative Funding	0	0
Pharmaceutical services	682	571
Local Pharmaceutical Services Pilots	0	0
New Pharmacy Contract	15,603	15,658
Non-GMS Services from GPs	0	0
Other	0	0
Total Primary Healthcare purchased	**138,880**	138,851
Purchase of Secondary Healthcare		
Learning Difficulties	19,882	19,070
Mental Illness	85,989	80,075
Maternity	14,978	15,069
General and Acute	221,397	219,415
Accident and emergency	13,950	14,109
Community Health Services	56,316	57,029
Other Contractual	31,446	28,922
Total Secondary Healthcare Purchased	**443,958**	433,689
Grant Funding		
Grants for capital purposes	0	0
Grants for revenue purposes	0	0
Total Healthcare Purchased by PCT	**582,838**	**572,540**
PCT self-provided secondary healthcare included above	0	0
Social Care from Independent Providers	0	0
Healthcare from NHS FTs included above	302,893	301,296

6. Operating Leases

6.1 PCT as lessee

	Land £000	Buildings £000	Other £000	2012-13 Total £000	2011-12 £000
Payments recognised as an expense					
Minimum lease payments				520	701
Contingent rents				0	0
Sub-lease payments				0	0
Total				520	701
Payable:					
No later than one year	0	285	15	300	693
Between one and five years	0	833	4	837	1,522
After five years	0	1,374	0	1,374	1,893
Total	0	2,492	19	2,511	4,108
Total future sublease payments expected to be received				0	0

The main types of operating leases are for buildings, lease cars and photocopiers.

Doncaster PCT has entered into certain financial arrangements involving the use of GP premises.
Under - IAS 17 leases
SIC 27 Evaluating the substance of transactions involving the legal form of a lease
IFRIC 4 Determining whether an arrangement contains a lease

The PCT has determined that those operating leases must be recognised, but as there is no defined term in the arrangements entered into, it is not possible to analyse the arrangements over financial years.

6.2 PCT as lessor

	2012-13 £000	2011-12 £000
Recognised as income		
Rental revenue	4,919	3,854
Contingent rents	0	0
Total	4,919	3,854
Receivable:		
No later than one year	4,734	3,860
Between one and five years	11,838	9,848
After five years	48,384	39,376
Total	64,956	53,084

The main operating leasing arrangements are where the PCT is the lessor for health centres occupied by GPs.

7. Employee benefits and staff numbers

7.1 Employee benefits

2012-13				Permanently employed			Other		
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Employee Benefits - Gross Expenditure									
Salaries and wages	7,856	6,978	878	7,009	6,470	539	847	508	339
Social security costs	940	861	79	928	857	71	12	4	8
Employer Contributions to NHS BSA - Pensions Division	567	531	36	556	525	31	11	6	5
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	204	0	204	140	0	140	64	0	64
Total employee benefits	9,567	8,370	1,197	8,633	7,852	781	934	518	416
Less recoveries in respect of employee benefits (table below)	(789)	(746)	(43)	(789)	(746)	(43)	0	0	0
Total - Net Employee Benefits including capitalised costs	8,778	7,624	1,154	7,844	7,106	738	934	518	416
Employee costs capitalised	0	0	0	0	0	0	0	0	0
Gross Employee Benefits excluding capitalised costs	9,567	8,370	1,197	8,633	7,852	781	934	518	416
Recognised as:									
Commissioning employee benefits	9,567			8,633			934		
Provider employee benefits	0			0			0		
Gross Employee Benefits excluding capitalised costs	9,567			8,633			934		

2012-13				Permanently employed			Other		
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Employee Benefits - Revenue									
Salaries and wages	640	601	39	640	601	39	0	0	0
Social Security costs	68	68	0	68	68	0	0	0	0
Employer Contributions to NHS BSA - Pensions Division	81	77	4	81	77	4	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	789	746	43	789	746	43	0	0	0

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	8,909	8,442	467
Social security costs	623	614	9
Employer Contributions to NHS BSA - Pensions Division	1,090	1,079	11
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	1,749	1,749	0
Total gross employee benefits	12,371	11,884	487
Less recoveries in respect of employee benefits	(785)	(760)	(25)
Total - Net Employee Benefits including capitalised costs	11,586	11,124	462
Employee costs capitalised	0	0	0
Gross Employee Benefits excluding capitalised costs	12,371	11,884	487
Recognised as:			
Commissioning employee benefits	12,371		
Provider employee benefits	0		
Gross Employee Benefits excluding capitalised costs	12,371		

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						
Medical and dental	4	4	0	4	4	0
Ambulance staff	0	0	0	0	0	0
Administration and estates	182	170	12	225	218	7
Healthcare assistants and other support staff	9	0	9	0	0	0
Nursing, midwifery and health visiting staff	18	11	7	12	12	0
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	8	8	0	8	8	0
Social Care Staff	0	0	0	0	0	0
Other	0	0	0	0	0	0
TOTAL	221	193	28	249	242	7
Of the above - staff engaged on capital projects	0	0	0	0	0	0

7.3 Staff Sickness absence and ill health retirements

	2012-13 Number	2011-12 Number
Total Days Lost	1,291	4,255
Total Staff Years	233	545
Average working Days Lost	5.54	7.81

	2012-13 Number	2011-12 Number
Number of persons retired early on ill health grounds	0	1
	£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
Less than £10,000	2	1	3	0	7	7
£10,001-£25,000	0	1	1	0	9	9
£25,001-£50,000	0	0	0	0	9	9
£50,001-£100,000	1	0	1	0	6	6
£100,001 - £150,000	0	0	0	0	2	2
£150,001 - £200,000	0	0	0	0	1	1
>£200,000	0	0	0	0	0	0
Total number of exit packages by type (total cost)	3	2	5	0	34	34
	£	£	£	£	£	£
Total resource cost	84,388	27,073	111,461	0	1,380,000	1,380,000

This note provides an analysis of Exit Packages agreed during the year. Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Redundancy Scheme under Section 16 of Agenda for Change..

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

Doncaster Primary Care Trust benefitted from the services of certain staff directly employed by PCTs across the South Yorkshire and Bassetlaw Cluster. As a result, the PCT has contributed towards the redundancy costs of those staff. The full redundancy costs are reported in the accounts of the employing PCT. Therefore the amounts reported above are in respect of staff directly employed by Doncaster PCT only.

7.5 Pensions 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	14,414	119,741	17,780	115,256
Total Non-NHS Trade Invoices Paid Within Target	13,744	117,027	16,935	112,419
Percentage of NHS Trade Invoices Paid Within Target	95.35%	97.73%	95.25%	97.54%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,692	385,525	3,957	371,171
Total NHS Trade Invoices Paid Within Target	3,518	383,442	3,801	370,509
Percentage of NHS Trade Invoices Paid Within Target	95.29%	99.46%	96.06%	99.82%

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

9. Investment Income

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest Income				
LIFT: equity dividends receivable	67	0	67	0
LIFT: loan interest receivable	104	0	104	59
Bank interest	0	0	0	0
Other loans and receivables	0	0	0	0
Impaired financial assets	0	0	0	0
Other financial assets	0	0	0	0
Subtotal	171	0	171	59
Total investment income	171	0	171	59

10. Other Gains and Losses

Doncaster Primary Care Trust had no other gains and losses in 2012-13 or in 2011-12.

11. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest				
Interest on obligations under finance leases	0	0	0	0
Interest on obligations under LIFT contracts:				
- main finance cost	2,583	0	2,583	2,046
- contingent finance cost	358	0	358	284
Interest on late payment of commercial debt	0	0	0	0
Other interest expense	0	0	0	0
Total interest expense	2,941	0	2,941	2,330
Other finance costs	0	0	0	0
Provisions - unwinding of discount	21		21	24
Total	2,962	0	2,962	2,354

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	1,845	45,050	0	68	1,342	28	3,157	1,014	52,504
Additions Purchased	0	502	0	[illegible]	79	0	0	0	581
Reclassifications	0	33	0	(68)	35	0	0	0	0
Upward revaluation/positive indexation	(20)	(9,164)	0	0	0	0	0	0	(9,184)
Impairments/negative indexation	0	(62)	0	0	0	0	0	0	(62)
Reversal of Impairments	0	321	0	0	0	0	0	0	321
At 31 March 2013	1,825	36,680	0	0	1,456	28	3,157	1,014	44,160
Depreciation									
At 1 April 2012	20	7,028	0	0	643	26	2,494	672	10,883
Upward revaluation/positive indexation	(20)	(9,164)	0	[illegible]	0	0	0	0	(9,184)
Impairments	0	548	0	0	0	0	0	0	548
Reversal of Impairments	0	(104)	0	0	0	0	0	0	(104)
Charged During the Year	0	1,692	0	[illegible]	170	2	322	152	2,338
At 31 March 2013	0	0	0	0	813	28	2,816	824	4,481
Net Book Value at 31 March 2013	1,825	36,680	0	0	643	0	341	190	39,679
Purchased	1,825	36,680	0	0	643	0	341	190	39,679
Total at 31 March 2013	1,825	36,680	0	0	643	0	341	190	39,679
Asset financing:									
Owned	1,825	7,761	0	0	643	0	341	190	10,760
On-SOFP LIFT contracts	0	28,919	0	0	0	0	0	0	28,919
Total at 31 March 2013	1,825	36,680	0	0	643	0	341	190	39,679

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	679	4,017	0	0	25	0	0	0	4,721
Movements (Net revaluation increases)	0	259	0	0	0	0	0	0	259
At 31 March 2013	679	4,276	0	0	25	0	0	0	4,980

12.2 Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:									
At 1 April 2011	**2,005**	**29,960**	**0**	**240**	**925**	**28**	**3,161**	**906**	**37,225**
Additions - purchased	0	13,183	0	68	372	0	133	108	**13,864**
Additions - donated	0	0	0	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	(240)	240	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**
Revaluation & indexation gains	0	2,117	0	0	0	0	0	0	**2,117**
Impairments	(160)	(210)	0	0	0	0	0	0	**(370)**
Reversals of impairments	0	0	0	0	0	0	0	0	**0**
In-year transfers to/from NHS bodies	0	0	0	0	(195)	0	(137)	0	**(332)**
Cumulative dep netted off cost following revaluation	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**1,845**	**45,050**	**0**	**68**	**1,342**	**28**	**3,157**	**1,014**	**52,504**
Depreciation									
At 1 April 2011	**0**	**1,258**	**0**		**595**	**22**	**2,034**	**420**	**4,329**
Reclassifications		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	20	4,402	0	0	0	0	85	91	**4,598**
Reversal of Impairments	0	(307)	0	0	0	0	0	0	**(307)**
Charged During the Year	0	1,675	0		48	4	375	161	**2,263**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluation	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**20**	**7,028**	**0**	**0**	**643**	**26**	**2,494**	**672**	**10,883**
Net Book Value at 31 March 2012	**1,825**	**38,022**	**0**	**68**	**699**	**2**	**663**	**342**	**41,621**
Purchased	1,825	38,022	0	68	699	2	663	342	**41,621**
Donated	0	0	0	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**1,825**	**38,022**	**0**	**68**	**699**	**2**	**663**	**342**	**41,621**
Asset financing:									
Owned	1,825	8,144	0	68	699	2	663	342	**11,743**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP LIFT contracts	0	29,878	0	0	0	0	0	0	**29,878**
LIFT residual: interests	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**1,825**	**38,022**	**0**	**68**	**699**	**2**	**663**	**342**	**41,621**

12.3 Property, plant and equipment

The District Valuer has valued the PCT's land and buildings as at 31 March 2013 at Fair Value.

Fair Value is based on market value on the assumption that the property is sold as part of the continuing enterprise in occupation ie effectively Existing Use Value (EUV).

The LIFT premises are held by the PCT at a fair value of £28,919k as at 31 March 2013 (£29,878k as at 31 March 2012).

13.1 Intangible non-current assets

Doncaster Primary Care Trust had no intangible assets at 31 March 2013 or at 31 Marc

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

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000
Property, Plant and Equipment impairments and reversals taken to SoCNE			
Loss or damage resulting from normal operations	73	0	73
Over-specification of assets	0	0	0
Abandonment of assets in the course of construction	0	0	0
Total charged to Departmental Expenditure Limit	**73**	**0**	**73**
Unforeseen obsolescence	0		0
Loss as a result of catastrophe	0		0
Other	0		0
Changes in market price	371		371
Total charged to Annually Managed Expenditure	**371**		**371**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Loss or damage resulting from normal operations	0		
Over Specification of Assets	0		
Abandonment of assets in the course of construction	0		
Unforeseen obsolescence	0		
Loss as a result of catastrophe	0		
Other	0		
Changes in market price	(259)		
Total impairments for PPE charged to reserves	**(259)**		
Total Impairments of Property, Plant and Equipment	**185**	**0**	**444**

15 Investment property

The PCT did not have any investment property in either 2012-13 or 2011-12.

16 Commitments

16.1 Capital commitments

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

	31 March 2013 £000	31 March 2012 £000
Property, plant and equipment	0	10
Intangible assets	0	0
Total	0	10

16.2 Other financial commitments

The PCT did not have any other financial commitments in either 2012-13 or 2011-12.

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	566	0	1,937	0
Balances with Local Authorities	766	0	308	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	419	0	8,215	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	1,741	0	22,709	21
At 31 March 2013	3,492	0	33,169	21
prior period:				
Balances with other Central Government Bodies	999	0	597	0
Balances with Local Authorities	273	0	0	0
Balances with NHS Trusts and Foundation Trusts	2,080	0	8,725	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	1,498	0	26,239	2
At 31 March 2012	4,850	0	35,561	2

18 Inventories

Doncaster Primary Care Trust had no inventories in 2012-13 or 2011-12.

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	592	1,063	0	0
NHS receivables - capital	0	0	0	0
NHS prepayments and accrued income	262	2,016	0	0
Non-NHS receivables - revenue	1,799	682	0	0
Non-NHS receivables - capital	0	0	0	0
Non-NHS prepayments and accrued income	533	781	0	0
Provision for the impairment of receivables	0	0	0	0
VAT	131	0	0	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables	44	308	0	0
Total	3,361	4,850	0	0
Total current and non current	3,361	4,850		
Included above:				
Prepaid pensions contributions	0	0		

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

19.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	1,664	2,824
By three to six months	3	45
By more than six months	78	160
Total	1,745	3,029

19.3 Provision for impairment of receivables

Doncaster Primary Care Trust has made no provision for the impairment of receivables in either 2012-13 or 2011-12.

20 NHS LIFT investments

	Loan £000	Share capital £000	Total £000
Balance at 1 April 2012	**897**	**4**	**901**
Additions	**0**	**0**	**0**
Disposals	**0**	**0**	**0**
Loan repayments	**0**	**0**	**0**
Revaluations	**0**	**0**	**0**
Loans repayable within 12 months	**0**	**0**	**0**
Balance at 31 March 2013	**897**	**4**	**901**
Balance at 1 April 2011	897	4	901
Additions	0	0	0
Disposals	0	0	0
Loan repayments	0	0	0
Revaluations	0	0	0
Loans repayable within 12 months	0	0	0
Balance at 31 March 2012	**897**	**4**	**901**

21.1 Other financial assets - Current

Doncaster Primary Care Trust did not have any other current assets in either 2012-13 or 2011-12.

21.2 Other Financial Assets - Non Current

	31 March 2013 £000	31 March 2012 £000
Opening balance 1 April	**901**	901
Additions	**0**	**0**
Revaluation	**0**	**0**
Impairments	**0**	**0**
Impairment Reversals	**0**	**0**
Transferred to current financial assets	**0**	**0**
Disposals	**0**	**0**
Transfers (to)/from Other Public Sector Bodies in year	**0**	**0**
Total Other Financial Assets - Non Current	**901**	**901**

21.3 Other Financial Assets - Capital Analysis

Doncaster Primary Care Trust did not have any other financial assets (capital) in either 2012-13 or 2011-12.

22 Other current assets

Doncaster Primary Care Trust did not have any other current assets in either 2012-13 or 2011-12.

23 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**1**	3
Net change in year	**97**	(2)
Closing balance	**98**	1
Made up of		
Cash with Government Banking Service	**98**	1
Commercial banks	**0**	**0**
Cash in hand	**0**	**0**
Current investments	**0**	**0**
Cash and cash equivalents as in statement of financial position	**98**	1
Bank overdraft - Government Banking Service	**0**	**0**
Bank overdraft - Commercial banks	**0**	**0**
Cash and cash equivalents as in statement of cash flows	**98**	1

24 Non-current assets held for sale

Doncaster Primary Care Trust had no assets held for sale in either 2012-13 or 2011-12.

25 Trade and other payables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
Interest payable	0	0		
NHS payables - revenue	6,161	5,151	0	0
NHS payables - capital	0	0	0	0
NHS accruals and deferred income	3,680	3,906	0	0
Family Health Services (FHS) payables	10,750	11,542		
Non-NHS payables - revenue	1,751	634	21	0
Non-NHS payables - capital	54	153	0	0
Non-NHS accruals and deferred income	7,853	9,835	0	2
Social security costs	92	72		
VAT	0	175	0	0
Tax	93	90		
Payments received on account	0	0	0	0
Other	2,424	4,003	0	0
Total	32,858	35,561	21	2
Total payables (current and non-current)	32,879	35,563		

Other payables include £126k (2011-12 £0) in respect of outstanding pension contributions at 31 March 2013.

26 Other liabilities

Doncaster Primary Care Trust had no other liabilities in either 2012-13 or 2011-12.

27 Borrowings

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
LIFT liabilities:				
Main liability	875	741	27,598	29,610
Lifecycle replacement received in advance	0	0	0	0
Total	875	741	27,598	29,610
Total other liabilities (current and non-current)	28,473	30,351		

Borrowings/Loans - Payment of Principal Falling Due in:

	DH	Other	Total	DH	Other	Total
	31 March 2013 £000s	31 March 2013 £000s	31 March 2013 £000s	31 March 2012 £000s	31 March 2012 £000s	31 March 2012 £000s
0 - 1 Years	0	875	875	0	740	740
1 - 2 Years	0	910	910	0	932	932
2 - 5 Years	0	1,339	1,339	0	1,956	1,956
Over 5 Years	0	25,349	25,349	0	26,723	26,723
TOTAL	0	28,473	28,473	0	30,351	30,351

28 Other financial liabilities

Doncaster Primary Care Trust did not have any other financial liabilities in either 2012-13 or 2011-12.

29 Deferred income

Doncaster Primary Care Trust did not have any deferred income in either 2012-13 or 2011-12.

30 Finance lease obligations

Doncaster Primary Care Trust did not have any finance lease obligations in either 2012-13 or 2011-12.

31 Finance lease receivables as lessor

Doncaster Primary Care Trust did not have any finance lease receivables as lessor in either 2012-13 or 2011-12.

32 Provisions

Comprising:

	Total £000s	Pensions to Former Directors £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Restructuring £000s	Continuing Care £000s	Equal Pay £000s	Agenda for Change £000s	Other £000s	Redundancy £000s
Balance at 1 April 2012	6,781	0	642	13	0	5,755	0	0	371	0
Arising During the Year	11,174	0	0	9	0	11,165	0	0	0	0
Utilised During the Year	(308)	0	(66)	0	0	(44)	0	0	(198)	0
Reversed Unused	(4,687)	0	0	0	0	(4,687)	0	0	0	0
Unwinding of Discount	21	0	16	0	0	0	0	0	5	0
Change in Discount Rate	0	0	0	0	0	0	0	0	0	0
Transferred (to)/from otherPublic Sector bodies	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2013	12,981	0	592	22	0	12,189	0	0	178	0
Expected Timing of Cash Flows:										
No Later than One Year	4,807	0	66	22	0	4,710	0	0	9	0
Later than One Year and not later than Five Years	7,781	0	265	0	0	7,479	0	0	37	0
Later than Five Years	393	0	261	0	0	0	0	0	132	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at 31 March 2013	2,168
As at 31 March 2012	195

Pensions relating to other staff are provisions relating to the premature retirement of former employees. There is no uncertainty about either the value or the timings of these agreed obligations.

Other relates to Permanent Injury Benefits. There is no uncertainty about either the value or the timings of Permanent Injury Benefits, The balance on Back to Back provisions with other NHS organisations was paid off in 2012-13.

In March 2012 the Department of Health announced that it was introducing a deadline for individuals (or their representatives) to submit retrospective claims for assessment for Continuing Health Care (CHC) eligibility. The deadline for periods prior to 31 March 2011 was 30 September 2012 and for periods up to 31 March 2012 the deadline was 31 March 2013.The introduction of these deadlines was accompanied by a nationally co-ordinated publicity campaign to inform the public of their right to apply for CHC eligibility and the timescales.

Doncaster PCT received over four hundred claims before the deadlines and a detailed assessment process on potential eligibility for CHC funding is underway. A methodology has been developed for estimating the level of financial liability arising from the claims submitted. This provides the basis of the provision included in these accounts of £12.189m.

33 Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities		
Equal Pay	0	0
Other	16,223	0
Amounts Recoverable Against Contingent Liabilities	0	0
Net Value of Contingent Liabilities	16,223	0
Contingent Assets		
Contingent Assets	0	0
Net Value of Contingent Assets	0	0

Doncaster Primary Care Trust had three employer's liability claims and one public liability claim outstanding at 31 March 2013. The NHS Litigation Authority has estimated the total contingent liability to be £4,250.

The PCT has estimated that if all claims for assessment for CHC eligibility were successful, other than those that have already been screened out, this would cost £28.412m. The difference between this maximum value and the sum provided in note 32, is £16.223m which is disclosed as a contingent liability above.

34 LIFT - additional information

Doncaster Primary Care Trust has a number of LIFT schemes that under the International Financial Reporting Standards rules requires the financial impact of these schemes to be shown within the financial statements.
There are nine LIFT schemes: Sandringham Road, Denaby, Thorne, Askern, Edlington, Hatfield and Moorends.Conisborough and the Town Centre 8-8 Centre.

The impact of the LIFT schemes on the Statement of Financial Position and the Operating Cost Statement of Doncaster PCT is provided below.

	Commenced	Terminates	Tranche
Sandringham Road	01/01/07	31/12/31	1A
Denaby	01/01/07	31/12/31	1A
Thorne	01/01/07	31/12/31	1A
Askern	29/09/08	28/09/33	1B
Edlington	03/11/08	02/11/33	1B
Hatfield	05/09/08	14/09/33	1B
Moorends	16/06/08	15/06/33	1B
Conisbrough (Stonecastle)	26/07/11	09/07/36	2
Town Centre 8-8 Centre (Flying Scotsman)	25/11/11	09/11/36	2

The LIFT Company: Doncaster Community Solutions (DCS) was established in September 2005 when the Doncaster PCTs reached financial close on three schemes in the first tranche (1A).
Doncaster PCT made a further investment in this company in 2007/08 of £321,000 bringing the total investment to £508,000:
Doncaster PCT made a further investment in this company in 2009/10 of £393,000 bringing the total investment to £901,000:

	Loan stock £000's	Equity £000's	Total £000's
Tranche 1A	184	2	186
Tranche 1B	320	2	322
Tranche 2	393	0	393
	897	4	901

DCS has the responsibility to design, construct and operate the nine LIFT buildings.
At the end of the contract, the PCT has exercised the option not to buy the buildings at open market value.

Charges to operating expenditure and future commitments in respect of on and off SOFP LIFT	31 March 2013 £000	31 March 2012 £000
Total Charge to Operating Expenses in year - OFF SOFP LIFT	0	0
Service element of on SOFP LIFT charged to operating expenses in year	710	588
Total	710	588

Payments committed to in respect of off SOFP LIFT and the service element of on SOFP LIFT.	31 March 2013 £000	31 March 2012 £000
LIFT Scheme Expiry Date:		
No Later than One Year	769	746
Later than One Year, No Later than Five Years	3,269	3,358
Later than Five Years	16,476	18,068
Total	20,514	22,172

Imputed "finance lease" obligations for on SOFP LIFT Contracts due	31 March 2013 £000	31 March 2012 £000
No Later than One Year	3,389	3,281
Later than One Year, No Later than Five Years	11,143	12,415
Later than Five Years	51,991	53,676
Subtotal	66,523	69,372
Less: Interest Element	(38,050)	(39,021)
Total	28,473	30,351

35 Impact of IFRS treatment

	31 March 2013 Total £000	Admin £000	Programme £000	31 March 2012 Total £000
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g LIFT/PFI)				
Depreciation charges	1,309	0	1,309	1,037
Interest Expense	2,941	0	2,941	2,330
Impairment charge - AME	0	0	0	2,460
Impairment charge - DEL	0	0	0	0
Other Expenditure	(467)	0	(467)	588
Revenue Receivable from subleasing	(3,708)	0	(3,708)	(3,045)
Total IFRS Expenditure (IFRIC12)	75	0	75	3,370
Revenue consequences of LIFT/PFI schemes under UK GAAP / ESA95 (net of any sublease income)	(975)	0	(975)	(646)
Net IFRS change (IFRIC12)	(900)	0	(900)	2,724
Capital Consequences of IFRS : LIFT and other items under IFRIC12				
Capital expenditure 2012-13	0	0	0	13,159

36 Financial Instruments

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

Currency risk

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

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

Credit Risk

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

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

36.1 Financial Assets	At 'fair value through profit and loss' £000	Loans and receivables £000	Available for sale £000	Total £000
Embedded derivatives	0			**0**
Receivables - NHS		854		**854**
Receivables - non-NHS		1,799		**1,799**
Cash at bank and in hand		98		**98**
Other financial assets	0	577	901	**1,478**
Total at 31 March 2013	**0**	**3,328**	**901**	**4,229**
Embedded derivatives	0			0
Receivables - NHS		3,079		3,079
Receivables - non-NHS		682		682
Cash at bank and in hand		1		1
Other financial assets	0	1,990	0	1,990
Total at 31 March 2012	0	5,752	0	5,752

36.2 Financial Liabilities	At 'fair value through profit and loss' £000	Other £000	Total £000
Embedded derivatives	0		**0**
NHS payables		9,841	**9,841**
Non-NHS payables		1,826	**1,826**
Other borrowings		0	**0**
PFI & finance lease obligations		28,473	**28,473**
Other financial liabilities	0	21,027	**21,027**
Total at 31 March 2013	**0**	**61,167**	**61,167**
Embedded derivatives	0		0
NHS payables		9,057	9,057
Non-NHS payables		787	787
Other borrowings		0	0
PFI & finance lease obligations		30,351	30,351
Other financial liabilities	0	25,380	25,380
Total at 31 March 2012	**0**	65,575	65,575

37 Related party transactions

Doncaster Primary Care Trust is a body corporate established by order of the Secretary of State for Health.

Doncaster Primary Care Trust has undertaken transactions for funding General Medical Services or Primary Medical Services with all GP practices within it's area. The PCT has included the GP members of the Doncaster Clinical Commisionng Group as Related Parties for the first time.The payments recored relate to the amounts paid to the individual GP's Practice for either GMS or PMS contracts.In addition, the payments made to the other organisations which they either control or influence are noted.

	Payments to Related Party 2012-13 £	Payments to Related Party 2011-12 £	Amounts owed to Related Party 2012-13 £	Amounts owed to Related Party 2011-12 £
Dr A Graves (Dr Inman & Partners) - GMS payments to practice	1,554,540	1,514,756	0	0
Dr A Graves (Hallcross Medical Services Ltd)	667,395	597,917	56,560	0
Dr E Kelly (Bentley Surgery - Dr Fox & Partners)	694,131	0	0	0
Dr N Tupper (Kingthorne Group Practice - Dr Coleman & Partners)	968,386	0	0	0
Dr N Tupper (Hallcross Medical Services)	667,395	0	56,560	0
Dr A Oakford (Dr Brown & Partners)	1,026,800	0	0	0
Dr S Feeney (Mount Group Practice - Dr Berry & Partners)	1,330,297	0	0	0
Dr S Feeney (Hallcross Medical Services)	667,395	0	56,560	0
Dr J Bradley (Hatfield Health Centre - Dr Simmonite and Partners)	956,808	0	0	0
Dr N Seddon (Carcroft Doctors Group - Dr Kerr and Partners)	1,156,308	0	0	0
Dr N Seddon (Chestnut Pharmacy)	617,693	0	0	0
Dr M Pieri (Petersgate Medical Centre - Dr Mckenna and Partners)	861,142	0	0	0
Dr G Harding (Church View Surgery - Dr Corrie & Partners)	693,214	0	0	0
Dr L Britten (Scott Practice - Dr Benson & Partners)	1,359,552	0	0	0
Dr L Britten (Danum Medical Services Ltd)	1,241,379	0	34,472	0
Dr P Barbour (Francis Medical Centre - Dr Braidwood and Partners)	1,582,408	0	0	0
Dr A Zafar (West End Clinic - Dr Taneja & Partners)	542,177	0	0	0
Dr A Zafar (Danum Medical Services Ltd)	1,241,379	0	34,472	0
Dr A Musah-Eroje (West End Clinic - Dr Taneja & Partners)	542,177	0	0	0
Dr A Kirkman (Burns Practice - Dr O'Horan & Partners)	992,961	0	0	0
Dr A Pierce (Mayflower Medical Centre - Dr Saddler & Partners)	841,523	0	0	0

The Department of Health is regarded as a related party. During the year Doncaster Primary Care Trust 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 listed below :

	Payments to Related Party 2012-13 £'000	Payments to Related Party 2011-12 £'000	Amounts owed to Related Party 2012-13 £'000	Amounts owed to Related Party 2011-12 £'000
Doncaster & Bassetlaw Hospitals NHS Foundation Trust	192,099	191,195	5,322	6,288
Rotherham, Doncaster & South Humber NHS Foundation Trust	86,602	84,201	1,058	390
Sheffield Teaching Hospitals NHS Foundation Trust	15,333	15,208	151	427
Sheffield Children's Hospital Foundation NHS Trust	4,047	4,631	193	215
The Rotherham NHS Foundation Trust	5,554	6,310	305	193
Leeds Teaching Hospitals NHS Trust	1,159	1,200	15	49
Mid Yorkshire Hospitals NHS Trust	585	584	50	37
Nottinghamshire Healthcare NHS Trust	10,482	9,999	188	411
Northern Lincolnshire & Goole Hospitals FT	1,156	1,214	0	0
Barnsley Hospital NHS Foundation Trust	357	371	0	0
Yorkshire Ambulance Service NHS Trust	9,977	9,627	28	331
Barnsley Primary Care Trust	47,126	42,316	1,160	0
Rotherham Primary Care Trust	462	57	441	134

In addition, the PCT has had a significant number of material transactions with other Government Departments and other Central and Local Government bodies. Most of these transactions have been with Doncaster Metropolitan Boriugh Cuoncil in respect of joint healthcare provision.

	Payments to Related Party 2012-13 £'000	Payments to Related Party 2011-12 £'000	Amounts owed to Related Party 2012-13 £'000	Amounts owed to Related Party 2011-12 £'000
NHS Supply Chain	140	0	0	0
NHS Pensions Agency	5,559	5,990	142	467
Doncaster Metropolitan Borough Council	18,708	16,407	247	0

Financial Assets :
The LIFT Company was established in September 2005 when the Doncaster PCTs reached financial close on three schemes in the first tranche. LIFTco is now categorised as a related party.The Doncaster PCTs made an investment in this company in 2007/08 of £321,000 bringing the total investment to £508,000.
A further investment was made in 2009-10 of £393,000 relating to LIFT Tranche 2 bringing the total investment to £901,000 which is disclosed under Note 20.
There has been no further investment since.

	Payments to Related Party 2012-13 £'000	Payments to Related Party 2011-12 £'000	Amounts owed to Related Party 2012-13 £'000	Amounts owed to Related Party 2011-12 £'000
Mr David Liggins (Cluster Non-Executive and Vice chair) is Chair and Non-Executive Director of Doncaster Community Solutions Ltd (DCS Ltd).Payments are made by Doncaster PCT to DCS Ltd. relating to lease payments for health centres provided under the LIFT programme.	6,626	5,326	0	0
Mr Steve Hackett (Cluster Executive Director of Finance) is Public Sector Director Doncaster Community Solutions Ltd (Doncaster LIFTco).	6,626	5,326	0	0

38 Losses and special payments

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

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

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

	Total Value of Cases £s	Total Number of Cases
Losses - PCT management costs	24,914	90
Special payments - PCT management costs	0	0
Losses in respect of the provision of family practitioner services	0	0
Special payments in respect of he provision of family practitioner services	0	0
Total losses	24,914	90
Total special payments	0	0
Total losses and special payments	24,914	90

39 Third party assets

The PCT did not hold any cash or cash equivalents at 31 March 2013 on behalf of patients (£0 at 31 March 2012).

40 Pooled budget

The PCT had no pooled budget arrangements in 2012-13 or in 2011-12.

41 Cashflows relating to exceptional items

The PCT had no cashflow related to exceptional items in 2012-13 or 2011-12.

42.1 Events after the end of the reporting period

Under the provisions of the Health and Social Care Act 2012, Doncaster Primary Care Trust was dissolved on 31 March 2013. The PCT's functions, assets and liabilities transferred to other public sector entities as outlined in Note 42 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.*

Transfer of functions as a result of PCT dissolution

In 2012-13 the Revenue Resource Limit for Doncaster Primary Care Trust was £589,845,000. The main functions carried out by Doncaster Primary Care Trust in 2012-13 are to be carried out in 2013-14 by the following public sector bodies:

NHS Doncaster Clinical Commissioning Group:
Commissioning of acute and community healthcare services and GP Prescribing. The Revenue Resource Limit for NHS Doncaster Clinical Commissioning Group in 2013-14 is £422,634,000.

NHS England:
Commissioning of specialised and secondary dental healthcare services, core contract healthcare services (from Primary Care Contractors) and certain Public Health services.

West & South Yorkshire & Bassetlaw Commissioning support Unit
Provision of a range of commissioning support services.

NHS Property Services
Provision of estate management services in respect of properties owned by Doncaster Primary Care Trust up to 31 March 2013;
Management of nine LIFT property leases (transferred to Community Health Partnerships Ltd).

Doncaster Metropolitan Borough Council
Certain Public Health functions.

Transfer of assets as a result of PCT dissolution
Three buildings transferred on 1 April 2013 to Rotherham Doncaster and South Humber NHS Foundation Trust with a value of £4,315k, nine LIFT buildings transferred on 1 April 2013 to Community Health Partnerships with a value of £29,745k and ten buildings transferred on 1 April 2013 to NHS Property Services with a value of £5,619k. All these buildings were considered operational at the year end, and so have not been impaired in the PCT's Accounts. It is for the successor body to consider whether to impair or revalue these assets.