Department of Health

NHS

Lincolnshire Teaching Primary Care Trust

2012-13 Annual Report and Accounts

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Lincolnshire Teaching Primary Care Trust

2012-13 Annual Report

NHS Lincolnshire

Annual Report and Summary Financial Statements 2012/13

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Chairman, Chief Executive and CCG Chairman Foreword

Welcome to the sixth Annual Report produced by NHS Lincolnshire (Lincolnshire Teaching Primary Care Trust), which covers the period 1 April 2012 to 31 March 2013.

The Health and Social Care Act 2012 set out a new vision for the health services in England which impacted on almost every organisation that delivers NHS care. Foremost, the intention of the Act was to abolish Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) from April 2013, and replace with an NHS Commissioning Board (NHS England), and GP led Clinical Commissioning Groups (CCGs).

NHS Lincolnshire played a critical role during 2012/13 by supporting the formation of, and transition to, the receiver organisations, i.e. the four Lincolnshire CCGs, the NHS England Area Team, NHS Property Services, the Commissioning Support Unit, and the complete transfer of Public Health to the Local Authority.

NHS Lincolnshire undertook a comprehensive programme of transition work aimed to ensure the readiness of receiver organisations for the new year of 2013/14. The programme of work included the production of a legacy document, a legacy library and a comprehensive quality handover document so as to ensure the memory of the PCT continues to be available.

At the same time as supporting the transition, NHS Lincolnshire continued business as usual, continued to drive clinical service change, and continued to ensure financial stability.

We would like to pay tribute to the staff members of NHS Lincolnshire who remained committed, professional and hardworking during a period of significant change within the NHS.

Richard Childs
Chairman

David Sharp
Chief Executive

Brynen Massey
CCG Council Chair

The Vision, Values and Principles of the Primary Care Trust

Our Mission:

To work with the people of Lincolnshire to improve health and health services.

Our Vision:

We have a vision of a Lincolnshire where:

People live longer because they are healthier, where the health and services people experience are not determined by age, sex or social class and where people are confident that when they use services they will have a first class experience.

To deliver this vision, we will by 2014:

- Increase life expectancy by 2.3 years for males and 1.5 years for females from 2005-07 levels.
  We expect to see greater change in Boston and Lincolnshire West PBC clusters than North Kesteven and Welland.
- Reduce health inequalities measured by the reduction in life expectancy variants between the least and most deprived populations from 6.7 years (2004-08) to 6.2 years for males and from 4.7 (2004-08) to 4.1 years for females.
  The greatest changes will be required in Skegness and Coast PBC cluster and the Lincoln City Spearhead area.
- Achieve top quartile performance for patient experience.
  This will be measured by the Public Confidence in the NHS metric and informed by patient experience and involvement at a GP practice and Practice Based Commissioning locality.

Values and Principles

Our Values

We have a set of values, embedded in the NHS constitution, which create a framework that applies to all that we do.

Access
Appropriate
Effective
Efficient
Fairness
Honesty
Openness
Safe

Our Principles:

We will:

- Provide and commission comprehensive and high quality services with equitable access for all, based on clinical need.
- Keep people healthy and work to reduce health inequalities.
- Work continuously to improve quality and safety.
- Make the most effective and sustainable use of resources and staff.
- Treat every patient with dignity and respect.
- Be innovative in designing our services to meet the health care needs of our local population.
- Practice and develop equality and non-discrimination.
- Support and value our staff.
- Work in partnership with others to ensure a seamless service for patients.
- Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance.

Who we were and what we did

NHS Lincolnshire was responsible for commissioning (planning and buying) healthcare for people across Lincolnshire – whether visiting general practitioners, seeing a nurse, picking up a prescription, having eyes tested, going to the dentist, or having treatment in a hospital. All of those services had been planned and bought by the PCT on behalf of the public.

The PCT had many different roles and responsibilities but essentially the organisation was here to engage with local people and understand their needs, and improve the health and well-being of the people of Lincolnshire.

During 2012/13 the PCT managed the transition of work required to deliver the vision of the Health & Social Care Act 2012. Four Clinical Commissioning Groups were set up with staff transferred to them. All of them achieved authorisation. The PCT played a major part in the implementation of a Commissioning Support Unit CSU). The Greater East Midlands CSU provides support services for vast area of England. PCT staff also played major roles in the setting up of the Leicestershire and Lincolnshire Area Team of NHS England, and the NHS Property Service organisation.

Our Services

NHS Lincolnshire invested over £1 billion in health care services for the people of Lincolnshire, across hospital services and primary care services. In addition to hospitals, Lincolnshire had

- 101 GP practices
- 66 dental practices
- 88 opticians
- 117 pharmacies

Certain specialist services were purchased from hospitals outside of the county, such as Peterborough, Scunthorpe and Grimsby, Leicester and Nottingham. However, the main providers in the county were United Lincolnshire Hospitals NHS Trust, Lincolnshire Partnership NHS Foundation Trust, Lincolnshire Community Health Services NHS Trust and East Midlands Ambulance Services NHS Trust.

Board members and Senior Management

NHS Lincolnshire Board

The Board has in addition to the Chairman, six non-executive directors, the GP Commissioning Executive Committee Chair and five executive directors (including the Chief Executive, Director of Finance and Director of Public Health).

Mrs Jean Hill, LINkS representative attended the Board meetings and had speaking rights.

Voting Board Members in 2012/13

Mr Richard Childs, Chairman
Mrs Gillian Wing, Non-Executive Director (Vice-Chair)
Mr Roger Buttery, Non-Executive Director
Mr Andrew Middleton, Non-Executive Director
Mrs Marianne Overton, Non-Executive Director
Dr Bob Price, Non-Executive Director
Mr Giles Walter, Non-Executive Director

Dr Brynnen Massey, Chair of the CCG Council/Medical Director (Commissioning)

Mr John McIvor, Chief Executive (up to 30 September 2012)
Mr Andrew Spring, Director of Finance, Performance Management and Contracting (up to 30 September)
Mr Andrew Leary, Director of Finance, Performance Management and Contracting (from the 1 October 2012)
Dr Tony Hill, Director of Public Health
Dr Martin McShane, Director of Commissioning Development and QIPP (up to 31 August 2012)
Mrs Edie Butterworth, Director of Quality, Nursing and Engagement

At its Board meeting on the 24 October 2012, the Board acknowledged that Mr McIvor, Chief Executive had commenced a secondment post from 1 October 2012. Mr David Sharp, Chief Executive had been confirmed as the Accountable Officer for Leicestershire and Lincolnshire Primary Care Trusts and the Local Area Team Managing Director.

At the Board meeting on 19 December 2012, the Governance Manual (incorporating the Standing Orders, Standing Financial Instructions and Reservation and Scheme of Delegation) was changed to amend the titles of the officer members as follows:

- Chief Executive to remain the same; however, by definition this will be 'The Accountable Officer, Chief Executive/LAT Managing Director for Leicestershire and Lincolnshire'.
- Director of Finance to Local Area Team Chief Finance Officer
- Director of Nursing, Quality and Engagement to Local Area Team Director of Nursing
- Director of Public Health (Lincolnshire) – remained the same
- Chair of the GP Commissioning Executive Committee to Chair of the CCG Council.

The LAT Medical Director became a voting member.

Non-Voting Board Members

Dr Bryan Anderson, Medical Director (Quality and Primary Care)
Mrs Wendy Cundy, Associate Director of Organisational Development
The LAT Director of Commissioning and Director of Operations and Delivery attended Lincolnshire PCT Board meetings, but were not voting members.

Commissioning and its Changing Landscape

The White Paper *Equity and Excellence: Liberating the NHS* was published in July 2010 and changed the NHS forever. A key part of the paper was the intention to replace Primary Care Trusts (PCTs) with GP led Clinical Commissioning Groups (CCGs) and the following year's NHS Operating Framework and PCT Cluster Implementation Guidance set the requirement for all PCTs to be clustered by June 2011.

NHS Lincolnshire was designated as a single Cluster and set about its work supporting the development of various new NHS organisations, including the emerging CCGs in Lincolnshire, and transferring its cluster functions. The Health and Social Care Bill – introduced into Parliament in January 2011, passed in March 2012 and receiving Royal Ascent in April 2012 – was another significant milestone for the NHS, paving the way for primary care clinicians to play a pivotal role in future commissioning as part of the CCGs.

NHS Lincolnshire was dissolved on 31 March 2013. Improving healthcare for its population, driving clinical change, ensuring financial stability and supporting the transition and emerging CCGs are the cornerstones of its legacy.

Four CCGs have now been authorised in Lincolnshire. NHS Lincolnshire East CCG, NHS Lincolnshire West CCG, NHS South Lincolnshire CCG and NHS South West Lincolnshire CCG between them are responsible for commissioning the majority of healthcare services for over 700,000 people and have a combined budget of approximately £1 billion.

As membership organisations, Lincolnshire's CCGs rely on the involvement of their combined 101 GP practices, who are now responsible for deciding how best to commission services for their local populations. Whilst each CCG has its own distinct challenges, there are many areas where they will work together, particularly when working to develop better solutions for Lincolnshire.

How we performed during 2012/13

This section details NHS Lincolnshire's performance for key national commissioning targets. In reviewing performance over the year it is not easy to draw conclusions due to the number of competing priorities and the complex and interdependent nature of many health related issues. Therefore comparative data is shown for all indicators where available and the targets structured into theme areas.

The main performance measures were reported each month to the public meeting of the PCT Board. Additionally regular performance reviews were conducted by the Midlands and East Strategic Health Authority prior to October 2012 and with reconfiguration within the NHS, this task was then performed by the forming NHS Commissioning Board Local Area Team.

Public Health (Health Inequalities)

A major challenge for the NHS is to reduce the level of health inequalities – this means giving everyone, whatever their background, equal access to health. There are a number of indicators used by the NHS to assess progress in this area care.

The key national inequalities indicators "All Age All-Cause Mortality" and "Life Expectancy" Lincolnshire rates were slightly above expectation although all continued to improve. Rates were improving year on year and Life Expectancy for both male and females were now in line with the national average (current performance still to be published nationally).

Immunisation rates for pre-school children and HPV vaccination rates for Year 7 girls attending first year secondary school all improved on previous years.

Teenage pregnancy performance remained high risk although since the 1998 baseline year rates had fallen by 34.5% from 50.1 to 32.8 conceptions per 1,000 females (aged 15-17). This is above than the national average reduction of 26.9%, although the local plan was to reduce the rate to no more than 23.0.

A summary of NHS Lincolnshire's performance against public health related targets are given as follows:-

Target description	10/11 Outturn	11/12 Outturn	12/13 Outturn
Diabetic retinopathy - eligible patients offered a test	99.0%	99%	**113.6%**
Diabetic retinopathy - eligible patients screened	74.2%	82%	**76.9%**
Mothers Smoking at Time of Delivery	18.3%	18%	**13.8%**
All Age All Cause Mortality Rate (DSR per 100,000) - Males	665.3	648.1	**n/a**
All Age All Cause Mortality Rate (DSR per 100,000) - Females	487.0	472.0	**n/a**
Life Expectancy (years) - Males	78.3	78.7	**n/a**
Life Expectancy (years) - Females	82.0	82.4	**n/a**
Cancer Mortality Rate (DSR per 100,000 aged under 75) - Males & Females	111.0	109.2	**n/a**
CVD Mortality Rate (DSR per 100,000 aged under 75) - Males & Females	69.9	67.8	**n/a**
Suicide & Injury of Undetermined Intent (DSR per 100,000) - Males & Females	10.0	9.7	**n/a**
Teenage Pregnancy Rate per 1,000 (females aged 15-17)*	37.5	34.3	**32.8**
Childhood Obesity - Reception Year	10.8%	9.4%	**9.8%**
Childhood Obesity - Year 6	19.5%	20.2%	**19.5%**
Childhood Immunisation: Aged 1*	95.1%	95.3%	**95.5%**
Childhood Immunisation: Aged 2*	90.4%	90.6%	**92.3%**
Childhood Immunisation: Aged 5*	82.2%	84.7%	**87.0%**
Childhood HPV vaccination: Females aged 12-13	79.2%	86.3%	**91.1%**
Mothers Breastfeeding at 6-8 weeks	38.9%	39.7%	**39.0%**
NHS Health Checks: Patients Invited	13.8%	14.8%	**17.8%**
NHS Health Checks: Acceptance Rate	77.0%	67.1%	**56.5%**
Smoking Quitters (up to Q3) - per 100,000 popn (aged 16+)*	715.3	716.1	**642.9**
Chlamydia Screening Rates - 15-24 year olds	28.7%	29%	**30.9%**
Admission Rate for Alcohol related conditions (per 100,000 popn EASR)*	1,661	1,772	**1,780**

** forecast or Q3 YTD*

Emergency Care

In order to ensure prompt access to emergency services, the NHS expects that in 95% of cases, anyone attending an A&E department, Minor Injuries Unit or Walk In Centre department is seen, treated and then discharged or admitted to hospital within 4 hours. In 2012/13, 97.1% of patients presenting at a major A&E department or Minor Injuries unit were seen within 4 hours. To support achievement of the target NHS Lincolnshire commissioned primary care “out of hours” services in Lincoln, Boston, Grantham and Skegness to also treat patients who went to an A & E department with minor injuries or minor illnesses. This helped to relieve the pressure on the A & E department enabling them to treat patients with more serious conditions.

Performance against the two Stroke targets care improved markedly over the past 12 months with the opening of two dedicated stroke wards at Pilgrim and Lincoln County hospital sites.
A summary of NHS Lincolnshire’s achievement against emergency care related targets are given as follows:-

Target description	10/11 Outturn	11/12 Outturn	12/13 Outturn
A&E: attendances under 4 hours (NHSL)	97.0%	95.4%	**97.1%**
Ambulance: Cat "A" responses within 8 Mins	72.3%	75.2%	**74.9%**
Ambulance: Cat "A" responses within 19 Mins (with patient transport)	93.5%	92.3%	**92.1%**
Stroke care (patients spending 90% time on stroke ward)*	31.5%	48.8%	**77.7%**
High Risk TIA patient scanned <24 hours*	4.3%	59.4%	**59.2%**

**April 2012 - February 2013*

Waiting times for treatment

2012/13 saw a continued reduction in waiting times. In line with national expectation over 90% of admitted patients, 95% of non-admitted patients were seen, diagnosed, admitted or discharged within 18 weeks of the initial referral by their GP; combined with less than 1% of patients waiting more than 6 weeks for a diagnostic test. For those patients waiting to receive their first definitive treatment, over 92% are waiting less than 18 weeks; again above national expectation.

Prompt access to cancer services considerably improves outcomes of treatment with emphasis to shorten the time from being seen by your GP to being seen and treated in hospital. Patient pathway redesign continued to ensure local GPs with patients initially suspected with cancer or breast cancer symptoms could expect to be referred urgently and seen within two weeks at a hospital clinic. Once referred for investigation, patients could expect diagnosis within 1 month of referral and treatment to begin within 2 months of referral. Patients from NHS Lincolnshire tended to be treated in hospitals within Lincolnshire and to a lesser extent, in Peterborough and Grimsby with some transfers to major centres such as Nottingham.

A summary of NHS Lincolnshire's performance against waiting list related targets is given below:

Target description	10/11 Outturn	11/12 Outturn	12/13 Outturn
Pathways completed within 18 weeks for admitted patients	88.4%	89.7%	**91.2%**
Pathways completed within 18 weeks for non-admitted patients	96.9%	95.6%	**95.9%**
Incomplete pathways within 18 weeks	-	92.3%	**93.3%**
Diagnostic waiters over 6 weeks (of all diagnostic waiters)	-	1.9%	**0.9%**
Direct Audiology patients seen and device fitted (if appropriate) within 18 weeks	98.5%	96.9%	**94.9%**
Cancer: first seen with 2 weeks of GP referral for suspected cancer*	94.8%	95.6%	**95.1%**
Cancer: first seen with 2 weeks of GP referral for sympomatic breast*	92.6%	92.7%	**91.8%**
Cancer: first treated within 62 days from urgent GP referral*	81.5%	81.4%	**84.3%**
Cancer: treated within 62 days from NHS screening service referral*	84.1%	85.9%	**94.0%**
Cancer: first treated within 31 days of diagnosis*	96.4%	97.0%	**97.0%**
Cancer: subsequent treatments by surgery within 31 days*	96.2%	96.6%	**96.4%**
Cancer: subsequently treated with chemotherapy within 31 days*	99.2%	98.8%	**98.4%**
Cancer: subsequently treated with radiotherapy within 31 days*	95.3%	96.2%	**95.8%**
Women who have seen a midwife or maternity healthcare professional by 12 completed weeks of pregnancy**	89.5%	90.5%	**90.0%**

**April 2012 - January 2013*

***Position as at Q2 2012/13*

Quality Measures & Patient Care

Healthcare Acquired Infections (HCAIs) remain an issue for the Health Service. The most commonly known are MRSA (Methicillin Resistant Staphylococcus Aureus) and CDiff (Clostridium difficile). NHS Lincolnshire's performance against targets in relation to Quality Measures is set out below:

Target description	10/11 Outturn	11/12 Outturn	12/13 Outturn
Incidence of MRSA bacteraemia	22	18	**9**
Incidence of C. Difficile	228	215	**186**
Patient Inpatient Experience Survey (ULHT)	74.8	73.3	**73.8**
Mixed Sex Accomodation breaches (rate per 10,000 FCEs)	26.0	1.7	**0.09**
VTE Risk Assessment (ULHT)*	76.8%	86.8%	**90.7%**

**April 2012 - February 2013*

Mental Health

NHS Lincolnshire commissioned extensive services for people who have mental health problems. These are mainly provided by Lincolnshire Partnership NHS Foundation Trust.

Performance remained high in all areas, with new patients identified for Early Intervention and Crisis resolution contacts remaining over 50% above plan; over 95% of CPA discharges followed up within 7 days and IAPT referral and recovery levels ranking Lincolnshire in the top 10% nationally.

NHS Lincolnshire's performance against targets in relation to mental health is set out below

Target description	10/11 Outturn	11/12 Outturn	12/13 Outturn
Number of New Patients with Early Intervention in Psychosis	165	164	**114**
Number of Crisis Resolution/Home Treatments	1,716	1,978	**2,529**
CPA discharges followed up within 7 Days	97.0%	96.1%	**96.5%**
Pyschological therapies: Patients with depression who are referred	14.8%	17.1%	**17.1%**
Pyschological therapies: patients completing and moving to "recovery"	45.1%	51.0%	**54.8%**

Primary & Community Care

There has been continued improvement in local access to NHS dental services. In March 2010, 369,125 people in Lincolnshire had accessed NHS dental services in the previous 24 months. By March 2012 this had increased by an extra 10,000 and continued to grow to over 382,000.

From the national GP survey the proportion of patients satisfied with practice opening times and the proportion of patients with a long term conditions who feel in control of their condition both continued above national levels.

Target description	10/11 Outturn	11/12 Outturn	12/13 Outturn
Health Visitor numbers (WTE)	105.7	104.8	**103.8**
Deaths at Usual Place of Residence (in Home or Care Home)	41.2%	43.9%	**46.5%**
Access to primary dental services (rate per 100,000)	52.7	53.8	**54.2**
Patients with Long Term Conditions in control of condition (National GP Survey)	-	86.7%	**86.5%**
Patients satisfied with GP practice opening times (National GP Survey)	92.9%	92.0%	**92.6%**

Staying Healthy

During 2012/13, the major public health issues have continued to be addressed. The health needs assessment programme looked at sexual health, the health of people with learning disabilities and the health of migrant populations. These were fed into the Joint Strategic Needs Assessment and has led to the development of the Joint Health and Wellbeing Strategy. This identifies health and wellbeing priorities for all organisations in Lincolnshire.

The Public Health Directorate was heavily involved in tobacco control, alcohol treatment and prevention, and obesity programmes to improve health and reduce health inequalities. Public Health specialists had also been working in partnership with many other organisations to improve immunisation, infection control, emergency planning and screening programmes. The Emergency Planning programme includes participation in a major flooding exercise in the county, training of senior staff on their roles in an emergency and a review of all NHS emergency plans. Work had also been carried out on the way in which community recovery will take place after a major incident.

In addition to meeting our objectives and targets in these areas, the PCT planned the transfer of public health responsibilities, budgets and staff to Lincolnshire County Council on 1st April 2013.

Supporting and Valuing staff

As 2012/13 has been the final year of the PCT, the continued focus has been to redeploy as many staff as possible in the new commissioning architecture and limit compulsory redundancies before closure on 31st March 2013. Following the release of the proposed changes by the Department of Health in mid-2010 workforce strategies were reviewed and a robust recruitment vacancy review process maintained. In addition the PCT has worked within the national guidelines and assisted redeployment through job matching and ring fenced recruitment wherever possible and this has enabled 96%of staff to be successfully redeployed in receiver organisations e.g. NHS England (Commissioning Board), the 4 Lincolnshire Clinical Commissioning Groups, Health Education England, the Local Authority, GEM Commissioning Support Unit and NHS Property Services Ltd.

Being in the final year, the PCT opted out of the national staff survey as results would not have been released in time to develop action plans, however, a local survey was conducted In January 2013 and the results showed an increased level of anxiety in staff regarding the new receivers and their futures, as some areas are still relatively immature. This was largely expected and mitigation was put into place to share the results with the receiver organisations so they could start working with staff and increase communication and engagement. The established partnership with PCT and regional staff side colleagues has been instrumental in limiting employee relations issues in the final year. Any grievances raised have been dealt with in line with local policy and have been reviewed quickly and effectively where possible for all parties. Staff side colleagues have played a vital role both in formal procedures and informal, development activities so that the staff 'voice' has been heard. Quarterly Workforce data has formed part of the monthly NHS Lincolnshire Board reports and is available on the website.

Learning and development has still been encouraged though there have been less opportunities for formal courses within the PCT, this has been largely due to capacity issues during transition, both in terms of delivery and attendance. However, there have been an increase in the numbers of staff accessing regional courses e.g. the East Midlands Leadership Academy and access to performance coaching and leadership diagnostics, which has been funded by NHS Lincolnshire.

Whilst most workforce issues have been resolved prior to the PCT closure, there are some outstanding issues that are still being raised and a small Legacy Management Team has been retained to deal with these for 3-4 months, to ensure ex-employees are still supported.

Sickness Absence and Ill Health Retirements

Absence metrics are produced on a monthly basis and form part of the quarterly workforce metrics reported to the Board. Reports include the overall percentage of staff absent, compared to the total number of staff in post, a breakdown of both 'long term' and 'short term' absence and 'days lost', based on the 'Full Time Equivalent' (FTE). The Department of Health requires that the Annual Report provides information on sickness levels and ill health retirements during the last full calendar year. The figures for 2012/13 are shown below:

Staff Sickness Absence

Public bodies must report sickness absence data. The data must be consistent to permit comparison and aggregation across the NHS and consequently the Department has issued 2012 calendar year data for use by all NHS bodies. Unfortunately, the national data includes employees of Lincolnshire Community Health Services NHS Trust. Therefore the following information, relating to the 2012/13 financial year, has been obtained from local information sources:

- Total days lost 8685
- Total staff years 560
- Average working days lost 15.5

Retirement through ill health

Total additional pensions liabilities accrued in the year were £350,000 (5 staff). (In 2011/12 it was £181,000 and 2 staff).

These figures are higher than 2011/12 as the overall headcount increased by approximately one third in April 2012 due to a Tupe transfer of Estates and Facilities staff from community health services (some having significant long term health issues). Transition has also undoubtedly played a factor in increased sickness levels in the PCT - staff anxiety and stress associated with potential threat of redeployment or job loss. Overall the sickness absence average for 2012/13 was 4.36% (2011/12 was 3.82%)

Off payroll engagements

Off payroll engagements are those where individuals undertake work that has the characteristics of employment but individuals are not paid through the payroll. Concern exists that PAYE Income Tax and National Insurance may not be properly paid for workers treated as either self-employed staff or engaged through an intermediary (such as an agency or limited company). HM Treasury has placed a new requirement on NHS bodies to disclose information in the Annual Report on

- off payroll engagements costing over £58,200 per annum that were in place as of 31 January 2012; and

- new off-payroll engagements between 23 August 2012 and 31 March 2013, for more than £220 per day and more than six months.

Although the PCT has had off payroll engagements, these have been for agency staff and did not reach either of the disclosure thresholds,

Equality and Diversity

NHS Lincolnshire set five equality objectives for the year. They were:

1. Improve awareness of the Equality Delivery System with Clinical Commissioning Groups
2. Develop the Equality and Diversity Impact Assessment process as part of Powersteering
3. Improve the data collection of ethnicity and other protected characteristics, embedding this as part of our planning process
4. Promote anti-discriminatory practice in the workplace and promote the reporting process if discrimination occurs.
5. Implement the Equality and Diversity Competency Framework with NHS leaders at all levels.

Progress towards objectives:

1. Clinical Commissioning Groups are aware of the Equality Delivery System (EDS), having had training on the subject. In addition, all Clinical Commissioning Groups have an Equality and Diversity Strategy and Action Plan, based on their self-assessment using the EDS and validated by agreement of the EDS Community Panel.

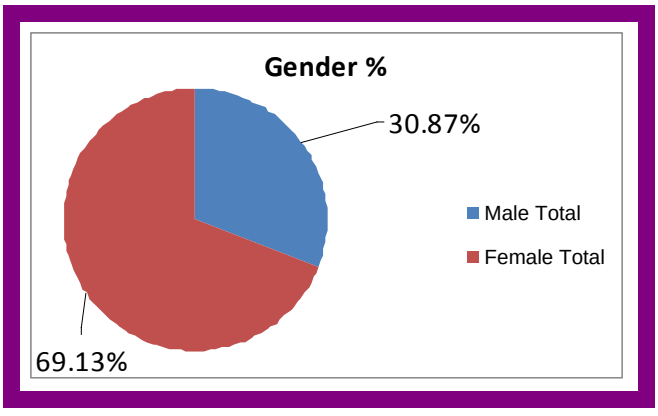
2. A joint process has been developed to carry out Equality Impact Assessments in tandem with Quality, Health Inequality and Privacy Impact Assessments. This has been embedded into the Powersteering project management process and has been successfully implemented.

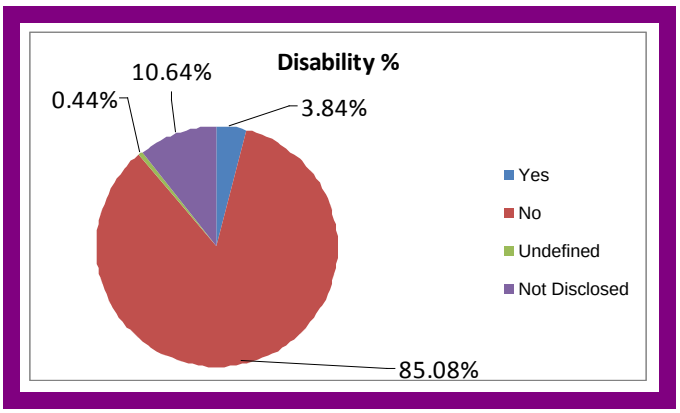
3. Capturing the data of patients by protected characteristic is now part of the quality schedule for Provider organisations and will be reported on quarterly in order to use it as part of the planning process from April 2013 onwards.

4. Work has been carried out to raise awareness of anti-discriminatory practice as part of our staff training programme.

5. A local Equality and Diversity Competency Framework has been developed and is being promoted via training.

Workforce Information by protected characteristic

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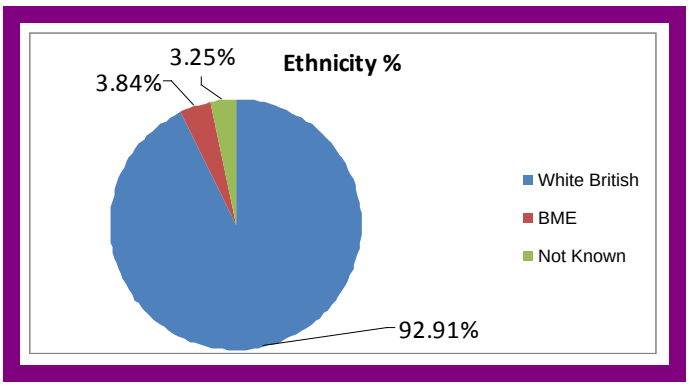
Not Disclosed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BME
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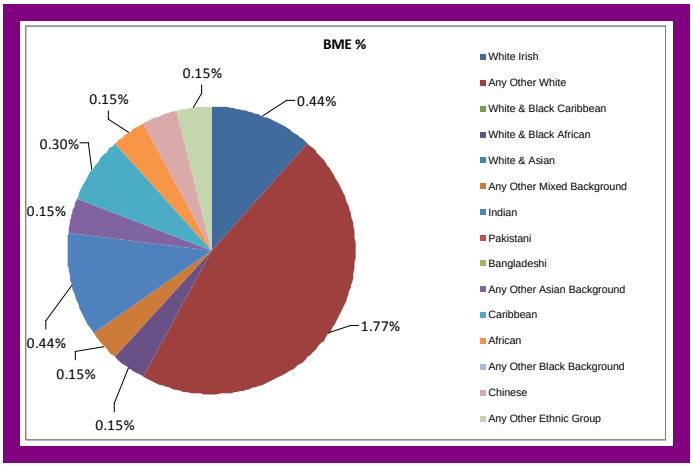
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0.15%
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Any Other White
White & Black Caribbean
White & Black African
White & Asian
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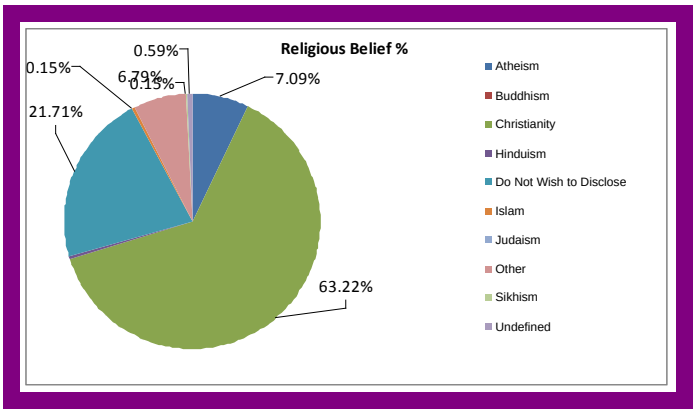
Pakistani
Bangladeshi
Any Other Asian Background
Caribbean
African
Any Other Black Background
Chinese
Any Other Ethnic Group


Religious Belief %
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0.15%
6.79%
0.13%
7.09%
21.71%
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Buddhism
Christianity
Hinduism
Do Not Wish to Disclose
Islam
Judaism
Other
Sikhism
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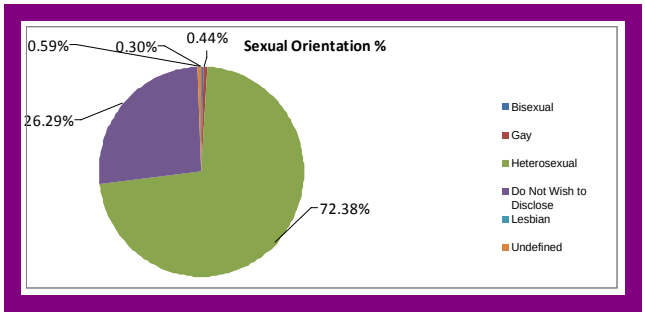
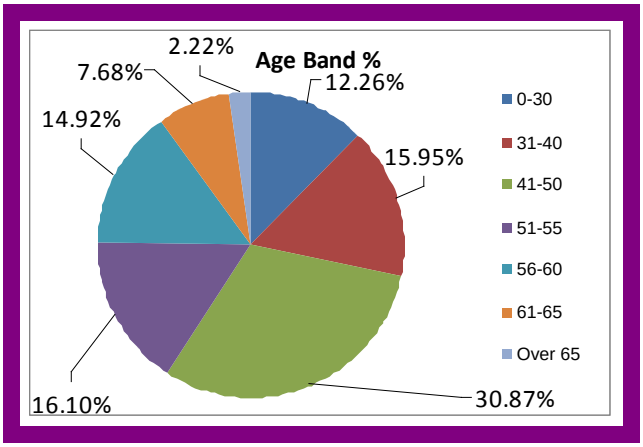




The organisation has a current Equality and Diversity policy and a policy on supporting disabled people. We are a Disability Symbol holder and a Mindful Employer.

Improving Quality and Involvement

NHS Lincolnshire recognised that it would only achieve its vision of reduced inequalities and improved health by securing high quality services for the people of Lincolnshire and therefore, continued to develop its systematic approach to the inclusion and embedding of quality at all stages of the commissioning cycle during 2012/13.

Engaging with the public and assuring patient safety was a high priority within NHS Lincolnshire and the PCT encouraged a culture of learning from experience. Systems were in place by which recommendations for learning arising from national reports were addressed and acted upon. Systems were in place as part of a local quality framework to monitor and review the quality encompassing the patient experience, patient safety and clinical effectiveness of the services of Providers.

NHS Lincolnshire worked in synergy with the ever maturing Clinical Commissioning Groups throughout 2012/13 to ensure a smooth transition into the new system where they would be able to maintain and further build on the robust approach to quality and involvement established.

Communications and Engagement

Excellent communications and involvement (incorporating patient and public involvement) was critical for the organisation's effectiveness and performance.

'No decision about me, without me' was about putting patients at the heart of the NHS. This meant a transformation of the relationship between the NHS, public and patients. NHS Lincolnshire continued to develop a systematic approach to communication, engagement and consultation which was integral to and underpinned its plans and related business processes and aligned to other associated documents such as the Organisational Transition Plan to improve health outcomes for the people of Lincolnshire.

Over the past year NHS Lincolnshire, working with Clinical Commissioning Groups (CCGs) continued to improve the overall health and wellbeing of the local population by speaking to and listening to local people, and discussing how the PCT plan and commission health services that are effective, efficient and safe. We developed a systematic approach to engagement and involvement, integral to business processes. The emerging CCGs therefore had a strong foundation on which to build on, and develop the legacy of meaningful patient and public engagement.

The PCT sustained a comprehensive Communications and Engagement Forward Work Programme for 2012/13 that was aligned to national, regional and local policy and the overall transition/QIPP programme. All communications and engagement activities were coordinated and consistently deployed and opportunities for collaborative working were sought wherever possible both in the NHS and with partner organisations to achieve efficiencies and improve the experience of those involved.

We continued to work closely with partners to establish local networks, implementation teams and forums, to ensure the effective involvement of a wide range of partners, stakeholders and the public in the development of local services. These networks played a vitally important role in the planning and commissioning of services within Lincolnshire Clinical Commissioning Groups (CCGs) and ensured effective clinical engagement across the health and social care system. We worked proactively with the Lincolnshire HealthWatch Pathfinder, for example, CCG Patient Participation Groups.

NHS Lincolnshire corporate communication and engagement programmes involved a wide range of activity on a national, regional and local basis, examples included:

- e-communications via NHS Lincolnshire website and social media e.g. Twitter, Facebook
- Inappropriate use of A&E, 111 (Urgent Care) Number
- Healthy Schools Initiative
- NHS Health Check
- Breast Feeding Awareness Week
- Childhood Obesity Reductions
- Dental Access
- Integrated Strategic Plan
- Transition Plan
- Patient Revolution Ambition (Family Friends Test, Real Time Patient Experience)
- Shaping Health for Mid Kesteven
- Transforming Mental Health Services for Lincolnshire
- Information Governance
- Developing CCG Vision and Goals
- Patient Participation Group evaluations
- Patient representatives
- CCG Equality Delivery Systems
- CCG Communication and Engagement Strategies

The key priorities in delivering the SHA Patient Revolution Ambition were reflected in the NHS Lincolnshire Patient Revolution Action Plan to deliver a customer services revolution; community and citizen partnership and patient experience at the clinician patient interface, including shared decision making. NHS Lincolnshire worked closely with Lincolnshire CCGs to create a culture of customer care and patient and public involvement including:

- CCG Authorisation and beyond – building on the legacy of NHS Lincolnshire we supported the CCGs with the production and implementation of robust Communications and Engagement Strategies, Action Plans

- Working closely with Lincolnshire Local Involvement Network (HealthWatch Pathfinder) to support CCGs in the development of GP Practice Patient Participation Groups.

- Commissioning the East Midlands Patient Experience (EMPES) Survey to triangulate patient experience with outcomes for patients

- Shaping Health Programme which came to national recognition setting the benchmark example of best practice in engaging the public, led by clinicians in planning service changes, for example, Shaping Health for Mid Kesteven, Transforming Mental Health Services for Lincolnshire has adopted the Shaping Health principles

- Creating a patient revolution system - analysis of NHS Choices, Patient Opinion and local and national surveys; in terms of early warning the use of intelligence from Patient Advice Liaison Service (PALS) feedback, patient experience stories, complaints and MP correspondence is triangulated and used to help inform commissioning decisions

- Working closely with our statutory representatives, such as the local authorities, specifically, robust and transparent arrangements are in place with local Health Scrutiny Committee and HealthWatch Pathfinder, such that issues were raised on both sides, for the benefit of the patients

The NHS Lincolnshire Shaping Health Programme was seen as an exemplar of good communications and engagement by the Department of Health.

Complaints Management

Patients have a right to complain about any aspect of NHS service which they feel has not been of an adequate standard or if they feel they have not been treated in the way they would expect. NHS Lincolnshire actively encouraged comments, complaints, and suggestions regarding the services provided by the organisation and those commissioned by NHS Lincolnshire, on behalf of the local population. Feedback from members of the public was a valuable method of assessing and improving the quality and range of services in Lincolnshire.

With effect from 1 April 2009 NHS and Adult Social Care organisations implemented a single approach to the management of complaints. The reform of the complaints procedure, instigated by the Department of Health, enabled greater personalisation of the investigation and management approach and supported greater flexibility to respond to complaints within a timeframe which reflected the complexities and requirements of the issues under investigation.

In terms of responding to the complaint following investigation of the issues identified, NHS Lincolnshire's Complaints Team continued to aim towards providing a full response within 25 working days. Where a more complex complaint was identified, an extended timescale may, however, have been negotiated at the outset of the complaints process.

Learning Lessons to Improve the Patient's Experience

In 2012/13 NHS Lincolnshire received 292 complaints. A significant number of new complaints related to transport and reflected difficulties encountered by patients when trying to book and secure transport. The underlying cause of these difficulties was addressed as a matter of extreme urgency by the provider and the number of formal complaints received by NHS Lincolnshire later declined.

85% of the complaints received were acknowledged within the three working days timescale.

It is worth noting that the total number of complaints included some complaints which were forwarded to independent contractors to respond directly to the complainant. The response time frame for these complaints is not, therefore, directly within the complaints team's authority to enforce.

Complaints about services provided by NHS Lincolnshire were managed directly by the NHS Lincolnshire Complaints Team.

During 2012/13, 89% of completed complaints were responded to within timescales as agreed in the complaints management plan, as negotiated with the complainant.

To promote a more satisfactory resolution of a complainant's concerns, NHS Lincolnshire's complaints team prioritised meeting complainants at the beginning of the complaints process.

NHS Lincolnshire received a number of contacts which had the potential to become complaints, however, as a result of active management, they were resolved before they went on to become formal complaints. NHS Lincolnshire recorded a total of 552 miscellaneous contacts in 2012 – 2013

The miscellaneous contacts received often related to persons requiring support in resolving a problem, rather that making a formal complaint and therefore earlier signposting to the PALS Service to offer appropriate advice and support was offered. The complaints received by NHS Lincolnshire during 2012/13 are recorded in the table below (please note that at the time of writing there are 18 cases that are ongoing):

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Upheld	9	10	12	7
Partially Upheld	19	11	9	10
Not Upheld	15	14	5	13
Not progressed	13	8	0	10
Ongoing	14	36*	37	33

The PCT followed the principles of the Health Service Ombudsman as set out in the 'Principles of Remedy' document. These principles included being open, transparent and accountable, acting fairly and proportionately, and putting things right.

The Principles for Remedy can be viewed at http://www.ombudsman.org.uk/improving-public-service/ombudsmansprinciples/principles-for-remedy

Examples of how these principles have been adopted are given below.

Getting it right?

NHS Lincolnshire considerd “getting it right” an issue of high importance in its handling of complaints. Developing a good working relationship with complainants was an important way of achieving this. Making the service accessible to complainants through home visits with service managers and careful clarification of complainants concerns at the early stages of the complaints process, supported the organisation’s aim to be proactive and client centred when responding to identified issues.

Being customer focussed and putting it right

In accordance with the guidance issued on 1 April 2009, NHS Lincolnshire continued to promote an individual approach to the management of patient complaints. Complainant care was a high priority. The organisation strived to ensure that patients were kept up to date and that its response was patient centred.

In the event that a complaints investigation indicated that the standard of service delivery (which caused the complaint) could have been better, NHS Lincolnshire provided an apology and gave a clear explanation of why things may have gone wrong. Organisational learning was a core element of the complaints process. Steps taken to prevent reoccurrence of the circumstances and identification and monitoring of lessons learnt demonstrated the organisation’s commitment to this.

Acting fairly and proportionately

NHS Lincolnshire considerd all complaints carefully and seriously. Organisation staff were trained to undertake complaints investigations, and to manage and receive complaints from members of the public so as to promote confidence and access to the complaints service.

The complaints team was an important source of initial support for individuals who wished to raise a concern or comment about the services provided or commissioned by NHS Lincolnshire. Independent support was also offered to complainants at the outset of their complaint. The availability of complaints leaflets in a range of different languages, coupled with access to specialist language and communication services further assisted access to the complaints process.

Complaints were also raised through a range of different routes, including verbal, email and by letter. The organisation encouraged complainants to raise their concerns in whichever way they felt most comfortable.

Seeking continuous improvement

NHS Lincolnshire continued to be committed to fostering a culture of improvement and learning. The organisation learnt from complaints in different ways across the organisation.

All staff were provided, as identified, with training to promote their skills at receiving and responding to complaints in a proactive and patient centred way. Individual teams used the outcomes and findings of complaints investigations to refine local practice and facilitate learning and development.

The Risk and Governance Management Committee and NHS Lincolnshire Board received regular reports about the number and type of complaints received by NHS Lincolnshire, to support service improvement at a strategic level.

Conciliation

The role of the conciliator was to help resolve a complaint by assisting both parties to reach a common understanding. A total of five complaints had been the subject of conciliation between 1 April 2012 and 31 March 2013.

The Parliamentary & Health Service Ombudsman

From 1 April 2009, there had been a single approach for dealing with complaints about NHS and adult social care services. If local resolution had not been achieved, and the complainant wished to take their case further, they could ask The Parliamentary & Health Service Ombudsman to review the matter.

Between 1 April 2012 and 31 March 2013, three cases were referred to the Parliamentary & Health Service Ombudsman.

Learning Lessons and Improving Services

NHS Lincolnshire was committed to learning lessons from complaints to improve future services. A number of improvements have been made to our service, as a result of receiving complaints:-

- Provider staff training regarding the management of waiting lists.
- Improved communications between GP practice staff and patients regarding the changes of patient personal information eg addresses, the communicating of test results.
- Additional equipment and furniture secured to support good service deliver.
- Responsiveness in relation to patient transport services.

Freedom of information

The Freedom of Information Act has the purpose of promoting greater openness by public authorities. It gives the public a general right of access to all types of recorded information held by public authorities. Full access was granted in January 2005. This meant members of the public could question the decisions of public authorities more closely and therefore could help to improve the delivery of services provided by the public sector. The Act recognised that you have the right to know how public services, such as the NHS, are organised and run, and how much they cost. You also have the right to know which services are being provided, the targets that are being set, the standards of services that are expected and the results achieved.

As a public authority, NHS Lincolnshire had a legal duty to produce and maintain a Publication Scheme that informed the public how and when it would make information available. NHS Lincolnshire was committed to supporting the legislation and conducted an open and honest service for its staff, patients, carers and the public.

NHS Lincolnshire received a total of 274 Freedom of Information requests in 2012/13.

Reporting of Personal Data Related incidents

Summary of NHS Lincolnshire Information Governance incidents for 2012/13. The table below represents information Governance incidents /Personal data incidents reported by NHS Lincolnshire staff for the period 1 April 2012 to 31 March 2013. With the exception of one incident which was classified as a ‘1’, the incidents identified below were classified at a severity rating: 0 (zero) utilising the Department of Health’s Risk Assessment tool.

As identified above 1 reported was considered to be of a serious nature. The single incident classified as a '1' related to an incident reported by NHS Lincolnshire on behalf of an independent contractor. Since then, this incident has been reviewed and downgraded.

Table 1:

Category	Nature of Incident	Total
I	Loss of inadequately protected electronic equipment, devices or paper document documents from secured NHS premises	0
Ii	Loss of inadequately protected electronic equipment, devices or paper documents outside secured NHS premises	1
Iii	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
Iv	Unauthorised disclosure	1
V	Other	13
Total		**15**

Research Governance

NHS Lincolnshire had a robust research governance process in place to ensure that all research carried out within the organisation involving patients, service users, staff, or their organs, tissue or data, was safe and of high quality. Research governance is a statutory responsibility and all NHS Lincolnshire approval processes were conducted in accordance with national and local policies. Lincolnshire Community Health Services (LCHS) provided all research governance services to NHS Lincolnshire under a service specification agreement.

All health research must follow the Research Governance Framework for Health & Social Care 2nd edition (DoH 2005). This framework provides guidance for researchers to ensure they uphold high ethical and scientific standards, promote good practice, reduce adverse events, and prevent poor performance, fraud and misconduct.

Research Process

Health research generally falls into one of two categories; studies which have been adopted onto the National Institute for Health Research (NIHR) Portfolio and those which are not adopted.

NIHR Portfolio studies were processed though the Coordinated System for gaining NHS Permissions (CSP) before being presented to NHS Lincolnshire, via the LCHS Research & Development team, for sign off. NHS Lincolnshire had statutory responsibility for the studies and as such, the ultimate approval decision laid with the organisation. The CSP system was managed by the Comprehensive Local Research Networks (CLRN); the local network being Trent CLRN. The Trent CLRN Senior Managers and the Research & Development team worked closely together on studies to provide a streamlined sign off process. NHS Lincolnshire had representation on the Trent CLRN Board ensuring that the organisation was up to date and contributed to any changes in health research.

Non-portfolio studies were governed by the LCHS R&D Team on behalf of NHS Lincolnshire in line with the requirements of the Research Governance Framework 2nd edition 2005, ensuring a robust approval process. In addition, studies were regularly monitored and audited for quality to confirm compliance with standards and that patients and staff were protected. Approval was sought from service managers and checks for each study were carried out by the Caldicott Guardian and Data Protection team, as well as the checks conducted by the research team. So as to ensure continuing quality, research issues were raised at the quarterly Lincolnshire Health & Social Care Steering Group which reported to the Risk & Governance Committee. Research colleagues from across the Trent region were also consulted on local and national issues. Changes to the processes were then made as necessary and as advised by the Department of Health.

The national Research Passport scheme is fully implemented to provide researchers, NHS Organisations and universities with a streamlined system for issuing honorary research contracts and letter of access, where appropriate, and clear guidance on their use.

NHS Lincolnshire worked closely with LCHS, Universities and the Research Support services so as to ensure any application for health research funding was appropriate, of high quality and demonstrated clear outcomes; and to assist academic research partners to meet the necessary governance requirements for NHS Trust approval.

Current Research

During 2012/13 there were 59 active research studies; 47 studies are adopted onto the NIHR portfolio, and 12 were non-portfolio studies. 100% of studies were monitored and an annual audit inspected 10% of all studies.

The research team held quarterly research forums, presented at conferences and issued newsletters and leaflets, in order to raise awareness and to help people understand the importance of health research and its proper governance.

Sustainable Development

NHS Lincolnshire was able to accurately report on its Carbon Footprint for the 3rd year running and include all scope 1 and 2 categories and several scope 3. The carbon footprint was decreased by a further 7.9% compared to the previous year to 5,872 tonnes CO2e. Between 2009/10 and 2011/12 the carbon footprint had decreased by 17.6%, this exceeded the NHS reduction target of 10% by 2015.

Throughout the process of transition NHS Lincolnshire had continued a leading role within the East Midlands on Sustainability and within the wider Midlands and East region of NHS Property Services. All NHS Lincolnshire properties were transferred onto the GPS framework agreement so as to ensure getting best value on utility contracts.

Recycling increased both in the general waste stream and the clinical waste stream, the target for 2012 was 90% of waste to be recycled, this was exceeded by a recycling rate at 92.96%. This was achieved as the majority of general waste goes through a materials recycling centre and the clinical waste was used as a refuse derived fuel in a cement kiln.

A project to install smart meters across the PCT property portfolio began in September 2012 and the contract was signed in February 2013. The AMR meters provide half hourly data on gas, electricity and water use and provide this data via a web portal. This allowed the issuing of 100% accurate utility bills and gave building users access to energy use data to aid with energy saving campaigns.

From the 1st April CCGs will be required to have a Sustainable Development Plan and Lincolnshire and Leicestershire NHS Property Services Team will be offering assistance to the four CCGs in Lincolnshire in order to fulfill this requirement. NHS Lincolnshire Estates team have contributed towards the Midlands and East Region Sustainable Development Plan which will contribute towards the national NHS Property Services Sustainable Development Plan.

Information Management and Technology

The main focus of the information management and technology work during 2012/13 was the transition work to support the readiness of the new organisations of 1st April 2013. The PCT produced a Legacy Document to support the new organisations to access the history of the PCT, and a Legacy Library includes all PCT information and data that the new organisations may need access to. The PCT undertook a thorough document archive programme.

As more and more frontline NHS staff rely on technology for their day-to-day patient information needs, and services use mobile devices rather than desktop computers to support care closer to home, so the workload in IM&T had increased, however, the identification of equipment to be transferred to each new organisation was achieved.

The Choose & Book team also undertook a programme of change work to ensure readiness for the service provision post 31st March 2013.

Board Meetings

The Board, whose key role was to set the strategic direction of the organisation and to ensure high standards of corporate governance, manages the business of NHS Lincolnshire.
The PCT Board had been in place since the formation of the PCT on 1st October 2006. During June 2011, the Cluster Board Committee was established. The Cluster Board Committee ensured the PCT continued to operate effectively until its disestablishment to deliver the NHS Lincolnshire strategic objectives as set out in the Integrated Plan. The Cluster Board Committee was responsible for managing the transfer of residual functions from the PCT to the successor organisations and to manage the closedown of the PCT in line with guidance from the Department of Health, legal requirements and guidance from the Strategic Health Authority whilst ensuring accountabilities were maintained.

During October 2012, changes to the Chief Executive and Executive Directors were made in line with Department of Health instruction. The Director of the National Commissioning Board Leicestershire and Lincolnshire Area Team (NCBAT) became the Chief Executive and Accountable Officer of the PCT Cluster, the NCBAT Director of Nursing became the Director of Nursing, Quality and Engagement, and the NCBAT Director of Finance became the Director of Finance of the PCT Cluster. To enable the NCBAT Directors to attend both the Lincolnshire and Leicestershire Cluster Board meetings, during the autumn of 2012, the Cluster Board meetings became bi-monthly.

This resulted in only two Board meetings not taking place, that is the November 2012 and January 2013 meetings. However, during November 2012, the Corporate risk Register, Board Assurance framework and Quality and Safety performance reports were presented to the Risk and Governance Management Committee. Finance reports were distributed to all Board members monthly. Performance reports were being presented to each Clinical Commissioning Group Governing Body on a monthly basis, and at monthly National Commissioning Board meetings with the Area Team. The attendance record of the Board was excellent, being fully quorate throughout the year of 2012/13.

The GP Commissioning Executive Committee/CCG Council

During June 2011, the arrangements for the Professional Executive Committee were revised, the outcome being the GP Commissioning Executive Committee (GPCEC). The GPCEC embedded the clinical leadership at the heart of commissioning in Lincolnshire and supported the transition to the new model of GP commissioning set out in the NHS White Paper. The Committee was responsible for advising the NHS Lincolnshire Board on its commissioning strategy, resource utilisation in line with health needs, and decommissioning and reinvestment across all pathway groups. It underpinned the commissioning of safe, clinically effective high quality services to improve the health and wellbeing of people in Lincolnshire and to reduce inequalities. The Committee received regular reports from the Organisation's Prescribing and Clinical Effectiveness Forum (PACEF) which was the strategic advisory network which had responsibility for ensuring cost effective use of medicines and other healthcare interventions. During June 2012 the GPCEC became the CCG Council. The attendance record of the GPCEC and the CCG Council were excellent, being fully quorate throughout the year of 2012/13.

The Audit Committee

The Audit Committee was chaired by a Non-Executive Director. The Committee met six times during 2012/13 and reported directly to the Board. Its role included the consideration of detailed reports with recommendations for the improvement of the PCT's systems of internal control. The Committee formulated and agreed the annual audit plan, driven by the Board Assurance Framework and the Risk Register. Senior managers attended meetings of the Audit Committee, as did both the internal and external auditors, as well as Counter Fraud managers, and once a

year the Committee met the auditors on their own for private discussions. An Audit Committee Annual Report was presented to the Board annually.

The 2012/13 report was presented to the Board during May 2013 and included comments regarding the Organisation's internal financial control, counter fraud arrangements and any investigations, maintenance of accountability records, and the reliability of financial information. The Committee regularly undertook a review of the plans to produce the final accounts, which provided assurance that functions were being carried out under appropriate statutory powers with proper delegated authorities in place throughout the year. The Committee received the annual report of the Counter Fraud Service. The Audit Committee reviewed the reliability, integrity and comprehensiveness of assurances to meet the needs of the Board and the Accountable Officer, the adequacy of relevant policies, legality issues and codes of conduct, and reviewed the methods in place to counter fraud and corruption. The attendance record of the Audit committee was excellent, being quorate throughout the year.

Members of the Audit Committee:

Mr Roger Buttery, Non-Executive Director (Chair)
Mr Andrew Middleton, Non-Executive Director
Mrs Marianne Overton, Non-Executive Director
Mr Giles Walter, Non-Executive Director

Clinical Commissioning Group Committees

In September 2011, the Board approved the establishment of Clinical Commissioning Group Committees to the Board which were implemented and well attended. The four Clinical Commissioning Group Committees were established so as to work towards authorisation, and the delivery of the QIPP plans.

Clinical Commissioning Group Council

The Clinical Commissioning Group Council is chaired by the GP Chairof one of the four Lincolnshire Clinical Commissioning Groups. Membership of the group included the GP Chairs of all Clinical Commissioning Groups, the Accountable Officers, the Chief Finance Officers, the Public Health and PCT Directors. The minutes of these meetings were presented to the Board.

The Remuneration and Terms Of Service Committee

The Remuneration and Terms of Service Committee members were Non-Executive Directors except the Chair of Audit Committee. The purpose of the Committee was to agree on behalf of the Organisation, about appropriate remuneration and terms of service for the Chief Executive, Executive Directors, and other Directors including all aspects of salary, provisions for other benefits, arrangements for termination of employment and other contractual terms.

Declaration of Interests

The declared interests of the NHS Lincolnshire Board Members during 2012/13 are detailed below:

R Childs	Member of Fitness to Practice Committee, General Dental Council Commissioner for the Commission of Rural Communities Director and principal for the Community Safety Consultancy Ltd (non health consultancy) Non-executive Director of ACPO CPI Ltd (non health licensing body)
R Buttery	Director - Hadrian Trustees Ltd Deputy Chairman, Board of Governors, University of Lincoln (until December 2012) Member of the Chartered Institute of Public Finance and Accountancy Trustee and Chairman – TransLinc Pension Scheme Trustee Director of the Shipbuilding Industries Pension Scheme Trustee of the Center Parcs Senior Staff Pension Scheme
G Wing	Non-Executive Director – South Holland Citizens Advice Bureau Non-Executive Director ACIS Housing Group Owner of Strawberry Glass Committee member of Lincs Artist Forum and representative on the Creative People and Places Consortium Member of the Health and Art Steering Group at Realitas Community Arts Centre (registered charity)
A Middleton	Lay Member of the National Clinical Audit and Enquiries Group Board member, National College for School Leadership (for training senior children's services staff) Lay member of East Midlands Advisory Committee for Clinical Excellence Awards
M Overton	Director – Biosearch Expeditions Elected Member – Lincolnshire County Council Elected Member – North Kesteven District Council Trustee (voluntary role) for Relate Lincolnshire Business Champion - East Midlands Development Agency Vice Chairman – Society of Biology (East Midlands) Vice Chairman of the Local Government Association for England and Wales
R Price	Vice President – British Paralympic Association President of the International Sports Federation for Persons with Intellectual Disability
G Walter	Director and Controlling Shareholder- Cammeringham Properties Ltd Director and Shareholder of Tillbridge Developments LLP Trustee at Frederick Andrew Convalescent Trust Trustee at Caterham School Wife - PA at the Ingham GP Surgery
J McIvor	Wife employed part-time by Lincolnshire Partnership NHS Foundation Trust Ad hoc consulting for Accession Healthcare Consulting Ltd Ad hoc consultation with Adephi Market Research
E Butterworth	Nil

B Massey	Senior Partner at North Thoresby Practice Acting Chair of the Lincolnshire East Clinical Commissioning Group Member of St Andrews Hospice Shareholder in Louth and District Medical Services (LADMS) Wife works at North Thoresby GP Practice
M McShane	Wife - Consultant at Doncaster and Bassetlaw Foundation Trust Academy Associate: East Midlands Leadership Academy Occasional Consultant for Cumberlege Connections Project work- Mckinseys Management Consultants on behalf of NHS Lincolnshire on a time bank basis Adhoc consulting for Accession Healthcare Consulting Ltd
A Spring	Nil
A Hill	Executive Director of Lincolnshire County Council Member of the Governing Body of Bishop Grossteste University Member of Lincoln Diocesan Synod
D Sharp	Member of the Chartered Institute of Public Finance and Accountancy Member of the Chartered Institute of Certified Accountants Lecturer and Research Funding Recipient, Warwick University Business School Partner employed by the Greater East Midlands Commissioning Support Unit (NHS)
A Leary	Parish Councillor – Winthorpe and Langford Parish Council

Remuneration Report

Tables 1 and 2 on subsequent pages of this report summarise the remuneration (excluding National Insurance contributions) and pension status of the PCT's Board of Directors, Professional Executive Committee (GP Executive Committee) members and other senior managers for the year ended 31 March 2013.

Performance Related Pay and Other Benefits

The PCT complied with the Very Senior Managers Pay Framework on the reward package available for the PCT's very senior managers.

The Chief Executive had routine meetings with the Directors and Senior Managers throughout the year which culminate in an appraisal and personal development plan being agreed.

Contracts, Notice and Termination Payments

Non-Executive Directors of the Board and members of the Professional Executive Committee were 'office holders'. The NHS Appointments Commission governs the selection and appointment of Board Non-Executive Directors who are appointed on a fix term basis (usually three to four years). Non-Executive Directors were local people appointed for their wide range of skills and experience.

The Chairman and Non-Executive Directors appointed the Chief Executive and together they appointed the Executive Directors, including a nurse, doctor and accountant. The Executive Directors were appointed on permanent contracts which were reviewed annually by the Remuneration and Terms of Service Committee.

Termination payments include contractual payments, such as redundancy or early retirement provisions as well as the 'novel or unusual payments' covered by the HMT Treasury Guidance 'Managing Public Money'. As set out in the guidance, extra-contractual payments on termination should be exceptional and made only where a payment is in the public interest and represents value for money.

Pay Multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.
The banded remuneration of the highest paid director in Lincolnshire Teaching PCT in the financial year 2012-13 was annualised remuneration of £170-175,000 (2011-12, £170-175,000). This was 7 times (2011-12, 6 times) the median remuneration of the workforce, which was annualised remuneration of £20-25,000 (2011-12, £25-30,000). The median annualised remuneration has decreased due to the transfer of the operational Estates staff.

In 2012-13 0 employees (2011-12, 0) received remuneration in excess of the highest-paid director.

Remuneration of Senior Managers

Senior managers are those persons who have authority or responsibility for directing or controlling the major activities of the PCT. Table 1 discloses information regarding salaries and allowances of senior managers. Table 2 discloses information regarding any pension benefit for senior managers.

Salaries and Allowances

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, severance payments and 'buy-out' of untaken Annual Leave and therefore may differ from the annualised remuneration used in the calculation of pay multiples. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Officers & Office Holders

Lincolnshire Teaching PCT and Lincolnshire County Council each pay 50% of the cost for Dr Anthony Hill, Joint Director of Public Health. Therefore, 50% of the cost is disclosed in this report.

As part of the transition process, new executive arrangements were put in place for Lincolnshire Teaching PCT from 01/10/2012.

i) John McIvor commenced a secondment on 01/10/2012 and David Sharp took on responsibility for Lincolnshire Teaching PCT on 01/10/2012. The cost of John McIvor has been shown for the full year because he remained a PCT employee during this time.
ii) Edie Butterworth and Andrew Spring became Transitional Directors from 01/10/2012. The cost has been shown for the full year because they remained PCT employees during that time.
iii) Martin McShane commenced a secondment on 01/09/2012. The cost has been shown for the full year because he remained a PCT employee during that time. Jim Heys has been included from 01/09/2012 when he became Acting Director during Martin McShane's secondment.

GPs

The GPs listed above were all members of GPEC from 01/04/2012 until this was replaced by the CCG Council on 01/08/2012 when they became members of the CCG Council from 01/08/2012.
Dr Brynnen Massey became the Chair of Lincolnshire East CCG during 2012-13.
Dr Sunil Hindocha became the Accountable Officer of Lincolnshire West CCG during 2012-13.
Dr Richard Gent became the Chair of South West Lincolnshire CCG during 2012-13.
Dr Miles Langdon became the Chair of South Lincolnshire CCG during 2012-13.
Dr Charles Lennon became the Vice Chair of South Lincolnshire CCG during 2012-13.

Table 1: Salaries and Allowances for the year ending 31 March 2013

Name and Title	Further Description	2012-13 Dates	2012-13 Salary (bands of £5000) £'000	2012-13 Other remuneration (bands of £5000) £'000	2012-13 Bonus Payments (bands of £5000) £'000	2012-13 Benefits in kind (rounded to the nearest hundred pounds) £'00	2011-12 Dates	2011-12 Salary (bands of £5000) £'000	2011-12 Other remuneration (bands of £5000) £'000	2011-12 Bonus Payments (bands of £5000) £'000	2011-12 Benefits in kind (rounded to the nearest hundred pounds) £'00
Mr John McIvor, Chief Executive	Chief Executive until 30/09/2012 On secondment from 01/10/2012	Full Year	175 - 180	0	0	0	Full Year	170-175	0	0	0
Mrs Edie Butterworth, Director of Quality and Involvement	Director until 30/09/2012 Transitional Director from 01/10/2012	Full Year	115 - 120	0	0	0	Full Year	85-90	0	0	0
Mr Andrew Spring, Director of Finance, Performance & Contracting	Director until 30/09/2012 Transitional Director from 01/10/2012	Full Year	115 - 120	0	0	0	Full Year	115-120	0	0	0
Dr Martin McShane, Director of Strategic Planning & Health Outcomes	Director until 31/08/2012	Full Year	110 - 115	0	0	35	Full Year	110-115	0	0	21
Mr Jim Heys, Acting Director of Strategic Planning & Health Outcomes	Acting Director from 01/09/2012	From 01/09/12	55 - 60	0	0	0					
Mr David Sharp, Managing Director, Leics & Lincolnshire Local Area Team*	Chief Executive from 01/10/2012	*					-	-	-	-	-
Mr Andy Leary, Director of Finance, Leics & Lincolnshire Local Area Team*	Director from 01/10/2012	*					-	-	-	-	-
Mrs Maggie Boyd, Director of Nursing & Quality, Leics & Lincs Local Area Team*	Director from 01/10/2012	*					-	-	-	-	-
Dr Aly Rashid, Medical Director, Leics and Lincolnshire Local Area Team*	Director from 01/10/2012	*					-	-	-	-	-
Mrs Trish Thompson, Director of Operations & Delivery, Leics and Lincs LAT*	Director from 01/10/2012	*					-	-	-	-	-
Mr Peter Huskinson, Director of Commissioning, Leics and Lincs Local Area Team*	Director from 01/10/2012	*					-	-	-	-	-
Dr Anthony Hill, Joint Director of Public Health	Joint Director with Lincolnshire County Council	Full Year	60 - 65	0	10 - 15	32	Full Year	60-65	0	10-15	19
Mr Richard Childs, Chairman	-	Full Year	35 - 40	0	0	0	Full Year	35-40	0	0	0
Mrs Gillian Wing, Non-Executive Director	-	Full Year	5 - 10	0	0	0	Full Year	5-10	0	0	0
Mr Roger Buttery, Non-Executive Director	-	Full Year	10 - 15	0	0	0	Full Year	10-15	0	0	0
Dr Robert Price, Non-Executive Director	-	Full Year	5 - 10	0	0	0	Full Year	5-10	0	0	0
Mr Andrew Middleton, Non-Executive Director	-	Full Year	5 - 10	0	0	0	Full Year	5-10	0	0	0
Mrs Marianne Overton, Non-Executive Director	-	Full Year	5 - 10	0	0	0	Full Year	5-10	0	0	0
Mr Giles Walter, Non-Executive Director	-	Full Year	5 - 10	0	0	0	Full Year	5-10	0	0	0
Mrs Sarah Newton, Chief Operating Officer, Lincolnshire West CCG	In 2011-12, a PCT Director until 31/10/2011	Full Year	95 - 100	0	0	53	To 31/10/11	45-50	0	0	43
Mr Gary James, Accountable Officer, Lincolnshire East CCG	In 2011-12, a PCT Director until 31/10/2011	Full Year	95 - 100	0	0	24	To 31/10/11	50-55	0	0	17
Mr Gary Thompson, Accountable Officer, South Lincolnshire CCG**	Not employed directly by the PCT	Full Year	105 - 110	0	0	0	-	-	-	-	-
Mr Allan Kitt, Accountable Officer, South West Lincolnshire CCG	-	Full Year	85 - 90	0	0	0	-	-	-	-	-
Mr Rob Croot, Chief Finance Officer, Lincolnshire West CCG**	Not employed directly by the PCT	Full Year	100 - 105	0	0	0	-	-	-	-	-
Mrs Sandra Williamson, Chief Finance Officer, Lincolnshire East CCG	-	From 01/10/12	40 - 45	0	0	0	-	-	-	-	-
Miss Joanne Wright, Chief Finance Officer, South West Lincolnshire CCG	-	From 01/10/12	35 - 40	0	0	0	-	-	-	-	-
Mrs Caroline Hall, Chief Finance Officer, South Lincolnshire CCG**	Not employed directly by the PCT	From 12/11/12	35 - 40	0	0	0	-	-	-	-	-

* The Local Area Team (LAT) Directors were not employed by the PCT. Their salary was not recharged to the PCT but was borne by their substantive employer.

**Although not employed directly by the PCT, their salary was recharged to the PCT by their employer.

Table 1: Salaries and Allowances for the year ending 31 March 2013

Name and Title	Further Description	2012-13 Dates	2012-13 Salary (bands of £5000) £'000	2012-13 Other remuneration (bands of £5000) £'000	2012-13 Bonus Payments (bands of £5000) £'000	2012-13 Benefits in kind (rounded to the nearest hundred pounds) £'00	2011-12 Dates	2011-12 Salary (bands of £5000) £'000	2011-12 Other remuneration (bands of £5000) £'000	2011-12 Bonus Payments (bands of £5000) £'000	2011-12 Benefits in kind (rounded to the nearest hundred pounds) £'00
GPs											
Dr Brynnen Massey, CCG Council Chair & PCT Medical Director	Chair, Lincolnshire East CCG	Full Year	45 - 50	0	0	0	Full Year	0-5	0	0	0
Dr Sunil Hindocha, CCG Council	Accountable Officer, Lincolnshire West CCG	Full Year	0	0	0	0	Full Year	0-5	0	0	0
Dr Peter Holmes, CCG Council	-	Full Year	0	0	0	0	Full Year	0-5	0	0	0
Dr Richard Gent, CCG Council	Chair, South West Lincolnshire CCG	Full Year	0	0	0	0	Full Year	0-5	0	0	0
Dr Miles Langdon, CCG Council	Chair, South Lincolnshire CCG	Full Year	0	0	0	0	From 01/06/11	0-5	0	0	0
Dr Charles Lennon, CCG Council	Vice Chair, South Lincolnshire CCG	Full Year	0	0	0	0	From 01/06/11	0-5	0	0	0
Dr James Howarth, CCG Council	-	Full Year	0	0	0	0	From 01/06/11	0-5	0	0	0
Dr John Elder, GPEC Member	-	-	-	-	-	-	To 31/05/11	0-5	0	0	0
Dr Thomas Busch, GPEC Member	-	-	-	-	-	-	To 31/05/11	0-5	0	0	0
Dr David Corlett, GPEC Member	-	-	-	-	-	-	To 31/05/11	0-5	0	0	0
Dr Shahid Ansari, GPEC Member	-	-	-	-	-	-	To 31/05/11	0-5	0	0	0

Key

0 = Disclosure is required in the financial year, but the amount is zero.

- = Disclosure is not required in the financial year.

Table 2: Pension Benefits for the year ending 31 March 2013

This table includes only those senior managers that were employees of the PCT.

Name and Title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2013 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2012	Real increase in Cash Equivalent Transfer Value	Employer's contribution to stakeholder pension
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Mr John McIvor, Chief Executive	(0 - 2.5)	(2.5 - 5)	65 - 70	205 -210	1,444	1,361	12	0
Mrs Edie Butterworth, Director of Quality and Involvement	5 - 7.5	15 - 17.5	40 - 45	125 -130	Not Available*	813	Not Available*	0
Mr Andrew Spring, Director of Finance, Performance & Contracting	(0 - 2.5)	(0 - 2.5)	30 - 35	100 -105	646	602	13	0
Dr Martin McShane, Director of Strategic Planning & Health Outcomes	0 - 2.5	0 - 2.5	45 -50	140 -145	1,002	919	36	0
Mr Jim Heys, Acting Director of Strategic Planning & Health Outcomes	2.5 - 5	12.5 - 15	30 - 35	100 - 105	627	450	89	0
Dr Anthony Hill, Joint Director of Public Health	0 - 2.5	5 - 7.5	55 - 60	170 - 175	1,231	1,099	75	0
Mrs Sarah Newton, Chief Operating Officer, Lincolnshire West CCG	(0 - 2.5)	(0 - 2.5)	30 - 35	95 - 100	598	560	9	0
Mr Gary James, Accountable Officer, Lincolnshire East CCG	(0 - 2.5)	(0 - 2.5)	30 - 35	90 - 95	628	582	16	0
Mr Allan Kitt, Accountable Officer, South West Lincolnshire CCG	0 - 2.5	0 - 2.5	40 - 45	125 - 130	797	735	24	0
Mrs Sandra Williamson, Chief Finance Officer, Lincolnshire East CCG	0 - 2.5	0 - 2.5	10 - 15	35 - 40	174	160	3	0
Miss Joanne Wright, Chief Finance Officer, South West Lincolnshire CCG	0 - 2.5	0 - 2.5	10 - 15	30 - 35	151	137	3	0

Cash Equivalent Transfer Values

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

Real Increase in CETV

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

Please note the real increase is proportionate to the amount of time spent in post during the financial year.

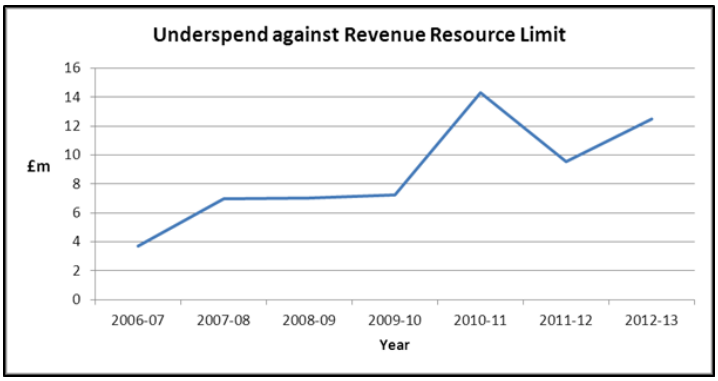
*Please note the 'Not Available' figures relate to NHS Pensions Agency guidance which states no CETV will be issued for certain categories of employee based upon age and/or pension status.

Financial Review 2012/13

I am pleased to be able to report that NHS Lincolnshire has met its statutory financial duties for the financial year ending 31st March 2013. The statutory financial duties are to remain within:

1. Revenue Resource Limit (RRL)
2. Capital Resource Limit (CRL)
3. Cash Limit (CL)

The PCT was created in 2006-07 and during that time, the PCT has always achieved a revenue surplus. Please see the below graph which shows that, for the seventh year running, the organisation has achieved a revenue surplus.



The PCT's revenue surplus for 2012-13 was £12.5m. The PCT's initial plan for the year was to deliver a surplus of £7.5m; this figure was revised during the year to reflect a revised planned surplus of £12.5m.

The 2012-13 revenue surplus represents 1%, or 3.6 days, of the total annual expenditure. The surplus will be passed on to the successor bodies of Lincolnshire Teaching PCT as follows:

	£m
o Lincolnshire East Clinical Commissioning Group	3.2
o Lincolnshire West Clinical Commissioning Group	2.7
o South West Lincolnshire Clinical Commissioning Group	1.5
o South Lincolnshire Clinical Commissioning Group	1.8
o NHS Commissioning Board	3.3
Total	**12.5**

The PCT's capital expenditure at £4.5m was significantly below the planned level due to delays in commencement of major building works.

I would like to acknowledge the work of our partners, staff and contractors across Lincolnshire in supporting and enabling the achievement of a surplus that will be available in future years for the benefit of the population of Lincolnshire.

I have every confidence that the successor bodies will build on the work achieved by the PCT.

Andy Leary
Director of Finance for Leicestershire & Lincolnshire Local Area Team

Summary Financial Statements 2012/13

The summary financial information shown here is taken from the full accounts of Lincolnshire Teaching Primary Care Trust and has been subject to independent audit examination. A copy of the full set of audited accounts are available upon request without charge by contacting Executive Personal Assistant, Andrea Pickford, (telephone (01522) 513355 or email andrea.pickford@lpct.nhs.uk).

The PCT received funding from the Department of Health to provide the services to its population, subject to ceilings called the annual resource limits. This funding amounted to an average of approximately **£1,700 per head of population**. Most of the PCT's funding was used to pay for healthcare services that the PCT commissioned from other NHS bodies or the private sector. The running costs of the PCT for 2012-13 is **£33 per head of population.**

The information below demonstrates how financial targets were met in 2012-13.

Table 1: Financial Performance Targets

During 2012-13 the PCT had authority to spend as follows:

Revenue Resource Limit	**£000**
Revenue Resource Limit	**1,270,154**
Net Operating Cost for the Financial Year	**1,257,637**
Underspend Against Revenue Resource Limit (RRL)	**12,517**

Capital Resource Limit	**£000**
Capital Resource Limit	**9,026**
Charge to Capital Resource Limit	**4,472**
Underspend Against Capital Resource Limit (CRL)	**4,554**

Table 2: Statement of Comprehensive Net Expenditure for the Year Ended 31st March 2013

This statement records the income and expenditure incurred by the PCT during the year in the course of running its operations.

	£000
Gross Employee Benefits	23,350
Other Costs	1,270,395
Finance Costs	1,213
Other Losses	22
Gross Operating Costs for the Financial Year (See Chart 1)	**1,294,980**
Income	(37,343)
Net Operating Cost for the Financial Year	**1,257,637**
Impairment	2,350
Net Gain on Revaluation of Plant, Property and Equipment	(11,576)
Release of Reserves to Statement of Comprehensive Net Expenditure	(125)
Total Comprehensive Net Expenditure for the Year	**1,248,286**

Chart 1: Proportion of Gross Operating Costs (£1,295m) spent on Healthcare

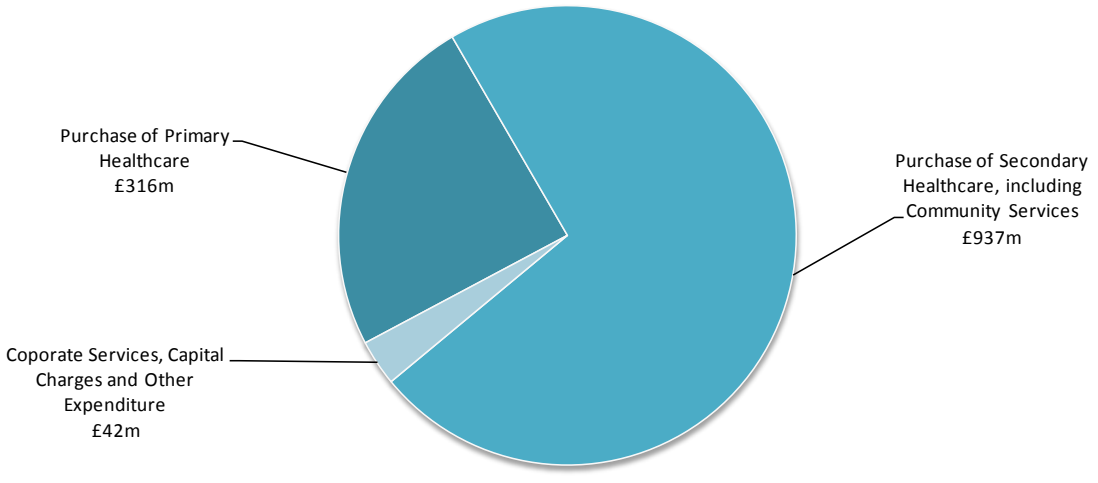


Chart 2: Purchase of Primary Healthcare (£316m)

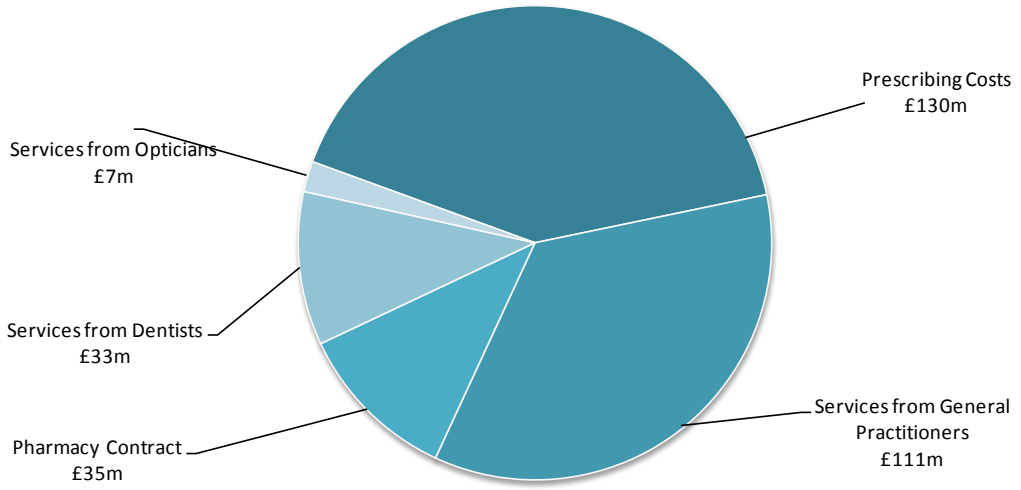


Chart 3: Purchase of Secondary Healthcare (£937m)

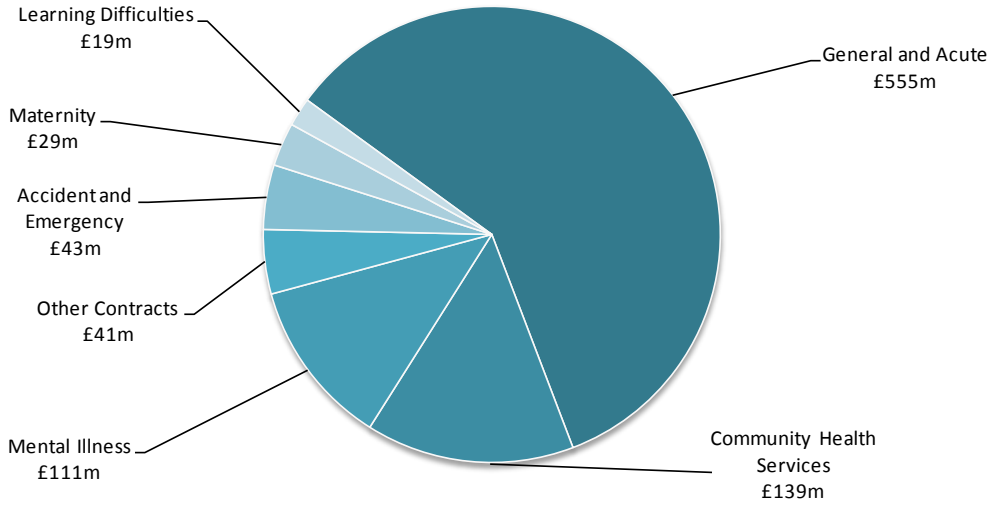


Table 3: Statement of Financial Position as at 31st March 2013

This statement of financial position is a summary of the PCT's assets, liabilities and equity (ownership by the taxpayers) on 31st March 2013. It provides a snapshot of the financial position at that date only. The PCT has liabilities exceeding its assets but this does not indicate a weak financial position. The Department of Health provides cash to the PCT only when required to meet its liabilities. Because the PCT has liabilities in excess of its assets, it has a negative taxpayers' equity. This represents a common position for PCTs since it is routine for the Department of Health to meet the net liabilities of the PCT at the balance sheet date by providing the cash funding in future years.

	£000	£000
Non-Current Assets		
Property, plant and equipment	60,853	
Trade and other receivables	25	
Non-current assets held for sale	950	
Total Non-Current Assets		**61,828**
Current Assets		
Trade and other receivables	10,201	
Cash and cash equivalents	1,944	
Total Current Assets		**12,145**
Total Assets		**73,973**
Current Liabilities		
Trade and other payables	(73,492)	
Provisions	(3,050)	
Borrowings	(731)	
Total Current Liabilities		**(77,273)**
Non-current assets plus/less net current assets/liabilities		**(3,300)**
Non-Current Liabilities		
Provisions	(21,181)	
Borrowings	(25,432)	
Total Non-Current Liabilities		**(46,613)**
Total Assets/(Liabilities) Employed:		**(49,913)**
Financed by Taxpayers' Equity		
General fund		(67,254)
Revaluation reserve		17,341
Total Taxpayers' Equity:		**(49,913)**

Table 4: Statement of Changes in Taxpayers' Equity for the Year Ended 31st March 2013

	£000
Balance at 1 April 2012	(45,552)
Net Operating Cost for the Financial Year	(1,257,637)
Net Increase in Revaluation Reserve	9,226
Release of Reserves to SOCNE	125
Net Parliamentary Funding	1,243,925
Balance at 31 March 2013	**(49,913)**

Table 5: Statement of Cash Flows for the Year Ended 31st March 2013

This Statement of Cash Flows shows the PCT's outgoing and incoming cash during the year. The statement shows how operating, investing, and financing activities affected cash.

	£000	£000
Net Cash Outflow From Operating Activities		(1,236,825)
Investing Activities		
Payments For Property, Plant & Equipment	(4,537)	
Proceeds Of Disposal Of Assets Held For Sale	125	
Net Cash Outflow From Investing Activities		(4,412)
Net Cash Outflow Before Financing		(1,241,237)
Financing Activities		
Net Parliamentary Funding	1,243,925	
Capital Element In Respect Of Finance Lease & On-SOFP PFI	(753)	
Net Cash Inflow From Financing Activities		1,243,172
Net Increase In Cash From Current Activities		1,935
Cash & Cash Equivalents At 1 April 2012		9
Cash & Cash Equivalents At 31 March 2013		**1,944**

Table 6: Better Payment Practice Code - Measure of Compliance

The PCT is required to comply with the Better Payment Practice Code and arrange its procedures to uphold the four cornerstones of Prompt Payment as follows.

1 agreeing payment terms at the outset of a deal and not changing them;
2 explaining payment procedures to suppliers;
3 paying bills in accordance with any contract agreed with the supplier or as required by law; and
4 telling suppliers without delay when an invoice is contested, and settling disputes quickly.

The PCT target is to pay at least 95% of all NHS and non-NHS trade creditors within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

	2012-13		2011-12	
	Number	**£000**	Number	£000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**40,263**	**134,563**	32,286	127,132
Total Non-NHS Trade Invoices Paid Within Target	**37,100**	**125,194**	30,149	117,154
Percentage of Non-NHS Trade Invoices Paid Within Target	**92.14%**	**93.04%**	93.38%	92.15%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**6,776**	**858,913**	4,596	823,148
Total NHS Trade Invoices Paid Within Target	**5,967**	**844,841**	4,269	818,855
Percentage of NHS Trade Invoices Paid Within Target	**88.06%**	**98.36%**	92.89%	99.48%

Table 7: Running Costs for the Year Ended 31st March 2013

The broad definition of running costs includes any cost incurred that is not a direct payment for the provision of healthcare. The requirement for PCTs is to show Commissioning Services and Public Health running costs per head of population. The weighted population figures originate from the Department of Health, and are based on Office of National Statistics projections, rather than being actuals.

	Commissioning Services	**Public Health**	**Total**
Running costs (£000s)	21,481	2,763	**24,244**
Weighted population (number in units)	726,236	726,236	**726,236**
Running costs per head of weighted population (£ per head)	**29.58**	**3.80**	**33.38**

Table 8: External Auditor's Remuneration 2012-13

The External Auditor of the PCT is KPMG LLP. The opinion on the Summary Financial Statements is shown elsewhere in this Annual Report. The cost of external audit services performed during the year was £147k including VAT.

INDEPENDENT AUDITOR'S REPORT TO THE RESPONSIBLE OFFICER OF LINCOLNSHIRE TEACHING PCT ON THE SUMMARY FINANCIAL STATEMENT

We have examined the summary financial statement for the year ended 31 March 2013 set out on pages 35 to 40.

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

Respective responsibilities of directors and auditor

The Responsible Officer is responsible for preparing the Annual Report. Our responsibility is to report to you our opinion on the consistency of the summary financial statement within the Annual Report with the statutory financial statements.

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

Basis of opinion

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

Opinion

In our opinion the summary financial statement is consistent with the statutory financial statements of Lincolnshire Teaching PCT for the year ended 31 March 2013 on which we have issued an unqualified opinion.

Tony Crawley for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
St Nicholas House
31 Park Row
Nottingham
NG1 6FQ

June 2013

Department of Health

NHS

Lincolnshire Teaching Primary Care Trust

2012-13 Accounts

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Lincolnshire Teaching Primary Care Trust

2012-13 Accounts

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

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

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

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

nb: sign and date in any colour ink except black

Signed.....Designated Signing Officer

Name: david sharp

Date.....4/6/13

2012-13 Annual Accounts of Lincolnshire Teaching Primary Care Trust

STATEMENT OF RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

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

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

- make judgements and estimates which are reasonable and prudent;

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

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

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

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

By order of the Permanent Secretary.

nb: sign and date in any colour ink except black

4/6/13 .....Date..... R P .....Signing Officer

4/6/13 .....Date..... .....Finance Signing Officer

NHS Lincolnshire

THE ANNUAL GOVERNANCE STATEMENT 2012/13

The Lincolnshire Teaching Primary Care Trust

Organisation Code: 5N9

SCOPE OF RESPONSIBILITY

1. NHS Lincolnshire (the Lincolnshire Teaching Primary Care Trust) was at the heart of the local NHS, responsible for commissioning (planning and buying) healthcare for 745,000 people across Lincolnshire. The PCT worked in partnership with the Local Authority and had good, effective relationships with its providers of healthcare services.

2. The Board had overall responsibility for maintaining and reviewing the effectiveness of a sound system of internal control which supported the achievement of its mission, vision and goals, whilst safeguarding the public funds and assets for which it was responsible.

3. The system of internal control was designed to manage, rather than eliminate, the risk of failure to achieve business objectives and to provide reasonable and not absolute, allowance against material reinstatement or loss.

4. The Chief Executive of the Board was the Accountable Officer of the Organisation. The relevant responsibilities of the Accountable Officer are as set out in the Accountable Officer Memorandum issued by the Department of Health and includes ensuring systems are in place to:-
   - safeguard public monies,
   - implement corporate governance,
   - ensure value for money is achieved,
   - ensure expenditure is as intended by Parliament,
   - ensure sound financial management and comprehensive accounts.

   The Accountable Officer provided leadership to the PCT to promote and cultivate integrity, openness, honesty and accountability.

   It is the Accountable Officer's responsibility for maintaining a sound system of internal control that supports the achievement of the Organisation's policies, aims and objectives, whilst safeguarding the public funds and the Organisation's assets.

THE GOVERNANCE FRAMEWORK OF THE ORGANISATION

5. The PCT endeavoured to conduct its business in accordance with the seven principles identified by the Committee on Standards in Public Life (selflessness, integrity, objectivity, accountability, openness, honesty and leadership).

6. The Organisation had a comprehensive governance framework with a number of Committees authorised to ensure governance is in place and to support the Board and its

management, in the leadership of all aspects of risk.

7. There was a formal and well established process of controls within NHS Lincolnshire to enable the Board to have confidence that the Organisation would achieve its aims and objectives. This included the integrated plan which set out a basis for underpinning the delivery of the Organisation's commissioning. Commissioning plans were based on the needs of the population emanating from extensive discussion and consultation with local people and other stakeholders, the Joint Strategic Needs Assessment, the Director of Public Health Annual Report, the Operating Framework, and working in close partnership with Clinical Commissioning Groups and the Local Authority.

8. THE PCT BOARD

   The PCT Board had been in place since the formation of the PCT during October 2006. During June 2011, the Cluster Board Committee was established. The Cluster Board Committee ensured the PCT continued to operate effectively until its disestablishment to deliver the NHS Lincolnshire strategic objectives as set out in the Integrated Plan. The Cluster Board Committee was responsible for managing the transfer of residual functions from the PCT to the successor organisations and to manage the closedown of the PCT in line with guidance from the Department of Health, legal requirements and guidance from the Strategic Health Authority whilst ensuring accountabilities were maintained. During October 2012, changes to the Chief Executive and Executive Directors were made in line with Department of Health instruction. The Director of the National Commissioning Board Leicestershire and Lincolnshire Area Team (NCBAT) became the Chief Executive and Accountable Officer of the PCT Cluster, the NCBAT Director of Nursing became the Director of Nursing, Quality and Engagement, and the NCBAT Director of Finance became the Director of Finance of the PCT Cluster. To enable the NCBAT Directors to attend both the Lincolnshire and Leicestershire Cluster Board meetings, during the autumn of 2012, the Cluster Board meetings became bi-monthly. This resulted in only two Board meetings not taking place, that is the November 2012 and January 2013 meetings. However, during November 2012, the corporate risk register, board assurance framework and Quality and Safety performance reports were presented to the Risk and Governance Management Committee. Finance reports were distributed to all Board members monthly. Performance reports were being presented to each Clinical Commissioning Group Governing Body on a monthly basis, and at monthly National Commissioning Board meetings with the Area Team. The attendance record of the Board was excellent, being fully quorate throughout the year of 2012/13.

9. THE GP COMMISSIONING EXECUTIVE COMMITTEE

   During June 2011, the arrangements for the Practitioner Executive Committee were revised, the outcome being the GP Commissioning Executive Committee (GPCEC). The GPCEC embedded the clinical leadership at the heart of commissioning in Lincolnshire and supported the transition to the new model of GP commissioning set out in the NHS White Paper. The Committee was responsible for advising the NHS Lincolnshire Board on its commissioning strategy, resource utilisation in line with health needs, and decommissioning and reinvestment across all pathway groups. It underpinned the commissioning of safe, clinically effective high quality services to improve the health and wellbeing of people in Lincolnshire and to reduce inequalities. The Committee received regular reports from the Organisation's Prescribing and Clinical Effectiveness Forum (PACEF) which was the strategic advisory network which had responsibility for ensuring cost effective use of medicines and other healthcare interventions. The attendance record of the GPCEC was excellent, being fully quorate throughout the year of 2012/13.

10. THE AUDIT COMMITTEE

The Audit Committee was chaired by a non-executive Director. The Committee met six times during 2012/13 and reported directly to the Board. Its role included the consideration of detailed reports with recommendations for the improvement of the PCT's systems of internal control. The Committee formulated and agreed the annual audit plan, driven by the Board Assurance Framework and the Risk Register. Senior managers attended meetings of the Audit Committee, as did both the internal and external auditors, as well as Counter Fraud managers, and once a year the Committee met the auditors on their own for private discussions. An Audit Committee Annual Report was presented to the Board annually. The 2012/13 report was presented to the Audit Sub Committee during May 2013 and included comments regarding the Organisation's internal financial control, counter fraud arrangements and any investigations, maintenance of accountability records, and the reliability of financial information. The Committee regularly undertook a review of the plans to produce the final accounts, which provided assurance that functions were being carried out under appropriate statutory powers with proper delegated authorities in place throughout the year. The Committee received the annual report of the Counter Fraud Service. The Audit Committee reviewed the reliability, integrity and comprehensiveness of assurances to meet the needs of the Board and the Accountable Officer, the adequacy of relevant policies, legality issues and codes of conduct, and reviewed the methods in place to counter fraud and corruption. The attendance record of the Audit committee was excellent, being quorate throughout the year.

11. THE RISK AND GOVERNANCE MANAGEMENT COMMITTEE

The Risk & Governance Management Committee ensured that the Organisation had a co-ordinated range of policies and procedures to cover all governance activity. The Risk & Governance Management Committee oversaw the continuing implementation of the Trust's risk management strategy and integrated governance plans and reviewed it on a regular basis. The Risk & Governance Management Committee oversaw the work of sub groups which led on implementation of a number of separate and diverse initiatives, ensuring that they were integrated to maximise effective governance arrangements across the PCT. The Risk & Governance Management Committee met five times during 2012/13 and had full quorate attendance at each meeting. The Committee was chaired by the Chief Executive and the chair of the Audit Committee was a member.

12. THE JOINT CONSULTATION AND NEGOTIATION COMMITTEE

The Joint Consultation and Negotiation Committee (JCNC) was a formal subcommittee of the Risk and Governance Management Committee which reported on a bi-monthly basis. The committee was co-chaired by the Associate Director of Organisational Development and the Staff Side Chair. The Committee membership provided both management and staff side organisational/national updates and discusses workforce implications. The committee also provided a consultation and negotiation forum for working arrangements and policy development and in the latter months had incorporated the HR Transition Subgroup agenda. External full time union representatives had historically been invited to attend meetings.

13. THE HEALTH AND SAFETY COMMITTEE

The Health and Safety Committee was a formal sub-committee of the Risk and Governance Management Committee which it reported to on a quarterly basis. The Committee reviewed and promoted the measures taken by the Organisation to ensure health and safety at work for employees, visitors and contractors on site. It oversaw the implementation of the health and safety, fire and security policies and procedures.

14. ASSURING QUALITY IN COMMISSIONING COMMITTEE

The Assuring Quality in Commissioning Committee was focused upon clinical governance in commissioning. The Committee was chaired by the Director of Nursing, Quality and

Engagement. It provided assurance in the quality of all commissioning services to the Board through the Risk & Governance Management Committee. The Committee's Clinical Governance Annual Report of October 2012 included the methods, outcomes and assurances of clinical governance processes, clinical risk management, patient and public involvement, equality and human rights, research governance, medical appraisal and revalidation, practitioner performance, safeguarding, deprivation of liberty functions, care homes, and strategic development.

15. THE PATIENT AND PUBLIC EXPERIENCE STEERING GROUP

The Patient and Public Experience Steering Group is a sub-committee of the Board and was chaired by the Director of Nursing, Quality and Engagement, and was championed by the Chairman of the PCT who was the PCT champion for equality and diversity, security and health & safety. The group assured the Board of the provision of strategic oversight of the arrangements of patient and public involvement.

16. PHARMACEUTICAL SERVICES COMMITTEE

The Pharmaceutical Service Committee provided regular updates to the Board regarding the level and quality of the pharmaceutical services within Lincolnshire.

17. CLINICAL COMMISSIONING GROUP SUB-COMMITTEES

During the September 2011 Board meeting, the Board approved the establishment of Clinical Commissioning Group sub-committees to the Board which were implemented and well attended. The four Clinical Commissioning Group sub-committees were established so as to work towards authorisation, and the delivery of the QIPP plans.

18. THE CLINICAL COMMISSIONING GROUP COUNCIL

The Clinical Commissioning Group Council is chaired by the GP Chair and Medical Director of one of the four Lincolnshire Clinical Commissioning Groups. Membership of the group included the GP Chairs of all Clinical Commissioning Groups, the Accountable Officers, the Chief Finance Officers, the Public Health and PCT Directors. The minutes of these meetings were presented to the Board.

19. EAST MIDLANDS OPERATIONAL OVERSIGHT GROUP

The East Midlands Operational Oversight Group included senior manager membership from each PCT within the area of the East Midlands Strategic Health Authority. The group operationally managed the specialised commissioning within the area. The minutes of each of the meetings were presented to the Board.

20. THE REMUNERATION AND TERMS OF SERVICE COMMITTEE

The Remuneration and Terms of Service Committee members were Non-Executive Directors. The purpose of the Committee was to agree on behalf of the Organisation, about appropriate remuneration and terms of service for the Chief Executive, Executive Directors, and other Directors including all aspects of salary, provisions for other benefits, arrangements for termination of employment and other contractual terms.

21. ADDITIONAL SUPPORT TO THE BOARD

Further to the responsibilities of the Committee structure of the Board, additional work which supported deterring, preventing and managing risks were:-

- Equality and Diversity:-
    - The PCT recognised its public duties under the Equality Act 2010 and met its duties by taking the NHS Equality Delivery System approach. The Equality Delivery System was a systematic and patient centred approach to meet a range of targets to improve patient and staff experience and to ensure that this commitment to equality was at the heart of the PCT work. The Equality Delivery system was overseen by a governance group which reported into the organisation's Equality and Human Rights Steering Group. The self-assessment of the delivery system undertaken with stakeholders had scored the system as amber.
    - The organisation was committed to the improvement of health, the eradication of inequality in health status and the promotion of equality. Equality impact assessments and the Equality Delivery system ensured this commitment to equality was part of the organisational culture.
    - The Equality Impact Assessments were published on the organisation's website and were subject to audit inspection. The actions arising from the assessments fed into the service planning and improvement.
    - The Board published its equality and delivery objectives.
    - Workforce equality analysis was carried out annually and the results were published on the organisation's website.
    - Control measures were in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation were complied with.

- Workforce
    - The Organisational Development Group was replaced by the HR Transition Group mid-way through 2012 and, due to competing staff demands during transition, was arranged alongside the JCNC to ensure quoracy. The bi-monthly group enabled the workforce negotiations to be worked through on a more formal footing alongside the transition agenda. In between these meetings the group met more informally to hold development sessions between the PCT (as Sender) and the Receiver organisations with staff side colleagues. A workforce report was reported to the Board quarterly.

- Clinical Audit
    - Clinical audit was an essential tool to monitor compliance to statute and national regulation, and was important for healthcare associated infection, clinical waste management and decontamination of medical devices. The Organisation had a full programme of audit across the whole health community including all GP and dental sites. Audit findings were reported and follow up audits and self-assessments demonstrated that recommendations were implemented and that compliance was restored and maintained. The results of this work were reported to the Board quarterly.

- Quality and Safety
    - Quarterly quality review meetings with providers included the reporting of high risks. These meetings played a critical part of the overall quality improvement structure. Quality accounts were seen as a key mechanism by which it could be demonstrated that a relentless focus on improving service quality was maintained.
    - A Learning from Experience report was presented to the Risk & Governance Management Committee on a quarterly basis which identified good practices and enabled the organisation to continually improve services.
    - The Organisation's comprehensive complaints process allowed robust analysis of trends and also allowed the Organisation to identify potential problems, identify risks and prevent them, highlight opportunities for improvement, and support the review of services.

- Quality and safety reports were provided to each Board meeting.

- Financial Management

  - A financial monitor report was presented at each Board meeting and included the year to date and forecast outturn position against the plans agreed by the Board. The reports showing forecasted budget outturns, take into account the performance of healthcare contract activity versus the planned activity.

- Patient and Public Involvement

  - A systematic and multi-faceted approach in engaging patients, their carers and the public ensured that the organisation had the voice of local residents as an early warning system of issues and risks. Methods included the following examples; the patient and public engagement steering group who had the strategic overview of the organisation, the learning from experience steering group where incidents, complaints and other feedback were synthesised and acted upon so as to mitigate risks, and working closely with the Health Scrutiny Committee and Local Involvement Network so as issues were identified and addressed.

- Performance

  - The PCT had a formal reporting structure with the Strategic Health Authority and, since October 2012, by the National Commissioning Board. This took the form of regular meetings which involved reviews and structured reporting against key target objectives. Comprehensive performance against national and local targets, contracts and the NHS operating framework were presented to the Board at each meeting.

- Business Continuity

  - The Organisation had comprehensive business continuity plans. Business continuity plans were reviewed quarterly.

- Information Governance

  - The Information Governance Group oversaw information governance across the Organisation. During the year it carried out the agreed work programme which included the review and updating of key information governance policies on confidentiality and information protection, and reviewed the Freedom of Information requests, relevant incidents and oversaw the annual information governance toolkit self-assessment.

22. THE BOARD ASSESSMENT OF EFFECTIVENESS AND COMPLIANCE WITH THE CORPORATE GOVERNANCE CODE

- The October and December 2012 Boards reviewed its governance cycle to ensure compliance with the corporate governance code and its requirements to ensure the Board is provided with all the information it needs so as to be assured of all key strategic issues and risks so as it can fulfil its governance responsibilities. There have been no departures from the corporate governance code.

- The Board reviewed the Standing Orders and Schemes of Delegation during October and December 2012 and made changes due to the change of Directors' responsibilities. The PCT's statutory functions were also reviewed and found to be in place and legal.

23. THE PCT TRANSITION PROGRAMME

The PCT had a Transition Programme in place since 2010. The programme aim was to ensure the smooth transition from the PCT to the Receiver Organisations in line with the Health and Social Care Act. The governance structure of the transition programme included the PCT Transition Programme Board chaired by the PCT Chief Executive, the Transition Operational Group which was chaired by the Director of Nursing, Quality and Engagement who is the lead Director for the transition programme. Various other groups completed the programme structure; working groups leading on healthcare contract transition, non healthcare contract transition, estates and facilities, communications, workforce, finance, information and information technology, quality and safety, clinical commissioning groups, and commissioning support unit. The PCT worked closely with Staff Side colleagues throughout the transition. The PCT submitted the legal documents to the Department of Health within timescales. The PCT produced comprehensive Quality Handover, and Legacy documents. The comprehensive handover of quality and safety functions and intelligence to the appropriate receiver organisations was completed. The comprehensive handover of all assets, liabilities, data, property and risks was completed during March 2013. The PCT Transfer Scheme and supporting schedules clarify the receiver of each item.

The Governance framework for the scrutiny of accounts and sign off are in place. An Audit Sub Committee led by three current Non Executive Directors including the current Audit Committee Chairman.

24. RISK ASSESSMENT

25. The system of internal control was designed to manage risks to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives. It provided reasonable assurance of effectiveness. The system of internal control was based on an embedded 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.

26. Risk management was the basis for the Organisation's corporate induction and annual mandatory training programmes and was promoted as the responsibility of all staff and as positive. All levels of staff were involved in identifying and mitigating risks.

27. The risk management policy, guidance and assessment form were available to view or download from the Organisation's website.

    The risk management policy clearly set out the Organisation's commitment to the management of risk and the Board's intent to use risk management processes as a means to help achieve the organisation's goals. The policy defined the structure for the management, ownership, review of risks and the risk criteria, controls and assurances of risks, and the methods in which risk issues were considered and assessed during planning cycles including staff objective setting and day to day business.
    The risk management process also ensured that the organisation operated within the corporate governance framework, including the rules and regulations specified in the organisation's Standing Orders and Standing Financial Instructions.

28. The risk register was considered and reviewed by the Senior Management Team and the Board at each meeting. The risks were recorded and assessed in terms of the impact and probability. The corporate risk register reported the medium and high risks (those scored eight and above). As well as risks to the business as usual, all projects and programmes of work were risk assessed and if appropriate, added to the corporate register and assurance framework.

29. The Organisation had a robust Board Assurance Framework in place which set out the key controls and assurances to safeguard against the risks to the achievement of strategic objectives.

30. Together, both the corporate risk register and the board assurance framework enabled the organisation to identify resource, capacity and capability gaps and implement clear robust actions to address these gaps and to support the decision of the Board to accept the risk or not. Each document stated the assurance provided by internal audit reports and external agencies. Both of these documents were published on the organisation's website on a monthly basis and could therefore be viewed by all partners and stakeholders.

31. Newly identified risks during 2012/13 are set out below:-

Risk	Mitigation	Outcome assessment undertaken by:
The transition plans and changes carry risks that the organisation may be unable to continue existing responsibilities and support the transition programme before and following the 31st March 2013.	Comprehensive transition action plan continually monitored and managed via the Transition Operational Group and the Programme Board. Robust programme management structure with various subgroups reporting to the Operational Group. Governance processes in place for the transition programme with transition risks that are on the corporate risk register presented to the meetings monthly.	The Transition Programme Board.
The capacity and capability of the PCT Receiver Organisations to be ready by 1st April 2013.	Work plans to achieve the requirements to become authorised.	The Transition Programme Board.
The performance and service quality of provider organisations.	Performance reviewed monthly at Contract and Performance meetings and various programme boards for instance the Planned Care Board or the Unscheduled Care Board. Quarterly Quality Review meetings monitor the action plans In accordance with compliance. Quality and safety visits to Providers. Quality summit meetings.	Performance report to Board. Quality and Safety report to Board. Quality Review meetings. The Assuring Quality in Commissioning Group.
The resource to deal with Continuing Health Care retrospective reviews	Work plan to deal with claims. Budget management for claim payments.	The Board.
Various health and safety issues	The provision of support and appropriate training. The production and distribution of advice to staff.	The Health & Safety Committee. The Board.

32. There have been no major risks identified regarding data security. None have been reported to the information Commissioner. In accordance with the Information Governance Toolkit requirements, all major risks have been mitigated and the Organisation has achieved a level two in all its information governance requirements. There is a Memorandum of Understanding in place between the organisation and the local authority regarding the

information governance arrangements for the public health staff who had transferred office base to the local authority.

NHS Lincolnshire as commissioner of Lincolnshire Health care services also had a responsibility to ensure that its provider organisations undertook and submitted a satisfactory Information Governance Toolkit return so as to provide assurance of their information governance standards. The information governance service had worked to support organisations with the requirements. Where organisations were not assessed as being satisfactory, an improvement plan was required to be submitted in order that their intended action plans to make improvements could be monitored.

33. In relation to the key Integrated Performance Measures derived from the NHS Operating Framework 2012/13, performance for all Referral To Treatment targets have been consistently above national expectation with over 90% of Lincolnshire patients experiencing admissions within 18 weeks of referral, over 95% starting definitive treatment within 18 weeks on a "non-admission" pathway and more than 92% of patients experiencing waits of less than 18 weeks before commencing definitive treatment. Patient waits in major and minor A&E departments have been above the 95% national threshold over the year for those patient attendances waiting 4 hours or less from arrival to admission/discharge. With the opening of the two new dedicated stroke units in the County during February 2012, stroke service performance continued to improve throughout 2012/13, with admitted stroke patients spending 90% of their time on a stroke unit and High risk TIA patients scanned within 24 hours just below national expectation in Quarter three. Lincolnshire patients seen within 2 weeks of urgent referral for suspected cancer and those diagnosed and were treated within a month of decision to treat both exceed national standards. However cancer treatments within 2 months from urgent referral remained below expectation.

34. The Organisation had a process in place which routinely undertook a root cause analysis of every 'never event', and every incidence of healthcare acquired infections.

THE RISK AND CONTROL FRAMEWORK

35. The review of governance due to the changes required to support the Health and Social Care Act resulted in some changes to the responsibilities of individual directors (also see item 8). In summary:-

- The Director of Nursing, Quality and Engagement had responsibility for the internal control of the Quality and Safety framework, clinical risk management, corporate risk management, organisational business continuity management, information governance, legal support, Care Quality Commission regulations and Providers' compliance, and the Transition Programme. Reports were provided to each Board.

- The Director of Finance had responsibility for the internal control of financial management and planning, counter fraud, contracting and procurement, information support and performance analysis and reporting. Reports were provided to each Board.

- The Director of Public Health had responsibility for the internal control of the identification of the needs of the population, emergency planning, some healthcare services such as screening programmes, business continuity of the providers of health in the community, infection control and waste management, the Health and Wellbeing programme and the transition of the public health services. Reports were provided to the Board including regarding the management of the healthcare associated infection levels and management.

- The Director of Quality, Innovation, Productivity and Prevention (QIPP) and Commissioning had responsibility for the internal control of the QIPP programme and the establishment of Clinical Commissioning Groups and their ability to take responsibility for QIPP projects, and strategic planning for commissioning. The Director also manages the project to support the implementation of a Commissioning Support Service. An interim Director of QIPP and Commissioning had been in place during 2012/13 due to the secondment of the substantive director.

- The Director of Information Technology was the designated Senior Information Risk Officer of the Organisation. During 2012/13 this Director also led one of the Lincolnshire Clinical Commissioning Groups as the interim Accountable Officer, however, continued with the role of Senior Information Risk Officer.

- The PCT had, throughout 2012/13, a comprehensive audit programme. Recommendations made were managed by the Deputy Directors of Finance and Risk and Governance respectively, and progress against the recommendations were reported quarterly to the Audit Committee.

36. The PCT had an embedded formal risk management process. The Risk and Governance Management Committee undertook quarterly reviews of all risk areas and updated the Board on the status of risk management processes in the organisation.

37. A key element of the risk and control framework was the Organisation's Corporate Risk Register and Board Assurance Framework.

38. The full corporate risk register and board assurance framework were presented to the Risk & Governance Management Committee at each meeting. The high risks and full board assurance framework were reported to the Board at each meeting. Each risk was challenged at each meeting so as to fully understand the risk score, controls, assurances, mitigating plans as well as to enable the committee and the Board to form a view as to whether the risks should be accepted or reduced. The gaps and risks associated with the organisation's strategic objectives were managed through the lead Executive Director and the Board. Action plans had been in place throughout the year to meet gaps.

39. The risk management process was reviewed during October 2012 and January 2013. It was reviewed annually. Some changes to the process were made, an example being that the corporate risk register was redesigned to reflect the receiver organisations and therefore support the transfer of the management of the ongoing corporate risks.

40. A key element of the work had been the understanding of the risks and controls needed to mitigate the risks arising from the transition programme to support the implementation of the Health and Social Care Act, and arising from the work needed to keep the PCT 'business as usual' continuing.

41. At the March Board meeting, the Board undertook the final year-end review of the 2012/13 corporate risk register and board assurance framework. The full corporate risk register was then handed over to the Receiver Organisations.

REVIEW OF THE EFFECTIVENESS OF RISK MANAGEMENT AND INTERNAL CONTROL

42. Internal Audit reviewed a number of areas during 2012/13:-

- Finance Systems and Budgetary Control,
- Risk management and governance,
- Preparedness of transition to the Greater East Midlands Commissioning Support Unit,
- Quality, Innovation, Productivity and Prevention programme,

- GP commissioning and the support to the Clinical Commissioning Groups,
- Follow up of previous years recommendations,
- The hardclose of accounts.

The audit undertaken regarding the preparedness of transition to the Greater East Midlands Commissioning Support Unit, resulted in the overall classification of the report as high risk. Three high risks were identified relating to;

- The scope of the offers/specification of services,
- The performance measurements,
- The roles and responsibilities between the Unit and their customers.

Following discussion of this audit report, the Audit Committee invited the Lincolnshire Lead of the Commissioning Support Unit to a Committee meeting. The Lead advised the Committee of the Unit being fully aware of the audit report and advised of the actions being taken/planned to address the areas highlighted.

The audit undertaken regarding the review of the financial hard close, resulted in the overall classification of the report as high risk. One high risk was identified relating to;

- The progress made in validating and calculating the potential financial impact of the retrospective claims for continuing care costs.

Following this recommendation, PCT officers took action to ensure sufficient progress had been made to enable a reasonable estimate of the financial liability to be included in the 2012/13 accounts. The successor bodies were made aware of the need to make further progress in this regard and are addressing it.

43. The Audit Committee undertook a self-assessment of its effectiveness each year. The assessment was last discussed during June 2012 and found the Committee to be effective.

44. The Annual Governance Report is produced by External Audit colleagues each year and is due in June 2013. The opinion of external audit in the report of June 2012 stated an Unqualified opinion for financial statements and for value for money.

45. The PCT had supported the four Lincolnshire Clinical Commissioning Groups to gain their authorisation. PriceWaterhouse Cooper were commissioned to support their development and had been working with the groups during 2011/12 and 2012/13 regarding effective risk management and good governance.

46. Public Health colleagues had been accommodated within the Local Authority premises since 2011/12 and had continued to integrate during 2012/13. The Health and Wellbeing Board was established and was a national pathfinder. Lincolnshire was an exemplar in this area.

47. The Board had a comprehensive development programme which took place during the first quarter of 2012/13 and included:-

- The development of the Clinical Commissioning Groups,
- Performance, specifically areas of concern,
- Public Health transition,
- The Health and Social Care Act.

The Health and Social Care Act had been discussed in detail at each Board meeting and updates were provided by the Chief Executive and Chairman.

Audit Committee members and Clinical Commissioning Group lay members attended a workshop during December 2012 which included risk management, good governance, board assurance, audit and counter fraud.

48. The Board reviewed its arrangements for the management and leadership of all aspects of risk during October 2012 following changes to the Board and Senior Management. As a result, changes took place in the responsibilities of individual directors (see items 8 and 34).

49. The Accountable Officer reviewed the effectiveness of the system of internal control.

50. The review was informed in a number of ways:-

- The Head of Internal Audit provided an opinion on the overall arrangements for gaining assurance through the Board Assurance Framework and on the controls reviewed as part of the internal audit work. The Head of Internal Audit opinion was based on the audit work undertaken by PricewaterhouseCoopers LLP. During 2012/13, Parkhill Audit Agency undertook the audit of functions provided by the Lincolnshire Shared Service with whom the PCT had a contract for commercial contracts procurement, invoice payments and payroll. The opinion of the audit lead of Parkhill Audit Agency also informed the Accountable Officer review.
- Executive Managers with responsibility for the development and maintenance of systems of internal control also provided assurance.
- Directors accepted their compliance with the Code of Conduct and Accountability and their declaration of interests were recorded in public throughout the year. They also accepted compliance with the Code of Practice for Openness in the NHS.
- The Annual Governance report provided by External Audit.
- The Audit Committee approval of the Counter Fraud annual plan, regular reports and annual report, the Audit Committee Annual Report.
- The robust process to ensure actions were taken in response to the internal audit recommendations.
- The management processes and reporting of the corporate risk register and board assurance framework, and the regular reviews of the processes to support the continued improvement of that reporting.

51. The Board reviewed the effectiveness of risk management and internal control. There was in place a programme of risk management in accordance with the Department of Health assurance framework requirements which had been approved and monitored by the Board.

52. The programme of risk management and internal control included:-

- Processes to identify and quantify risks and potential liabilities,
- Engender among all levels of staff of a positive attitude to control risk,
- Processes to ensure significant risks and potential risks are addressed including effective systems of internal control, and the decisions on the acceptable level of retained risk,
- Contingency plans to offset the impact of adverse events,
- Audit arrangements,
- A risk management review programme.

53. The Head of Internal Audit, PricewaterhouseCoopers LLP, has provided an overall opinion as significant assurance. However, some high risks were identified: the identification of the potential cost of Continuing Health Care retrospective reviews, and the readiness and service specifications of the Greater East Midlands Commissioning Support Unit. Parkhill Audit Agency undertook reviews of the payroll and finance work undertaken by the Lincolnshire Partnership Foundation Trust shared services.

54. The review confirms that NHS Lincolnshire had a sound system of internal control that supports the achievement of its policies, aims and objectives.

55. In summary, the Lincolnshire health economy and NHS Lincolnshire PCT faced a number of significant challenges during 2012/13. All issues were identified in the corporate risk register, board assurance framework and within the internal control systems of the organisation.

Accountable Officer: Mr David Sharp

Organisation: Lincolnshire Teaching Primary Care Trust

Signature:

Date: 4th June 2013

INDEPENDENT AUDITOR'S REPORT TO THE RESPONSIBLE OFFICER FOR LINCOLNSHIRE TEACHING PCT

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

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

- the table of salaries and allowances of senior managers and related narrative notes on pages 31 to 32;
- the table of pension benefits of senior managers and related narrative notes on page 33; and
- the table of pay multiples and related narrative notes on page 30.

This report is made solely to the Responsible Officer for Lincolnshire Teaching PCT in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

Respective responsibilities of the Signing Officer and Finance Signing Officer, and auditors

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

Scope of the audit of the financial statements

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

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 Lincolnshire Teaching PCT as at 31 March 2013 and of its net operating costs for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters

In our opinion:

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

Matters on which we report by exception

We report to you if:

- in our opinion the governance statement does not reflect compliance with the Department of Health's Guidance;
- we refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have reason to believe that the PCT, or an officer of the PCT, 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.

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

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

efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report any matters that prevent us being satisfied that the audited body has put in place such arrangements.

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

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

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

Certificate

We certify that we have completed the audit of the accounts of Lincolnshire Teaching PCT in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Tony Crawley
on behalf of KPMG LLP

1 Waterloo Way
Leicester
LE1 6LP

7 June 2013

Annual Accounts 2012/13

The following pages contain the Annual Accounts for Lincolnshire Teaching Primary Care Trust (PCT) for the year ended 31st March 2013.

In the accounts, a distinction is drawn between "Programme Expenditure" which is the cost of the healthcare commissioned and "Administration Costs" which are the costs of undertaking the commissioning function.

The main function of the PCT was to commission healthcare for patients registered with Lincolnshire's general medical practices. The Health and Social Care Act 2012 abolished all PCTs on 31st March 2013 and transferred their functions to other bodies. As the current PCT functions are to continue, these accounts have been prepared on a 'going concern' basis.

It is suggested that the Annual Accounts are read in conjunction with the Annual Report to ensure complete understanding of the background to the figures.

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	**23,350**	17,860
Other costs	5.1	**1,270,395**	1,229,701
Income	4	**(37,343)**	(31,704)
Net operating costs before interest		**1,256,402**	1,215,857
Other (gains)/losses	10	**22**	0
Finance costs	11	**1,213**	1,229
Net operating costs for the financial year		**1,257,637**	1,217,086
Of which:			
Administration Costs			
Gross employee benefits	7.1	**21,103**	17,049
Other costs	5.1	**17,243**	15,104
Income	4	**(15,285)**	(9,015)
Net administration costs before interest		**23,061**	**23,138**
Finance costs	11	**1,183**	1,221
Net administration costs for the financial year		**24,244**	**24,359**
Programme Expenditure			
Gross employee benefits	7.1	**2,247**	811
Other costs	5.1	**1,253,152**	1,214,597
Income	4	**(22,058)**	(22,689)
Net programme expenditure before interest		**1,233,341**	**1,192,719**
Other (gains)/losses	10	**22**	0
Finance costs	11	**30**	8
Net programme expenditure for the financial year		**1,233,393**	**1,192,727**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**2,350**	415
Net (gain) on revaluation of property, plant & equipment	**(11,576)**	(1,911)
Release of Reserves to Statement of Comprehensive Net Expenditure	**(125)**	0
Total comprehensive net expenditure for the year*	**1,248,286**	**1,215,590**

* This is the sum of the rows above plus net operating costs for the financial year.

Notes 3 to 11 form part of this account.

Statement of Financial Position at 31 March 2013

		31 March 2013	31 March 2012
	NOTE	**£000**	£000
Non-current assets:			
Property, plant and equipment	12	**60,853**	49,245
Intangible assets	13	**0**	5
Trade and other receivables	19	**25**	21
Total non-current assets		**60,878**	49,271
Current assets:			
Trade and other receivables	19	**10,201**	14,141
Cash and cash equivalents	23	**1,944**	9
Total current assets		**12,145**	14,150
Non-current assets held for sale	24	**950**	1,425
Total assets		**73,973**	64,846
Current liabilities			
Trade and other payables	25	**(73,492)**	(74,959)
Provisions	32	**(3,050)**	(6,438)
Borrowings	27	**(731)**	(752)
Total current liabilities		**(77,273)**	(82,149)
Non-current assets plus/less net current assets/liabilities		**(3,300)**	(17,303)
Non-current liabilities			
Provisions	32	(21,181)	(2,084)
Borrowings	27	(25,432)	(26,164)
Total non-current liabilities		**(46,613)**	(28,248)
Total Assets Employed:		**(49,913)**	(45,552)
Financed by taxpayers' equity:			
General fund		(67,254)	(53,920)
Revaluation reserve		17,341	8,368
Total taxpayers' equity:		**(49,913)**	(45,552)

Notes 12 to 42 form part of this account.

The financial statements were approved by

Responsible Officer: Date:

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

	General fund	Revaluation reserve	Total reserves
	£000	£000	£000
Balance at 1 April 2012	**(53,920)**	**8,368**	**(45,552)**
Changes in taxpayers' equity for 2012-13			
Net operating cost for the year	(1,257,637)		**(1,257,637)**
Net gain / (loss) on revaluation of property, plant, equipment		11,576	**11,576**
Impairments and reversals		(2,350)	**(2,350)**
Transfers between reserves	378	(378)	**0**
Release of Reserves to SOCNE		125	**125**
Total recognised income and expense for 2012-13	**(1,257,259)**	**8,973**	**(1,248,286)**
Net Parliamentary funding	1,243,925		**1,243,925**
Balance at 31 March 2013	**(67,254)**	**17,341**	**(49,913)**
Balance at 1 April 2011	**(51,620)**	**7,181**	**(44,439)**
Changes in taxpayers' equity for 2011-12			
Net operating cost for the year	(1,217,086)		(1,217,086)
Net gain / (loss) on revaluation of property, plant, equipment		1,911	1,911
Impairments and Reversals		(430)	(430)
Transfers between reserves	294	(294)	0
Total recognised income and expense for 2011-12	(1,216,792)	1,187	(1,215,605)
Net Parliamentary funding	1,214,492	0	1,214,492
Balance at 31 March 2012	**(53,920)**	**8,368**	**(45,552)**

Statement of cash flows for the year ended 31 March 2013

	2012-13	2011-12	
		Per Audited Accounts	*Per FMA form **
	£000	£000	*£000*
Cash Flows from Operating Activities			
Net Operating Cost Before Interest	**(1,256,402)**	(1,215,857)	*(1,215,857)*
Depreciation and Amortisation	**1,913**	1,843	*1,843*
Impairments and Reversals	**759**	(1,372)	*(1,372)*
Interest Paid	**(1,183)**	(1,216)	*(1,216)*
(Increase)/Decrease in Trade and Other Receivables	**3,936**	(7,521)	*(5,241)*
Increase/(Decrease) in Trade and Other Payables	**(1,526)**	11,852	*977*
Provisions Utilised	**(1,806)**	(1,219)	*(1,219)*
Increase/(Decrease) in Provisions	**17,484**	5,374	*5,374*
Net Cash Inflow/(Outflow) from Operating Activities	**(1,236,825)**	**(1,208,115)**	***(1,216,710)***
Cash flows from investing activities			
(Payments) for Property, Plant and Equipment	**(4,537)**	(1,228)	*(1,228)*
Proceeds of disposal of assets held for sale (PPE)	**125**	45	*45*
Net Cash Inflow/(Outflow) from Investing Activities	**(4,412)**	**(1,183)**	***(1,183)***
Net cash inflow/(outflow) before financing	**(1,241,237)**	**(1,209,298)**	***(1,217,893)***
Cash flows from financing activities			
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**(753)**	(698)	*(698)*
Net Parliamentary Funding	**1,243,925**	1,214,492	*1,214,492*
Net Cash Inflow/(Outflow) from Financing Activities	**1,243,172**	**1,213,794**	***1,213,794***
Net increase/(decrease) in cash and cash equivalents	**1,935**	**4,496**	***(4,099)***
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**9**	**(4,487)**	***(4,487)***
Cash and Cash Equivalents (and Bank Overdraft) at year end	**1,944**	**9**	***(8,586)***

** These values for 2011-12 link to the proforma Financial Monitoring and Accounts (FMA) form issued by the Department of Health and include presentational inconsistencies which cannot be amended by the PCT as access is locked.*

1. Accounting Policies

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

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

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.

1.1.1 Acquistions & Discontinued Operations including Transforming Community Services

1.1.1.1 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.

1.1.1.2 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 are to be accounted for by use of absorption accounting in line with the Treasury Financial Reporting Manual (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.

1.1.2 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.

1.1.2.1 Going concern

Under the provisions of The Health and Social Care Act 2012 (Commencement No.4. Transitional, Savings and Transitory Provisions) Order 2013, Lincolnshire Teaching PCT was dissolved on 31st 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 Statement of Financial Postition (SOFP) has therefore been drawn up at 31st 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.

1. Accounting Policies (continued)

1.1.2.2 Critical judgements in applying accounting policies

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

1.1.2.2.1 It is appropriate to prepare the accounts on a 'going concern' basis (see 1.1.2.1 above).

1.1.2.2.2 The need to make provisions for restructuring and onerous contracts associated with organisational change.

1.1.2.2.3 That all arrangements containing leases have been correctly identified in accordance with the relevant interpretation issued by the International Financial Reporting Interpretations Committee (IFRIC 4); and

1.1.2.2.4 Having reviewed all leases, that they have been correctly indentified in accordance with the relevant International Accounting Standard (IAS 17) as being an operating or finance lease.

1.1.2.3 Key sources of estimation uncertainty

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

1.1.2.3.1 The most significant area of estimation uncertainty relates to the estimation of accruals for healthcare in the latter months of the year for which actual data was not received prior to the closure of the accounts. The major accruals relate to hospital activity, provision of healthcare by the private sector, GP prescriptions and items of service provided by GPs, dentists & opticians. Previous experience has been that the actual costs have not differed from the estimate by a material amount.

1.1.2.3.2 The other major area of estimation relates to the provision for the cost of retrospective claims for continuing healthcare. The Department of Health announced a deadline of 30th September 2012 for claims relating to before 31st March 2012. As a result of this, over 1,000 claims for retrospective restitution have been received by the PCT. An estimate of the PCT's liability in relation to those claims has been made in accordance with IAS 37.

1.1.2.3.3 The final major area of uncertainty relates to the valuation of property and the expected useful life of buildings.

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

Lincolnshire Teaching Primary Care Trust is not designated as a Care Trust by the Secretary of State under s45 of the Health and Social Care Act 2001.

1.4 Pooled Budgets

The PCT has entered into pooled budgets with Lincolnshire County Council (LCC) under s75 of the National Health Service Act 2006. The PCT accounts for its share of the assets, liabilities, income and expenditure of the pools as determined by the pooled budget agreements.

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

The 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 "Administration and Programme". For PCTs, the Department has defined "Administration 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. "Administration" is defined as running costs excluding certain technical adjustments for depreciation, impairments and provisions. Expense incurred under NHS transition redundancy programmes is however classed as "Programme" under Treasury budgetary control arrangements and so is recorded as such in the financial statements.

1. Accounting Policies (continued)

1.7 Property, Plant & Equipment

1.7.1 Recognition

- 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.

1.7.2 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.

Non-operational properties have, where appropriate, been valued to Fair Value (Market Value) reflecting alternative use potential.

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 (MEA) and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Valuations are all undertaken by the Valuation Office Agency (VOA). A full valuation is undertaken no less frequently than every five years. Land and buildings not subject to a full valuation at the year end have been revalued by the District Valuer to the year end value on a desktop basis. This valuation uses Building Cost Information Service (BCIS) indices and location factors for MEA valuations and, for non-specialised properties, comparable market evidence, Land Registry records, and the VOA's database of land values to establish appropriate Market Value. Where it has been considered impractical to determine fair value on a desktop basis, or where a significant change has occurred in the substance or use of the property, a full professional valuation has been obtained.

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.

1.7.3 Subsequent expenditure

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

1 Accounting Policies (continued)

1.8 Intangible Assets

1.8.1 Recognition

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

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

1.8.2 Measurement

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

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

1.9 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.

1.10 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. Accounting Policies (continued)

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 the General Fund.

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

The PCT does not account for any inventories.

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.

1.17 Employee Benefits

1.17.1 Short-Term Employee Benefits

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.17.2 Retirement Benefit Costs

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

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

1. Accounting Policies (continued)

1.18 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

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

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.

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.

1.23.1 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.

1.23.2 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. Accounting Policies (continued)

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.

1.26 Financial Instruments

1.26.1 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.

1.26.1.1 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.

1.26.1.2 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.

1.26.1.3 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.

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.

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)

1.26.2 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.

1.26.2.1 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.

1.26.2.2 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 Private Finance Initiative (PFI) Transactions

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

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

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

a) Services received

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

b) PFI assets, liabilities, and finance costs

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

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

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

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

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

c) Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the PCT's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value. The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

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

1. Accounting Policies (continued)

1.28 Accounting Standards that have been issued but have not yet been adopted

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

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

2 Operating segments

Lincolnshire Teaching Primary Care Trust operated as a single segment (commissioning of healthcare), operating solely in the United Kingdom.

Four Clinical Commissioning Groups (CCGs) were authorised during 2012-13 which operated in shadow form as committees of the PCT board. Discrete financial information systems for the CCGs have been evolving during the year. The Chief Operating Decision Maker continued to be the PCT Board throughout the year.

3. Financial Performance Targets

3.1 Revenue Resource Limit

	2012-13 £000	2011-12 £000
The PCT's performance is as follows:		
Total Net Operating Cost for the Financial Year	**1,257,637**	1,217,086
Revenue Resource Limit	**1,270,154**	1,226,611
Under/(over)spend Against Revenue Resource Limit (RRL)	**12,517**	9,525

This note discloses the PCT's performance against its statutory duty to contain net expenditure within the Revenue Resource Limit set by the Department of Health. The Revenue Resource Limit is the maximum the PCT can spend on commissioning healthcare for its resident population.

3.2 Capital Resource Limit

	2012-13 £000	2011-12 £000
The PCT is required to keep within its Capital Resource Limit (CRL)		
Capital Resource Limit	**9,026**	1,209
Charge to Capital Resource Limit	**4,472**	732
(Over)/Underspend Against CRL	**4,554**	**477**

This note discloses the PCT's performance against its statutory duty to contain net expenditure within the Capital Resource Limit set by the Department of Health. Capital expenditure is on items with a useful life expectancy greater than one year and with a value greater than £5,000 (for example on land and buildings).

3.3 Provider full cost recovery duty

Previously the PCT had a duty to achieve full cost recovery in relation to its directly managed provider services. These services were transferred out of the PCT at the end of 2010-11.

3.4 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**1,243,925**	1,214,492
Cash Limit	**1,243,925**	1,214,492
Under/(Over)spend Against Cash Limit	**0**	**0**

This note discloses the PCT's performance against its statutory duty to contain net cash expenditure (revenue and capital) within the cash limit set by the Department of Health.

3.5 Reconciliation of Cash Drawings to Parliamentary Funding (current year)

	2012-13 £000
Total cash received from DH (Gross)	1,102,399
Less: Trade Income from DH	0
Less/(Plus): movement in DH working balances	0
Sub total: net advances	**1,102,399**
(Less)/plus: transfers (to)/from other resource account bodies	0
Plus: cost of dentistry schemes (central charge to cash limits)	22,096
Plus: drugs reimbursement (central charge to cash limits)	119,430
Parliamentary funding credited to General Fund	**1,243,925**

4 Miscellaneous Revenue

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12 Total
	£000	£000	£000	£000
Dental Charge income from Contractor-Led GDS & PDS	**9,410**	0	9,410	9,430
Prescription Charge income	**7,968**	0	7,968	7,313
Strategic Health Authorities	**3,910**	932	2,978	3,546
NHS Trusts	**11,491**	11,247	244	7,128
NHS Foundation Trusts	**2,758**	2,464	294	1,890
Primary Care Trusts - Other	**213**	3	210	149
Recoveries in respect of employee benefits	**462**	462	0	343
Local Authorities	**542**	0	542	947
Education, Training and Research	**1**	1	0	73
Other Non-NHS Patient Care Services	**41**	0	41	55
Rental revenue from operating leases	**347**	0	347	347
Other revenue	**200**	176	24	483
Total miscellaneous revenue	**37,343**	**15,285**	**22,058**	**31,704**

This note discloses the income that relates directly to the operating activities of the PCT.

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	**99,760**		99,760	89,572
Non-Healthcare	**604**	604	0	863
Total	**100,364**	**604**	**99,760**	**90,435**
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	**489,646**	1,238	488,408	483,977
Goods and services (other, excl Trusts, FT and PCT))	**244**	6	238	182
Total	**489,890**	**1,244**	**488,646**	**484,159**
Goods and Services from Foundation Trusts	**206,784**	324	206,460	198,721
Purchase of Healthcare from Non-NHS bodies	**124,382**	0	124,382	109,229
Expenditure on Drugs Action Teams	**8,851**	0	8,851	7,187
Non-GMS Services from GPs	**1,488**	1,484	4	1,175
Contractor Led GDS & PDS (excluding employee benefits)	**31,443**	0	31,443	32,156
Salaried Trust-Led PDS & PCT DS (excluding employee benefits)	**1,720**	0	1,720	1,490
Chair, Non-executive Directors & PEC remuneration	**128**	128	0	99
Executive committee members costs	**55**	55	0	70
Consultancy Services	**632**	632	0	360
Prescribing Costs	**129,795**	0	129,795	134,185
G/PMS, APMS and PCTMS (excluding employee benefits)	**110,787**	0	110,787	112,256
Pharmaceutical Services	**5,907**	0	5,907	6,041
New Pharmacy Contract	**29,759**	0	29,759	27,841
General Ophthalmic Services	**6,548**	0	6,548	6,473
Supplies and Services - Clinical	**3,171**	65	3,106	2,067
Supplies and Services - General	**1,375**	1,375	0	528
Establishment	**2,298**	2,064	234	2,141
Transport	**13**	12	1	21
Premises	**7,448**	6,812	636	6,247
Impairments & Reversals of Property, plant and equipment	**484**	0	484	(1,372)
Impairments and Reversals of non-current assets held for sale	**275**	0	275	0
Depreciation	**1,909**	1,350	559	1,842
Amortisation	**4**	4	0	1
Impairment of Receivables	**(67)**	(67)	0	(68)
Research and Development Expenditure	**44**	33	11	106
Audit Fees	**147**	147	0	243
Other Auditors Remuneration	**0**	0	0	37
Clinical Negligence Costs	**62**	62	0	106
Education and Training	**3,805**	747	3,058	3,717
Other	**894**	168	726	2,208
Total Operating costs charged to Statement of Comprehensive Net Expenditure	**1,270,395**	**17,243**	**1,253,152**	**1,229,701**
Employee Benefits (excluding capitalised costs)				
PCT Officer Board Members	**890**	890	0	820
Other Employee Benefits	**22,460**	20,213	2,247	17,040
Total Employee Benefits charged to SOCNE	**23,350**	**21,103**	**2,247**	**17,860**
Total Operating Costs	**1,293,745**	**38,346**	**1,255,399**	**1,247,561**

This note provides an analysis of the PCT's gross operating costs. The total equals the sum of employee benefits and other costs shown on the Statement of Comprehensive Expenditure.

There were no grants made by the PCT during 2012-13.

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**24,244**	21,481	2,763
Weighted population (number in units)*	**726,236**	726,236	726,236
Running costs per head of population (£ per head)	**33.38**	**29.58**	**3.80**
PCT Running Costs 2011-12			
Running costs (£000s)	**24,359**	21,292	3,067
Weighted population (number in units)	**726,236**	726,236	726,236
Running costs per head of population (£ per head)	**33.54**	**29.32**	**4.22**

* Weighted population figures are not available for 2012-13 as the weighted capitation formula for PCT allocations was not updated for 2012-13. This was because it was decided to give all PCTs the same percentage growth in their allocations in this transitional year rather than differential growth based on a weighted capitation formula. Therefore, 2011-12 weighted populations have been used when calculating 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	110,787	112,256
Prescribing costs	129,795	134,185
Contractor led GDS & PDS	31,443	32,156
Trust led GDS & PDS	1,720	1,490
General Ophthalmic Services	6,548	6,473
Department of Health Initiative Funding	0	0
Pharmaceutical services	5,907	6,041
Local Pharmaceutical Services Pilots	0	0
New Pharmacy Contract	29,759	27,841
Non-GMS Services from GPs	4	5
Other	0	0
Total Primary Healthcare purchased	**315,963**	320,447
Purchase of Secondary Healthcare		
Learning Difficulties	18,895	21,259
Mental Illness	110,745	102,833
Maternity	28,780	27,031
General and Acute	554,809	562,812
Accident and emergency	42,778	41,447
Community Health Services	138,576	93,090
Other Contractual	42,606	45,678
Total Secondary Healthcare Purchased	**937,189**	894,150
Grant Funding		
Grants for capital purposes	0	0
Grants for revenue purposes	0	0
Total Healthcare Purchased by PCT	**1,253,152**	**1,214,597**
PCT self-provided secondary healthcare included above	0	0
Social Care from Independent Providers	0	0
Healthcare from NHS FTs included above	206,460	198,296

6. Operating Leases

The 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) and IFRIC 4 (Determining whether an Arrangement Contains a Lease) the PCT has determined that those arrangements contain operating leases but, as there is no defined term in the arrangements, it is not possible to analyse the arrangements over financial years. The financial value of such leases included in the Statement of Comprehensive Net Expenditure for 2012/13 is £8,210,034 (£7,983,698 in 2011/12).

Other lease arrangements are included below.

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				**1,243**	1,396
Total				**1,243**	**1,396**
Payable:					
No later than one year	**0**	**1,130**	**139**	**1,269**	1,291
Between one and five years	**0**	**3,399**	**58**	**3,457**	3,928
After five years	**0**	**6,818**	**0**	**6,818**	7,565
Total	**0**	**11,347**	**197**	**11,544**	**12,784**
Total future sublease payments expected to be received. (These are for a GP practice referred to in note 6.2).				392	511

6.2 PCT as lessor

	2012-13 £000	2011-12 £000
Recognised as income		
Rental Revenue	**347**	347
Contingent rents	**0**	0
Total	**347**	347
Receivable:		
No later than one year	**334**	247
Between one and five years	**1,079**	872
After five years	**1,869**	1,208
Total	**3,282**	2,327

The main elements of the above are
i) the lease of the LPFT Headquarters building
ii) the leases of GP practices

7. Employee benefits and staff numbers

7.1 Employee benefits

	Total			Permanently employed			Other		
	Total £000	**Admin £000**	**Programme £000**	**Total £000**	**Admin £000**	**Programme £000**	**Total £000**	**Admin £000**	**Programme £000**
Employee Benefits - Gross Expenditure 2012-13									
Salaries and wages	**18,690**	17,845	845	**16,555**	15,710	845	**2,135**	2,135	0
Social security costs	**1,284**	1,226	58	**1,237**	1,178	58	**47**	47	0
Employer Contributions to NHS BSA - Pensions Division	**2,129**	2,033	96	**2,051**	1,955	96	**78**	78	0
Other pension costs	**754**	0	754	**754**	0	754	**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	**493**	0	493	**493**	0	493	**0**	0	0
Total employee benefits	**23,350**	**21,103**	**2,247**	**21,090**	**18,843**	**2,247**	**2,260**	**2,260**	**0**
Less recoveries in respect of employee benefits (table below)	**(462)**	(462)	0	**(462)**	**(462)**	**0**	**0**	**0**	**0**
Total - Net Employee Benefits including capitalised costs	**22,888**	**20,641**	**2,247**	**20,628**	**18,381**	**2,247**	**2,260**	**2,260**	**0**
Employee costs capitalised	**0**	0	0	**0**	0	0	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**23,350**	**21,103**	**2,247**	**21,090**	**18,843**	**2,247**	**2,260**	**2,260**	**0**
Recognised as:									
Commissioning employee benefits	**23,350**			**21,090**			**2,260**		
Provider employee benefits	**0**			**0**			**0**		
Gross Employee Benefits excluding capitalised costs	**23,350**			**21,090**			**2,260**		

	Total			Permanently employed			Other		
	Total £000	**Admin £000**	**Programme £000**	**Total £000**	**Admin £000**	**Programme £000**	**Total £000**	**Admin £000**	**Programme £000**
Employee Benefits - Income 2012-13									
Salaries and wages	**391**	391	0	**391**	391	0	**0**	0	0
Social Security costs	**27**	27	0	**27**	27	0	**0**	0	0
Employer Contributions to NHS BSA - Pensions Division	**44**	44	0	**44**	44	0	**0**	0	0
Other pension costs	**0**	0	0	**0**	0	0	**0**	0	0
Other Post Employment Benefits	**0**	0	0	**0**	0	0	**0**	0	0
Other Employment Benefits	**0**	0	0	**0**	0	0	**0**	0	0
Termination Benefits	**0**	0	0	**0**	0	0	**0**	0	0
TOTAL excluding capitalised costs	**462**	**462**	**0**	**462**	**462**	**0**	**0**	**0**	**0**

"Permanently employed" staff are those directly employed by the PCT. "Other" staff are those on inward secondment from other organisations, bank staff, agency staff, temporary staff and contract staff.
"Income" relates to those staff on secondment to other organisations.

7. Employee benefits and staff numbers

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	**14,223**	12,482	1,741
Social security costs	**1,018**	997	21
Employer Contributions to NHS BSA - Pensions Division	**1,612**	1,585	28
Other pension costs	**0**	0	0
Other post-employment benefits	**0**	0	0
Other employment benefits	**0**	0	0
Termination benefits	**1,007**	1,007	0
Total gross employee benefits	**17,860**	**16,070**	**1,790**
Less recoveries in respect of employee benefits	**(343)**	(295)	(48)
Total - Net Employee Benefits including capitalised costs	**17,517**	**15,775**	**1,742**
Employee costs capitalised	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**17,860**	**16,070**	**1,790**
Recognised as:			
Commissioning employee benefits	**17,860**		
Provider employee benefits	**0**		
Gross Employee Benefits excluding capitalised costs	**17,860**		

7.2 Staff Numbers

	2012-13 Total Number	2012-13 Permanently employed Number	2012-13 Other Number	2011-12 Total Number	2011-12 Permanently employed Number	2011-12 Other Number
Average Staff Numbers						
Medical and dental	**4**	4	0	**4**	4	0
Administration and estates	**409**	369	40	**330**	312	19
Healthcare assistants and other support staff	**99**	97	2	**2**	2	0
Nursing, midwifery and health visiting staff	**34**	34	1	**31**	30	0
Scientific, therapeutic and technical staff	**16**	16	0	**17**	17	0
TOTAL	**562**	**519**	**43**	**384**	**365**	**19**
Of the above - staff engaged on capital projects	**0**	0	0	**0**	0	0

This note uses the same definitions as those applied to note 7.1 above. Numbers are whole time equivalents based on contracted hours of employment.
The number of staff increased in 2012-13 due, mainly, to the transfer of Estates staff from the Lincolnshire Community Health Services Trust back to Lincolnshire Teaching PCT on the 1st April 2012.

7.3 Staff Sickness absence and ill health retirements

Details of staff sickness absence are included in the Annual Report.

	2012-13 Number	2011-12 Number
Number of persons retired early on ill health grounds	**5**	2
	£000s	£000s
Total additional pensions liabilities accrued in the year	**350**	181

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	5	0	5	4	0	4
£10,001-£25,000	4	0	4	3	1	4
£25,001-£50,000	2	0	2	2	0	2
£50,001-£100,000	8	0	8	0	0	0
£100,001 - £150,000	5	0	5	0	0	0
£150,001 - £200,000	1	0	1	0	0	0
>£200,000	2	0	2	0	0	0
Total number of exit packages by type (total cost	**27**	**0**	**27**	**9**	**1**	**10**
	£s	**£s**	**£s**	**£s**	**£s**	**£s**
Total resource cost	**2,167,269**	**0**	**2,167,269**	**143,000**	**13,000**	**156,000**

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

This disclosure reports the number and value of exit packages agreed in the year. Note that the expense associated with these departures may have been recognised in part or in full in a previous period.

7.5 Pension costs

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

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

a) Accounting valuation

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

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

b) Full actuarial (funding) valuation

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

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

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

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

c) Scheme provisions

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

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.
With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".
Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

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

8. Better Payment Practice Code

8.1 Measure of compliance

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**40,263**	**134,563**	32,286	127,132
Total Non-NHS Trade Invoices Paid Within Target	**37,100**	**125,194**	30,149	117,154
Percentage of Non-NHS Trade Invoices Paid Within Target	**92.14%**	**93.04%**	93.38%	92.15%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**6,776**	**858,913**	4,596	823,148
Total NHS Trade Invoices Paid Within Target	**5,967**	**844,841**	4,269	818,855
Percentage of NHS Trade Invoices Paid Within Target	**88.06%**	**98.36%**	92.89%	99.48%

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

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

The PCT has nothing to disclose under this note.

9. Investment Income

The PCT has nothing to disclose in this note.

10. Other Gains and Losses

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Gain/(Loss) on disposal of assets other than by sale (PPE)	**(22)**	0	(22)	0
Total	**(22)**	**0**	**(22)**	0

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	**5**	5	0	8
Interest on obligations under PFI contracts:				
- main finance cost	**1,178**	1,178	0	1,208
Total interest expense	**1,183**	**1,183**	**0**	**1,216**
Other finance costs	**16**	0	16	0
Provisions - unwinding of discount	**14**	0	14	13
Total	**1,213**	**1,183**	**30**	**1,229**

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	**9,277**	**38,590**	**0**	**0**	**982**	**0**	**2,677**	**417**	**51,943**
Additions of Assets Under Construction	0	0	0	146	0	0	0	0	**146**
Additions Purchased	4,000	271	0	0	101	0	79	0	**4,451**
Additions Donated	125	0	0	0	0	0	0	0	**125**
Disposals other than for sale	0	0	0	0	(218)	0	0	0	**(218)**
Upward revaluation/positive indexation	0	11,576	0	0	0	0	0	0	**11,576**
Impairments/negative indexation	(2,080)	(195)	0	0	0	0	0	0	**(2,275)**
At 31 March 2013	**11,322**	**50,242**	**0**	**146**	**865**	**0**	**2,756**	**417**	**65,748**
Depreciation									
At 1 April 2012	**0**	**0**	**0**	**0**	**547**	**0**	**1,943**	**208**	**2,698**
Disposals other than for sale	0	0	0	0	(196)	0	0	0	**(196)**
Impairments	0	551	0	0	0	0	0	0	**551**
Reversal of Impairments	0	(67)	0	0	0	0	0	0	**(67)**
Charged During the Year	0	1,420	0	0	140	0	276	73	**1,909**
At 31 March 2013	**0**	**1,904**	**0**	**0**	**491**	**0**	**2,219**	**281**	**4,895**
Net Book Value at 31 March 2013	**11,322**	**48,338**	**0**	**146**	**374**	**0**	**537**	**136**	**60,853**
Purchased	11,197	48,025	0	146	367	0	537	136	**60,408**
Donated	125	313	0	0	7	0	0	0	**445**
Total at 31 March 2013	**11,322**	**48,338**	**0**	**146**	**374**	**0**	**537**	**136**	**60,853**
Asset financing:									
Owned	11,322	30,572	0	146	374	0	537	136	**43,087**
Held on finance lease	0	146	0	0	0	0	0	0	**146**
On-SOFP PFI contracts	0	17,620	0	0	0	0	0	0	**17,620**
Total at 31 March 2013	**11,322**	**48,338**	**0**	**146**	**374**	**0**	**537**	**136**	**60,853**

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	**3,698**	**4,490**	**0**	**0**	**4**	**0**	**0**	**1**	**8,193**
Movements (specify)	(1,955)	11,105	0	0	(1)	0	0	(1)	**9,148**
At 31 March 2013	**1,743**	**15,595**	**0**	**0**	**3**	**0**	**0**	**0**	**17,341**

Additions to Assets Under Construction in 2012-13

	£000
Land	0
Buildings excl Dwellings	146
Dwellings	0
Plant & Machinery	0
Balance at 31.3.13	**146**

Donated land has been recognised during the year arising from a s.106 agreement with a value of £125k.

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	**10,527**	**35,852**	**0**	**666**	**960**	**0**	**2,598**	**417**	**51,020**
Additions - purchased	0	676	0	0	22	0	79	0	**777**
Reclassifications	0	666	0	(666)	0	0	0	0	**0**
Reclassified as held for sale	(1,325)	(100)	0	0	0	0	0	0	**(1,425)**
Revaluation & indexation gains	75	1,836	0	0	0	0	0	0	**1,911**
Impairments	0	(415)	0	0	0	0	0	0	**(415)**
At 31 March 2012	**9,277**	**38,515**	**0**	**0**	**982**	**0**	**2,677**	**417**	**51,868**
Depreciation									
At 1 April 2011	**0**	**0**	**0**		**340**	**0**	**1,678**	**135**	**2,153**
Impairments	0	358	0	0	42	0	0	0	**400**
Reversal of Impairments	0	(1,772)	0	0	0	0	0	0	**(1,772)**
Charged During the Year	0	1,339	0		165	0	265	73	**1,842**
At 31 March 2012	**0**	**(75)**	**0**	**0**	**547**	**0**	**1,943**	**208**	**2,623**
Net Book Value at 31 March 2012	**9,277**	**38,590**	**0**	**0**	**435**	**0**	**734**	**209**	**49,245**
Purchased	9,277	38,255	0	0	427	0	734	209	**48,902**
Donated	0	335	0	0	8	0	0	0	**343**
At 31 March 2012	**9,277**	**38,590**	**0**	**0**	**435**	**0**	**734**	**209**	**49,245**
Asset financing:									
Owned	9,277	20,016	0	0	435	0	734	209	**30,671**
Held on finance lease	0	156	0	0	0	0	0	0	**156**
On-SOFP PFI contracts	0	18,418	0	0	0	0	0	0	**18,418**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**9,277**	**38,590**	**0**	**0**	**435**	**0**	**734**	**209**	**49,245**

12.3 Economic lives of property, plant and equipment

	Min Life Years	Max Life Years
Buildings exc Dwellings	5	69
Dwellings	0	0
Plant & Machinery	5	15
Transport Equipment	0	0
Information Technology	4	4
Furniture and Fittings	5	10

13.1 Intangible non-current assets

2012-13	Software purchased £000	Total £000
Cost		
At 1 April 2012	**19**	**19**
Disposals other than by sale	(6)	**(6)**
At 31 March 2013	**13**	**13**
Amortisation		
At 1 April 2012	**14**	**14**
Disposals other than by sale	(5)	**(5)**
Charged during the year	4	**4**
At 31 March 2013	**13**	**13**
Net Book Value at 31 March 2013	**0**	**0**
Net Book Value at 31 March 2013 comprises		
Purchased	0	**0**
Total at 31 March 2013	**0**	**0**

Revaluation reserve balance for intangible non-current assets

	Software purchased £000	Total £000
At 1 April 2012	**0**	**0**
Movements	0	**0**
At 31 March 2013	**0**	**0**

13.2 Intangible non-current assets

2011-12	Software purchased £000	Total £000
At 1 April 2011	**19**	**19**
At 31 March 2012	**19**	**19**
Amortisation		
At 1 April 2011	**13**	**13**
Charged during the year	1	**1**
At 31 March 2012	**14**	**14**
Net Book Value at 31 March 2012	**5**	**5**
Net Book Value at 31 March 2012 comprises		
Purchased	5	**5**
Total at 31 March 2012	**5**	**5**

13.3 Economic lives of intangible non-current assets

It is not the PCT's policy to index or revalue intangible assets.
They are measured initially at cost and then written off over their useful life, shown in the table below.

Economic Lives of Intangible Non-Current Assets

	Min Life Years	Max Life Years
Software Licences	4	4

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	124	0	124
Total charged to Departmental Expenditure Limit	**124**	**0**	**124**
Changes in market price	360	0	360
Total charged to Annually Managed Expenditure	**360**	**0**	**360**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Changes in market price	2,350	0	0
Total impairments for PPE charged to reserves	**2,350**	0	0
Total Impairments of Property, Plant and Equipment	**2,834**	**0**	**484**
Total Impairments charged to Revaluation Reserve	2,350	0	0
Total Impairments charged to SoCNE - DEL	224	0	224
Total Impairments charged to SoCNE - AME	535	0	535
Overall Total Impairments	**3,109**	**0**	**759**
Of which:			
Impairment on revaluation to "modern equivalent asset" basis	**0**	0	0

The County Hospital Louth site was purchased during the year and revalued on a modern equivalent asset basis. This resulted in an upward revaluation of buildings by £11,281k and an impairment of land by £2,080k which was offset in the revaluation reserve.

There were no impairments or reversals relating to intangible assets or non-current assets held for sale.

15 Investment property

The PCT has nothing to disclose in this note.

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	**408**	0
Intangible assets	**0**	0
Total	**408**	0

16.2 Other financial commitments

Leases and PFI scheme financial commitments are disclosed in notes 30 and 34.
The commitments below relate to the Nottingham Independent Sector Treatment centre.

	31 March 2013 £000	31 March 2012 £000
Not later than one year	**296**	712
Later than one year and not later than five year	**0**	297
Later than five years	**0**	0
Total	**296**	1,009

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	2,264	0	1,792	0
Balances with Local Authorities	82	0	569	0
Balances with NHS Trusts and Foundation Trusts	4,735	0	18,048	0
Balances with bodies external to government	3,120	0	53,083	0
At 31 March 2013	**10,201**	**0**	**73,492**	**0**
Prior period:				
Balances with other Central Government Bodies	762	0	2,889	0
Balances with Local Authorities	3,871	0	353	0
Balances with NHS Trusts and Foundation Trusts	6,523	0	16,143	0
Balances with bodies external to government	2,985	21	55,574	0
At 31 March 2012	**14,141**	**21**	**74,959**	**0**

18 Inventories

The PCT does not account for inventories in the Statement of Financial Position.

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	**4,246**	2,372	**0**	0
NHS prepayments and accrued income	**2,359**	4,625	**0**	0
Non-NHS receivables - revenue	**949**	179	**0**	0
Non-NHS prepayments and accrued income	**2,611**	7,127	**0**	0
Provision for the impairment of receivables	**(296)**	(369)	**0**	0
VAT	**332**	207	**0**	0
Other receivables	**0**	0	**25**	21
Total	**10,201**	14,141	**25**	21
Total current and non current	**10,226**	14,162		

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

19.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	**2,360**	68
By three to six months	**112**	40
By more than six months	**0**	1,011
Total	**2,472**	1,119

19.3 Provision for impairment of receivables

	2012-13 £000	**2011-12 £000**
Balance at 1 April 2012	**(369)**	(451)
Amount written off during the year	**6**	14
Amount recovered during the year	**28**	27
(Increase)/decrease in receivables impaired	**39**	41
Balance at 31 March 2013	**(296)**	(369)

Receivables are impaired after individual appraisal to assess their estimated fair value.

20 NHS LIFT investments

The PCT has nothing to disclose in this note.

21 Other financial assets

The PCT has nothing to disclose in this note.

22 Other current assets

The PCT has nothing to disclose in this note.

23 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**9**	0
Net change in year	**1,935**	9
Closing balance	**1,944**	9
Made up of		
Cash with Government Banking Service	**1,944**	9
Commercial banks	**0**	0
Cash in hand	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**1,944**	9
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**1,944**	9
Patients' money held by the PCT, not included above	**0**	0

24 Non-current assets held for sale

	Land	Buildings, excl. dwellings	Total
	£000	£000	£000
Balance at 1 April 2012	1,325	100	**1,425**
Less assets sold in the year	(125)	0	**(125)**
Less impairment of assets held for sale	(250)	(100)	**(350)**
Balance at 31 March 2013	**950**	**0**	**950**
Liabilities associated with assets held for sale at 31 March 2013	**0**	**0**	**0**
			0
Balance at 1 April 2011	60	0	**60**
Plus assets classified as held for sale in the year	1,325	100	**1,425**
Less assets sold in the year	(45)	0	**(45)**
Less impairment of assets held for sale	(15)	0	**(15)**
Balance at 31 March 2012	**1,325**	**100**	**1,425**
Liabilities associated with assets held for sale at 31 March 2012	0	0	**0**

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

At 31 March 2012	175
At 31 March 2013	0

25 Trade and other payables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
NHS payables - revenue	**10,524**	(855)	**0**	0
NHS accruals and deferred income	**8,421**	19,282	**0**	0
Family Health Services (FHS) payables	**25,003**	28,047	0	0
Non-NHS payables - revenue	**5,540**	4,292	**0**	0
Non-NHS payables - capital	**101**	42	**0**	0
Non NHS accruals and deferred income	**22,519**	21,998	**0**	0
Social security costs	**243**	164	**0**	0
Tax	**352**	180	**0**	0
Other	789	1,809	0	0
Total	**73,492**	74,959	**0**	0
Total payables (current and non-current)	**73,492**	**74,959**		

26 Other liabilities

The PCT has nothing to disclose in this note.

27 Borrowings

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
PFI liabilities:				
Main liability	**710**	704	**25,432**	26,143
Finance lease liabilities	**21**	48	**0**	21
Total	**731**	**752**	**25,432**	**26,164**
Total other liabilities (current and non-current)	**26,163**	**26,916**		

28 Other financial liabilities

The PCT has nothing to disclose in this note.

29 Deferred income

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Opening balance at 1 April 2012	**335**	102	**0**	0
Deferred income addition	**163**	335	**0**	0
Transfer of deferred income	**(335)**	(102)	**0**	0
Current deferred Income at 31 March 2013	**163**	335	**0**	0
Total other liabilities (current and non-current)	**163**	**335**		

30 Finance lease obligations

The PCT has an arrangement to use the Nottingham NHS Treatment Centre. Under IFRS a share of the asset must be treated as a finance lease. Therefore, the Nottingham NHS Treatment Centre, being an Independent Sector Treatment Centre (ISTC), has been included as a finance lease in respect of the proportion of the total Modern Equivalent Asset value allocated to the PCT. This relates solely to the buildings element of the Centre and the lease expires during 2013-14.

Amounts payable under finance leases (Buildings)	**Minimum lease payments**		**Present value of minimum lease payments**	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Within one year	**21**	53	**21**	48
Between one and five years	**0**	22	**0**	21
After five years	**0**	0	**0**	0
Less future finance charges	**0**	(6)		
Present value of minimum lease payments	**21**	69	**21**	69
Included in:				
Current borrowings			**21**	48
Non-current borrowings			**0**	21
			21	69

31 Finance lease receivables as lessor

The PCT has nothing to disclose in this note.

32 Provisions

	Total £000s	Legal Claims £000s	Restructuring £000s	Continuing Care £000s	Redundancy £000s	Other £000s
Balance at 1 April 2012	**8,523**	20	271	2,418	1,039	4,775
Arising During the Year	**20,744**	3	474	19,336	772	159
Utilised During the Year	**(1,806)**	(10)	(86)	(202)	(247)	(1,261)
Reversed Unused	**(3,260)**	(10)	(89)	(86)	(294)	(2,781)
Unwinding of Discount	**14**	0	9	0	0	5
Change in Discount Rate	**16**	0	5	0	0	11
Balance at 31 March 2013	**24,231**	**3**	**584**	**21,466**	**1,270**	**908**
Expected Timing of Cash Flows:						
No Later than One Year	**3,050**	**3**	**500**	**830**	**1,270**	**447**
Later than One Year and not later than Five Years	**20,894**	**0**	**84**	**20,636**	**0**	**174**
Later than Five Years	**287**	**0**	**0**	**0**	**0**	**287**

Legal claims relate to non-clinical cases and are based upon information provided by the NHS Litigation Authority and legal representatives.

Restructuring relates to possible staff and systems transition costs resulting from the abolition of the PCT.

Continuing Care relates to the anticipated costs of continuing care claims where it is probable that the PCT will incur costs. The provision is for claimants' retrospective entitlement to health costs and includes administration and interest costs. It resulted from a Department of Health initiative and the process has been closed to applications received after 31.3.13.

Compulsory redundancy costs resulted from the abolition of the PCT.

The most significant of the "Other" provisions arising in year were:
- Exit costs associated with changes in service provision
- Injury benefit

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

As at 31 March 2013	2,654
As at 31 March 2012	2,559

33 Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities		
Equal Pay	**0**	0
Other	**(45,000)**	(3,390)
Amounts Recoverable Against Contingent Liabilities	**0**	0
Net Value of Contingent Liabilities	**(45,000)**	(3,390)
Contingent Assets		
Contingent Assets	**0**	0
Net Value of Contingent Assets	**0**	0

The PCT has provided for the anticipated costs of continuing care claims (see note 32 above) where it is probable that the PCT will incur costs. Note 33 discloses a further contingent liability, calculated using costs for other patients where the PCT does not think there is a probable liability although claims have been lodged.

34 PFI and LIFT - additional information

The PCT does not have any off-Statement of Financial Position schemes.

	31 March 2013 £000	31 March 2012 £000
34.1 Charges to operating expenditure and future commitments in respect of on and off SOFP PFI		
Service element of on SOFP PFI charged to operating expenses in year	**644**	635
Total	**644**	**635**
Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI		
No Later than One Year	**663**	637
Later than One Year, No Later than Five Years	**2,852**	2,739
Later than Five Years	**21,823**	22,302
Total	**25,338**	25,678

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

	31 March 2013 £000	31 March 2012 £000
34.2 Imputed "finance lease" obligations for on SOFP PFI contracts due		
Analysed by when PFI payments are due		
No Later than One Year	**1,858**	1,883
Later than One Year, No Later than Five Years	**7,286**	7,334
Later than Five Years	**34,619**	36,429
Subtotal	**43,763**	45,646
Less: Interest Element	**(17,621)**	(18,799)
Total	**26,142**	26,847

35 Impact of IFRS treatment - 2012-13

	Total £000	Admin £000	Programme £000
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g. LIFT/PFI)			
Depreciation charges	**405**	405	0
Interest Expense	**1,178**	1,178	0
Other Expenditure	**734**	734	0
Total IFRS Expenditure (IFRIC12)	**2,317**	**2,317**	**0**
Revenue consequences of LIFT/PFI schemes under UK GAAP / ESA95 (net of any sublease income)	**(2,612)**	(2,612)	0
Net IFRS change (IFRIC12)	**(295)**	**(295)**	**0**
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12			
UK GAAP capital expenditure 2012-13 (Reversionary Interest)	342	342	0

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 than 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. Apart from cash at bank and in hand, no other financial assets or liabilities are disclosed in this note as they are disclosed elsewhere in these accounts.

36.1 Financial Assets	**At 'fair value through profit and loss'**	**Loans and receivables**	**Available for sale**	**Total**
	£000	**£000**	**£000**	**£000**
Cash at bank and in hand	0	1,944	0	**1,944**
Total at 31 March 2013	**0**	**1,944**	**0**	**1,944**
Cash at bank and in hand	0	9	0	9
Total at 31 March 2012	0	9	0	9

36.2 Financial Liabilities

The PCT has nothing to disclose in this note (see above).

37 Related Party Transactions

37.1 Details of related party transactions with individuals are as follows:

Name & Job Title	Related Party Detail	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Partv
		£'000	£'000	£'000	£'000
Officers & Office Holders					
Mr John McIvor, Chief Executive	Partner employed by Lincolnshire Partnership Foundation Trust	76,937	4,563	0	509
Dr Martin McShane, Director of Strategic Planning & Health Outcomes	Partner employed by Doncaster and Bassetlaw Foundation Trust	1,180	0	0	0
Dr Anthony Hill, Joint Director of Public Health	Joint employee with Lincolnshire County Council	25,422	924	20	252
Mr Roger Buttery, Non-Executive Director	Deputy Chairman, Board of Governors, University of Lincoln (until 31/12/12)	(24)	3	0	0
Mrs Marianne Overton, Non-Executive Director	i) Elected Member, North Kesteven District Council	105	0	0	0
	ii) Elected Member, Lincolnshire County Council	25,422	924	20	252
Mr Giles Walter, Non-Executive Director	Partner employed by Ingham Surgery	849	0	0	0
Mr Gary James, Accountable Officer, Lincolnshire East CCG	Non-Executive Director, Lincolnshire Sports Partnership	123	0	0	0
Mr Rob Croot, Chief Finance Officer, Lincolnshire West CCG	Partner employed by Leicestershire Partnership NHS Trust	322	0	6	0
	Former partner employed by Nottingham University Hospitals Trust	18,402	89	0	0
GPs					
Dr Sunil Hindocha, CCG Council & Accountable Officer, Lincolnshire West CCG	i) Partner, City Medical Practice, Lincoln	2,567	0	0	0
	ii) Partner employed by Glebe Park Surgery	833	0	0	0
Dr Brynnen Massey, CCG Council Chair & PCT Medical Director	i) Partner, North Thoresby Practice, East Lindsey	2,899	1	0	0
	ii) Member of St Andrews Hospice	50	0	0	0
Dr Peter Holmes, CCG Council	Partner, Stuart House Surgery, Boston	2,310	1	0	0
Dr Richard Gent, CCG Council	GP Principal, Ancaster Surgery	2,765	0	0	0
Dr Miles Langdon, CCG Council	Partner, St Marys Medical Centre, Stamford	3,925	0	0	0
Dr Charles Lennon, CCG Council	Senior Partner, Munro Medical Centre, Spalding	6,336	1	0	0
Dr James Howarth, CCG Council	Partner, Marisco Medical Practice, Skegness	6,845	2	0	0

37.2 The Department of Health is regarded as a related party. During the year Lincolnshire Teaching PCT has had a significant number of material transactions with the Department and with other entities for which the Department is regarded as the parent Department. For example :

- Strategic Health Authorities
- NHS Foundation Trusts
- NHS Trusts
- NHS Litigation Authority
- NHS Business Services Authority

37.3 In addition, the PCT has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Lincolnshire County Council.

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	1,220	9
Special payments - PCT management costs	35,913	9
Losses in respect of the provision of family practitioner services	3,578	1
Special payments in respect of he provision of family practitioner services	0	0
Total losses	40,710	19
Total special payments	0	0
Total losses and special payments	40,710	19

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	4,403	5
Special payments - PCT management costs	0	0
Losses in respect of the provision of family practitioner services	2,738	14
Special payments in respect of he provision of family practitioner services	0	0
Total losses	7,141	19
Total special payments	74,139	8
Total losses and special payments	81,280	27

Losses or special payments are payments that Parliament would not have envisaged healthcare funds being spent on when it originally provided the funds. Full details have been reported to the Audit Committee.

39 Third party assets

Assets held on behalf of other bodies are not accounted for in these Accounts.

40 Pooled budgets

The PCT has entered into pooled budgets with Lincolnshire County Council (LCC) under s75 of the National Health Service Act 2006. The pooled budgets are for Learning Disabilities and Child and Adolescent Mental Health Services. These budgets are hosted and managed on a day to day basis by LCC. As a commissioner of healthcare services, the PCT makes a contribution to the pool which is then used to purchase healthcare services. The PCT accounts for its share of the assets, liabilities, income and expenditure of the pool as determined by the pooled budget agreement. The memorandum accounts for the pooled budget will not be produced until after the publication of these accounts.

In addition, the PCT hosts the budget for substance misuse on behalf of the Lincolnshire Drug and Alcohol Action Team (DAAT) which is now under a Memorandum of Understanding across the DAAT partnership. The budget for substance misuse is termed a virtual pooled fund arrangement but is not operated under s75 of the National Health Service Act 2006.

41 Cash flows relating to exceptional items

There were no cash flows relating to exceptional items.

42 Events after the end of the reporting period

The Health and Social Care Act 2012 abolished Primary Care Trusts on 31.3.13.

The main functions carried out by Lincolnshire PCT in 2012-13 are to be carried out in 2013-14 by the following public sector bodies:

Organisation	Function
Lincolnshire East Clinical Commissioning Group	Commissioning of non-specialised hospital and community health services
Lincolnshire West Clinical Commissioning Group	Commissioning of non-specialised hospital and community health services
South Lincolnshire Clinical Commissioning Group	Commissioning of non-specialised hospital and community health services
South West Lincolnshire Clinical Commissioning Group	Commissioning of non-specialised hospital and community health services
NHS Commissioning Board	Commissioning of primary care and specialised hospital services
NHS Property Services	Management of former PCT land and buildings
Lincolnshire County Council	Commissioning of public health services
Lincolnshire Community Health Services Trust	Ownership of certain community health services premises
Department of Health	Discharging of residual PCT responsibilities

The assets and liabilities of the PCT at 31.3.13 were transferred to the above successor bodies on 1.4.13