Department of Health

NHS

Calderdale Primary Care Trust

2012-13 Annual Report and Accounts

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Calderdale Primary Care Trust

2012-13 Annual Report

NHS
Calderdale

Annual Report 2012-13

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FOREWORD

Welcome to our Annual Report for 2012/13 from Angela Monaghan, Chair and Mike Potts, Chief Executive

This has been a momentous year for the NHS, nationally and locally, as the Health and Social Care Act 2012 became law, heralding the end of Primary Care Trusts (PCTs) and the advent of new Clinical Commissioning Groups (CCGs).

Consequently, this is the last Annual Report for Calderdale Primary Care Trust (known as NHS Calderdale). The GP-led CCGs assumed responsibility for commissioning most local health care services from 1 April 2013, bringing the voice of the patient closer to the boardroom.

Business as usual for local people

This year has marked the culmination of a massive change process lasting over two years, and we have worked hard to make sure that the NHS locally is in good shape to meet the requirements of the new Health and Social Care Act. Despite the upheaval of the large scale changes required, we are pleased to report that it has still been business as usual for local people. NHS professionals are still committed to helping local people lead healthier lives, and continue to work to improve health and social care services both in hospitals and in the community.

Calderdale, Kirklees and Wakefield District working together

The PCTs that cover Calderdale, Kirklees and Wakefield District have worked together since October 2011, led by one Board, with one Chair and one Chief Executive. However, while coming together under one Board, the three PCTs did not merge; each continued as a statutory body in its own right, until the abolition of the PCTs on 31 March 2013.

The benefits of clustering have been substantial, enabling us to secure resilience during transition, helping us to make efficiency savings and, crucially, allowing us to provide robust support for the emerging CCGs as they prepared to take over the commissioning reins. There will be more about the CCGs later on in this report.

Patients and local people have been at the centre of everything we have done and even at this time of major change we have continued to maintain our focus on quality, ensuring patients have received the best possible clinical outcomes of their treatment and that they have had a good experience of local NHS services.

In February, Robert Francis QC published his report into the events at Mid Staffordshire Hospital. The report made harrowing reading for all of us who work in, and are responsible for commissioning and managing, NHS services. The challenge for the new system will be to embrace his recommendations and ensure that they become embedded into the NHS of the future so that the mistakes made at Mid Staffordshire Hospital are never repeated.

Our commitment

So, change and challenge have been the backdrop to all the achievements of the year and it is a tribute to both the commitment of our staff and the constructive support of our partners in the public, private and voluntary sectors that we have continued to see improvements in services and care. We were determined that local people should have confidence in local health services, and that people who currently have some of the poorest health outlooks in the country should have a healthier future.

Mike Potts
Chief Executive

Angela Monaghan
Chair

THE CHANGING FACE OF THE NHS

Different organisations have come into being as a result of the reforms embodied in the Health and Social Care Act 2012. These include clinical commissioning groups, NHS England (formerly the National Commissioning Board) and Health and Wellbeing Boards, as well as the transfer of public health responsibilities to local authorities.

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

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

Clinical Commissioning Groups worked in 'shadow' form until they took over the shaping and commissioning of local health services from the Primary Care Trusts on 1 April 2013. They agreed a series of priorities to work towards:

- keeping people safe
- preventing premature death
- improving quality of life for people with long-term conditions
- supporting recovery from injury and illness
- creating a positive patient experience
- reducing inequalities

Each of England's 211 CCGs went through a rigorous authorisation process to prove to NHS England that they were properly constituted and had the ability to function effectively and legally. The authorisation process included interviews and assessments for the Chairs and Chief Officers; submitting documents to prove that the CCG had policies and procedures either in place or in development and a final assessment day.

During the assessment day, members of each CCG's Governing Body were closely questioned about their work, priorities and plans so that the inspection team was assured the organisation really was ready and able to take on local leadership of the NHS. If there were any concerns, they were expressed as conditions.

The CCGs were assessed in waves: NHS Calderdale CCG was in wave one and was authorised without conditions.

Strategic health authorities (SHAs) were created to manage the local NHS on behalf of the Secretary of State for Health. They were abolished on 31 March 2013.

Primary care trusts (PCTs), including NHS Calderdale, were abolished at the end of March 2013 and the majority of the PCT's public health responsibilities were transferred to the local Council. The PCT already had a jointly appointed Director of Public Health and had been working with Calderdale Council and the Calderdale Clinical Commissioning Group to ensure that plans were in place for an effective transition of staff and programmes.

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

Local Involvement Networks (LINks) were transformed into **HealthWatch** on 1 April 2013. Its purpose is to ensure that the views and feedback from patients and carers are an integral part of local commissioning across health and social care.

Health and Wellbeing Boards now bring together key decision makers to set a clear direction for the commissioning of healthcare, social care and public health, and to drive the integration of services across communities. CCG representatives are members of these Boards, and each has already been working in shadow form, building on existing relationships and developing their joint agenda to create a **Joint Health and Wellbeing Strategy** and **Joint Strategic Needs Assessment**.

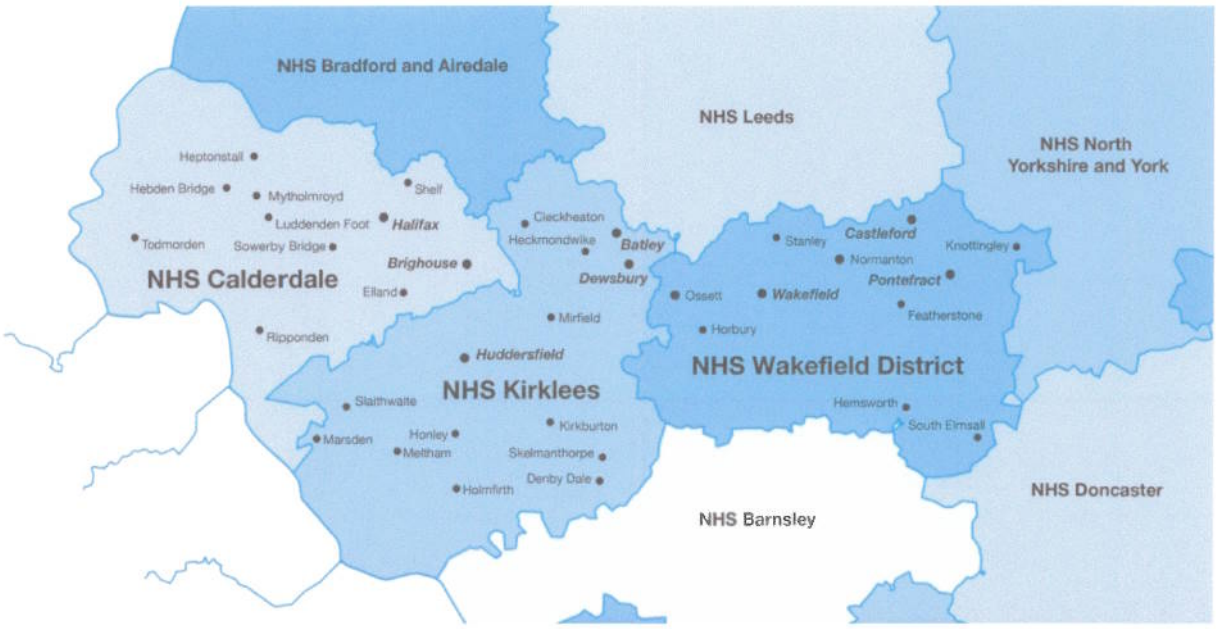
The **Calderdale Health and Wellbeing Board** brings together key health, social care and voluntary organisations. The aim of the board is to work together and develop a strategy for improving the health and wellbeing of the people within Calderdale.

The priority outcomes from the Joint Health and Wellbeing Strategy are that Calderdale is a place:

- where people have good health
- with a balanced and dynamic local economy
- where fewer children under the age of five live in, and are born into, poverty
- where children and young people are ready for learning and ready for life
- where older people live fulfilling and independent lives
- where everyone has a sense of pride and belonging based on mutual respect

In addition, there are also be a number of new national bodies which will set the direction for local services, including **NHS England** (formerly the NHS Commissioning Board), **Public Health England** and **Health Watch England**.

ABOUT US – NHS CALDERDALE



Until 1 April 2013, NHS Calderdale was responsible for all NHS health services provided for over 214,365 people living in the district. The PCT employed around 150 staff.

We have worked closely with doctors, dentists, opticians, pharmacists, local hospitals and social services to ensure accessible, high quality, safe services.

There are 26 general practices in the area, 33 dental practices, 50 pharmacies and 42 opticians.

Throughout its lifetime, the PCT's aim was to improve the health and lives of local people by increasing life expectancy, reducing health inequalities and ensuring quality services. As part of this we wanted to ensure that local people could see a healthcare professional when and where they chose, knowing that they were receiving the best care for them and their family.

The PCT was also responsible for providing information and services to help local people live healthier lives.

Other NHS services locally are:

- acute services provided by Calderdale and Huddersfield NHS Foundation Trust
- mental health services provided by South West Yorkshire Partnership NHS Foundation Trust

- community nursing, most therapies and other local healthcare provided by Calderdale and Huddersfield NHS Foundation Trust
- emergency ambulances and patient transport provided by Yorkshire Ambulance Service NHS Trust
- some therapies provided by South West Yorkshire Partnership NHS Foundation Trust

The Joint Strategic Needs Assessment for Calderdale highlights some important local strategic priorities for improving health and wellbeing, preventing illness and reducing inequalities:

- reducing premature mortality and improving life expectancy
- meeting the needs of those with long-term conditions
- responding to an ageing society and the needs of older people
- improving children and young people's life chances
- increasing healthy lifestyles and breaking the cycle of deprivation
- responding to local economic vulnerability

Changes to the structure of the NHS across England mean that all PCTs, including NHS Calderdale, were abolished on 31 March 2013 when NHS Calderdale Clinical Commissioning Group (CCG) took over our responsibilities.

The new NHS Calderdale Clinical Commissioning Group (CCG) is a publicly accountable statutory organisation made up of local GPs and their practice teams, nurses, hospital consultants and lay members who will work together to lead and continue to improve the NHS in Calderdale.

The Government introduced CCGs in the 2012 Health and Social Care Act because it believed that medical professionals are closer to their patients, understand local health needs and are in the best place to make important decisions about buying health services to keep their patients healthy.

This means that all of Calderdale's GP practices are now involved in commissioning healthcare for the local population.

During 2012/13 we continued to provide our robust support to the emerging NHS Calderdale Clinical Commissioning Group (CCG) to ensure they were ready to take on their full commissioning responsibilities from April 2013.

MEET THE BOARD

NHS Calderdale, Kirklees and Wakefield District PCT Cluster

NHS Calderdale, Kirklees and Wakefield District Primary Care Trusts (PCTs) became a Cluster in June 2011. Each PCT continued to be a statutory organisation in its own right, but all three were managed by a single Board which came into being on 1 October 2011.

The NHS Calderdale, Kirklees and Wakefield District Cluster Board was made up of the Chair, seven Non-Executive Directors and six Executive Directors. The Board met in public every two months with meetings at locations around Calderdale, Kirklees and Wakefield.

Mike Potts was Chief Executive for the Cluster whilst Angela Monaghan was the Cluster Chair.

The Board was responsible for the strategy, plans and performance of NHS Calderdale, Kirklees and Wakefield District, and it assessed the delivery of health services in the locality. The Board made sure any necessary changes were made to ensure high quality services were delivered.

The executive directors during 2012/13 were:

Mike Potts - Chief Executive
Ann Ballarini - Executive Director of Commissioning and Service Development
Sue Cannon - Executive Director of Quality and Governance (Nursing)
Ian Currell - Executive Director of Finance and Efficiency
Dr Damian Riley - Executive Medical Director (a joint appointment with NHS Airedale, Bradford & Leeds)
Dr Graham Wardman, Dr Judith Hooper and Dr Andrew Furber – Executive Director of Public Health (sharing one executive director position)

The non-executive directors were:

Angela Monaghan - Chair
Roger Grasby - Vice Chair
Ann Liston
Sandra Cheseldine
Mehboob Khan
Roy Coldwell
Tony Gerrard
Keith Wright (Audit Committee Chair)

Audit and Remuneration Committees

In 2012/13 NHS Calderdale, Kirklees and Wakefield District were served by a Cluster Audit Committee and Cluster Remuneration Committee.

The Cluster Audit Committee members were:

Sandra Cheseldine (NHS Wakefield)
Keith Wright (NHS Calderdale) - chair
Tony Gerrard (NHS Kirklees)

Members of the Cluster Remuneration Committee were:

Ann Liston (NHS Calderdale) - chair
Mehboob Khan (NHS Kirklees)
Roger Grasby (NHS Wakefield)

OUR RESPONSIBILITIES

Quality and safeguarding

Quality and safeguarding is critically important across the NHS, especially in the wake of Robert Francis' lengthy inquiry report about failings at Mid Staffordshire Hospitals NHS Foundation Trust, published in February 2013.

Responding to the Francis Report will be the work of all NHS bodies, including CCGs, in the months to come.

Throughout the transition period, the Clinical Commissioning Groups' Heads of Quality and Safety have been working to a nationally agreed quality handover and transition plan. The plan not only set out how business as usual should be maintained, but also kept up the growing emphasis on driving service improvement and quality: the PCT Cluster's enduring legacy.

A detailed, 150 page quality handover document, the product of nine months' work, was delivered to Calderdale CCG for formal adoption by its Governing Body on the 11 April 2013. The document was a snapshot of issues, projects and risks affecting quality and safety, with a comprehensive 'who's who' stakeholder contact list to effect a seamless handover and make sure nothing was missed.

Managing the risks

Our risk management systems have enabled us to monitor and test how health services are provided, including the performance of our commissioned services

against government targets and best practice standards such as treatment times and control of infection in hospitals.

Effective incident reporting, complaints and public involvement have all contributed to our risk management, and added to our knowledge of what has been happening with our services and how the public receive and perceive NHS services.

Internal systems of control and communication have ensured that serious issues have been raised in a timely and relevant way within the organisation, from specialist team meetings through to Cluster Board meetings where appropriate.

In January 2012 we aligned our risk register and risk reporting procedures, using a live database system and timeline across the three PCTs.

Our risk management teams have reported incidents nationally to the National Patient Safety Agency and to the Counter Fraud and Security Management Service. This has helped us compare ourselves with other organisations and learn lessons to prevent similar incidents from happening in our area.

Risk management has formed part of our integrated governance arrangements; evidence shows that well managed organisations have better outcomes, including:

- safe and clinically effective services for patients
- maintenance of core services in times of emergency
- better value in our use of resources
- better health outcomes for our population.

In other words, good governance can save lives.

Safeguarding the information we hold

Information governance (IG) ensures that information is used and stored appropriately and securely. It includes personal information which relates to patients, service users and our employees and corporate information such as financial accounts or other records, in line with our legal requirements.

Robust information governance systems and processes have been in place across our organisation to help us protect our patients and the information we hold. We have measured our compliance regularly and ensured all staff are trained annually.

Staff have been continually reminded to make sure personal information was kept secure at all times and, in particular, that data held electronically had been encrypted (including data on USB sticks and laptops). Any incidents involving the loss of unencrypted data such as theft of an unencrypted laptop may incur a fine.

During the year there were no information governance breaches reported to the Information Governance Ombudsman.

Responding to queries, concerns and complaints

One way that we have gathered people's views, and responded to their concerns, has been through our Customer Liaison Service. During the year, the service dealt with a total of 906 enquiries. We responded to sixty-two complaints, as follows:

Medical (GPs)	30	Opticians	1
Dentists	19	Commissioned services (e.g. nursing homes)	11
Pharmacies	1	**TOTAL**	**62**

We also supported GPs, pharmacists, dentists and opticians to respond thoroughly to the complaints they received.

Freedom of Information Act

NHS Calderdale received 10 Freedom of Information (FOI) requests during the period November 2012 to March 2013. The Calderdale, Kirklees and Wakefield Cluster received a further 20 FOI requests. Among others, information was requested from members of the public, private companies, the media, MPs and researchers.

FOI gives individuals or organisations the right to request information held by public authorities. We have aimed to make as much information as possible available on our website through our publication scheme. However, when the information was not available on our website, it could be requested in writing and was provided unless an exemption applied.

Safeguarding adults and children in Calderdale

The safeguarding of children and adults has remained a priority for NHS Calderdale. It has been integral to the services we have commissioned and we have continued to demonstrate strong local safeguarding leadership across the health economy by making a significant contribution to multi-agency partnerships and by playing a lead role in both the Safeguarding Children and Safeguarding Adults boards.

We have also contributed to the safeguarding board's sub-groups and the regional safeguarding networks. We have also continued to contribute to the violence against women and girl's strategy and, more recently, the Calderdale Prevent Agenda (designed to build resilience to violent extremism).

Training and safeguarding support to our primary care providers including GPs, dentists, opticians and pharmacists has been a particularly important aspect of our work for which a programme of training was in place. Every GP practice in Calderdale has been encouraged to nominate a clinical colleague to take responsibility as their safeguarding lead and they have been supported by the provision of a Safeguarding Policy and regular updates via the GP Link. A dedicated safeguarding section is now provided on the CCG's intranet.

We have worked closely with safeguarding leads in our local NHS trusts to support the on-going development of safeguarding practice and strengthen the quality monitoring and performance management of our contracts. This included overseeing action plans from serious case reviews to ensure that learning from these cases has been incorporated into practice. We have continued to offer supervision to the named nurses for safeguarding within our local provider Trusts.

We have ensured all health provider organisations are fully compliant with national safeguarding standards included within all health contracts and service level agreements. Quality indicators for safeguarding are now included within the CCGs quality monitoring processes.

Liaising closely with local authority colleagues to improve safeguarding practice and quality monitoring in care homes has remained an important part of our work.

Being prepared for emergencies or incidents

During the year, emergency planning continued to be a key priority for the PCT, particularly during this period of transition and change for the NHS.

Primary care trusts were category one responders in the Civil Contingencies Act (2004) and, in relation to emergency preparedness, there were certain statutory obligations to which we responded and adhered:

- assessing the risk of emergencies and using this to inform planning;
- putting in place and regularly testing emergency plans, including training for key staff;
- putting in place business continuity arrangements;
- making information available to the public about civil protection matters and maintaining arrangements to warn, inform and advise the public in the event of an emergency;
- sharing information and co-operating with other local responders to enhance co-ordination and efficiency.

PERFORMANCE

Maintaining strong operational performance remained one of the key priorities for the NHS during the transition from Primary Care Trusts to the new clinically-led commissioning arrangements.

The past 12 months have seen many developments and improvements in healthcare provision across Calderdale and the overall performance in our district during 2012/13 has been strong, building on our successful track record.

As in previous years, our progress has been assessed using the standards associated with the priorities published in the Operating Framework.

Highlights include:

- the ongoing delivery of the four hour A&E standard and the 18 weeks referral to treatment waiting time target
- achievement of the cancer waiting standards for patients who, following referral, need urgent access to care
- higher than national and regional average performance for the utilisation of Choose and Book
- continued delivery of the ambulance response times standards for both category A targets
- continuing to offer our local residents, aged 40 to 74 years, a free NHS health check to assess their health and identify any health risks
- increasing the number of people who successfully quit smoking
- the delivery of mental health services - for patients needing access to psychological therapies we are exceeding the coverage levels

It is clear that some challenges remain and key priorities being monitored by Calderdale CCG during 2013/14 include:

- reduction in the number of reported incidents of healthcare acquired infections
- reducing breaches of mixed sex accommodation

OUR STAFF

Valuing our staff – NHS Calderdale

Recent changes to the NHS have had major implications for the people who worked for NHS Calderdale. It has undoubtedly been a challenging year for staff as the pace of change has continued to increase. Despite this, and at a time of great uncertainty, our motivated, capable and committed team have continued to work hard to ensure that healthcare in Calderdale has continued to meet the needs of local people. One of our main priorities this year has been to lead and support staff as the changes come into force.

Support during organisational change

In order to support our staff colleagues through this time we organised a range of initiatives, including:

- organisational change briefings
- pensions advice sessions
- financial planning sessions
- career management workshops
- human resources drop-in sessions.

Monitoring sickness

We have continued to monitor sickness data and to provide relevant support to staff according to their needs. During the year our sickness rate was 1.6%, which is significantly lower than our target rate of 2.5%.

Equality and diversity

We have taken our responsibilities for equality and diversity very seriously and have complied with our duty to monitor our workforce on key employment indicators by ethnicity, disability status, age and gender. We have tried to ensure that our workforce represents our local communities and that all employees are treated fairly and equally.

Investing in a diverse NHS workforce has enabled us to deliver a better service and improve patient care in Calderdale.

Equality is about creating a fairer society where everyone has the opportunity to fulfill their potential and diversity is about recognising and valuing difference in its broadest sense.

Workforce comparisons 2012/13: NHS Calderdale

Gender		
	Count	%
Male	30	22%
Female	104	78%
Disability		
No	118	88%
Yes	3	2%
Not declared	13	10%
Religious belief		
Atheism	13	10%
Christianity	68	51%
Islam	4	3%
Sikhism	2	1%
Other	3	2%
Not declared	44	33%
Sexual orientation		
Gay	1	1%
Lesbian	1	1%
Heterosexual	91	68%
Not declared	41	31%
Age group		
Under 25	3	2%
25 – 34	26	19%
35 – 44	38	28%
45 – 54	54	40%
55+	13	10%
Ethnic origin		
White - British	113	84%
White - Irish	4	3%
White - any other white background	4	3%
White - unspecified	1	1%
Mixed - White & Black Caribbean	1	1%
Mixed - White & Asian	1	1%
Asian or Asian British - Indian	4	3%
Asian or Asian British - Pakistani	2	1%
Asian or Asian British - any other Asian background	1	1%
Black or Black British - Caribbean	1	1%
Any other ethnic group	1	1%
Not stated	1	1%

Our vision for diversity and equality is outlined in two main aims:

- to recruit, develop and retain a workforce that is able to deliver high quality services that are accessible, responsive and appropriate to meet the diverse needs of different groups and individuals.

- to ensure NHS Calderdale is a fair employer, achieving equality of opportunity and outcomes in the workplace.

Keeping staff informed

During 2012/13 we kept our staff up to date with issues that may affect them via a number of channels, including our intranet site, a weekly email bulletin and monthly staff briefings with the Chief Executive and other directors. Staff also had the chance to ask questions directly of the Chief Executive via the intranet and the communications team email box.

INVESTING IN SERVICES

Residents urged to have their say

During the year residents across Calderdale were urged to have their say and help shape dental services for people without a regular dentist or who need urgent care out of hours.

NHS Calderdale launched the initiative in February 2013, asking people to shape the new service for the whole of West Yorkshire by sharing their experiences of unplanned or urgent dental services in their area.

There are currently five services across West Yorkshire providing unplanned or urgent dental care.

These services are for people:

- without a regular dentist who need treatment, or
- who need treatment urgently but cannot access their regular dentist, for example during a bank holiday.

The contracts for the five services, which were managed by the primary care trusts covering Airedale, Bradford, Leeds, Calderdale, Kirklees and Wakefield, come to an end in March 2014. A new service needs to be provided across the whole of West Yorkshire.

The key benefit of having a West Yorkshire-wide services is that people will no longer be limited to accessing the service in their own district - for example Wakefield - but will have choice across West Yorkshire. This could be an advantage for those who live and work in different areas and need to see a dentist urgently.

'You're welcome' at Boulevard Medical Practice

The Boulevard Medical Practice in Halifax was the first GP practice in Calderdale to achieve the Government's *You're Welcome* status during 2012/13.

Along with Barnardos Cornerstone, a family support service, the practice achieved the kite mark. The accreditation is in recognition of the inclusive and young person friendly services provided for those aged under 20. Indeed, part of the rigorous assessment for the accreditation is performed by young people aged 14 to 19 to ensure that even the most vulnerable groups are able to access services that are suited to their needs.

You're Welcome is underpinned by the ethos that all young people are entitled to receive appropriate healthcare wherever they access it. The practice, alongside Barnardos Cornerstone, joins a growing list of organisations in Calderdale who have achieved this award as part of NHS Calderdale's continuing drive to see continued improvements in children's and young people's health services.

'Think Contraception'

A campaign encouraging young people to seek advice about contraception and sexual health was launched across Calderdale district at Christmas time to coincide with the 'party season'. Advertising on buses and bill boards together with activity on social networking channels encouraged young people to talk about contraception and sexual health so that they don't feel as anxious about seeking professional advice.

Calderdale has seen a continued reduction in its teenage conception rate, which is now lower than the average for Yorkshire and the Humber region, and the seasonal campaign was part of the ongoing work being done to support young people in taking responsibility for their sexual health.

The 'Think Contraception' initiative highlighted the many support services for young people including their local CASH clinic or GP surgery, as well as Sexual Health Clinics.

National Infection Prevention and Control Week

A team of infection prevention and control nurses took to the road across Calderdale to promote hand hygiene.

Specialist nurses visited local B&Q stores to raise awareness of the preventable infections, Clostridium difficile infection (CDI) and Methicillin Resistant Staphylococcus Aureus (MRSA), which can be the cause of serious illness. They provided supporting information and advised on how the infections can be detected, prevented and managed.

The initiative introduced an information card for anyone who is affected by one of the infections. The card allows the person to become more involved in their care and also provides healthcare workers with an easy method of identifying someone who has had CDI and/or MRSA. This helps when prescribing antibiotic treatment. Health professionals also received advice on signs and symptoms to look for and how to manage the conditions.

THE FUTURE

The NHS Calderdale Clinical Commissioning Group (CCG) took on full commissioning responsibilities on 1 April 2013.

During 2012/13 the CCG operated in shadow form, increasingly taking on the responsibilities of NHS Calderdale. This means that NHS Calderdale Clinical Commissioning Group (CCG) already has a wealth of experience and understands the health needs of local people.

They will continue the work already underway to transform services and their vision is to commission quality services that will improve patients' experiences of care and health outcomes, by involving and listening to patients, practices, partners and staff when redesigning services.

The CCG is chaired by Dr Alan Brook, a GP based in Rastrick and the Governing Body includes GPs from the member practices, , registered nurse, a secondary care specialist, as well as lay members. Dr Matt Walsh is the Chief Officer and is responsible for ensuring that the CCG fulfils its statutory duties in commissioning healthcare for Calderdale. The CCG's headquarters are based at Dean Clough in Halifax.

Its priorities are: preventing people from dying prematurely, enhancing the quality of life for people with a long-term condition, helping people to recover and maintain their independence, ensuring people have a positive experience of care, ensuring a

safe environment and protecting people from harm, and reducing inequalities in Calderdale.

You can contact Calderdale CCG at:

Calderdale Clinical Commissioning Group
5th floor, F Mill
Dean Clough
Halifax
HX3 5AF

Telephone: 01422 281300
Email: CCG.FEEDBACK@calderdale.nhs.uk
website www.calderdaleccg.nhs.uk

FINANCE

Director of Finance Commentary

In the last 12 months, as well as managing the transition to the new NHS, we have had some very challenging targets to meet. I am pleased to say that, by working with our partners, we have delivered these within the financial resources available.

We have continued to focus on maintaining quality and safety, whilst achieving value for money across all the services we commission.

We have once again delivered our share of the national Quality, Innovation, Productivity and Prevention (QIPP) challenge, working more efficiently to contribute to the £20bn savings which the NHS has to achieve by 2015 by delivering a range of schemes designed to reduce expenditure, whilst at the same time maintaining quality.

Over the next few years the NHS will continue to face financial challenges due to increases in demand. The new Clinical Commissioning Group (CCG) is committed to working with patients and partners to it maximises the most of the money it spends on public services for local people.

During 2012/13 we invested over £350million to improve the health of local people through the commissioning of high quality services.

Our investment resulted in:

- Improved Quality in Care Homes – Investment in information technology in care homes to enable better access to important information about the care of patients. This will continue through 2013/14 with the commissioning of a new multi-disciplinary team to deliver care to residents of 17 care homes in Calderdale.

- Work with the third sector - Additional support for parents with a disabled children, better support for carers, enabled Overgate Hospice to improve its facilities and provided additional money for health grants for a range of health-related projects, and support to enable them to become 'business ready'.
- Getting people home – Additional resources to Calderdale and Huddersfield Foundation Trust and Calderdale Metropolitan Borough Council to purchase equipment and adaptations to support people to be discharged home and remain as independent as possible.
- Rehabilitation – Intermediate care services to support older people to remain independent and in their own home for as long as possible, and commissioned new beds in care homes aimed at providing intensive rehabilitation and preparing people for their return home.
- Healthy Children – Building on the energy being created by the Tour de France coming to Calderdale we have commissioned a new bike track for schoolchildren in Calderdale.

The PCT's financial statements have been prepared in accordance with the Resource Accounting Manual (RAM) issued by HM Treasury. The full details of the accounting policies adopted by the Primary Care Trust can be obtained from our Audited Accounts.

The accounts attached to the Annual Report reflect the financial decisions of the PCT and the achievement of objectives for the twelve month period ending 31 March 2013.The PCT has achieved its statutory financial duties within a challenging economic environment.

The PCT has:

- achieved operational financial balance, i.e. its expenditure is not in excess of its income.
- contained expenditure within its resource limit and has reported a £3,600K surplus at the end of the year as required by NHS North of England. An element of this surplus will be carried forward for use in the NHS Calderdale Clinical Commissioning Group in 2013/14.
- remained within its cash limit, with a year end cashbook balance of £2K.

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. Details of our achievement of the payment of all invoices within 30 days are noted in Note 8.1 to the Audited Accounts.

The statutory Accounts have been audited by KPMG, at a cost of £74K; other audit services were provided during the year at a cost of £25K.

Remuneration Report 2012/13

Section 234B and Schedule 7A of the Companies Act, as interpreted for the public sector, require NHS bodies to prepare a remuneration report containing information about the remuneration of directors.

In the NHS, the report will cover those senior managers "having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments."

Membership of the Cluster Remuneration and Terms of Service Committee (RTSC)

Members of the Cluster Remuneration Committee were:

Ann Liston (NHS Calderdale) - chair
Mehboob Khan (NHS Kirklees)
Roger Grasby (NHS Wakefield)

The non-executive director who chairs the Audit Committee does not attend in order to make sure separation of duties. The Chief Executive is in attendance (except when his own terms and conditions are considered). The committee is supported by the Directorate of Human Resources and Organisational Development.

The role of the RTSC is to make decisions about appropriate remuneration and terms of service for the Chief Executive, directors, clinical executive members' allowances and in exceptional circumstances, individual issues arising for staff on Agenda for Change terms. This includes the determination of basic pay for the Chief Executive and other directors, together with any annual uplifts and performance bonuses.

Statement of the policy on remuneration of higher paid employees for current and future financial years

NHS Calderdale works within the Pay Framework for Very Senior Managers in Strategic and Special Health Authorities, Primary Care Trusts and Ambulance Trusts as set out by the Department of Health and which became operable from 1 April 2007. This helps to make sure that NHS Calderdale is able to recruit, retain and motivate high calibre staff and is consistent, competitive and comparable to other PCTs.

Explanation of methods used to assess whether performance conditions were met and why those methods were chosen

The RTSC reviews appropriate levels of pay for the Chief Executive and other directors under the very Senior Managers Framework. In line with best employment

practice, where performance should be assessed by the line manager, the Chief Executive conducts the performance assessments for the directors.

The Chairman assesses the performance of the Chief Executive. Assessments are conducted using established appraisal and personal development review processes, which include clearly defined responsibilities with measurable objectives. The discretionary element of pay is covered by performance bonus arrangements as referred to above in the section on the statement of the remuneration of higher paid employees.

Explanation of relative importance of the relevant proportions of remuneration which are, and which are not, subject to performance conditions

Please refer to information on the role of the Remuneration and Terms of Service Committee.

Summary and explanation of policy on the duration of contracts, notice periods and termination payments

Chief Executive and director appointments are made on a substantive basis, with notice provisions normally six months clearly identified and articulated in the contract.

Directors Remuneration Report (audited by an independent auditor)

NHS Calderdale, Kirklees and Wakefield District Cluster

As from 1st April 2012 the PCT was part of the NHS Calderdale, Kirklees and Wakefield Cluster (NHS CKW). Costs were split across the NHS CKW cluster on a unified weighted capitation % basis: Calderdale 21.68% Kirklees 43.73% and Wakefield 34.59%. Table 1 shows Calderdale's share of the cost of each named individual for 2012/13.

Table 1. Calderdale, Kirklees and Wakefield District Cluster share.

	2012/2013			2011/2012		
Name and Title	Salary (Bands of £5000)	BIK £000's (Rounded to £100)	Other (Bands of £5000)	Salary (Bands of £5000)	BIK £000's (Rounded to £100)	Other (Bands of £5000)
Mike Potts, Chief Executive (Note C)	30-35	1.1	30-35	25-30	1.5	0
Jonathan Molyneux Interim Executive Director of Finance and	0	0	5-10	30-35	0	0

Efficiency						
Ian Currell Executive Director of Finance and Efficiency	20-25	0	0	0	0	0
Ann Ballarini Executive Director of Commissioning and Service Development(Note C)	20-25	1.0	30-35	15-20	0.6	0
Peter Flynn Director of Performance and Commissioning Development	15-20	1.0	0	15-20	0.8	0
June Goodson-Moore Director of HR and Organisational Development	See Note A					
Matt Walsh Executive Medical Director	5-10	0	0-5	35-40	0	5-10
Damien Riley Executive Medical Director	See Note A					
Sue Cannon Executive Director of Quality and Governance (Nursing)	15-20	0	0	30-35	0	0
Gillian Galdins Executive Director of Corporate Development and Transition	10-15	1.0	40-45			
Angela Monaghan Cluster Chair	5-10	0	0	20-25	0	0
Keith Wright	0-5	0	0	5-10	0	0

Cluster Non-Executive						
Ann Liston Cluster Non-Executive	0-5	0	0	0-5	0	0
Roy Coldwell Cluster Non-Executive	0-5	0	0	0-5	0	0
Mehboob Khan Cluster Non-Executive	0-5	0	0	0-5	0	0
Tony Gerrard Cluster Non-Executive	0-5	0	0	0-5	0	0
Sandra Cheseldine Non-Executive Associate	0-5	0	0	0-5	0	0
Roger Grasby Cluster Non-Executive	0-5	0	0	0-5	0	0

NHS Calderdale only

	2012/2013			2011/2012		
Name and Title	Salary (Bands of £5000)	BIK £000's (Rounded to £100)	Other (Bands of £5000)	Salary (Bands of £5000)	BIK £000's (Rounded to £100)	Other (Bands of £5000)
Matt Walsh Chief Operating Officer (Note B)	70-75	0	10-15	0	0	0
Julie Lawreniuk Chief Operating Officer	25-30	0	0	85-90	0	0
Graham Wardman Director of Public Health	95-100	0	20-25	95-100	0	20-25

Notes:

Note A: These people held roles across the NHS Calderdale, Kirklees and Wakefield (NHS CKW) and NHS Airedale, Bradford and Leeds (NHS ABL) clusters providing strategic HR and Communications advice. All costs were incurred by NHS ABL.

Note B: This person was previously in a CKW Cluster role to 31 July 2012.

Note C: Other early exit package costs paid to the NHS Pensions Agency, rather than the individual, are not included in this note.

Table 3. CKW Cluster remuneration report (audited by an independent auditor) Indicating the full cost of each named individual for the period stated

Name and Title	**Dates**	**Full Costs Salary** (Bands of £5000)	**Benefits in Kind** £000's (Rounded to £100)	**Other** (Bands of £5000)
Mike Potts Chief Executive (see note B)	01.04.12 to 31.03.13	140-145	5.0	140 - 145
Jonathan Molyneux Interim Executive Director of Finance and Efficiency	01.04.12 to 23.06.12	0	0	20-25
Ian Currell Executive Director of Finance and Efficiency	23.04.12 to 31.03.13	95-100	0	0
Ann Ballarini Executive Director of Commissioning and Service Development (see note B)	01.04.12 to 31.03.13	95-100	2.3	140-145
Peter Flynn Director of Performance and Commissioning Development	01.04.12 to 31.03.13	90-95	5.0	0
June Goodson-Moore Director of HR and Organisational Development	01.04.12 to 31.03.13	See Note A		
Matt Walsh Executive Medical Director	01.04.12 to 31.07.12	35-40	0	5-10
Damien Riley Executive Medical Director	01.08.12 to 31.03.13	See Note A		

Sue Cannon Executive Director of Quality and Governance (Nursing)	01.04.12 to 31.03.13	90-95	0	0
Gillian Galdins Director of Corporate Development and Transition	01.07.12 to 31.03.13	60-65	2.8	205 - 210
Angela Monaghan Cluster Chair	01.04.12 to 31.03.13	35-40	0	0
Keith Wright Cluster Non-Executive	01.04.12 to 31.03.13	10-15	0	0
Ann Liston Cluster Non-Executive	01.04.12 to 31.03.13	5-10	0	0
Roy Coldwell Cluster Non-Executive	01.04.12 to 31.03.13	5-10	0	0
Mehboob Khan Cluster Non-Executive	01.04.12 to 31.03.13	5-10	0	0
Tony Gerrard Cluster Non-Executive	01.04.12 to 31.03.13	10-15	0	0
Sandra Cheseldine Non-Executive Associate	01.04.12 to 31.03.13	10-15	0	0
Roger Grasby Cluster Non-Executive	01.04.12 to 31.03.13	10-15	0	0

Notes

Note A: These people held roles across the NHS Calderdale, Kirklees and Wakefield (CKW) and NHS Airedale, Bradford and Leeds (NHS ABL) clusters providing strategic human resources and communications advice. All costs were incurred by NHS ABL.

Note B: Other early exit package costs paid to the NHS Pensions Agency, rather than the individual, are not included in this note.

Table 4. Pension disclosure (audited by an independent auditor)

	Real increase in pensions 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 2012 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2012 (bands of £5,000)	CETV at 31 March 2013 £000	CETV at 31 March 2012 £000	Real increase in CETV £000
NHS Calderdale employed staff							
Julie Lawreniuk	(0-2.5)	(0-2.5)	25-30	75-80	442	412	8
Matt Walsh	(0-2.5)	(0-2.5)	45-50	135-140	807	751	17
Graham Wardman	(0-2.5)	(0-2.5)	50-55	150-155	1005	944	12
Sue Cannon	(0-2.5)	(5-7.5)	40-45	130-135	921	883	-8
CKW Cluster Employed staff							
Mike Potts	(0-2.5)	(5-7.5)	65-70	200-205	0	1440	-1515
Ian Currell	0-2.5	5-7.5	25-30	80-85	426	365	42
Peter Flynn	0-2.5	0-2.5	20-25	60-65	442	393	29
Ann Ballarini	(0-2.5)	(0-2.5)	25-30	85-90	0	628	-660
Gillian Galdins (Note A)	(0-2.5)	(0-2.5)	35-40	105-110	0	669	-704

Note A: This person moved into a NHS CKW Cluster role from 1 July 2012, having previously worked as the Chief Operating Officer at Wakefield. The above details reflect the whole of 2012-13.

Cash Equivalent Transfer Value

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.

Pension Liabilities

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. Note 7.5 to the Audited Accounts is the relevant accounting policy providing more detail. Further information can be found in the Audited Accounts and Annual Report of NHS Pensions.

Exit Packages

Further information on any Exit packages can be found in Note 7.4 to the Audited Accounts.

Tax arrangements of public sector appointees

In line with HM Treasury guidance, where personal service companies have been engaged, we have taken actions to gain assurance that they are adequately accounting for, and responsible for, their own tax and NI arrangements. During the year we engaged three persons through these arrangements.

Pay multiples

	2012/13	2011/12
Midpoint of Highest paid director	£122,544	£122,544
Median remuneration	£34,189	£34,189
Multiple	3.58	3.58

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 NHSC in the financial year 2012-13 was £120k -125k (2011-12, £120k – 125k).

This was 3.58 times (2011-12, 3.58) the median remuneration of the workforce, which was £34,189 (2011-12, £34,189).

The highest paid director was calculated on a full time equivalent basis of the cost incurred by the organisation. Where a director worked across the Calderdale, Kirklees and Wakefield (CKW) Cluster, the entities proportion was grossed up to full year costs.

The median salary was calculated using staff in post at the year end. The salaries for part time staff were then grossed up to reflect a full time equivalent. The median point of those salaries was then calculated.

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

Company directorships

Name	Position	Company directorships
Mike Potts	Chief Executive	None
Sue Cannon	Executive Director of Quality and Governance (Nursing)	None
Ian Currell	Executive Director of Finance and Efficiency	None
Roy Coldwell	Non Executive Director	Trustee and Company Secretary of Catalyst Science Discovery Centre Director of RS Clare and Company Lubricants manufacturer Non-Executive Director PICME - Business Improvement Consultancy Risk Management Consultant – HFL Risk Services
Roger Grasby	Non Executive Director	Independent Member – West Yorkshire Police Authority Justice of the Peace – Wakefield/Pontefract Bench Non-legal member – Employment Tribunal Chair/Director, Spectrum Community Health CIC Ltd
Gill Galdins	Chief Operating Officer –	None

	NHS Wakefield District	
Julie Lawreniuk	Chief Operating Officer - NHS Calderdale	None
Ann Liston	Non Executive Director	Independent Member of West Yorkshire Police Authority Counsellor and external training manager - Leeds Counselling Treasurer, Hope Baptist Church, Hebden Bridge
Jonathan Molyneux	Interim Executive Director of Finance and Efficiency	None
Angela Monaghan	Chair	None
Matt Walsh	Medical Director	Ownership of a $^{2}/_{7}$ share of premises at Thornton Medical Centre, Bradford (a PMS practice with a Bradford contract) Spouse is an employee of Calderdale and Huddersfield Foundation Trust
Graham Wardman	Executive Director of Public Health – NHS Calderdale	None
Dr Judith Hooper	Director of Public Health – NHS Kirklees	Employed by GP contractor to NHS Calderdale, Kirklees and Wakefield Cluster – GP assistant Meltham Road Surgery. Partner provides services under contract to NHS Calderdale, Kirklees and Wakefield District Cluster via Bradford Teaching Hospitals NHS Foundation Trust – Tier 2 Pain Service South Kirklees. Clinical Lead for Kirklees Chronic Pain
Peter Flynn	Director of Performance and Commissioning Intelligence	None
Keith Wright.	Non Executive Director	Director of ICATs Ltd (a dormant company) NHS consultancy support to NHS organisations
Ann Ballarini	Executive Director of Commissioning and Service Development	None
Sandra	Non Executive Director	Chair of the Trustees Board for Wakefield

Cheseldine		District Citizens Advice Bureau
Dr Andrew Furber	Director of Public Health – NHS Wakefield District	Trustee – North to North Health Partnership Honorary Senior Clinical Lecturer – Sheffield University
Mehboob Khan	Non Executive Director	Local Authority Councillor - Kirklees School Governor Greenhead College, Huddersfield Member of West Yorkshire Fire Authority Board members of the Standards Board of England Board member of Local Government Association Council of Europe. Shareholder in Excol Consulting Ltd.
Sue Ellis	Director of Human Resources and Organisational Development	Spouse is an employee at Gilthwaites First School, Denby Dale Church Council Secretary and worship leader Denby Dale Methodist Church
Tony Gerrard	Non Executive Director	Director of Tony Gerrard Associates Ltd
Carol McKenna	Chief Operating Officer – NHS Kirklees	None
June Goodson-Moore	Executive Director of Workforce and Corporate Development	Executive Director for NHS Airedale, Bradford and Leeds A Partner Governor for Leeds and York Mental Health Partnership Trust

Disclosure of information for audit purposes

Andrew Buck, Chief Officer – NHS England (West Yorkshire Area Team) - has signed a letter of representation that confirms, after making enquiries of directors and non-executive directors, that all accounting records and all other records and related information have been made available to our external auditor in the course of the 2012/13 audit.

Audited accounts

The audited accounts for 2012/13 are attached at Appendix A.

the people of Kirklees. During 2012/13 we significantly reduced our running cost by around £2m or 12% of the total.

The two shadow GP Clinical Commissioning Groups for Kirklees have been in existence for almost two years and took over statutory responsibility for commissioning and financial management on the 1st April 2013. We also worked with other bodies, such as the local authority and NHS Commissioning Board to ensure that we successfully handed over responsibility for Public Health and Primary Care commissioning to them on the 1st April 2013.

We have also clustered with neighbouring PCTs covering Wakefield and Calderdale. This combined body was responsible for overseeing the successful implementation of the new arrangements and ensuring the proper and orderly closure of the PCT at the end of 2012/13.

NHS Kirklees took its responsibilities for safeguarding public money and achieving value for money very seriously. On behalf of the Board, the Audit Committee considered financial governance. The members of the Committee received regular reports from our external auditors, the Audit Commission, and from our internal auditors. In addition to their statutory audit of the PCT's accounts, the Audit Commission also provided a number of other reports that help us achieve value for money.

Financial Information

A full set of Annual Accounts are appended to this document. These detail the financial performance of the PCT as summarised above. In addition the following disclosures within the Annual Accounts are drawn to the attention of the reader:

- The way in which we account for pensions liabilities is explained in note 7.5
- Severance payments are detailed in note 7.4
- We have signed up to the 'Prompt Payment' code, and our performance against the better payments practice code is shown in note 8.1
- Our external auditors are KPMG and the cost of work performed by them in the year is disclosed in note 5.1

Remuneration report 2012/13

Section 234B and Schedule 7A of the Companies Act, as interpreted for the public sector, require NHS bodies to prepare a remuneration report containing information about the remuneration of directors.

In the NHS, the report will cover those senior managers "having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments."

Cheseldine		District Citizens Advice Bureau
Dr Andrew Furber	Director of Public Health – NHS Wakefield District	Trustee – North to North Health Partnership Honorary Senior Clinical Lecturer – Sheffield University
Mehboob Khan	Non Executive Director	Local Authority Councillor - Kirklees School Governor Greenhead College, Huddersfield Member of West Yorkshire Fire Authority Board members of the Standards Board of England Board member of Local Government Association Council of Europe. Shareholder in Excol Consulting Ltd.
Sue Ellis	Director of Human Resources and Organisational Development	Spouse is an employee at Gilthwaites First School, Denby Dale Church Council Secretary and worship leader Denby Dale Methodist Church
Tony Gerrard	Non Executive Director	Director of Tony Gerrard Associates Ltd
Carol McKenna	Chief Operating Officer – NHS Kirklees	None
June Goodson-Moore	Executive Director of Workforce and Corporate Development	Executive Director for NHS Airedale, Bradford and Leeds A Partner Governor for Leeds and York Mental Health Partnership Trust

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Audited accounts

The audited accounts for 2012/13 are attached at Appendix A.

Signing Officer: Andrew Buck Date: 6/6/13

Department of Health

NHS

Calderdale Primary Care Trust

2012-13 Accounts

Published to gov.uk, in PDF format only.

www.gov.uk/dh

Calderdale Primary Care Trust

2012-13 Accounts

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.

06 June 2013 .....Signing Officer

06 June 2013 .....Finance Signing Officer

2012-13 Annual Accounts of Calderdale Primary Care Trust

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.

* except for capital/revenue expenditure in excess of resource limits which was not intended by Parliament and did not conform to the authorities which govern them.

Signed.....Designated Signing Officer

Name: Mr Andy Buck, Signing Officer, West Yorkshire Area Team

Date 6/6/13

NHS Calderdale (Calderdale Primary Care Trust)

5J6 Calderdale

GOVERNANCE STATEMENT 2012/13

1.0. Scope of Responsibility

The Board is accountable for internal control. As Accountable Officer and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. Patient safety remains our first priority and I take personal responsibility for this along with safeguarding the public funds and the organisation's assets, as set out in the Accountable Officer Memorandum. I am also responsible for ensuring that the organisation is administered efficiently and effectively within our resources. Internal auditors have throughout the year reviewed governance arrangements and found these to be satisfactory.

NHS Calderdale is part of the local health and social care economy that aims to improve health and wellbeing for the people of Calderdale. It works with its partners to support the development of local services to deliver better health and wellbeing. Our Operating Plan for 2012/13 set out our objectives and targets which were taken forward by Calderdale's Clinical Commissioning Executive (CCE) under delegated authority from our Cluster Board. The Operating Plan also set out the medium term objectives and targets which will be taken forward by NHS Calderdale Clinical Commissioning Group from 1st April 2013.

The Board oversees delivery of the Operating Plan, supported by its sub-committee arrangements which maintain the focus on the local priorities. The NHS North of England assesses and monitors performance of the PCT against national and local objectives through the reporting arrangements in place with the SHA.

2.0 The Governance Framework of the Organisation

NHS Calderdale operates within a cluster arrangement with the three Boards of Calderdale, Kirklees and Wakefield District Primary Care Trusts which has responsibility for overseeing the transition to the new structure of the NHS. This arrangement retained the three Boards as accountable and responsible for the commissioning of safe and effective local health services within the financial resources.

There is one executive management structure including one Chief Executive and Accountable Officer for the three organisations and one set of executive directors and non executive directors who sat on the Boards of all three organisations. Standing Orders and Standing Financial Instructions were in place.

As Chief Executive I appointed a Chief Operating Officer for NHS Calderdale PCT until June 2012 with responsibility for operational management of the organisation to ensure a sound governance framework within the organisation on my behalf. A Shadow Accountable Officer for NHS Calderdale Clinical Commissioning Group (CCG) was in place from July 2012, when the Chief Operating Officer role ceased.

2.1 Board Committee Structure

The governance structure had the following cluster wide Board Committees in place:

- Audit Committee
- Remuneration and Terms of Service Committee
- Governance Committee
- Clinical Commissioning Executives
- Yorkshire and the Humber Specialised Commissioning Group
- Joint Committee of the West Yorkshire Commissioning Support Unit (from July 2012)
- Procurement Committee (from October 2012)

The Clinical Commissioning Executive was supported by three reporting sub- groups covering Audit and Governance, Finance and Performance and Quality.

Terms of reference agreed by the Board were in place for all Board sub committees.

Membership of the Board committees was in line with the organisation's Standing Orders, with three Non Executive Directors as members of the Audit Committee. There was a balance of Directors and Non Executive Directors who collectively took responsibility for the organisation. Once appointed, the Shadow Accountable Officer of the CCG attended Board meetings.

Good attendance was maintained at Board and Board subcommittee meetings throughout 2012/13 and this is demonstrated in the minutes.

The Committee structure was re-assessed during the year and the following changes were made to support an effective governance framework:

- Joint Committee of West Yorkshire Commissioning Support Unit (WYCSU) established with the neighbouring cluster, NHS Airedale, Bradford and Leeds, to establish and oversee the management of the WYCSU in shadow form during 2012/13 , operating within Standing Financial Instructions, to ensure it is fit for purpose as a CSU from April 2013

- Governance Committee - terms of reference revised and approved by the Board twice to refocus the committee's work to support transition (once in June 2012 to reflect changes to membership and once in September 2012 to ensure the Committee focussed on assurance relating to handover and transition issues)

- The frequency of Board meetings was reviewed in July 2012, being reduced for

the latter part of the year as the Clinical Commissioning Executive began to prepare to work as a Shadow Governing Body, with the Shadow Accountable Officer reporting to the Board

- A Procurement Committee was established by the Board once the frequency of Board meetings was reduced to ensure that procurement decisions were managed in a timely manner.

- Amendments were made to the terms of reference of the Commissioning Executive Committee and Standing Financial Instructions to enable the Chief Operating Officer and Shadow Accountable Officer to take on delegated limits.

The Cluster Board has had an independent review of the effectiveness of its governance arrangements from internal auditors who confirmed an audit opinion of significant assurance for governance arrangements

2.2 Coverage of work by Board

During 2012/13 the Board meetings covered a wide range of work which is outlined below.

- Chief Executive Reports
- Quality and Performance Reports
- Finance and QIPP reports
- Board Assurance Framework
- Governance and Risk Reports
- Transformation Report
- Commissioning Development and Transition Reports
- CCG report
- Review of Committee minutes
- Annual Reports

Seven Board meetings were held in public during the year. The Board also held business meetings during the year.

2.3 Audit Committee

The Audit Committee performed the key role of reviewing and monitoring the system of internal control during 2012/13, supported by an Audit and Governance group was which reported to the Clinical Commissioning Executive. The chair of the Audit and Governance group is a Non Executive Director and a member of the Cluster Audit Committee, ensuring linkage between the two groups.

These arrangements have included regular reports on the work and findings of the internal and external auditors. Minutes of the Audit Committee were reported regularly to the Board and minutes of the Audit and Governance Group were reviewed by the Cluster Audit Committee.

2.4 Transition

To ensure that there was appropriate focus on governance, transition and closedown I appointed a Director of Corporate Development and Transition from July 2012, who established a Transition Programme Office and Transition and Closedown Steering Group to oversee effective handover and closure, reporting to the Governance Committee on progress with transition.

The following actions for completing operational handover and closure and ensuring scrutiny of these arrangements are given below.

- Two events held across West Yorkshire with receiver organisations, to confirm the details of the transition process, supported by legal advisors
- Face to face meetings to produce the due diligence information in preparation of transfer scheme documentation.
- Attendance at the Public Health Transition Steering Group meetings
- Attendance at the CCG senior management team meetings
- Engagement with West Yorkshire Commissioning Support Unit (WYCSU) transition team
- Clarification of sign off process for transition for NHS Commissioning Board
- 'Page turn' process for the quality handover document with providers
- Programme highlight report produced for Cluster Governance Committee
- Assurance on transition process from Internal audit, through attendance at Steering Group meetings and a high level review to consider the governance arrangements and structures in place to manage the transition, confirming that the programme was well structured and key milestones had been achieved
- External audit (KPMG) have also received the appropriate level of information to provide assurance
- All ongoing risks have a future risk destination identified within the risk register
- Risks will be handed over as part of the quality and legacy process
- Quality Assembly held on 19 March 2013 for the formal handover of the quality documentation to receivers
- Board scrutiny of transfer documentation on 21 March 2013, including review of corporate legacy documentation

2.5 Accounts Scrutiny and Handover for 2012/13

In line with Department of Health guidance the NHS Calderdale, Kirklees and Wakefield District cluster will establish a cluster wide sub-committee of the Department of Health's own Audit and Risk committee. This sub-committee will meet in early June to review the annual report, financial statements and governance statement of the PCT prior to sign off by the West Yorkshire Area Team Director and Director of Finance. The three existing members of the cluster Audit Committee have agreed to be members of this committee.

To support this committee in discharging it's functions, NHS Calderdale CCG will review the PCT annual report, financial statements and governance statements through their own Audit Committees in April and May and will provide feedback to the cluster wide

Audit sub-committee.

In addition the draft governance statement will be reviewed by the PCT's Executive Team and cluster Audit Committee during March. A draft annual report will be reviewed by the cluster Chief Executive and Chair in March. Their feedback will be available for the Audit sub committee to review at it's meeting in June.

2.6 Corporate Governance

The organisation has in place a corporate governance framework with standing orders, standing financial instructions, a scheme of delegation, and a code of conduct. This has been revised during the year to reflect changed governance arrangements to enable shadow clinical commissioning groups to make financial decisions within an agreed framework.

Whilst there is no national corporate governance code in place for PCTs (such as the Monitor Code of Governance for Foundation Trusts), the PCT is compliant with principles within this code including:

- a Board of directors in place meeting regularly to discharge their duties
- a clear division of responsibilities of the Chair and Chief Executive
- a balance of Executive and Non Executive Directors
- information and professional development – a number of Board Business meetings have been held.

I confirm that effective arrangements have been in place during 2012/13 for the discharge of statutory duties, that there have been no irregularities and that the organisation has been legally compliant.

2.7 Partnership Governance

The Health and Wellbeing Board (HWB) has been established in shadow form in Calderdale since June 2011. This is supported by the main public sector organisations in Calderdale, alongside the private and voluntary sectors. The Chair is a member of the Board. The Assistant Clinical Chair of the shadow NHS Calderdale Clinical Commissioning Group is also a member of the HWB ensuring continuity beyond April 2013.

NHS Calderdale plays a significant part in collaborative working within the region. This is particularly important in the light of real financial pressures being felt across the system in the short and medium term and the need to create a system with reduced management costs. In 2011, seven local health and social care organisations across the Calderdale and Huddersfield health and social care economy agreed to work together on large-scale change in order to deliver improvements in care and financial stability. Together we created a clinically-led transformation Programme – the Calderdale and Kirklees Health and Social Care Strategic Review. The seven partners in the

programme are the shadow NHS Calderdale CCG, shadow Greater Huddersfield CCG, Calderdale and Huddersfield Foundation Trust, South West Yorkshire Partnership Foundation Trust, Kirklees Council, Locala and Calderdale Council. The Strategic Review Programme Executive reports into the Clinical Commissioning Executive and the Health and Wellbeing Board. The CCG will continue to develop the reporting and partnership governance arrangements beyond 1st April 2013.

Our partnership with Calderdale Council provides opportunities for efficiency and improved impact. Our Strategic Plan outlines how we are working together to deliver this significant agenda. We also continue to lead the way on the integration of health and social care services through the development of the Intermediate Tier work and single point of access, working in partnership to improve services for older people.

3.0 The Risk and Control Framework

The Chief Operating Officer, on my behalf, was responsible for maintaining the corporate risk register for NHS Calderdale. The organisation has maintained a corporate risk register which in turn has populated the cluster-wide risk register. Directors, managers and all staff work together to provide an integrated approach to the management of risk.

A standardised and approved Cluster wide Risk Management Strategy has been utilised within the organisation which sets out how risks are identified, assessed, managed and controlled. A key element in the system is the maintenance of the corporate Risk Register, including the Assurance Framework.

The PCT risk assessment processes are supported and delivered through the use of a bespoke risk register and risk reporting system.

The corporate risk register is managed under a regulated programme including sign off by Senior Management Teams. A High Level risk log of all risks scoring above a threshold is reviewed and scrutinised by Cluster Executive, Governance Committee and ultimately the Board. The Audit Committee also review related finance risks.

Over the 2012/13 period the risks have been aligned to the receiving organisations including the Clinical Commissioning Group who have utilised the same system and process with assurances being provided the Cluster Executive.

The Board Assurance Framework has been developed around the objectives within the cluster accountability framework and has been presented to the Governance Committee, Audit Committee and Board.

During 2012/13 the organisation took a range of actions to reduce risk and provide assurance about risk mitigation. This included:

- Continuously improvement to the quality of commissioned health services Closely monitoring compliance with national and local infection prevention and control targets
- Ongoing review and testing of emergency preparedness and resilience planning
- Compliance with Information Governance responsibilities
- Reviewing all contracts and contract documentation to ensure safe handover to successor bodies

- Transition of PCT functions and resources to new receiver organisations including the management of risks and challenges to the organisation. In particular, the ability to implement the changes with the associated impact on our staff, while ensuring that patients continue to receive safe, high quality care and that we deliver good value for money
- General risks included delivering the challenging cost improvement and QIPP agenda to meet the financial pressures across the NHS and public sector, maintaining staff engagement and ensuring appropriate staffing levels to deliver changes to the commissioning architecture and supporting the establishment of clinical commissioning groups.
- Risk of commissioned Trusts not achieving Foundation Trust status and the implications for the local health economies

3.1 Data Security

Risks relating to information governance continue to be monitored closely through the Risk Register. The Senior Information Risk Owner (SIRO) has responsibility for ensuring organisational information risk is properly identified and managed and that appropriate assurance mechanisms exist. They are familiar with risk management and the organisations response to risk. Any incident reports are thoroughly investigated and the lessons learned shared throughout the organisations.

Risks relating to data security appear on the risk register and due to good controls there have been no serious incidents and security lapses remain at a low level. There have been no information security incidents to report to the Information Commissioner.

The organisation continues to work towards improving performance to achieve level "2" compliance against the requirements of the Information Governance Toolkit.

3.2 Prevention and Deterrence of Risks

To provide assurances about the prevention of risk, the organisational governance framework consider any potential risks and their impact by:

- including an assessment of risk within Board and Committee papers
- ensuring risk management has an integral role in all major projects and developments within the organisation, keeping a specific risk register, for specific projects and escalating risk on to the corporate risk register.

Risk management policies and procedures were also in place during the year to ensure that risk was managed consistently throughout the organisation.

Regular reports on counter fraud were presented to the Audit Committee and counter fraud representatives attended the local Audit and Governance Group. Regular reports on counter fraud are given, with updates on any investigations, raising awareness of fraud amongst staff as a deterrent.

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

As Accountable Officer, I have responsibility for reviewing the effectiveness of the

system of internal control and risk management processes in practice.

The governance arrangements in place within NHS Calderdale during 2012/13 managed risk and provided assurance to the Board as described below:

Governance Committee

The Governance Committee reviewed the risks identified within the Board Assurance Framework and Corporate Risk Register at each meeting.

Audit Committee

The Audit Committee reviewed financial issues including the annual accounts. The Committee also sought assurance on the effectiveness of internal control from internal and external audit reports and opinions, counter fraud progress reports and the Board Assurance Framework. Internal and External Auditors actively participate in the Audit Committee.

Remuneration and Terms of Service Committee

This Committee ensured that governance arrangements were in place to manage remuneration and terms of service issues on behalf of the Board.

Clinical Commissioning Executive (CCE)

This Committee ensured clinical engagement on a broad range of both operational and strategic issues and was responsible for the majority of the commissioning budgets throughout 2012/13. The terms of reference for this Committee contained specific details on managing conflicts of interest.

CCE membership included Non Executive Directors/ Associates to provide scrutiny and assurance during the year.

Revisions to the scheme of delegation arising from the establishment of the cluster meant that from December 2011 three sub groups supported the CCE in monitoring the system of internal control. These were:

- Audit and Governance Group
- Finance and Performance Group
- Quality Group.

These groups provided assurance in the areas of corporate governance, financial governance and clinical governance.

In addition, I am assured that significant risks to the organisation are being managed by the following:

- Chief Officer, who has responsibility for risk management within the organisation
- Senior Management Team
- Internal Audit - opinions (including the Head of Internal Audit Opinion) and reports by Internal Audit, who work to a risk-based annual plan with topics that cover governance and risk management, financial management and control, procurement, service delivery and performance, operational and other reviews,

including the Yorkshire and Humber Specialised Commissioning Group (audit undertaken by the South Yorkshire and North Derbyshire Audit Services).

- External Audit - opinion and reports from our external auditors
- Performance reports
- Governance and risk reports
- Investigation reports and action plans following serious incident
- Safeguarding reports / Serious Case Reviews for Children

Where any weaknesses are identified a system is in place to manage these.

5.0. Conclusion

In line with the definition of significant issues, 2012/13 Governance Statements Guidance (Gateway Reference: 18561) I have not identified any significant issues during the year.

My review confirms that during 2012/13 NHS Calderdale had effective arrangements in place for the stewardship of the organisation.

Accountable Officer: Andy Buck

Organisation: West Yorkshire Area Team

Signature: 

Date: 6/6/13

INDEPENDENT AUDITORS' REPORT TO THE SIGNING OFFICER OF CALDERDALE PCT

We have audited the financial statements of Calderdale PCT for the year ended 31 March 2013 on pages 1 to 40. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England. We have also audited the information in the Remuneration Report that is subject to audit.

This report is made solely to the signing officer of Calderdale 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 signing officer of the PCT those matters we are required to state to them in an auditors' report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the signing officer of the PCT for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of Signing Officer and auditor

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

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the 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.

Opinion on financial statements

In our opinion the financial statements:

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

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

Opinion on regularity prescribed by the Code of Audit Practice 2010 for local NHS bodies

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 other matters prescribed by the Code of Audit Practice 2010 for local NHS bodies

In our opinion:

- the part of the Remuneration Report subject to audit has been properly prepared 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; and

- the information given in the director's report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Code of Audit Practice 2010 for local NHS bodies requires us to report to you if:

- in our opinion, the Governance Statement does not reflect compliance with the Department of Health's requirements;
- any referrals to the Secretary of State have been made under section 19 of the Audit Commission Act 1998; or
- any matters have been reported in the public interest under the Audit Commission Act 1998 in the course of, or at the end of, the audit.

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 2010 for local NHS bodies, 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.

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 Calderdale PCT in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission.

John Graham Prentice, for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
1 The Embankment
Neville Street
Leeds LS1 4DW

6 June 2013

FOREWORD TO THE ACCOUNTS

CALDERDALE PCT

These accounts for the year ended 31 March 2013 have been prepared by
Calderdale PCT under the National Health Service Act 2006
in the form which the Secretary of State has, with the approval of the Treasury, directed.

Statement of Comprehensive Net Expenditure for year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure			
Gross employee benefits	7.1	**6,843**	7,236
Other costs	5.1	**375,437**	366,106
Income	4	**(21,431)**	(18,995)
Net operating costs before interest		**360,849**	354,347
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**8**	7
Net operating costs for the financial year		**360,857**	354,354
Transfers by absorption -(gains)		**0**	0
Transfers by absorption - losses		**0**	0
Net (gain)/loss on transfers by absorption		**0**	0
Net Operating Costs for the Financial Year including absorption transfers		**360,857**	**354,354**
Of which:			
Administration Costs			
Gross employee benefits	7.1	**6,320**	7,078
Other costs	5.1	**6,378**	5,271
Income	4	**(1,287)**	(1,063)
Net administration costs before interest		**11,411**	**11,286**
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**0**	0
Net administration costs for the financial year		**11,411**	**11,286**
Programme Expenditure			
Gross employee benefits	7.1	**523**	158
Other costs	5.1	**369,059**	360,835
Income	4	**(20,144)**	(17,932)
Net programme expenditure before interest		**349,438**	**343,061**
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**8**	7
Net programme expenditure for the financial year		**349,446**	**343,068**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**0**	45
Net (gain) on revaluation of property, plant & equipment	**0**	(264)
Net (gain) on revaluation of intangibles	**0**	0
Net (gain) on revaluation of financial assets	**0**	0
Net (gain)/loss on other reserves	**0**	0
Net (gain)/loss on available for sale financial assets	**0**	0
Net (gain) /loss on Assets Held for Sale	**0**	0
Release of Reserves to Statement of Comprehensive Net Expenditure	**0**	0
Net actuarial (gain)/loss on pension schemes	**0**	0
Reclassification Adjustments		
Reclassification adjustment on disposal of available for sale financial assets	**0**	0
Total comprehensive net expenditure for the year*	**360,857**	**354,135**

The notes on page 7 to 40 form part of this account.

Statement of Financial Position at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	12	4,528	5,741
Intangible assets	13	0	0
investment property	15	0	0
Other financial assets	21	0	0
Trade and other receivables	19	0	0
Total non-current assets		4,528	5,741
Current assets:			
Inventories	18	0	0
Trade and other receivables	19	1,731	5,328
Other financial assets	36	0	0
Other current assets	22	0	0
Cash and cash equivalents	23	2	2
Total current assets		1,733	5,330
Non-current assets held for sale	24	0	0
Total current assets		1,733	5,330
Total assets		6,261	11,071
Current liabilities			
Trade and other payables	25	(20,833)	(25,901)
Other liabilities	26,28	0	0
Provisions	32	(800)	(1,693)
Borrowings	27	0	0
Other financial liabilities	36.2	0	0
Total current liabilities		(21,633)	(27,594)
Non-current assets plus/less net current assets/liabilities		(15,372)	(16,523)
Non-current liabilities			
Trade and other payables	25	0	0
Other Liabilities	28	0	0
Provisions	32	(1,704)	(2,448)
Borrowings	27	0	0
Other financial liabilities	36.2	0	0
Total non-current liabilities		(1,704)	(2,448)
Total Assets Employed:		(17,076)	(18,971)
Financed by taxpayers' equity:			
General fund		(17,914)	(19,809)
Revaluation reserve		838	838
Other reserves		0	0
Total taxpayers' equity:		(17,076)	(18,971)

The notes on pages 7 to 40 form part of this account.

The financial statements on pages *1 to 40* were approved by the Cluster Audit Committee and signed on its behalf by:

Signing Officer: Date: 6/6/13

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

	General fund	Revaluation reserve	Other reserves	Total reserves
	£000	£000	£000	£000
Balance at 1 April 2012	**(19,809)**	**838**	**0**	**(18,971)**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(360,857)			**(360,857)**
Net gain on revaluation of property, plant, equipment	0	0	0	**0**
Net gain on revaluation of intangible assets	0	0	0	**0**
Net gain on revaluation of financial assets	0	0	0	**0**
Net gain on revaluation of assets held for sale	0	0	0	**0**
Impairments and reversals	0	0	0	**0**
Movements in other reserves	0	0	0	**0**
Transfers between reserves*	0	0	0	**0**
Release of Reserves to SOCNE	0	0	0	**0**
Reclassification Adjustments	0	0	0	
Transfers between Revaluation Reserve & General Fund in respect of assets transferred under absorption	0	0	0	**0**
Net actuarial gain/(loss) on pensions	0	0	0	**0**
Total recognised income and expense for 2012-13	**(360,857)**	**0**	**0**	**(360,857)**
Net Parliamentary funding	362,752	0	0	**362,752**
Balance at 31 March 2013	**(17,914)**	**838**	**0**	**(17,076)**
Balance at 1 April 2011	**(17,241)**	**619**	**0**	**(16,622)**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(354,354)	0	0	(354,354)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment	0	264	0	264
Net Gain / (loss) on Revaluation of Intangible Assets	0	0	0	0
Net Gain / (loss) on Revaluation of Financial Assets	0	0	0	0
Net Gain / (loss) on Assets Held for Sale	0	0	0	0
Impairments and Reversals	0	(45)	0	(45)
Movements in other reserves			0	0
Transfers between reserves*	0	0	0	0
Release of Reserves to Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification Adjustments				
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0	0
On disposal of available for sale financial assets	0	0	0	0
Net actuarial gain/(loss) on pensions	0	0	0	0
Total recognised income and expense for 2011-12	(354,354)	219	0	(354,135)
Net Parliamentary funding	351,786	0	0	351,786
Balance at 31 March 2012	**(19,809)**	**838**	**0**	**(18,971)**

Statement of cash flows for the year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities			
Net Operating Cost Before Interest		**(360,849)**	(354,347)
Depreciation and Amortisation		**1,361**	721
Impairments and Reversals		**0**	0
Other Gains / (Losses) on foreign exchange		**0**	0
Donated Assets received credited to revenue but non-cash		**0**	0
Government Granted Assets received credited to revenue but non-cash		**0**	0
Interest Paid		**0**	0
Release of PFI/deferred credit		**0**	0
(Increase)/Decrease in Inventories		**0**	0
(Increase)/Decrease in Trade and Other Receivables		**3,597**	(1,282)
(Increase)/Decrease in Other Current Assets		**0**	0
Increase/(Decrease) in Trade and Other Payables		**(4,987)**	3,200
(Increase)/Decrease in Other Current Liabilities		**0**	0
Provisions Utilised		**(1,502)**	(763)
Increase/(Decrease) in Provisions		**(143)**	1,233
Net Cash Inflow/(Outflow) from Operating Activities		**(362,523)**	**(351,238)**
Cash flows from investing activities			
Interest Received		**0**	0
(Payments) for Property, Plant and Equipment		**(229)**	(547)
(Payments) for Intangible Assets		**0**	0
(Payments) for Other Financial Assets		**0**	0
(Payments) for Financial Assets (LIFT)		**0**	0
Proceeds of disposal of assets held for sale (PPE)		**0**	0
Proceeds of disposal of assets held for sale (Intangible)		**0**	0
Proceeds from Disposal of Other Financial Assets		**0**	0
Proceeds from the disposal of Financial Assets (LIFT)		**0**	0
Loans Made in Respect of LIFT		**0**	0
Loans Repaid in Respect of LIFT		**0**	0
Rental Revenue		**0**	0
Net Cash Inflow/(Outflow) from Investing Activities		**(229)**	**(547)**
Net cash inflow/(outflow) before financing		**(362,752)**	**(351,785)**
Cash flows from financing activities			
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**0**	0
Net Parliamentary Funding		**362,752**	351,786
Capital Receipts Surrendered		**0**	0
Capital grants and other capital receipts		**0**	0
Cash Transferred (to)/from Other NHS Bodies (free text note required)		**0**	0
Net Cash Inflow/(Outflow) from Financing Activities		**362,752**	**351,786**
Net increase/(decrease) in cash and cash equivalents		**0**	**1**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**2**	**1**
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies		**0**	0
Cash and Cash Equivalents (and Bank Overdraft) at year end		**2**	**2**

1. Accounting policies

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

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

In accordance with the directed accounting policy from the Secretary of State, the PCT does not consolidate the NHS charitable funds for which it is the corporate trustee.

Under the provisions of the Health and Social care Act 2012 (Commencement No 4. Transitional, Savings and Transitory Provisions) Order 2013, Calderdale PCT was dissolved on the 1st April 2013. The PCT's functions, assets and liabilities transferred to other public bodies as outlined in Note 42.1 Events after the Reporting Period. Where reconfiguration of this nature takes place within the public sector, Government accounting requires that the activities concerned are to be considered as continuing operations, and so the closing entity prepared accounts on a "going concern" basis.

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

1.1 Accounting Conventions

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

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

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

Critical judgements in applying accounting policies
The PCT has made no critical judgements, apart from those involving estimations. Management has made no critical judgement in the process of applying the entity's accounting policies that could have the most significant effect on the amounts recognised in the financial statements.

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.

Tangible Assets have been valued on a Modern Equivalent Asset Basis from 01/04/09 and the difference in valuations will be managed through the Revaluation Reserve with no impact on I/E. A further Professional valuation was carried out by the District Valuer's of the Inland Revenue Government Department in March 2012. Tangible Assets were re-valued on a Modern Equivalent Asset basis at this date and any differences have been managed through the Revaluation Reserve with no impact on I/E. Asset lives are reviewed annually to ensure the correct depreciation rates are applied and I/E is charged appropriately. Provision balances are reviewed annually to ensure that the carrying amount is sufficient. As a result of the introduction of deadlines for the assessment of a patient's eligibility for continuing healthcare funding, a significant number of retrospective claims for continuing healthcare funding up to 31 March 2013 have been received by the PCT. A provision has been made for the expected cost of these claims, but actual costs will only be confirmed on completion of in-depth case reviews which will be completed in the following financial year. Actual claim values will differ from the estimates made, but the overall difference is not expected to be

1. Accounting policies (continued)

1.2 Revenue and Funding

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

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

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

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

1.3 Care Trust Designation

Calderdale PCT is not a designated Care Trust.

1.4 Pooled budgets

The PCT has entered into a pooled budget with Calderdale MBC. Under the arrangement funds are pooled under S75 of the NHS Act 2006 for Joint Equipment Store activities and a memorandum note to the accounts (Note 40) provides details of the joint income and expenditure.

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

The PCT hosts a pooled budget for the Drugs Action Team with Calderdale MBC and a note providing details of the joint income and expenditure is shown in the notes to the accounts.

1.5 Taxation

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

1.6 Administration and Programme Costs

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

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

1. Accounting policies (continued)

1.7 Property, Plant & Equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation

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

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

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

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

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

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

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the PCT's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the PCT; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

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

NHS Calderdale does not hold any Intangible Assets.

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. Accounting policies (continued)

1.10 Donated assets

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

The PCT does not have any donated assets.

1.11 Government grants

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

1.12 Non-current assets held for sale

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

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

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

The PCT does not have any non current assets classified as held for sale.

1.13 Inventories

The PCT does not carry 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. Accounting policies (continued)

1.17 Employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, *except for bonuses earned but not yet taken which, like leave earned but not yet taken is not accrued for at the year end, on the grounds of immateriality.

Retirement benefit costs

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

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

1.18 Research and Development

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

The PCT does not have any research and development expenditure.

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

The PCT does not participate in the EU Emissions Trading Scheme.

1. Accounting policies (continued)

1.22 Contingencies

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

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

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

1.23 Leases

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

The PCT as lessee

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

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

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

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

The PCT as lessor

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

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.24 Foreign exchange

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

The PCT does not have any foreign exchange transaction to report.

1.25 Provisions

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

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

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

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

1. Accounting policies (continued)

1.26 Financial Instruments

Financial assets

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

Financial assets are initially recognised at fair value.

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

Financial assets at fair value through profit and loss

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

Held to maturity investments

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

Available for sale financial assets

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

Loans and receivables

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

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

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

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

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

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

1. Accounting policies (continued)

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

Financial liabilities are initially recognised at fair value.

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

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

Other financial liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.27 Private Finance Initiative (PFI) and NHS LIFT 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 does not have any PFI or LIFT transactions.

1. Accounting policies (continued)

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

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

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

1.29 GMS Leases
NHS Calderdale has entered into certain financial arrangments involving the use of GP premises.

The financial value included in the Statement of Comprehensive Net Expenditure for 2012/13 is £2,344k (2011/12 : £2,378k).

These arrangements have been assessed under IFRIC4 (determining whether an arrangement contains a lease) under normal circumstances future operating cost commitments would be disclosed in note 6.1.

However, as they have no defined term it is not possible to analyse future operating lease commitments for these

1.30 Revenue recognition and long term contracts
NHS Calderdale has accrued for the value of incomplete spells for Secondary Healthcare services provided by NHS Foundation and NHS Trusts excluding mental health providers.

1.31 Legal Charges
The PCT has 4 Legal Charges over properties exchanged between St. Anne's Shelter and Housing Action and the SHA in 1994.

The agreement required the properties to be available for people with either Learning Disabilities or Mental Health issues. it has been established legally that a service concession does not exist and as such these arrangements create a Contingent Asset.

If the properties cease to be used for the specified purposes of the value of the Legal Charge will be repayable. The Total value of the Legal Charges at the transfer date was £1,365,505 (2012 : £1,365,505).

2 Operating segments

	Segment		Segment		Total	
	2012-13 £000	2011-12 £000	2012-13 £000	2011-12 £000	2012-13 £000	2011-12 £000
Expenditure	0	0	0	0	0	0
Surplus/(Deficit)						
Segment surplus/(deficit)	0	0	0	0	0	0
Common costs	0	0	0	0	0	0
Surplus/(deficit) before interest	0	0	0	0	0	0
Net Assets:						
Segment net assets	0	0	0	0	0	0

Operating segments have been considered by the PCT and are not considered to be appropriate.

3. Financial Performance Targets

3.1 Revenue Resource Limit

	2012-13 £000	2011-12 £000
The PCTs' performance for the year ended 2012-13 is as follows:		
Total Net Operating Cost for the Financial Year		
Net operating cost plus (gain)/loss on transfers by absorption	**360,857**	354,354
Adjusted for prior period adjustments in respect of errors	**0**	0
Revenue Resource Limit	**364,457**	357,822
Under/(Over)spend Against Revenue Resource Limit (RRL)	3,600	3,468

Net operating costs include £1M which has been lodged in the Strategic Investment fund.

3.2 Capital Resource Limit

	2012-13 £000	2011-12 £000
The PCT is required to keep within its Capital Resource Limit.		
Capital Resource Limit	**170**	613
Charge to Capital Resource Limit	**148**	613
(Over)/Underspend Against CRL	**22**	**0**

3.3 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**362,752**	351,786
Cash Limit	**362,752**	351,786
Under/(Over)spend Against Cash Limit	**0**	**0**

4 Miscellaneous Revenue

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Fees and Charges	**14**	14	0	10
Dental Charge income from Contractor-Led GDS & PDS	**2,859**	0	2,859	2,792
Dental Charge income from Trust-Led GDS & PDS	**0**	0	0	0
Prescription Charge income	**2,007**	0	2,007	1,906
Strategic Health Authorities	**584**	326	258	282
NHS Trusts	**51**	0	51	1
NHS Foundation Trusts	**978**	3	975	1,110
Primary Care Trusts Contributions to DATs	**0**	0	0	0
Primary Care Trusts - Other	**363**	0	363	616
Primary Care Trusts - Lead Commissioning	**8,383**	27	8,356	8,596
English RAB Special Health Authorities	**0**	0	0	0
NDPBs and Others (CGA)	**0**	0	0	0
Department of Health - SMPTB	**0**	0	0	0
Department of Health - Other	**1**	1	0	(16)
Recoveries in respect of employee benefits	**832**	764	68	863
Local Authorities	**1,116**	1	1,115	1,040
Patient Transport Services	**0**	0	0	0
Education, Training and Research	**994**	0	994	751
Non-NHS: Private Patients	**0**	0	0	0
Non-NHS: Overseas Patients (Non-Reciprocal)	**0**	0	0	0
NHS Injury Costs Recovery	**0**	0	0	0
Other Non-NHS Patient Care Services	**0**	0	0	0
Charitable and Other Contributions to Expenditure	**1**	0	1	1
Receipt of donated assets	**0**	0	0	0
Receipt of Government granted assets	**0**	0	0	0
Rental revenue from finance leases	**0**	0	0	0
Rental revenue from operating leases	**0**	0	0	0
Other revenue	**3,248**	151	3,097	1,043
Total miscellaneous revenue	**21,431**	**1,287**	**20,144**	**18,995**

5. Operating Costs

5.1 Analysis of operating costs:

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
Goods and Services from Other PCTs				
Healthcare	23,162	0	23,162	19,941
Non-Healthcare	1,440	1,440	0	822
Total	24,602	1,440	23,162	20,763
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	22,272	0	22,272	21,656
Goods and services (other, excl Trusts, FT and PCT))	28	28	0	221
Total	22,300	28	22,272	21,877
Goods and Services from Foundation Trusts	183,295	722	182,573	178,761
Purchase of Healthcare from Non-NHS bodies	42,860	0	42,860	41,321
Social Care from Independent Providers	0	0	0	0
Expenditure on Drugs Action Teams	3,033	0	3,033	2,956
Non-GMS Services from GPs	994	0	994	751
Contractor Led GDS & PDS (excluding employee benefits)	12,906	0	12,906	12,645
Salaried Trust-Led PDS & PCT DS (excluding employee benefits)	0	0	0	0
Chair, Non-executive Directors & PEC remuneration	101	101	0	107
Executive committee members costs	601	601	0	566
Consultancy Services	104	104	0	1
Prescribing Costs	33,481	0	33,481	33,582
G/PMS, APMS and PCTMS (excluding employee benefits)	33,532	0	33,532	35,692
Pharmaceutical Services	(1)	0	(1)	(1)
Local Pharmaceutical Services Pilots	0	0	0	0
New Pharmacy Contract	9,196	0	9,196	8,841
General Ophthalmic Services	2,005	0	2,005	1,975
Supplies and Services - Clinical	868	0	868	906
Supplies and Services - General	153	153	0	165
Establishment	448	398	50	481
Transport	3	3	0	31
Premises	3,106	392	2,714	2,901
Impairments & Reversals of Property, plant and equipment	0	0	0	0
Impairments and Reversals of non-current assets held for sale	0	0	0	0
Depreciation *	1,361	1,361	0	721
Amortisation	0	0	0	0
Impairment & Reversals Intangible non-current assets	0	0	0	0
Impairment and Reversals of Financial Assets	0	0	0	0
Impairment of Receivables	0	0	0	0
Inventory write offs	0	0	0	0
Research and Development Expenditure	0	0	0	0
Audit Fees	100	100	0	166
Other Auditors Remuneration	0	0	0	0
Clinical Negligence Costs	805	805	0	0
Education and Training	146	146	0	100
Grants for capital purposes	0	0	0	0
Grants for revenue purposes	0	0	0	0
Impairments and reversals for investment properties	0	0	0	0
Other**	(562)	24	(586)	798
Total Operating costs charged to Statement of Comprehensive Net Expenditure	375,437	6,378	369,059	366,106
* Depreciation includes £779K Of accelerated depreciation in relation to a number of assets that had no further use				
** Other costs include a reversal of an unused redundancy provision				
Employee Benefits (excluding capitalised costs)				
Employee Benefits associated with PCTMS	0	0	0	0
Trust led PDS and PCT DS	0	0	0	0
PCT Officer Board Members	709	709	0	881
Other Employee Benefits	6,134	5,610	524	6,355
Total Employee Benefits charged to SOCNE	6,843	6,319	524	7,236
Total Operating Costs	382,280	12,697	369,583	373,342
For capital purposes				
Grants to fund Capital Projects - GMS	0	0	0	0
Grants to Local Authorities to Fund Capital Projects	0	0	0	0
Grants to Private Sector to Fund Capital Projects	0	0	0	0
Grants to Fund Capital Projects - Dental	0	0	0	0
Grants to Fund Capital Projects - Other	0	0	0	0
Total Capital Grants	0	0	0	0
Grants to fund revenue expenditure				
To Local Authorities	0	0	0	0
To Private Sector	0	0	0	0
To Other	0	0	0	0
Total Revenue Grants	0	0	0	0
Total Grants	0	0	0	0

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	11,410	10,354	1,056
Weighted population (number in units)*	202,408	202,408	202,408
Running costs per head of population (£ per head)	56	51	5
PCT Running Costs 2011-12			
Running costs (£000s)	11,286	10,310	976
Weighted population (number in units)	202,408	202,408	202,408
Running costs per head of population (£ per head)	56	51	5

The PCT hosts the Yorkshire Cancer Network and does not include these costs in its calculation for running costs.

5.2 Analysis of operating expenditure by expenditure classification	2012-13 £000	2011-12 £000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	28,844	30,687
Prescribing costs	33,481	33,582
Contractor led GDS & PDS	12,906	12,458
Trust led GDS & PDS	0	0
General Ophthalmic Services	2,005	1,975
Department of Health Initiative Funding	0	0
Pharmaceutical services	(1)	(1)
Local Pharmaceutical Services Pilots	0	0
New Pharmacy Contract	9,196	8,841
Non-GMS Services from GPs	1,005	751
Other	0	0
Total Primary Healthcare purchased	**87,436**	88,293
Purchase of Secondary Healthcare		
Learning Difficulties	11,145	11,598
Mental Illness	30,615	31,867
Maternity	12,024	10,169
General and Acute	147,936	146,029
Accident and emergency	16,268	13,288
Community Health Services	50,708	45,371
Other Contractual	0	0
Total Secondary Healthcare Purchased	**268,696**	258,322
Grant Funding		
Grants for capital purposes	0	0
Grants for revenue purposes	0	0
Total Healthcare Purchased by PCT	**356,132**	**346,615**
PCT self-provided secondary healthcare included above	0	0
Social Care from Independent Providers	0	0
Healthcare from NHS FTs included above	182,573	174,745

6. Operating Leases

The PCT has entered into lease arrangements to secure proprty for conducting the business of healthcare and associated administration. All arrangements have been assessed individually and determined to be operating leases with reference to IAS 17.

There were not material leasing arrangements entered into during 2012/13.

More detail of GMS leases are included in the accounting policies note 1.29.

Transforming Community Services
The receiver organisations of the provider services functions previously undertaken by the PCT have rights to occupy premises under business transfer arrangements. This right to occupy constitutes an embedded leasing arrangement as defined by IFRIC 4. All risks and rewards of ownership rest with the PCT and as such the arrangements have been deemed to be operating leases. The right to occupy (licence) are not for a fixed term therefore it is not possible to disclose future minimum receipts.

The mechanism for this arrangement is for income to be generated from the recharge of costs incurred by the PCT on behalf of the provider organisation. This relates to an effective rent for service occupation. The provider is funded for this expense by way of a contract variation.

The values of these transations are not considered material and do not appear in the operating lease notes.

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	0	1,418	0	1,418	1,423
Contingent rents	0	0	0	0	0
Sub-lease payments	0	0	0	0	0
Total	0	1,418	0	1,418	1,423
Payable:					
No later than one year	0	1,012	0	1,012	1,426
Between one and five years	0	4,049	0	4,049	5,589
After five years	0	9,772	0	9,772	12,532
Total	0	14,833	0	14,833	19,547
Total future sublease payments expected to be received				0	0

6.2 PCT as lessor

The Primary Care Trust has no leasing arrangements with third parties from the perspective of a lessor.

7. Employee benefits and staff numbers

7.1 Employee benefits

2012-13				Permanently employed			Other		
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Employee Benefits - Gross Expenditure									
Salaries and wages	5,788	5,345	443	5,678	5,235	443	110	110	0
Social security costs	436	403	33	428	395	33	8	8	0
Employer Contributions to NHS BSA - Pensions Division	619	572	47	607	560	47	12	12	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Total employee benefits	6,843	6,320	523	6,713	6,190	523	130	130	0
Less recoveries in respect of employee benefits (table below)	(832)	(764)	(68)	(832)	(764)	(68)	0	0	0
Total - Net Employee Benefits including capitalised costs	6,011	5,556	455	5,881	5,426	455	130	130	0
Employee costs capitalised	0	0	0	0	0	0	0	0	0
Gross Employee Benefits excluding capitalised costs	6,843	6,320	523	6,713	6,190	523	130	130	0
Recognised as:									
Commissioning employee benefits	6,843			6,713			130		
Provider employee benefits	0			0			0		
Gross Employee Benefits excluding capitalised costs	6,843			6,713			130		

2012-13				Permanently employed			Other		
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Employee Benefits - Revenue									
Salaries and wages	704	646	58	704	646	58	0	0	0
Social Security costs	53	49	4	53	49	4	0	0	0
Employer Contributions to NHS BSA - Pensions Division	75	69	6	75	69	6	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	832	764	68	832	764	68	0	0	0

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	6,107	6,063	44
Social security costs	458	455	3
Employer Contributions to NHS BSA - Pensions Division	671	666	5
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Total gross employee benefits	7,236	7,184	52
Less recoveries in respect of employee benefits	(863)	(863)	0
Total - Net Employee Benefits including capitalised costs	6,373	6,321	52
Employee costs capitalised	0	0	0
	7,236	7,184	52
Recognised as:			
Commissioning employee benefits	7,236		
Provider employee benefits	0		
Gross Employee Benefits excluding capitalised costs	7,236		

7.2 Staff Numbers

2012-13				2011-12		
	Total Number	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number
Average Staff Numbers						
Medical and dental	4	4	0	4	4	0
Ambulance staff	0	0	0	0	0	0
Administration and estates	106	104	2	115	115	0
Healthcare assistants and other support staff	0	0	0	0	0	0
Nursing, midwifery and health visiting staff	14	14	0	14	14	0
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	3	3	0	4	4	0
Social Care Staff	0	0	0	0	0	0
Other	0	0	0	0	0	0
TOTAL	127	125	2	137	137	0
Of the above - staff engaged on capital projects	0	0	0	0	0	0

7.3 Staff Sickness absence and ill health retirements

	2012-13 Number	2011-12 Number
Total Days Lost	520	1,403
Total Staff Years	140	265
Average working Days Lost	3.71	5.29

	2012-13 Number	2011-12 Number
Number of persons retired early on ill health grounds	0	1
	£000s	£000s
Total additional pensions liabilities accrued in the year	0	3

7.4 Exit Packages agreed during 2012-13

	2012-13			2011-12		
Exit package cost band (including any special payment element)	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band
	Number	**Number**	**Number**	Number	Number	Number
Lees than £10,000	**3**	**0**	**3**	0	0	0
£10,001-£25,000	**2**	**6**	**8**	0	5	5
£25,001-£50,000	**3**	**2**	**5**	0	3	3
£50,001-£100,000	**1**	**1**	**2**	0	4	4
£100,001 - £150,000	**0**	**0**	**0**	0	0	0
£150,001 - £200,000	**0**	**1**	**1**	0	0	0
>£200,000	**0**	**0**	**0**	0	0	0
Total number of exit packages by type (total cost	**9**	**10**	**19**	0	12	12
	£s	**£s**	**£s**	**£s**	**£s**	**£s**
Total resource cost	**224,000**	**424,000**	**648,000**	0	462,000	462,000

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs in this note are accounted for in full in the year of departure. 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 taken by staff leaving in the year. Note: The expense associated with these departures have been recognised in full in this period.

Movement in the redundancy provision is shown in Note 32 Provisions and classified as Other expenditure in analysis of operating costs in Note 5.1.

In addition to the above costs there are five exit packages for officers employed across the Calderdale, Kirklees and Wakefield cluster for which Calderdale PCT has been recharged £203K being 22% of the total cost. The full cost for these packages of £937K has been shown in the accounts of Kirklees PCT and Wakefield District PCT.

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 prescibed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is cotained 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 access 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 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	**10,571**	**52,352**	10,518	47,595
Total Non-NHS Trade Invoices Paid Within Target	**10,478**	**52,098**	10,451	47,348
Percentage of NHS Trade Invoices Paid Within Target	99.12%	99.51%	99.36%	99.48%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3,138**	**240,122**	2,768	229,765
Total NHS Trade Invoices Paid Within Target	**3,088**	**239,611**	2,729	229,399
Percentage of NHS Trade Invoices Paid Within Target	98.41%	99.79%	98.59%	99.84%

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

	2012-13 £000	2011-12 £000
Amounts included in finance costs from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**0**	0

9. Investment Income

Rental Income - NHS Calderdale has no Rental Income.

Interest Income - NHS Calderdale has no Interest Income.

10. Other Gains and Losses

NHS Calderdale has no Other Gains and Losses.

11. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest				
Interest on obligations under finance leases	0	0	0	0
Interest on obligations under PFI contracts:				
- main finance cost	0	0	0	0
- contingent finance cost	0	0	0	0
Interest on obligations under LIFT contracts:				
- main finance cost	0	0	0	0
- contingent finance cost	0	0	0	0
Interest on late payment of commercial debt	0	0	0	0
Other interest expense	0	0	0	0
Total interest expense	0	0	0	0
Other finance costs	0	0	0	0
Provisions - unwinding of discount	8		8	7
Total	8	0	8	7

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	858	3,380	0	0	894	0	2,895	1,560	9,587
Additions of Assets Under Construction				0					0
Additions Purchased	0	0	0		0	0	148	0	148
Additions Donated	0	0	0	0	0	0	0	0	0
Additions Government Granted	0	0	0	0	0	0	0	0	0
Additions Leased	0	0	0		0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassifications as Held for Sale	0	0	0	0	0	0	0	0	0
Disposals other than for sale	0	0	0	0	0	0	0	0	0
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	0
Impairments/negative indexation	0	0	0	0	0	0	0	0	0
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	0
At 31 March 2013	858	3,380	0	0	894	0	3,043	1,560	9,735
Depreciation									
At 1 April 2012	0	263	0	0	846	0	2,545	192	3,846
Reclassifications	0	0	0		0	0	0	0	0
Reclassifications as Held for Sale	0	0	0		0	0	0	0	0
Disposals other than for sale	0	0	0		0	0	0	0	0
Upward revaluation/positive indexation	0	0	0		0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Charged During the Year	0	683	0		48	0	434	196	1,361
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	0
At 31 March 2013	0	946	0	0	894	0	2,979	388	5,207
Net Book Value at 31 March 2013	858	2,434	0	0	0	0	64	1,172	4,528
Purchased	858	2,434	0	0	0	0	64	1,172	4,528
Donated	0	0	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	858	2,434	0	0	0	0	64	1,172	4,528
Asset financing:									
Owned	858	2,434	0	0	0	0	64	1,172	4,528
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	858	2,434	0	0	0	0	64	1,172	4,528

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	259	579	0	0	0	0	0	0	838
Movements (specify)	0	0	0	0	0	0	0	0	0
At 31 March 2013	259	579	0	0	0	0	0	0	838

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	**903**	**2,777**	**0**	**0**	**894**	**0**	**2,869**	**1,312**	**8,755**
Additions - purchased	0	339	0	0	0	0	26	248	**613**
Additions - donated	0	0	0	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	0	0	0	**0**
Revaluation & indexation gains	0	264	0	0	0	0	0	0	**264**
Impairments	(45)	0	0	0	0	0	0	0	**(45)**
Reversals of impairments	0	0	0	0	0	0	0	0	**0**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluatio	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**858**	**3,380**	**0**	**0**	**894**	**0**	**2,895**	**1,560**	**9,587**
Depreciation									
At 1 April 2011	**0**	**0**	**0**	**0**	**826**	**0**	**2,199**	**100**	**3,125**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassifications as Held for Sale	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	0	0	0	0	**0**
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Charged During the Year	0	263	0	0	20	0	346	92	**721**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluatio	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**0**	**263**	**0**	**0**	**846**	**0**	**2,545**	**192**	**3,846**
Net Book Value at 31 March 2012	**858**	**3,117**	**0**	**0**	**48**	**0**	**350**	**1,368**	**5,741**
Purchased	858	3,117	0	0	48	0	350	1,368	**5,741**
Donated	0	0	0	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**858**	**3,117**	**0**	**0**	**48**	**0**	**350**	**1,368**	**5,741**
Asset financing:									
Owned	858	3,117	0	0	48	0	350	1,368	**5,741**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**858**	**3,117**	**0**	**0**	**48**	**0**	**350**	**1,368**	**5,741**

12.3 Property, plant and equipment

There have been no donated assets in year. The PCT does not have any donated assets.

The range of estimated lives of each class of fixed asset is given below :

Buildings excluding dwellings:
Minimum Life - 30 Years
Maximum Life - 99 Years

Plant and Machinery :
Minimum Life - 3 Years
Maximum Life - 15 Years

Information Technology :
Minimum Life - 1 Year
Maximum Life - 3 Years

Furniture and Fittings :
Minimum Life - 3 Years
Maximum Life - 15 Years

No assets have had their asset lives changed during the year.

Details of the last revaluation are contained in the accounting policies section.

13.1 Intangible non-current assets

The PCT has never recognised any intangible non current assets.

Economic Lives of Non-Current Assets

	Min Life Years	Max Life Years
Intangible Assets		
Software Licences	0	0
Licences and Trademarks	0	0
Patents	0	0
Development Expenditure	0	0
Property, Plant and Equipment		
Buildings exc Dwellings	0	0
Dwellings	0	0
Plant & Machinery	0	0
Transport Equipment	0	0
Information Technology	0	0
Furniture and Fittings	0	0

Open Market Value of Assets at balance sheet date	Land	Buildings excl. dwellings	Dwellings	Total
	£000s	£000s	£000s	£000s
Open Market Value at 31 March 2013	0	0	0	0
Open Market Value at 31 March 2012	0	0	0	0

15 Investment property

The PCT does not hold any investment property.

16 Commitments

16.1 Capital commitments

The PCT does not have any capital commitments going forward.

16.2 Other financial commitments

The PCT has not entered into non-cancellable contracts (which are not leases or PFI contracts or other service concession arrangements).

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	204	0	1,534	0
Balances with Local Authorities	4	0	1,084	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	413	0	3,342	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	1,110	0	14,873	0
At 31 March 2013	**1,731**	**0**	**20,833**	**0**
prior period:				
Balances with other Central Government Bodies	3,229	0	466	0
Balances with Local Authorities	260	0	1,167	0
Balances with NHS Trusts and Foundation Trusts	674	0	2,589	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	1,165	0	21,679	0
At 31 March 2012	**5,328**	**0**	**25,901**	**0**

18 Inventories

The PCT does not hold any inventories.

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	**493**	3,216	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**35**	606	**0**	0
Non-NHS receivables - revenue	**442**	745	**0**	0
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**688**	679	**0**	0
Provision for the impairment of receivables	**0**	0	**0**	0
VAT	**71**	81	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	**0**	0	**0**	0
Interest receivables	**0**	0	**0**	0
Finance lease receivables	**0**	0	**0**	0
Operating lease receivables	**0**	0	**0**	0
Other receivables	**2**	1	**0**	0
Total	1,731	5,328	0	0
Total current and non current	1,731	5,328		
Included above:				
Prepaid pensions contributions	0	0		

The great majority of trade is with other NHS bodies, including other Primary Care Trusts as commissioners for NHS patient care services.

19.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	**139**	3,569
By three to six months	**20**	0
By more than six months	**0**	6
Total	159	3,575

19.3 Provision for impairment of receivables

20 NHS LIFT investments

NHS Calderdale does not have any NHS LIFT investments.

21.1 Other financial assets - Current

NHS Calderdale does not have any Other financial assets - Current.

21.2 Other Financial Assets - Non Current

NHS Calderdale does not have any Other financial assets - Non Current.

21.3 Other Financial Assets - Capital Analysis

NHS Calderdale does not have any Other financial assets - Capital Analysis.

22 Other current assets

NHS Calderdale does not have any Other current assets.

23 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**2**	2
Net change in year	**0**	0
Closing balance	**2**	2
Made up of		
Cash with Government Banking Service	**2**	2
Commercial banks	**0**	0
Cash in hand	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**2**	2
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**2**	2
Patients' money held by the PCT, not included above	**0**	0

24 Non-current assets held for sale

The PCT does not have any non current assets held for sale.

25 Trade and other payables

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Interest payable	**0**	0	**0**	0
NHS payables - revenue	**1,674**	637	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**2,915**	2,194	**0**	0
Family Health Services (FHS) payables	**8,156**	7,796	0	0
Non-NHS payables - revenue	**1,961**	999	**0**	0
Non-NHS payables - capital	**0**	81	**0**	0
Non_NHS accruals and deferred income	**5,855**	13,964	**0**	0
Social security costs	**62**	68	**0**	0
VAT	**0**	0	**0**	0
Tax	**141**	70	**0**	0
Payments received on account	**0**	0	**0**	0
Other	69	92	0	0
Total	**20,833**	25,901	**0**	0
Total payables (current and non-current)	**20,833**	**25,901**		

26 Other liabilities

NHS Calderdale has no Other liabilities.

27 Borrowings

NHS Calderdale has no borrowings.

28 Other financial liabilities

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Embedded Derivatives at Fair Value through SoCNE	**0**	0	**0**	0
Financial liabilities carried at fair value through SoCNE	**0**	0	**0**	0
Amortised Cost	**0**	0	**0**	0
Total	**0**	0	**0**	0
Total other liabilities (current and non-current)	**0**	**0**		

29 Deferred income

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Opening balance at1 April 2012	**2,595**	3,338	**0**	0
Deferred income addition	**0**	72	**0**	0
Transfer of deferred income	**(2,595)**	(815)	**0**	0
Current deferred Income at 31 March 2013	**0**	2,595	**0**	0
Total other liabilities (current and non-current)	**0**	**2,595**		

30 Finance lease obligations

The PCT has no finance lease obligations.

32 Provisions

Comprising:

	Total £000s	Pensions to Former Directors £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Restructuring £000s	Continuing Care £000s	Equal Pay £000s	Agenda for Change £000s	Other £000s	Redundancy £000s
Balance at 1 April 2012	**4,141**	0	77	461	0	1,103	0	0	0	2,500
Arising During the Year	**1,500**	0	0	0	0	1,500	0	0	0	0
Utilised During the Year	**(1,502)**	0	(77)	(469)	0	(99)	0	0	0	(857)
Reversed Unused	**(1,643)**	0	0	0	0	0	0	0	0	(1,643)
Unwinding of Discount	**8**	0	0	8	0	0	0	0	0	0
Change in Discount Rate	**0**	0	0	0	0	0	0	0	0	0
Transferred (to)/from otherPublic Sector bodies	**0**	0	0	0	0	0	0	0	0	0
Balance at 31 March 2013	**2,504**	**0**	**0**	**0**	**0**	**2,504**	**0**	**0**	**0**	**0**
Expected Timing of Cash Flows:										
No Later than One Year	**800**	**0**	**0**	**0**	**0**	**800**	**0**	**0**	**0**	**0**
Later than One Year and not later than Five Years	**800**	**0**	**0**	**0**	**0**	**800**	**0**	**0**	**0**	**0**
Later than Five Years	**904**	**0**	**0**	**0**	**0**	**904**	**0**	**0**	**0**	**0**

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at 31 March 2013	0
As at 31 March 2012	0

As a result of the introduction of deadlines for the assessment of a patient's eligibility for continuing healthcare funding, a significant number of retrospective claims for continuing healthcare funding up to 31 March 2013 have been received by the PCT. A provision has been made for the expected cost of these claims, but actual costs will only be confirmed on completion of in-depth case reviews which will be completed in the following financial year. Actual claim values will differ from the estimates made, but the overall difference is not expected to be material

The £2.5m continuing care provision is in relation to restitution claims and will be transferred to NHS Calderdale CCG on 1st April 2013.
The in year movement in the redundancy provision is shown through "Other" expenditure in the Analysis of Operating Costs in note 5.1. In year costs are recognised in the Exit Packages note 7.2.

33 Contingencies

The PCT recognises that there may be a contingent liability in relation to continuing healthcare claims of £3.8m. This is the balance of the full potential cost of the continuing healthcare claims less the provision included in note 32 above.
The PCT also recognises that there may be other unknown contingent costs as a result of the changes in the NHS not currently met through restructuring provision.

34 PFI and LIFT - additional information

The PCT does not have any PFI or LIFT schemes.

36 Financial Instruments

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

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

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

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

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

36.1 Financial Assets	At 'fair value through profit and loss' £000	Loans and receivables £000	Available for sale £000	Total £000
Embedded derivatives	0	0	0	**0**
Receivables - NHS	0	493	0	**493**
Receivables - non-NHS	0	442	0	**442**
Cash at bank and in hand	0	2	0	**2**
Other financial assets	0	0	0	**0**
Total at 31 March 2013	**0**	**937**	**0**	**937**
Embedded derivatives	0	0	0	0
Receivables - NHS	0	3,216	0	3,216
Receivables - non-NHS	0	745	0	745
Cash at bank and in hand	0	2	0	2
Other financial assets	0	0	0	0
Total at 31 March 2012	0	3,963	0	3,963

36.2 Financial Liabilities	At 'fair value through profit and loss' £000	Other £000	Total £000
Embedded derivatives	0	0	**0**
NHS payables	0	1,674	**1,674**
Non-NHS payables	0	14,071	**14,071**
Other borrowings	0	0	**0**
PFI & finance lease obligations	0	0	**0**
Other financial liabilities	0	0	**0**
Total at 31 March 2013	**0**	**15,745**	**15,745**
Embedded derivatives	0	0	0
NHS payables	0	637	637
Non-NHS payables	0	20,037	20,037
Other borrowings	0	0	0
PFI & finance lease obligations	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2012	**0**	20,674	20,674

37 Related party transactions

Calderdale Primary Care Trust is a body corporate established by order of the Secretary of State for Health. During the year none of the Department of Health Ministers, Board Members or members of the key management staff or parties to them has undertaken any material transactions with Calderdale Primary Care Trust.

In accordance with the requirements of the Accounts the Directors and Non-Executive Directors have no Related Party transactions. The compensation paid to cluster officers and CCE committee members is disclosed in Note 7 Employee benefits on Page 21 and within the Remuneration report within the Annual Report.

In accordance with the requirements of the Accounts the Primary Care Contract values for the members of the Clinical Commissioning Executive who are either General Practitioners or Pharmacy providers have been disclosed below. The amounts cover the business expenses for the whole of the practice and personal remuneration to GP and Pharmacy partners who are Committee members. The sums paid or owed to practices do not include reimbursements in relation to FHS Drugs as this is not available on a practice basis. The total value of FHS drugs paid by the PCT and reimbursed to practices was £851K in 2012/13. No comparative information is provided due to the change in governance structures. The transactions relate to the new Clinical Commissioning Committee, previously members of the PEC were disclosed therefore prior year information has not be disclosed for PEC members or the new CCE members except where noted.

Details of related party transactions with individuals are as follows:

Details of related party transactions with individuals are as follows:

	2012/13		201
	Payments to Related Party	**Amounts owed to Related Party**	Payments to Related Party
	£	£	£
In post all Year :			
Dr. A. Brook - CCG Chair	442,718	32,339	319,685
Dr. S. Cleasby - CCG Member	1,383,871	91,106	1,167,129
Dr. H. Carsley - CCG Member	1,242,643	89,984	1,009,623
Dr. N. Taylor - CCG Member	2,609,982	186,787	2,410,653
Dr. P. Davies - CCG Member	1,276,462	109,965	1,127,458
Dr. J. Taylor - CCG Member	999,851	79,101	912,264
Dr. M. Azeb - CCG Member	427,734	23,921	320,014
In post - 01/04/12 to 30/09/12 :			
Dr. S. Chambers - CCG Member	685,773	0	1,179,534
Dr. B. Krishnakumar - CCG Member	236,287	0	287,518
Dr. D. Kumar - CCG Member	935,640	0	1,327,154

Dr. M. Walsh's, CCG Chief Officer, wife is a Consultant Anaesthetist at Calderdale and Huddersfield NHSFT and material transactions are detailed below.

Dr. A.Brook's, CCG Chair , wife is a Consultant Anaesthetist at the Mid Yorkshire NHS Trust and material transactions are detailed below.

The Department of Health is regarded as a related party. During the year NHS Calderdale 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. Other materials transactions with enttities within the NHS are listed below :

	2012/13	2011/12
	£000	£000
Calderdale and Huddersfield NHSFT	**153,831**	147,908
Bradford Teachings Hospitals NHSFT	**7,786**	8,450
Mid Yorkshire Hospitals NHS Trust	**719**	849
South West Yorkshire Partnership NHSFT	**21,531**	20,690
Leeds Teaching Hospitals NHS Trust	**10,305**	9,900
Yorkshire Ambulance NHS Trust	**9,213**	8,658
Barnsley PCT	**23,014**	19,270
Leeds PCT (including WYCSA)	**29,052**	27,882
NHS Pensions Agency	**992**	999
Prescripition Pricing Authority	**39,566**	39,896
NHS Direct	**5,169**	5,439

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 Calderdale MBC.

	2012/13	2011/12
	£000	£000
Calderdale MBC	**15,625**	12,584

38 Losses and special payments

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

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

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

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

39 Third party assets

The PCT held no cash or cash equivalents at 31 March 2013 on behalf of patients or any other third parties.(Nil at 31 March 2012).

40 Pooled budgets

NHS Calderdale has a pooled budget arrangement with Calderdale MBC for the Integrated Community Equipment Store and this is hosted by Calderdale MBC.

The PCT's shares of the income and expenditure handled by the pooled budget in the financial year were:

	2012-13 £	2012-13 £
Income :		
Final adjustment 2011/12	112,333	
CMBC Social Services - Adults	184,102	
CMBC Social Services - Children's	41,210	
PCT Contribution	77,160	**414,805**
Expenditure :		
CMBC Social Services - Adults	183,342	
Health	58,021	
CMBC Social Services - Children's	34,397	
CMBC Payables	139,045	**414,805**
Total		**0**

The expected surplus is an estimate and may be subject to minor change, any adjustment will be reflected in the opening adjustment line.

NHS Calderdale also hosts the Calderdale Drugs Action Team on behalf of the Calderdale Community.

	2012-13 £	2012-13 £
Income :		
Non - Recurrent Carried Forward	166,389	
DOH Allocation	1,936,315	
Calderdale MBC	363,986	
PCT Contribution	525,031	**2,991,721**
Expenditure :		
Adult Drugs Provider Contract	896,242	
Drug Intervention Programme	542,989	
Alcohol Interventions Provider	340,570	
Treatment Service	471,275	
DAT Infrastructure	161,716	
Self Help / Recovery	137,505	
Social Care	355,084	
Alcohol Interventions	98,316	**3,003,697**
Deficit		**11,976**

41 Cashflows relating to exceptional items

There were no cashflows relating to exceptional items.

42.1 Events after the end of the reporting period

The main functions carried out by Calderdale PCT are to be carried out in 2013/14 by the following public sector bodies:

NHS Calderdale CCG (will commission for the majority of secondary care functions)

NHS England (will commission for specialised and primary care services).

Certain assets have transferred to NHS Property Services on 1st April 2013. These were considered operational at the year end, and so have not been impaired in the PCT books. It is for the successor body to consider whether, in 2013/14, it is necessary to review these for impairment.