Department of Health

NHS

Norfolk Primary Care Trust

2012-13 Annual Report and Accounts

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Norfolk Primary Care Trust

2012-13 Annual Report

NHS Norfolk
Annual Report and Accounts
2012-2013

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1. Welcome

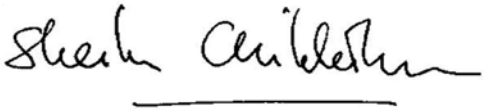
I am proud to have led the Board of NHS Norfolk over seven years, since its inception in 2006. They have been seven challenging, eventful and highly successful years both for the PCT and, I believe, for our patient population. I must pay tribute to the strong leadership in our Chief Executives and Board over that time, for their wisdom, courage and drive.

Our five year strategy, “Bold and Ambitious” set out clearly how we would deliver more care out of hospitals and closer to people’s homes, how we would work to prevent illness and set out our commitment to equal access to healthcare.

In that time we have put in place new and better ways of caring for older and frail patients in their own homes, integrating care with GPs, community nursing staff, social care staff and hospital consultants. There have been huge strides in care for people with dementia, including the opening of a superb in-patient unit in Norwich and new Dementia Intensive Care Teams. Stroke care has been transformed including the opening of a new in-patient unit and 24/7 thrombolysis. Our provider arm, Norfolk Community Health & Care became an independent and successful NHS Trust. We have splendid new premises such as Fakenham Medical Centre and the Norwich walk-in centre to name but a few.

The challenges included clearing an inherited deficit of £47million between 2006 and 2008 and facing up to the need to close some community hospital beds in north Norfolk. We had to take some difficult decisions but we did so by finding innovative new ways of working and involving our patients and stakeholders. This approach led to the opening of the Aylsham health campus, the renovation of the community hospital in North Walsham and our support for Wells Community Hospital as an independent facility. The PCT leaves the local health system in a robust financial position at this year-end consistent with maintaining value for money.

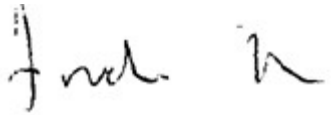
We live in a large and rural county with a large and growing population and there will always be pressures to face. But as we hand over the baton to our four Clinical Commissioning Groups we can say in the past year and in the past seven years we have commissioned NHS care with our patients' interests foremost. We hand over a robust local health service. Our patients have a wide range of GP practices, dentists, opticians, pharmacies, hospitals, community and mental health services to choose from. I hope Primary Care Trusts – NHS Norfolk in particular – will be regarded as having laid the foundation for a healthy future for our local NHS.



June 17, 2013
Sheila Childerhouse
Chair

Foreword from the Accountable Officer

This is the last Annual Report of Norfolk Primary Care Trust. All PCTs were dissolved on 31st March 2013 and their functions and responsibilities have been distributed within a new NHS commissioning landscape. In Norfolk we have established four vibrant Clinical Commissioning Groups, which are led by local doctors and nurses, to commission local NHS care for their patients. We describe each CCG in more detail below. Each has a small team of management staff to drive forward their work. We have also transferred functions to other bodies including NHS England, Public Health and NHS Anglia Commissioning Support Unit. This very major transition has been achieved whilst still commissioning high quality care for our patients.



7th June 2013

Andrew Reed
Designated Accountable Officer on behalf of the Department of Health

2. About Us

NHS Norfolk was established as a Primary Care Trust on 1st October 2006, based at Lakeside 400, Norwich with offices in St James, King's Lynn. It served a population of approximately 763,500 people living in the county of Norfolk (excluding Great Yarmouth and Waveney).

The role of NHS Commissioners is to plan which services are appropriate for the patient population, working closely with key strategic partners such as local councils, patient groups and the Norfolk Local Involvement Network (LINk). This is done within frameworks set annually by the NHS nationally and regionally.

The right services are then put in place for patients by holding contracts with “providers” - NHS Trusts or independent organisations. We “buy” the care we commission using public funds provided to the NHS.

In addition NHS Norfolk was responsible for contracting with Primary Care providers such as GP and dental practices, meeting Public Health targets and acting as lead commissioner for the East of England Ambulance Service, acting with and on behalf of all PCTs in the region.

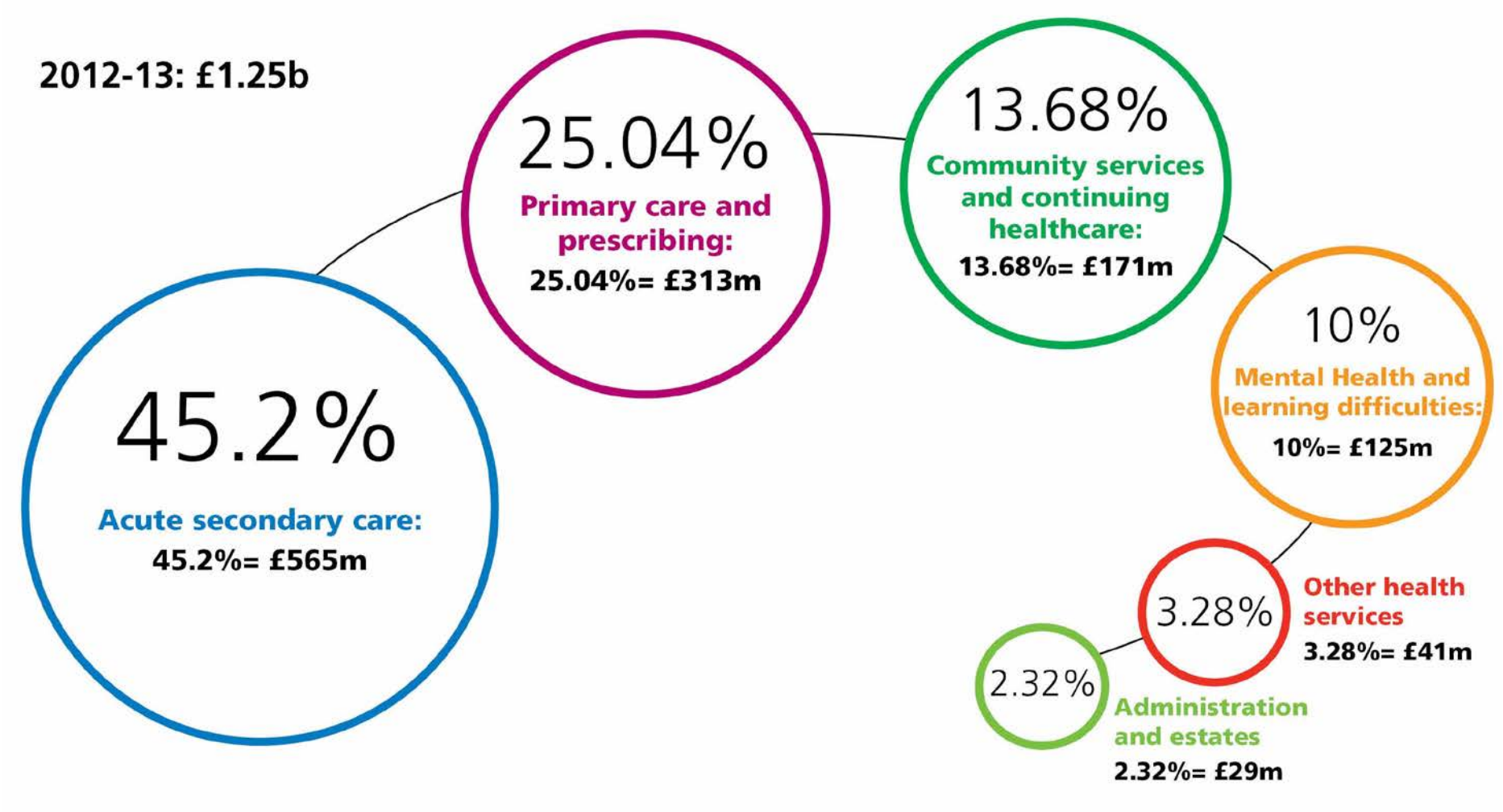
Our five-year strategy “Bold and Ambitious” describes how our commissioning was driven, focusing on key objectives such as preventing ill health, moving care closer to patients’ homes where appropriate and helping patients live safely and well at home. Increasingly our focus has been on integrating NHS care with social care, so patients have a truly “joined up” service. Our integrated commissioning team combines NHS Norfolk commissioning staff with those from Norfolk County Council.

Who provides NHS services?

- Patients can choose which hospital they want to be treated at but the majority elect to be treated at one of three in Norfolk and Waveney - the Norfolk and Norwich University Hospitals NHS Foundation Trust, The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust and the James Paget University Hospitals NHS Foundation Trust. Some patients live closer to the West Suffolk Hospital in Bury St Edmunds or Addenbrooke's Hospital in Cambridge and choose to have treatment there or further afield.
- Most mental health services in our area are provided by Norfolk and Suffolk NHS Foundation Trust.
- Many community health services are provided by Norfolk Community Health & Care NHS Trust
- The East of England Ambulance NHS Trust provides ambulance services for the region, our Out of Hours GP service and our 111 service.
- Primary care services are provided by GPs, dentists, opticians and pharmacies.
- There are also a large number of independent and third-sector organisations which provide NHS care.

How we spent our money

We were provided with a budget by the Department of Health to pay for NHS care within our PCT area. This year the budget was just over £1.25 billion.



Changes introduced by the Health and Social Care Act 2012

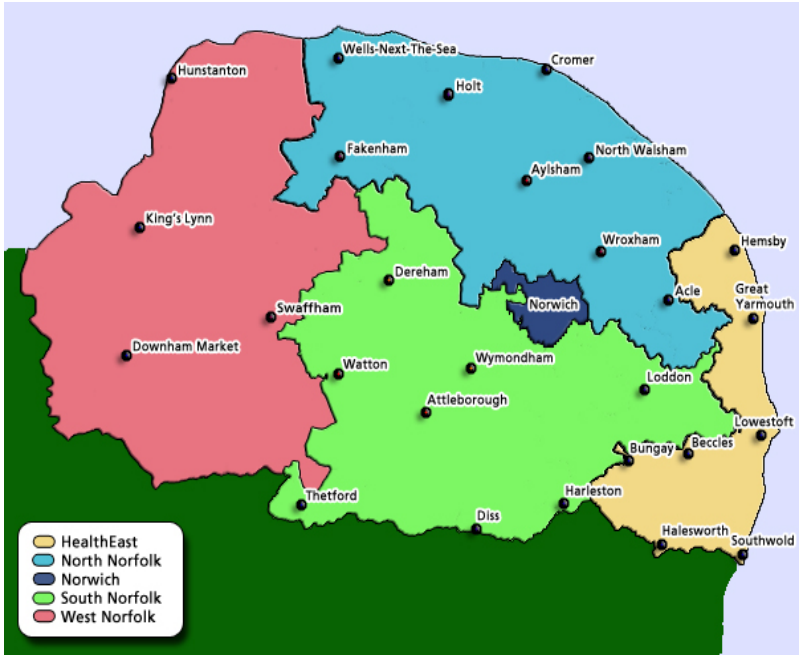
The Health and Social Care Act 2012 set in train the abolition of Primary Care Trusts and the establishment of Clinical Commissioning Groups and NHS England, which have taken over many PCT functions. Public Health responsibilities have been transferred to local authorities.

In readiness, we formed a PCT Cluster with NHS Great Yarmouth and Waveney in 2011 and, whilst remaining a separate statutory body, we have operated with a single Board and Executive Team.

Clinical Commissioning Groups

Four Clinical Commissioning Groups (CCGs) have been established in the Norfolk PCT area, which work alongside Great Yarmouth & Waveney CCG. These are led by family doctors and other local clinicians, supported by small teams of professional NHS management. Our CCGs operated as committees of our Board until on April 1st, 2013 they became statutory organisations in their own rights.

- **North Norfolk** www.northnorfolkccg.nhs.uk
- **West Norfolk** www.westnorfolkccg.nhs.uk
- **Norwich** www.norwichccg.nhs.uk
- **South Norfolk** www.southnorfolkccg.nhs.uk
- A CCG was also established to commission NHS care in Great Yarmouth and Waveney, www.gywpct.nhs.uk



Commissioning Support Unit. This unit was established to provide expertise in commissioning, contracting, corporate and other support functions for CCGs and other clients. It remains based at Lakeside 400 in Norwich.

NHS England. NHS England is accountable for the outcomes achieved by the NHS, and providing leadership for the new commissioning system. Its Area Teams are responsible for contracting with primary care providers such as GPs, dentists, pharmacists and opticians, holding CCGs to account and directly commissioning some NHS services.

Public Health has transferred to Norfolk County Council.

3. Who's Who

NHS Norfolk has been led by a Cluster Board, created on 1st December 2011, consisting of members drawn from both Norfolk and Great Yarmouth and Waveney PCT Boards; prior to that, it was led by the Norfolk PCT Board.

Non-executive directors were recruited from the local community by the Appointments Commission. The Board also consisted of senior officers from NHS Norfolk and Waveney, members of our Clinical Cabinet representatives from Clinical Commissioning Groups and a representative from Norfolk Local Involvement Network (LINk)

Members of the NHS Norfolk and Waveney Cluster Board

Non-Executive Board Members

Sheila Childerhouse
Chair

Dr Edward Libbey
Non-Executive Director,
Audit Committee Chair

Louise Jordan-Hall
Vice Chair

Marion Headicar
Non-Exexcutive Director,

Hilary De Lyon
Non-Executive Director,
Audit Committee Member

Anna Lincoln
Non-Executive Director

John Plaskett
Non-Executive Director,
Audit Committee Member

Jeff Halliwell
Non-Executive Director

Executive Board Members

Andrew Morgan
Chief Executive Officer,
until 30th September 2012

Maureen Carson
Deputy Chief Executive;
Executive Director of
Nursing, Quality and Patient Safety

Sheila Bremner
Chief Executive Officer,
from 1st October 2012

Dr Alistair Lipp
Medical Director

Alison Taylor
Executive Director of Finance,
until 5th November 2012

Dr Jenny Harries
Joint Director of Public Health,
until 30th January 2013

Adrian Marr
Interim Director of Finance,
from 5th November 2012

Ian Ayres
Executive Director of Delivery and
Commissioning Development,
until 30th September 2012

Harper Brown
Executive Director of
Integrated Care Delivery,
until 30th September 2012

Sallie Mills Lewis
Interim Director of
Commissioning,
from 1st November 2012

Also in attendance (non voting)

Jonathan Cook
Company Secretary,
Director of Corporate
Affairs. Resigned through ill
health on 31st Jan 2012 and
sadly passed away Feb 2013

Anne Dray
Interim Director of
Corporate Affairs from 1st
April 2012 and Director of
Development from 1st
October 2012

Patrick Thompson
Norfolk LINk

Rob Garner
Interim Managing Director
of CSU

Clinical Commissioning Group

Chief Officers and Chairs (non voting) all from 1st October 2012, with one exception below

Dr Jon Bryson, Chair of South Norfolk CCG

Ann Donkin, Accountable Officer Designate South Norfolk CCG, from 1st November 2012

Dr Anoop Dhesi, Chair of North Norfolk CCG

Mark Taylor, Accountable Officer Designate North Norfolk CCG

Dr Tony Burgess, Chair West Norfolk until 16th October 2012 and

Dr Ian Mack, Chair West Norfolk CCG, from 16th October 2012

Sue Crossman, Accountable Officer Designate West Norfolk CCG

Dr Chris Francis and Dr Cath Robinson, Joint Chair, Norwich CCG

Jonathan Fagge, Accountable Officer Designate Norwich CCG

Clinical Cabinet Members

Dr Chris Francis (Clinical Executive Chair and voting member of board)

Becky Judge, Clinical Executive Nurse Representative on Board, in non voting capacity

Dr Victoria Holiday

Cathal Daly

Dr Alistair Lennox

Dr Hilary Byrne

Dr Jon Bryson

Dr Antonio Penart

Dr Cath Robinson

Dr Tony Burgess

Interests of Board members (note these are interests declared at Board meetings. Third party-related transactions which are professional payments made to Board members by the PCT are listed separately in the Remuneration Report)

Ian Ayres	Executive Director, Delivery & Commissioning Development	None
Sheila Bremner	Chief Executive from 1st October 2012	Chief Executive NHS Suffolk, Chief Executive NHS Cambridge & Peterborough and Local Area Director, NCB LAT, East Anglia
Harper Brown	Executive Director, Integrated Care Delivery	Member UEA Health Economics Steering Group
Dr Jon Bryson	Chair South Norfolk CCG	GP Partner, School Lane Surgery, Thetford
Dr Tony Burgess	Chair West Norfolk CCG until 16th October 2012	Shareholder West Norfolk Health Ltd; Shareholder Universal Pharmacy; Ltd Partner Great Massingham & Docking Surgeries
Maureen Carson	Executive Director of Nursing, Quality &	None

	Patient Safety	
Sheila Childerhouse	Chair	Trustee – Keystone Development Trust
Jonathan Cook	Director of Corporate Affairs	None
Hilary De Lyon	Non-Executive Director	Honorary Fellow of the Royal College of General Practitioners Fellow of the Royal College of Medicine Independent Adviser to, and Chair of, the Nominations Committee of The College of Social Work Co-opted member of the executive committee of Labour Women's Network Member of the Labour Party Ordinand sponsored by Norwich Diocese, studying at St Mellitus College, London.
Dr Anoop Dhesi	Chair North Norfolk CCG	GP Staithe Surgery Director, North Norfolk Healthcare CIC; Practice engaged at Level 3 in Research Site Initiative Scheme; Member, Norfolk and Waveney LMC
Ann Donkin	Accountable Officer Designate South Norfolk CCG Board member from 1st November 2012	Director, Adxtra Consulting Ltd
Anne Dray	Interim Director of Corporate Affairs & Director of Development	None
Jonathon Fagge	Accountable Officer Designate Norwich CCG Board member from 1st October 2012	None
Dr Chris Francis	Chair Clinical Cabinet and Co-Chair Norwich CCG	None

Rob Garner	Interim MD of CSS	None
Jeff Halliwell	Non Executive Director	Chair, Cafedirect PLC
Dr Jenny Harries	Joint Director of Public Health	Company Director Movente Ltd
Marion Headicar	Non-Executive Director Lay Member North Norfolk CCG	Chair Healthwatch, Norfolk Shadow Board
Louise Jordan-Hall	Non Executive Director Lay Member Great Yarmouth & Waveney CCG	Director, Props East Lead Assessor with Institute for Education Business excellence
Edward Libbey	Non-Executive Director	Chair World Energy Solutions, US listed corporation. Audit Chair NHS Cambridgeshire & NHS Peterborough PCT
Anna Lincoln	Non executive Director	None
Dr Alistair Lipp	Medical Director	Honorary Senior Lecturer, University of East Anglia Head of School of Public Health (East of England Multi-professional Deanery) Trustee & Board Member, Faculty of Public Health Member of Programme Advisory Board, Public Health Programme, National Institute of Health Research (advises on research funding).
Dr Ian Mack	Chair, West Norfolk CCG	Partner at Watlington Medical Centre, Director, Watlington Health Shareholder, West Norfolk Health Borough Councillor, Borough Council of King's Lynn and West Suffolk
Adrian Marr	Director of Finance from 5th November 2012	Parent Governor at Holbrook High School, Suffolk, LAT DoF responsibilities + DoF responsibilities for Cambs, & Peterborough PCT Cluster
Sallie Mills-Lewis	Director of Commissioning	Partner 3 Wishes Theatre Company Shareholder in Balkerne Gardens Trust
Andrew Morgan	Chief Executive until 30th September 2012	Non Executive Director, Health Enterprise East Ltd

John Plaskett	Non Executive Director Lay Member Great Yarmouth & Waveney CCG	Director of Norlife Ltd
Dr Cath Robinson	Co-Chair Norwich CCG	GP Partner Oak Street until August 12.
Sue Crossman	Accountable Officer Designate West Norfolk CCG Board member from 1st October 2012	Self Employed consultant
Alison Taylor	Director of Finance to 5th November 2012	None
Mark Taylor	Accountable Officer Designate North Norfolk CCG Board member from 1st October 2012	None
Patrick Thompson	Chairman Norfolk LINk	Chairman National Osteoporosis Society. HCAI Research Core Board Member Trustee TOC-H International, Chairman Health Trainers Great Yarmouth & Waveney Department of Health (DoH) HCAI SURF (Service Users Research Forum) (DoH) Policy Research Programme Standing Commissioning Panel

4. Our work

In addition to managing contracts with our hospitals, independent contractors and other major providers of NHS care in Norfolk (excluding Great Yarmouth and Waveney):

- We launched Norfolk 111, the new way for patients to find the care they need when it is urgent but not an emergency. The service is provided by the East of England Ambulance Service. Patients can call 111 for a range of reasons: if it's a non-life-threatening need for treatment and care, a question about medication, a medical concern about yourself or another person, a query that cannot wait until the following day for your GP or to find your nearest NHS dentist.

- A new Hospice at Home service was launched in West Norfolk, enabling patients nearing the end of their lives to receive palliative care at home and we extended our contract with Serco Health to provide primary care service in Norfolk's prisons.

- The CCGs in North Norfolk, Norwich and South Norfolk led a project to address delays to improve urgent/unplanned care for patients, including ambulance response times and handovers. This was called Project Domino. It was a collaborative project by clinicians and social care staff across the 'system'.

- We investigated reports circulating nationally that 3.5% of all discharges from hospitals were at night. We confirmed that this figure was heavily affected by anomalies and was certainly not the case in Norfolk. We reviewed the discharge policies of the Norfolk and Norwich, James Paget and Queen Elizabeth hospitals. All these policies avoid overnight discharges.

- Our annual flu campaign was focused on reaching pregnant mothers and people who have long term conditions. It included radio advertising, extensive media work and close collaboration by our public health teams with partners in primary and secondary care.

- A new mobile DEXA scanning service was introduced in West Norfolk, enabling patients at risk from osteoporosis and other conditions of the bone to be assessed for risk of fractures.

- We procured an interim primary care service at Beechwood branch surgery in Norwich following the decision by the previous practice to withdraw.

Patient Advice and Liaison Service (PALS)

The Patient Advice and Liaison Service (PALS) provides advice and information to patients, their carers and families about healthcare and NHS services. NHS Norfolk highlights the PALS contact details in press releases and patient information, particularly when a new service is introduced or changes are made to an existing policy or procedure.

Principles for remedy

NHS Norfolk's Complaints Handling Policy incorporates the Parliamentary and Health Service Ombudsman's Principles of Remedy: Getting it right, being customer focused, being open and accountable, acting fairly and proportionately, putting things right and seeking continuous improvement. We continue to ensure that these Principles are adhered to by all staff when handling complaints.

Governance

As a public body, it is important that we have strict governance arrangements in place to ensure financial probity, clinical quality and risk management. We have robust arrangements in place for managing person-sensitive information, working with the Information Commissioner's Office and with our auditors. And have followed national guidance and best practice.

During 2012/13, NHS Norfolk reported no serious incidents regarding data security to the Information Commissioner.

5. Sustainability

Our focus has been on ensuring the effective reallocation of resources to enable commissioning to adapt to the new delivery platform through the Clinical Commissioning Groups and the Commissioning Support Unit. Estate has been reconfigured to enable the effective sharing of resources and optimisation of site use. IT systems infrastructure has been rationalised with a strategic phased approach taken to ensure the higher volume of user entities are supported, and controls and security are retained. Human resource has been prioritised through the transition in terms of ensuring the key skills knowledge and experience are retained to secure effective service delivery in the future.

The commissioning environment has worked to mitigate its impact on the environment including management of Co2 emissions through proactive resource management and following the significant rationalisation of services led by the national change programme. A continuation of robust contract performance monitoring has enabled the PCT to achieve Quality, Innovation, Productivity and Prevention (QIPP) and performance targets during the year and specific procurements have resulted in streamlining the provider platform.

NHS Norfolk Board implemented the Board-approved Sustainable Development Management Plan (SDMP), which focused on reducing the environmental impact through a series of measures for the PCT as an employer, commissioner and owner of estate to reduce carbon, through the Good Corporate Citizen model.

The Sustainability Transition Framework for handover of responsibilities to successor bodies was included in the NHS Norfolk & Waveney Integrated Plan 2012/13.

Full sustainability data is not available due to the abolition of the PCT, but is held by Norfolk Community Health & Care NHS Trust.

6. Emergency Preparedness

Primary Care Trusts responsibilities were carried out in accordance with a variety of statutory requirements and legislation including the Civil Contingencies Act 2004, NHS Emergency Planning Guidance 2005 and Health & Social Care Act 2012.

NHS Norfolk and Waveney combined its Emergency Preparedness, Business Continuity and Out of Hours Director on- call arrangements from June 2012 as part of the Cluster development process. As part of on-going NHS Transitional arrangements senior staff from the Clinical Commissioning Groups were integrated onto the PCT Cluster on call roster. The emergency planning team continued to provide support to all partners with Emergency Planning Resilience & Response (EPRR) arrangements.

A major incident or emergency is usually defined as any event which causes a threat, death or injury, damage to property or the environment, or disruption to the community where the impact cannot be handled within routine service arrangements. The PCT coordinated health emergency preparedness within its geographical boundary in partnership with its health and multi-agency Local Resilience Forum (LRF) partners.

7. Equality and diversity

Equality and diversity have been fundamental to the achievement of our core vision. We recognise that this has been a huge agenda for the organisation and we have been committed to ensuring that we meet our statutory obligations as a commissioner of healthcare and as an employer; we have policies in place to promote equal opportunities for all, including disabled employees and all protected groups.

As a public authority we have a legal obligation under the Equality Act 2010 to promote equality of opportunity, foster good relations and eliminate discrimination in relation to the protected groups of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion, belief, sex, and sexual orientation. We have strived to move beyond our “legislative requirements” and have developed plans and strategies that are robust, meaningful and can deliver real change for our diverse communities.

During the last 12 months, NHS Norfolk and Waveney developed a legacy for CCGs in order to build on the work achieved, this includes INTRAN interpretation and translation services for our patients, the NHS Equality Delivery System and Public Sector Equality Duties. We have worked closely with Norfolk Community Cohesion Network to take forward countywide initiatives, including those from ‘Hidden in Plain Sight’ the report by the Equality and Human Rights Commission into Disability Hate Crime. Part of our legacy has been to ‘hand over’ the findings from the Eradicating Racism in Norfolk NHS (ERINN) 2011 report to CCGs.

8. Our staff

2012/2013 has been a transitional time for NHS Norfolk with the NHS Reforms and transition to Clinical Commissioning Groups (CCGs). This has resulted in developing and supporting our staff for transition to their new receiving organisations.

Supporting Staff Through Transition

A number of initiatives are programmed throughout the year with external consultants. A programme was created to support staff through transition to their new organisations. The format for these sessions included formal one to one career coaching opportunities with a flexible approach to staff needs on how they wanted the meeting to be structured. Workshops included CV writing, interview techniques, coaching and career planning. Competency based interview techniques were provided during the latter part of the year for

members of staff undertaking interviews. Non-Executive and Executive support packages were also available tailored to the need of the individual.

Joint Investment Funds Training for Bands 1-4

A number of our support staff took advantage of Job Investment Funds and used the opportunity to take further qualifications to enhance their roles.

Line Manager Essential Training

Line management training was introduced during the first quarter of the year to 'upskill' line managers and to support their introduction to new human resource policies and procedures. These were launched in-house and well received.

Learning and Development Interventions

Further training was provided on 'Job Evaluation' and 'Job Description' writing to ensure that staff understood the Agenda for Change process and to allow line managers to adapt job descriptions for the needs of future organisations.

Partnership Working

The Cluster has continually enjoyed the positive resource of the Staff Management Council who have supported the organisation through Transition as well as supporting staff during their difficult periods. Monthly meetings were supplemented with informal interaction and catch up meetings for the final quarter to ensure that information was actioned in a timely manner and shared with staff.

East of England Employment Framework 2012 (V2)

NHS Norfolk and Waveney continued to support the East of England Employment Framework introduced in 2010 by employing their own Redeployment Manager to support other Trusts within Norfolk.

The impact of the Quality, Innovation, Productivity and Prevention (QIPP) plans on workforces and the transactional work created by the NHS Transition as old organisations close and new structures emerge meant that an unprecedented number of staff found themselves at risk of redundancy. The underlying ethos of our Framework was that all NHS organisations would work together to minimise redundancy numbers and to retain valuable skills within the NHS. It was the “One NHS“ approach that all NHS organisations signed up to in the first edition of this Framework in 2010.

This consistent approach has meant that the Framework was extended regionally and ensured that staff that lived or worked near borders were provided with opportunities to avoid redundancy.

The Framework has been extremely successful and although created for the retention of skilled NHS staff during the Transition, will be continued through HR Directors and networks.

Performance Management

Staff have been supported through appraisal systems and informal one to ones to have clear objectives and an understanding of what acceptable levels of performance look like.

The HR team, together with line managers, manage employee relations with regular evaluations for sickness absence records and assisting with appropriate actions to support staff to return to work. As with other organisations we had a number of long term absences and occupational health and wellbeing support has been invaluable.

	2012-2013 Number	2011-2012 Number
Full Time Equivalent (FTE) Days Lost to sickness absence	1829	2680
Average FTE 2012	292	294
Average Sick Days per FTE	6.3	9.12

Data from Department of Health

Staff Networks

We continued through 2012/2013 to have active staff networks for staff from Black and Minority Ethnic Groups, staff with disabilities and staff who have identified themselves as Lesbian, Gay, Bisexual and Transsexual. These groups worked within our wider Equality and Diversity arrangements and assisted the organisation to provide policy frameworks for our broader equal opportunities and recruitment and employment policies.

Staff Communications and Engagements

Weekly all staff briefings were held with summary notes provided on the intranet to provide staff with timely communications of the NHS Reforms and Transition to the CCG's. Board meetings were continued with information made available to the public on the Cluster intranets, and via directorate and team meetings.

With the closure of the PCT and a number of staff transferring to new organisations it has been a priority of the Cluster to support staff through the Transition. Although Transition has been complex with so many receiving organisations there has been a safe and successful transfer of our workforce to approximately 22 receiving organisations providing the 'function' going forward.

9. Performance in 2012/13

The PCT, in conjunction with NHS Great Yarmouth & Waveney, as NHS Norfolk & Waveney, has demonstrated improvements in key areas of patient care and experience. There are, however, a number of areas such as public health, ambulance response times and reducing unplanned hospitalisations where delivery has fallen short of ambition.

Cancer Waiting Times

Delivery of the nine cancer waiting time standards were consistently met in the majority of months across the PCT responsible population and at both the main local providers, Norfolk and Norwich University Hospitals NHS Foundation Trust and the Queen Elizabeth Hospital NHS Foundation Trust, King's Lynn.

Health care-acquired Infections

The number of health care-acquired infections continues to fall across both the PCT responsible population, and at both the main local acute Trusts. There were no cases of MRSA attributable to the care at NNUH or QEH reported during the year. *Clostridium difficile* infections at both NNUH and QEH were significantly below the previous year at 37 and 19 respectively.

Ambulance Response Times

Ambulance response performance has proved challenging throughout the year with both the regional and local position below plan. New hospital turnaround penalties and a recovery plan are expected to deliver improvements in 2013/14.

A&E Waiting Time

After a challenging last quarter NNUH delivered the standard for the year at 95.0%. The QEH saw a significant decline from quarter three resulting in year-end performance of 93%, some 1,112 compliant waits away from standard.

Referral to Treatment (RTT) Waiting Time

The QEH delivered the standard throughout the year. After a period of underperformance during the opening months of the year, during which time NNUH reduced the number of patients waiting over 18 weeks for elective care, the Trust routinely achieved the RTT standard overall from September 2012. Both Trusts met the standard for patients receiving their first treatment in February 2013.

The table below sets out the latest performance status of the key national framework indicators.

12/13 Ref	Indicator	Actual 11/12	12/13 Plan	12/13 YTD	Latest Update
QUALITY 1. Preventing people dying prematurely					
PHQ01	Ambulance Cat A8	63.8	75	61.0	Full Year
PHQ02	Ambulance Cat A19	89.1	95	85.8	Full Year
PHQ03	Cancer 62 day - GP referral	86.6	85	86.8	Full Year
PHQ04	Cancer 62 day - screening	94.7	90	96.1	Full Year
PHQ05	Cancer 62 day - consultant upgrade	84.8	90	93.1	Full Year
PHQ06	Cancer 31 day treatment	97.4	96	98.3	Full Year
PHQ07	Cancer 31 day subsequent treatment - surgery	96.8	94	96.9	Full Year
PHQ08	Cancer 31 day subsequent treatment - drug	99.7	98	100.0	Full Year
PHQ09	Cancer 31 day subsequent treatment - radiotherapy	97.9	94	97.5	Full Year
QUALITY 2. Enhancing quality of life for people with long-term conditions					
PHQ10	New psychosis cases served emergency intervention team	85	Local	106	Full Year
PHQ11	Crisis Resolution Home Treatment	505	Local	1,497	Full Year
PHQ12	Care Programme Approach 7 day follow up	96.9	95	97.6	Full Year
PHQ13a	Improve access to pyschological therapy: People that enter treatment	5,299	11,064	9,226	Full Year
PHQ13b	Improve access to pyschological therapy: % people complete treatment, moving to	NEW	50.0	45.5%	Full Year
PHQ14	% LTC people independent / in control	71.9	Increase	N/a	
QUALITY 3. Helping people to recover from episodes of ill health or following injury					
PHQ15	Emergency admissions for chronic ambulatory care sensitive conditions	4,926	Reduction	5,237	Full Year
PHQ16	Emergency admissions for asthma, diabetes and epilepsy under 19s	555	Reduction	362	Full Year
PHQ17	Emergency admissions for community-managed conditions	7,965	Reduction	1,890	Full Year
QUALITY 4. Ensuring that people have a positive experience of care					
PHQ19	% admitted RTT <18wks	89.5	90	90.9	Full Year
PHQ20	% non-admitted RTT <18wks	97.7	95	97.7	Full Year
PHQ21	% incomplete RTT <18wks	92.3	92	94.2	Full Year
PHQ22	% diagnostics waiters >6wks	1.5	1.0	0.2	Full Year
PHQ23	% A&E waits <4h (Norfolk & Norwich University Hospitals)	94.9	95	95.0	Full Year
PHQ23	% A&E waits <4h (The Queen Elizabeth Hospital, King's Lynn)	95.3	95	92.8	Full Year
PHQ24	Cancer 2 weeks stnd	96.5	93	96.6	Full Year
PHQ25	Cancer 2 weeks breast stnd	97.4	93	97.6	Full Year
PHQ26	Mixed sex accommodation (MSA) breaches	34	0	19	Full Year
QUALITY 5. Treating + caring for people in safe environment + protecting from harm					
PHQ27	MRSA	22	17	9	Full Year
PHQ28	Clostridium difficile	244	216	200	Full Year
PUBLIC HEALTH					
PHQ30	Smoking quitters	4,747	5,928	3,779	Full Year
PHQ31_02	Health checks received	21,843	31,188	20,699	Full Year

10. Operating and Financial Review

Operating and Financial Review

This operating and financial review has been prepared by reference to the seven principles set out in the NHS Manual for Accounts for PCTs. Key indicators of our performance against our principle strategic service objectives are shown in the table on page 32.

All PCTs have four statutory financial targets:

- To provide health care for all of its population within a set budget known as its revenue resource limit
- To maintain capital expenditure within a permitted allocation (capital resource limit)
- To break even on the services it provides (provider full cost recovery duty)
- To keep cash spending within a designated cash limit

Norfolk PCT has achieved all relevant financial targets in 2012-13.

Revenue Resource Limit

	2012-13 £'000	**2011-12 £'000**
Total Spend	1,247,750	1,231,483
Revenue Resource Limit	1,254,751	1,232,886
Over (Under) spend	(7,001)	(1,403)

In 2012-13 a combination of robust contract management and realisation of benefits from QIPP schemes has resulted in reduced pressure on the costs of acute services. Price control and medicines management has led to underspends on primary prescribing costs. However the ageing population of Norfolk has led to further pressure on the costs of continuing healthcare. Additionally affecting this year, central government announced a series of deadlines by which any people wishing to claim retrospectively for NHS funding of continuing healthcare, had to register their claim. Known as restitution claims, these have always been a feature of continuing healthcare costs, but the introduction of a specific series of deadlines has increased the incidence of claims markedly in 2012-13. The PCT has made a significant provision for the cost of those claims which are detailed in notes in the Annual Accounts.

Following the introduction of the NHS and Social Care Act 2012, 2012-13 has marked the final year of the PCT as an organisation. Future commissioning of general acute and community healthcare for the patients of Norfolk will be undertaken by four local Clinical Commissioning Groups (CCGs). Specialist and Primary care will be commissioned by NHS England East Anglia Area Team. Public Health services will be commissioned by Norfolk County Council and Public Health England. This change has taken considerable planning with commissioning powers being formally delegated by the PCT to the CCGs from October 2012. The overall cost of change has included contractual staff severance, those costs are detailed in note 7.4 of the Annual Accounts.

Capital Resource Limit

The PCT has invested considerable capital in backlog maintenance and statutory compliance schemes this year in order to improve the estates stock. Additionally capital has been invested to develop a range of surplus community buildings for alternate uses and to develop certain primary care facilities.

The major developments planned for Norfolk were the Fairstead Primary Care development, premises improvement at Bowthorpe Health Centre and Kingswood Avenue to provide and establish a Respite Care Centre for adults with learning difficulties.

Following the introduction of the NHS and Social Care Act 2012, ownership of the PCT estate will transfer at the end of the year to the community provider Norfolk Community Health & Care NHS Trust or NHS Property Services Ltd or Community Health Partnerships Ltd.

	2012-13 £'000	**2011-12 £'000**
Total Spend	8,480	(1,289)
Capital Resource Limit	8,495	(1,223)
Over (under) spend	(15)	(66)

In 2011-12 the PCT disposed of surplus property which had a value in excess of capital investment made. The total spend reported above is the net spend less value of disposals, explaining why unusually the figures are negative.

In the opinion of the directors there is no significant difference between the carrying value and the market value of interests in land held by the PCT. This opinion has been informed by the valuation of the PCT estate undertaken as at 31st March 2013. Further details of the valuation are disclosed at note 12.3 of the Annual Accounts.

Provider full cost recovery

In Norfolk provider services were separated from the Primary Care Trust from 1 November 2010, so this financial duty no longer applies to this PCT.

Cash Management

PCTs are required by statute to keep their cash spending within a cash limit.

The PCT achieved its cash spending limit and Cash balances of £192,000 were being held at 31 March 2013 to facilitate late payment runs after PCT cessation

Other matters

The Better Payment Practice code requires the PCT to aim to pay valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. NHS Norfolk has signed up to the prompt payments code. A full disclosure of the PCT payment performance is included at note 8 of the Annual Accounts.

NHS Norfolk's auditors for 2012-13 were Ernst & Young. The cost of the statutory audit was £158,000.

The Directors of NHS Norfolk confirm that, as far as they are aware, there is no relevant audit information of which the organisation's auditors are unaware. They have taken all the steps that they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the auditors of NHS Norfolk are aware of that information.

For information on how pension liabilities are treated, please refer to accounting policy 1.17 and note 7.5 in the Annual Accounts. In respect of senior employees in the PCT, pension entitlements are disclosed in the remuneration report in Appendix 1 of this annual report.

The organisation has not made any political or charitable funds contributions in year. Neither have there been any special severance payments. NHS Norfolk has incurred £1,895,611 in termination benefits costs in 2012-13; this sum being wholly due to staff contractual entitlement under NHS terms of employment.

Public spending and reporting

As a public body, NHS Norfolk complies with the Treasury's Guidance on Public Spending and Reporting (Appendix 6.3) with regard to setting charges for information should this be necessary at any time.

However, NHS Norfolk makes every effort to ensure that as much information as possible is available free of charge to the public via its website. This includes information about our activities and services, consultation papers and all responses to requests received under the Freedom of Information Act 2000.

Off Payroll Engagement Data

For off payroll engagements at a cost of over £58200 per annum that were in place as of 31 January 2012.

Number in place on 31 January 2012	18
Of which:	
Number that have since come onto the Organisation's payroll	0
Of which:	
Number that have since been renegotiated / re-engaged to include contractual clauses allowing the organisation to seek assurance as to their tax obligations.	0
Number that have not been successfully re-negotiated and therefore continue without contractual clauses allowing the organisation to seek assurance as to their tax obligations	0
Number that have come to an end	0
Total	18

Appendix 1 -Remuneration Report

NHS Norfolk Remuneration Report

This report gives details of the NHS Norfolk's Remuneration Committee and the PCT's policies in relation to the remuneration of its senior managers which the Board has defined as Executive and Non-Executive Directors, Chairs and Chief operating Officers of the CCGs, the Chief Executive of the CSU and members of the Clinical Cabinet.

Details of remuneration payable to the senior managers of NHS Norfolk in respect of their services during the year ended 31 March 2013 are given in the tables at the end of this report.

Pay Multiples (this section is subject to audit)

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 NHS Norfolk in the financial year 2012-13 was £232,500(2011-12, £158,525). This was 8.4 times (2011-12, 5.04 times) the median remuneration of the workforce, which was £27,660 (2011-12,£31,200).The decrease in the median between 2011-12 and 2012-13 is largely due to the effect of the re-structuring programme that formed part of the preparation for the closure of the PCT as at 31 March 2013, which involved the loss of some higher paid posts, and despite the pay increases granted to staff on less than £21,000 per annum. The increase in the multiple from 5.04 to 8.4 times the median salary is due to the engagement of an Interim Chief Executive for the CSU employed therefore at a higher salary due to the interim nature of the appointment, and who as a result became the highest paid director.

In 2012-13, nil of the employees (2011-12, nil employees) received remuneration in excess of the highest-paid director. Remuneration ranged from £3,538 to £233,040.

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

All staff on Agenda for Change Terms and Conditions on more than £21,000 per annum were subject to a pay freeze in 2012-13 except for annual incremental increases.

The Remuneration Committee

The Remuneration Committee is a committee of the Board and holds responsibility, under its Terms of Reference, for determining the salaries of the Chief Executive and Executive Directors on Very Senior Manager Terms and Conditions. Under the terms of the Framework, the Remuneration Committee has responsibility for determining salary, recruitment and retention premia, additional responsibility allowances and any non-consolidated bonus payments for the Chief Executive and the Directors.

During the year the Committee was chaired by Anna Lincoln (Non Executive Director) and its other members were Sheila Childerhouse (Chair of the Board) and Hilary De Lyon (Non Executive Director).

Executive Directors: remuneration policy

The salaries for the Chief Executive and Directors of the PCT are determined through national terms and conditions, and the NHS “Pay Framework for Very Senior Managers in Strategic Health Authorities, Special Health Authorities, Primary Care Trusts and Ambulance Trusts” updated 30 July 2012.

Performance bonus payments are non-consolidated, non-pensionable, and in addition to the consolidated annual uplift are payable in organisations that have achieved their financial control targets.

No more than 25% of Very Senior Manager's within each PCT Cluster could receive an award based on 2012-13 performance. Further the monetary ceiling for awards was set at 5% of reckonable pay for A and B performers only.

Mirroring the pay freezes in Agenda for Change staff, the Remuneration Committee determined that no non-consolidated bonus payments would be made for the year ended 31 March 2013 to the Chief Executive and Executive Directors.

Direction for determining notice periods for the Chief Executive and the Directors are laid out in the NHS Bodies Employment Contracts (Notice Periods) Directions 2008. The contracted notice period for the termination of the chief executive is six months by either party and for the executive directors is six months notice from the PCT and 3 months notice from the employee. All of the PCT's Directors, except those members of the Area team who were appointed on a substantive basis during the transitionary period to the close of the PCT, have been issued with and signed a contract of employment. Following the demise of the PCT, all directors' contracts are terminated at 31st March 2013.

The termination payments to Directors and Senior staff is governed by the guidance issued by the Department of Health on 30th August 2012, which requires all termination payments to directors and Senior Management to be authorized by the relevant SHA prior to the PCT proceeding with any payment.

Executive Directors and employee members of the Clinical Cabinet only are eligible to participate in the NHS Pension Scheme which provides salary-related pension benefits on a defined benefit basis.

Executive directors had rolling service contracts; the table below discloses contract dates for the PCT and the Cluster. The Health and Social Care Act provides for the dissolution of all PCTs by 2013. As a consequence all PCT and Cluster Director's contracts, including the members of the Clinical Cabinet, have been terminated on 31 March 2013. Contracts for the CCG chairs and Chief Officer continue as shown.

Executive Director in post at 31 March 2013	Role	Start date with Norfolk PCT	Contract start date as Cluster Executive Director	Leave Date for Directors Contracts
Sheila Bremner	Cluster Chief Executive	Not Applicable	1st October 2012	31 March 2013
Maureen Carson	Cluster Deputy Chief Executive; Executive Director of Nursing, Quality and Patient Safety	1st November 2007	31st May 2011	31 March 2013
Alistair Lipp	Cluster Medical Director	Not applicable	1 September 2011	31 March 2013
Adrian Marr	Cluster Interim Director of Finance	Not Applicable	5th November 2012	31 March 2013
Sallie Mills Lewis	Cluster Interim Director of Commissioning	Not Applicable	1st November 2012	31 March 2013
Anne Dray	Interim Director of Corporate Affairs	1 September 2010	Not Applicable	31 March 2013
Dr Ian Mack	Chair West Norfolk	16 October	Not Applicable	Not Applicable

	CCG	2012		
Sue Crossman	Chief Officer West Norfolk CCG	1st October 2012	Not Applicable	Not Applicable
Dr Jon Bryson	Chair South Norfolk CCG	1st October 2012	Not Applicable	Not Applicable
Ann Donkin	Chief Officer South Norfolk CCG	1st October 2012	Not Applicable	31st October 2013
Dr Catherine Robinson	Joint Chair Norwich CCG	1st October 2012	Not Applicable	31st March 2013
Dr Christopher Francis	Joint Chair Norwich CCG	1st October 2012	Not Applicable	31st March 2013
Dr Anoop Dhesi	Chair North Norfolk CCG	1st October 2012	Not Applicable	Not Applicable
Jonathan Fagge	Chief officer Norwich CCG	1st October 2012	Not Applicable	30th November 2013
Mark Taylor	Chief Officer North Norfolk	1st October 2012	Not Applicable	Not applicable

Non-Executive Directors: remuneration policy

Non-Executive Directors are appointed by the NHS Appointments Commission for a fixed term. Their remuneration consists of fees determined by the NHS Appointments Commission. No increase in pay was applied in 2012-13. Non-Executive Directors are reimbursed for out-of-pocket expenses incurred on the PCT's business. Non-Executive Directors are not eligible to participate in the NHS Pension Scheme.

The Non Executive appointments became effective on the following dates:

Non-Executive Director in post at 31 March 2013	Role	Norfolk PCT	Great Yarmouth & Waveney PCT
		Contract start date	Contract start date
Sheila Childerhouse	Chair	1 October 2010	4 November 2011
Louise Jordan-Hall	Vice Chair	1 December 2011	1 December 2007
Dr. Edward Libbey	Non-Executive director	1 October 2006	1 December 2011
Marion Headicar	Non-Executive director	1 July 2009	1 December 2011
Hilary De Lyon	Non-Executive director	1 February 2011	1 December 2011
Jeff Halliwell	Non-Executive director	1 April 2011	1 December 2011
Anna Lincoln	Non-Executive director	1 December 2011	11 February 2002
John Plaskett	Non-Executive director	1 December 2011	1 March 2007

Board appointments during 2012-13

Where directors have been identified as working across the PCT Cluster their costs have been split on a 50/50 basis between the two organisations from the date of their cluster appointment apart from the costs of the Interim Chief Executive of the CSU whose role is weighted towards Norfolk PCT.

In accordance with the provisions of the Health and Social Care Act 2012 which abolishes PCTs from 1st April 2013, all board appointments to the PCT Cluster cease on 31st March 2013.

Following a selection process for roles within Area Teams of NHS England the following were confirmed in director roles for the PCT Cluster.

Name	Position	Appointment date	Salary paid by existing employer (bands of £5000)
Sheila Bremner	Interim Chief Executive	1st October 2012	160-165
Adrian Marr	Interim Director of Finance	5th November 2012	125-130
Sallie Mills-Lewis	Interim Director of Commissioning	1st November 2012	115-120

In accordance with national guidance, the salary costs of the Area Team Office staff have continued to be met in full by their employer, rather than be accounted for in part by NHS Norfolk and so are not disclosed in Table 1 of this report.

The following ceased to be directors of the PCT Cluster, but as above their costs remained in full with the PCT Cluster, so are disclosed in this report.

- Alison Taylor was seconded to Birmingham, Solihull and the Black Country NHS Commissioning Board Local Area Team on 5th November 2012
- Andrew Morgan was seconded to the SHA on 30th September 2012 and subsequently to the East of England Ambulance Trust.

CCG Chief Officers and Chairs were members of the PCT Board in 2012/13 and reflected in the information above. From 1st October 2012, formal delegation of commissioning responsibilities, in line with the scheme of delegation and the signed Memorandum of Understanding, was given to CCGs. The Governing Bodies were committees of the PCT Board. Members of each CCG Governing Body made appropriate disclosures in respect of their role.

- Dr Ian Mack was appointed Chair of West Norfolk CCG on 16th October 2012
- Sue Crossman was appointed as Chief Officer West Norfolk CCG on 1st October 2012
- Dr Jon Bryson was appointed as Chair of South Norfolk CCG on 1st October 2012.
- Anne Donkin was appointed as Chief Officer South Norfolk CCG on 1st November 2012.
- Dr Cath Robinson and Dr Chris Francis were appointed as Joint Chairs of Norwich CCG on 1st October 2012.
- Jonathan Fagge was appointed as Chief Officer Norwich CCG on 1st October 2012
- Dr Anoop Dhesi was appointed as Chair of North Norfolk CCG on 1st October 2012
- Mark Taylor was appointed as Chief Officer North Norfolk CCG on 1st October 2012

Other changes in the year were:

- Jonathan Cook was the substantive Director of Corporate Affairs, but sadly he passed away 3rd February 2013, after a lengthy period of ill health.
- Harper Brown resigned on 30th September 2012.
- Ian Ayres resigned on 30th September 2012.
- Jenny Harries resigned on 31st January 2013.
- Maureen Carson was appointed as Deputy Chief Executive on 1st October 2012 and retained her post as Director of Nursing, Quality and Patient Safety.

- Dr Anthony Burgess resigned from the Clinical Cabinet on 16th October 2012.
- Anne Dray was appointed as Interim Director of Corporate Affairs on 1st April 2012
- Rob Garner was appointed as Interim Managing Director of the Commissioning Support Unit on 1st April 2012

Senior managers' remuneration for the year ended 31 March 2012

Details of remuneration payable to the senior managers of Norfolk PCT in respect of their services during the year ended 31 March 2012 are given in table 1 below.

NORFOLK PCT
(this section is subject to audit)
Table 1: Salaries and Allowances

Name and Title	2012-13						2011-12			
	NHS Norfolk			Total Paid (full value of cluster shared posts)			NHS Norfolk		Total Paid (full value of cluster shared posts)	
Norfolk PCT Board Members	Salary (bands of £5,000)	Compensation for loss of office (Bands of £5000)	Benefits in kind (rounded to the nearest £100)	Salary (bands of £5,000)	Compensation for loss of office (Bands of £5000)	Benefits in kind (rounded to the nearest £100)	Salary (bands of £5,000)	Benefits in kind (rounded to the nearest £100)	Salary (bands of £5,000)	Benefits in kind (rounded to the nearest £100)
Sheila Childerhouse (NHS Norfolk Chair) until 3 November 2011	0	0	0	0	0	0	20-25	0	0	0
Sheila Childerhouse (PCT Cluster Chair) from 4 November 2011	15-20	0	0	35-40	0	0	5-10	0	35-40	0
Louise Jordan-Hall (PCT Cluster Vice Chair) from 1 November 2011	5-10	0	0	10-15	0	0	0-5	0	10-15	0
Dr Edward Libbey (NHS Norfolk NED) until 30 November 2011	0	0	0	0	0	0	5-10	0	0	0
Dr Edward Libbey (PCT Cluster NED) from 1st December 2011	5-10	0	0	10-15	0	0	0-5	0	10-15	0

Name and Title	2012-13						2011-12			
	NHS Norfolk			Total Paid (full value of cluster shared posts)			NHS Norfolk		Total Paid (full value of cluster shared posts)	
Norfolk PCT Board Members	Salary (bands of £5,000)	Compensation for loss of office (Bands of £5000)	Benefits in kind (rounded to the nearest £100)	Salary (bands of £5,000)	Compensation for loss of office (Bands of £5000)	Benefits in kind (rounded to the nearest £100)	Salary (bands of £5,000)	Benefits in kind (rounded to the nearest £100)	Salary (bands of £5,000)	Benefits in kind (rounded to the nearest £100)
Marion Headicar (NHS Norfolk NED) until 30 November 2011	0	0	0	0	0	0	0-5	0	0	0
Marion Headicar (PCT Cluster NED) from 1 December 2011	0-5	0	0	5-10	0	0	0-5	0	5-10	0
Hilary De Lyon (NHS Norfolk NED) 1st February 2011 until 30 November 2011	0	0	0	0	0	0	0-5	0	0	0
Hilary De Lyon (PCT Cluster NED) from 1 December 2012	0-5	0	0	5-10	0	0	0-5	0	5-10	0
Jeff Halliwell (NHS Norfolk NED) from 1 april 2011 until 30 November 2011	0	0	0	0	0	0	0-5	0	0	0
Jeff Halliwell (PCT Cluster NED) from 1 December 2011	0-5	0	0	5-10	0	0	5-10	0	5-10	0
Anna Lincoln (PCT Cluster NED)	0-5	0	0	5-10	0	0	0-5	0	10-15	0
John Plaskett (PCT Cluster NED)	0-5	0	0	5-10	0	0	0-5	0	10-15	0

Name and Title	2012-13						2011-12			
	NHS Norfolk			Total Paid (full value of cluster shared posts)			NHS Norfolk		Total Paid (full value of cluster shared posts)	
Norfolk PCT Board Members	Salary (bands of £5,000)	Compensation for loss of office (Bands of £5000)	Benefits in kind (rounded to the nearest £100)	Salary (bands of £5,000)	Compensation for loss of office (Bands of £5000)	Benefits in kind (rounded to the nearest £100)	Salary (bands of £5,000)	Benefits in kind (rounded to the nearest £100)	Salary (bands of £5,000)	Benefits in kind (rounded to the nearest £100)
Maureen Carson (NHS Norfolk, Director of Nursing, Quality and Patient Safety) until 30 May 2011	0	0	0	0	0	0	15-20	0	0	0
Maureen Carson (PCT Cluster, Director of Nursing, Quality and Patient Safety) from 31 May 2011	55-60	110-115	0	115-120	225-230	0	40-45	0	100-105	0
Alistair Lipp Cluster Medical Director	60-65	0	1.7	125-130	0	3.4	35-40	0	130-135	0
Dr Jenny Harries (Cluster Director of Public Health to 31 January 2013)	50-55	0	0	100-105	0	0	55-60	0.7	110-115	0.7
Alison Taylor (Cluster Director of Finance) until seconded to Birmingham, Solihull, and the Black Country NHS Commissioning Board Local Area Team on 5th November 2012.	55-60	0	0	110-115	0	0	45-50	0	110-115	0
Harper Brown (Cluster Director of Integrated care and Delivery until 31st August 2012)	20-25	0	0.4	40-45	0	0.7	45-50	0.9	100-105	2

Name and Title	2012-13						2011-12			
	NHS Norfolk			Total Paid (full value of cluster shared posts)			NHS Norfolk		Total Paid (full value of cluster shared posts)	
Norfolk PCT Board Members	Salary (bands of £5,000)	Compensation for loss of office (Bands of £5000)	Benefits in kind (rounded to the nearest £100)	Salary (bands of £5,000)	Compensation for loss of office (Bands of £5000)	Benefits in kind (rounded to the nearest £100)	Salary (bands of £5,000)	Benefits in kind (rounded to the nearest £100)	Salary (bands of £5,000)	Benefits in kind (rounded to the nearest £100)
Ann Dray Interim Director of Corporate Affairs	105-110	305-310	0	105-110	305-310	0	65-70	0	65-70	0
Jonathan Cook (Cluster Director of Corporate Services until 31 January 2013)	115-120	0	0	115-120	0	0	90-95	0	90-95	0
Ian Ayres (NHS Norfolk Executive Director, Delivery & Commissioning Development) until 2 June 2011	0	0	0	0	0	0	20-25	0	0	0

Name and Title	2012-13						2011-12			
	NHS Norfolk			Total Paid (full value of cluster shared posts)			NHS Norfolk		Total Paid (full value of cluster shared posts)	
Ian Ayres (PCT Cluster Executive Director, Delivery & Commissioning Development) from 3 June 2012 to 30th September 2012)	30-35	0	0	60-65	0	0	75-80	0	135-140	1
Andrew Morgan (PCT Cluster Chief Executive) from 14 February 2011 until seconded to the SHA on 30th	70-75	245-250*	0.7	140-145	490-495*	1.3	70-75	0.7	145-150	1.4

September 2012.										
Dr Ian Mack (chair of West Norfolk CCG from 16 October 2012)	5-10	0	0	5-10	0	0	0	0	0	0
Ann Donkin (Chief Officer South Norfolk CCG from 1st November 2012)	40-45	0	0	40-45	0	0	0	0	0	0

*provided for but not yet paid

Name and Title	**2012-13**						**2011-12**			
	NHS Norfolk			**Total Paid (full value of cluster shared posts)**			**NHS Norfolk**		**Total Paid (full value of cluster shared posts)**	
Norfolk PCT Board Members	**Salary (bands of £5,000)**	**Compensation for loss of office (Bands of £5000)**	**Benefits in kind (rounded to the nearest £100)**	**Salary (bands of £5,000)**	**Compensation for loss of office (Bands of £5000)**	**Benefits in kind (rounded to the nearest £100)**	**Salary (bands of £5,000)**	**Benefits in kind (rounded to the nearest £100)**	**Salary (bands of £5,000)**	**Benefits in kind (rounded to the nearest £100)**
Jonathan Fagge (Chief Officer Norwich CCG from 1st October 2012)	65-70	0	0	65-70	0	0	0	0	0	0
Sue Crossman (Chief Officer West Norfolk CCG from 1st October 2012)	60-65	0	0	60-65	0	0	0	0	0	0
Rob Garner (Interim Managing Director of the CSU from 1st April 2012)	235-240	0	0	285-290	0	0	0	0	0	0
Mark Taylor (Chief Officer North Norfolk CCG from 1st October 2012)	50-55	0	0	50-55	0	0	0	0	0	0

Dr. Anoop Dhesi (Chair of North Norfolk CCG from 1st October 2012)	30-35	0	0	30-35	0	0	0	0	0	0
Dr. Jon Bryson (Chair of South Norfolk CCG from 1st October 2012)	15-20	0	0	15-20	0	0	0	0	0	0

Name and Title	**2012-13**						**2011-12**		
	NHS Norfolk			**Total Paid (full value of cluster shared posts)**			**NHS Norfolk**		
Norfolk PCT Board Members	**Salary (bands of £5,000)**	**Other Remuneration (bands of £5000)**	**Benefits in kind (rounded to the nearest £100)**	**Salary (bands of £5,000)**	**Other Remuneration (bands of £5000)**	**Benefits in kind (rounded to the nearest £100)**	**Salary (bands of £5,000)**	**Other Remuneration (bands of £5000)**	**Benefits in kind (rounded to the nearest £100)**
David Stonehouse (Deputy Chief Executive & Director of Finance) until 31 May 2011	0	0	0	0	0	0	20-25	0.5	20-25
Patricia Turner (NHS Norfolk, Director of Communications & Engagement) until 27 January 2012	0	0	0	0	0	0	55-60	95-100	0
Paul Cracknell (Executive Director, West Norfolk Delivery Unit and Organisational Services) from 1 May 2010 until 26 June 2011	0	0	0	0	0	0	25-30	60-65	1
Bryan Heap (NHS Norfolk Medical Director) until 27 January 2012	0	0	0	0	0	0	105-110	0	0

Jane Gurney-Read (NHS Norfolk NED) until 31 August 2011	0	0	0	0	0	0	0-5	0	0

Name and Title	**2012-13**						**2011-12**			
	NHS Norfolk			**Total Paid (full value of cluster shared posts)**			**NHS Norfolk**		**Total Paid (full value of cluster shared posts)**	
Clinical Cabinet formerly Clinical Executive Committee	**Salary (bands of £5,000)**	**Compensation for loss of office (Bands of £5000)**	**Benefits in kind (rounded to the nearest £100)**	**Salary (bands of £5,000)**	**Compensation for loss of office (Bands of £5000)**	**Benefits in kind (rounded to the nearest £100)**	**Salary (bands of £5,000)**	**Benefits in kind (rounded to the nearest £100)**	**Salary (bands of £5,000)**	**Benefits in kind (rounded to the nearest £100)**
Dr. Chris Francis - (CLEX Chair) Also acted as interim Joint Chair of Norwich CCG from 1st October 2012.	55-60	50-55	0	55-60	50-55	0	40-45	0	40-45	0
Dr Cath Robinson (Also acted as interim Joint Chair of Norwich CCG from 1st October 2012.)	40-45	45-50	0	40-45	45-50	0	40-45	0	40-45	0
Rebecca Judge	40-45	65-70	0	40-45	65-70	0	40-45	0	40-45	0
Cathal Daly	40-45	40-45	0	40-45	40-45	0	35-40	0	35-40	0
Victoria Holliday	40-45	15-20	0	40-45	15-20	0	40-45	0	40-45	0
Alistair Lennox from 1 June 2011	20-25	0	0	20-25	0	0	20-25	0	20-25	0
Antonio Penart from 1 July 2011	20-25	0	0	20-25	0	0	15-20	0	15-20	0
Hilary Byrne from 1 July 2011	20-25	0	0	20-25	0	0	15-20	0	15-20	0
Jon Bryson from 1 July	20-25	0	0	20-25	0	0	15-20	0	15-20	0

2011										
Dr Anthony Burgess until 16 October 2012	0-5	0	0	0-5	0	0	10-15	0	10-15	0
Malcolm Skinner from 1 July 2011 until 6 November 2011	0	0	0	0	0	0	5-10	0	5-10	0
Dr Anoop Dhesi chair from 1 July 2011 until 29 February 2012	0	0	0	0	0	0	45-50	0	45-50	0

The fees for Doctors Alistair Lennox, Antonio Pennart, Hilary Byrne, John Bryson , Anthony Burgess and Ian Mack were paid as reimbursements to their practices. Rob Garner's fees were paid to his personal service company.

The figures noted above relate to payments within the financial year, rather than annual salary costs. Figures for staff leaving or appointed part way through the year are for that part year only. There were no other remuneration or bonus payments made during 2012– 13

Jenny Harries' post of Director of Public Health is a joint appointment with Norfolk County Council.

Pension benefits

Disclosures about pension benefits only relate to directors that were in post at 31st March in the relevant financial year.

Table 2: NHS Norfolk Pension Benefits 2012 – 13

Name & Title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at age 60 (bands of £2,500	Total accrued at pension at age 60 at 31 March 2013 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2012	Real increase in Cash Equivalent Transfer Value
Norfolk PCT Board	£000	£000	£000	£000	£000	£000	£000
Andrew Morgan	(0-2.5)	(0-2.5)	25-30	80-85	982	973	8
Anne Dray	(0-2.5)	(5-7.5)	40-45	125-130	795	816	(21)
Maureen Carson	0-2.5	0-2.5	20-25	60-65	829	801	28
Alistair Lipp	(0-2.5)	(0-2.5)	15-20	55-60	740	721	19
Alison Taylor	0 - 2.5	0 - 2.5	10-15	40-45	479	455	25
Mark Taylor	2.5 - 5	12.5-15	35-40	110 - 115	635	542	94
Jonathan Fagge	0 - 2.5	0	0-5	0	6	0	6
Susan Crossman	0 - 2.5	0	0-5	0	10	0	10

NHS Norfolk clustered with NHS Great Yarmouth & Waveney throughout 2012-13 .Costs for Directors who work across the cluster have been shared on a 50/50 basis and the pension disclosures above reflect NHS Norfolk's share of changes in pension benefits in 2012-13 from the date that the director was appointed to the cluster except for CETV values which are shown in full.

The table below shows the full changes to the clustered director's pensions for the year.

Table 3: Full Pension Benefits for Directors working across the Cluster with NHS Great Yarmouth & Waveney 2012 - 13

Name & Title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at age 60 (bands of £2,500	Total accrued pension at age 60 at 31 March 2013 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2012	Real increase in Cash Equivalent Transfer Value
Andrew Morgan	(0-2.5)	(2.5-5)	50-55	160-165	925	973	8
Maureen Carson	0 - 2.5	0 - 2.5	40-45	120 -125	829	801	28
Alastair Lipp	(0 - 2.5)	(0 –2.5)	35-40	115 - 120	740	721	19
Alison Taylor	0 - 2.5	0 - 2.5	25-30	80 - 85	479	455	25

Cash Equivalent Transfer Values

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

include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries

Real Increase in CETV

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

NHS Norfolk does not make any contributions to stakeholder pensions.

Details are not reported for Non Executive directors, non pensionable managers and independent GPs who are on the Clinical Cabinet of the PCT since pension disclosures are not required for these groups.

No CETV values are disclosed for staff over the normal NHS retirement age.

Table 4: Pension Benefits 2011/12

Name & Title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at age 60 (bands of £2,500	Total accrued pension at age 60 at 31 March 2012 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2012 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2012	Cash Equivalent Transfer Value at 31 March 2011	Real increase in Cash Equivalent Transfer Value
	£000	£000	£000	£000	£000	£000	£000
Cluster PCT Board Members							
Andrew Morgan	2.5-5	7.5-10	50-55	155-160	925	758	143
Ian Ayres	0-2.5	5-7.5	20-25	65-70	494	423	58
Jenny Harries	5-7.5	17.5-20	25-30	75-80	511	352	148
Maureen Carson	0-2.5	0-2.5	35-40	110-115	762	690	50
Harper Brown	(0-2.5)	(0-2.5)	20-25	65-70	498	473	11
Alistair Lipp	0-2.5	2.5-5	35-40	110-115	686	581	86
Alison Taylor	2.5-5	10-12.5	20-25	70-75	432	320	102

Other Compensation Schemes - Exit Packages

There is a requirement to disclose exit package information which is set out in the table below:-

Exit package cost band (including special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total Cluster cost of exit packages by cost band (total cost)
£10,001 - £25,000	1		£17,000
£25,001 - £50,000	2		£91,000
£50,001 - £100,000	2		£122,000
£200,001 - £250,000	1		£228,000
£300,001 - £350,000	1		£310,000
£450,001-£500,000	1		£492,000
Total number of exit packages by type (total cost)	8		£1,260,000

The total number of special payments included in the table is £Nil. The total cost of special payments included in the table is

Department of Health

NHS

Norfolk Primary Care Trust

2012-13 Accounts

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Norfolk Primary Care Trust

2012-13 Accounts

Appendix 2
Full Accounts, including Annual Governance Statement and Independent Auditor's report to the Directors of Norfolk Primary Care Trust*)*

Annual

Accounts

2012/2013

CONTENTS

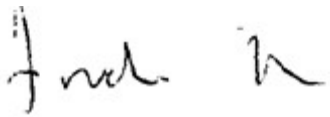
DIRECTORS' STATEMENTS

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

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

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

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



Signed.....Designated Signing Officer

Name: Andrew Reed, Area Director

Date...7th June 2013.....

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;

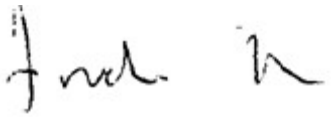
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

- 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.



7th June 2013.....Date.....Signing Officer

7th June 2013.....Date .....Finance Signing Officer

ANNUAL GOVERNANCE STATEMENT NHS NORFOLK 2012/13

1. Scope of responsibility

1.1. The Accountable Officer of NHS Norfolk had overall responsibility for maintaining a sound system of internal control to support the achievement of the organisation's objectives during 2012/13 and responsibility for safeguarding public funds and the organisation's assets, for demonstrating effective propriety and regularity, for prudent, economical administration and achievement of value for money, as set out in the Accountable Officer memorandum. The Audit Committee provided challenge in relation to their responsibilities to inquire into matters of propriety and regularity, supported by the programme of Internal Audit, culminating in the Head of Internal Audit Opinion.

1.2. There have been changes in Accountable Officer during the year, with formal handover processes followed. Andrew Morgan was Accountable Officer until 31st September, Sheila Bremner from 1st October, with Adrian Marr covering her role due to sickness absence from 29th December. I fulfilled the Accountable Officer role from the end of March.

1.3. NHS Norfolk Primary Care Trust (PCT) and NHS Great Yarmouth and Waveney Primary Care Trust joined together to form the Cluster PCT NHS Norfolk & Waveney in 2011 and although operating as a cluster, the two PCTs maintained a separate legal status and prepared separate accounts. This Annual Governance Statement relates to NHS Norfolk.

2. Governance Framework

2.1. **The Board – Performance and Effectiveness**

2.1.1. The NHS Norfolk Board was responsible for reviewing the effectiveness of the PCT's system of internal control. The system was designed to manage, rather than eliminate, the risk of failure to achieve business objectives and provided reasonable, not absolute, assurance that:

- the risks to the achievement of the PCT's objectives were identified and prioritised
- the likelihood of those risks being realised was evaluated and the impact, should they be realised, was managed efficiently, effectively and economically.

2.1.2. The Board was composed of the Chair, 7 non-officer members and 7 voting officer members and contained a balance of skills, experience, knowledge, diversity and independence to discharge its duties effectively, particularly during transition to the new architecture in relation to the Health & Social Care Act 2012. Clinical Commissioning Group (CCG) Chief Officers and Chairs were formally appointed as non-voting members as of 1st October 2012.

2.1.3. The Board met every two months in public. Between April and October it held additional private meetings and held Board to Board meetings with our main providers. It reviewed performance against the national priorities set out in the NHS Operating Framework 2012/13, quality and safety of patient care, financial management, the delivery of the Quality Innovation Productivity and Prevention (QIPP) schemes and the discharge of statutory functions. It provided robust challenge where there was underperformance, such as with ambulance turnaround and cost of continuing health care. It received regular reports on progress with transition and the delegation of commissioning to CCGs, ensuring the maintenance of operational and financial grip.

2.1.4. The Board benefited from good attendance, regular exchange between non-executives and the Chair and from development sessions throughout the year. The action plan produced following the formal review of Board effectiveness in March 2012, against the UK Corporate Governance Code, was implemented, resulting in a revised agenda focused on priority risk issues, inclusion of patient stories, greater involvement of CCGs and an improved performance report. Sheila Bremner undertook a review in October 2012 of the effectiveness of the Cluster structures and the Board approved the establishment of a CCG Performance Committee to improve assurance to the Board.

2.1.5. The Scheme of Delegation, Standing Orders and Financial Instructions were reviewed throughout the year and approved by the Board.

2.2. Board Committee - The Audit Committee

2.2.1. The Audit Committee met six times in the year to oversee financial, corporate and clinical governance, the discharge of statutory functions and risk management. In reviewing the adequacy of systems of internal control, the committee relied on the work of its sub-committees such as the Probity Group, Information Governance Committee, Health & Safety Committee and Business Continuity Group and received reports from the Quality & Patient Safety Committee, Finance Scrutiny Committee (the latter was replaced with the CCG Performance Committee from November 2012) and from Executive Directors, senior managers, the Commissioning Support Unit (CSU) and CCGs on their risk mitigation actions. The Committee reviewed areas of high risk within the PCT's Board Assurance Framework (BAF), Confidential BAF and supporting risk registers. It authorised and monitored the work of Internal Audit, External Audit and Counter Fraud, ensuring recommendations were actioned by management, and scrutinised the appropriateness of PCT tender waivers. The Committee reviewed the annual accounts and areas of judgement.

2.3. Board Committee - The Remuneration Committee

2.3.1. The levels of remuneration, terms of service of the Board and those in Very Senior Managers posts and key severance decisions were scrutinised by the Remuneration Committee and reported to Board and sent reports to members of the Audit Committee.

2.4. Board Committee - The Quality & Patient Safety Committee

2.4.1. The Quality & Patient Safety Committee monitored clinical risks and the quality and safety of provider services, including serious incidents, complaints, safeguarding issues, healthcare acquired infections, Care Quality Commission (CQC) reports and challenged poor performance of independent contractors via the Decision Making Group. Risks and issues were summarised in the confidential Part 2 BAF. Membership of the Committee in 2012/13 included representatives from the CCGs.

2.5. Board Committee - The Clinical Cabinet

2.5.1. The Clinical Cabinet, with clinical representatives of CCGs attending, provided clinical leadership and strategic commissioning direction and supported safe transition to CCG-led commissioning.

2.6. Board Committees - Clinical Commissioning Groups (CCGs)

2.6.1. The Boards of CCGs were constituted as committees of the PCT Board in 2012/13, to ensure robust governance and support for their authorisation as statutory bodies from 1st April 2013. The Board approved a Memorandum of Understanding with each CCG Board.

2.6.2. The four CCGs were authorised at the end of March, although with some conditions; further evidence submitted for review in June.

2.7. **The Time-Limited CCG Authorisation Committee**

2.7.1. This was established in July 2012 in order to approve any CCG Policies and procedures necessary for authorisation and to provide advice and support for CCG governance processes.

2.8. **Board Committee - CCG Performance Committee**

2.8.1. The Committee was established by the Board in November 2012 to monitor CCGs against their delegated responsibilities and statutory duties, providing the Board with assurance on delivery. It met monthly and was chaired by a Non-Executive Director and included two other Non Executive Directors and members of the Executive.

2.9. **Board Committee - Commissioning Support Unit (CSU)**

2.9.1. The CSU Board was constituted as a committee of the Board in 2012/13 to ensure robust governance during its development and business assurance review process. The Managing Director attended the Board in a non-voting capacity.

2.10. **Board Committee - The Pharmacy & Dispensing Committee**

2.10.1. The Committee was responsible for determining applications submitted under the NHS (Pharmaceutical Services) Regulations 2005 and from 1st August 2012, the 2012 regulations.

2.11. **Compliance with the Corporate Governance Code**

2.11.1. The NHS Norfolk Board complied with all aspects of the UK Corporate Governance Code, namely leadership, effectiveness, accountability and remuneration and with legal requirements for the discharge of statutory functions.

2.12. **Handover and Closure**

2.12.1. The Transition Leads Group met weekly, led by the Director of Development & Interim Director of Corporate Affairs, reporting to the Executive Team, Board and Audit Committee, via the Transition and Closedown milestone report and working closely with legal advisors. The closedown plan and transfer schemes, supporting the transfer of assets, liabilities, contracts and staff to receiver organisations, were reported regularly to the SHA, the Audit Committee and to the March Board. Transition risks were escalated as appropriate to the Board Assurance Framework (BAF) and transition was a priority area for internal audit.

2.12.2. Following delegation of functions, risks from the BAF were formally transferred to CCGs and the CSU, with the PCT retaining full statutory accountability until the 31st March and with the Board continuing to review all significant risks throughout the year. Outstanding risk issues were included in the General and Quality Handover documents for receiver organisations.

2.12.3. Formal, minuted meetings were held with successor bodies for handing over quality issues in the Quality Handover Document, iterations of which had been submitted to the SHA, regularly reviewed by the Quality & Patient Safety Committee and by the March Board.

2.12.4. As key staff moved to new organisations, formal handover meetings were held and appropriately recorded to ensure formal transfer of responsibilities, issues and risks. This included the Accountable Officer.

2.12.5. A governance framework was established to ensure the scrutiny and sign off of PCT 2012/13 accounts in line with the guidance in Gateway ref 18561, “Statutory Financial Returns and Agreement of Closing Balances”. Two Non-Executive members of the Audit Committee and the PCT Chair were nominated as members of the Audit Sub-Committee of the Department of Health Audit & Risk Committee.

3. Risk Assessment

3.1. There was a robust risk assessment process throughout NHS Norfolk in 2012/13, articulated through the Risk Strategy and Risk Management Framework, updated in year to reflect delegation to the CCGs and approved by the Board in September 2012.

3.2. The PCT supported a positive culture of risk management, encouraging staff to identify, report and assess risks to the delivery of corporate objectives, quantifying impact and likelihood. Risks were identified by proactive and reactive risk assessments via incidents, complaints, audits, CQC reports unannounced visits, patient and staff feedback, national inquiries and the Whistleblowing Policy.

3.3. The Executive Team and the Transition Leads Group assessed risks at each meeting reviewing the effectiveness of risk mitigation action and controls and any change in risk rating and recording this in the relevant risk register, escalating where necessary. Clinical risks were assessed by the Quality & Patient Safety Committee and reported to the Board via the confidential part 2 BAF. Residual risk continued to be evaluated. This defined the risk profile for NHS Norfolk.

3.4. Newly identified risks this year were:-

- Risks to operational grip with delegation to CCGs were mitigated by appointing Chief Officers as members of the Executive Team and Board, reporting on performance and financial management to each Board meeting and with the CCG Performance Committee monitoring their performance with delegated responsibilities.
- Risk of failure to implement the recommendations from the Winterbourne View Hospital Report. A local action plan was developed and monitored by the Mental Health Commissioning Board and Quality & Patient Safety Committee.
- Risk of impact of the Mid Staffordshire NHS Foundation Trust Public Inquiry “The Francis Report” was debated at the last PCT Board in March. Actions will be taken forward by successor bodies.
- Risk of quality and safety with the 111 service – a number of performance issues arose since the service went live in Norfolk. Contract notices were issued, CCG Quality Leads carried out in depth audits and worked with the provider on recovery plans. The Board received regular updates.
- Risk of failure to sign contracts in timely manner – although the process commenced earlier with more structure than in previous years, and with a clear mechanism for identifying agreement and dispute, delays in signing the contract with the Norfolk & Norwich University Hospital arose and were escalated to the Chief Executive and the contract signed in September. CCGs are leading the contract process this year and the majority are signed.
- Risk of excess running costs - an establishment process was introduced and the Executive Team regularly reviewed capacity, recruitment to new structures and redundancies.
- Risk to the closedown of the PCT in terms of the transfer of assets and liabilities - guidance changes and delays in receipt from the department impacted on the finalisation of the transfer schemes, which were completed by the Legacy Team after the end of March.

- Risk of failure of IT during transition - the Chief Information Officer was a key member of the Transition Leads group, which monitored risks. With the migration of IT services and setting up services in a number of new bodies, no significant incidents occurred.

3.5. On-going risks which remained highly rated this year included:-

- Risk of failure to deliver QIPP initiatives - QIPP was allocated to the CCGs as of October 2012 and monitored closely by the CCG Performance Committee and the Board. At the end of the year, the PCT had achieved QIPP savings of £24.364million against a plan of £27.032m.
- Failure to manage demand at all three acute hospitals remained an issue in 2012/13 and was mitigated by a number of QIPP schemes managed by the CCGs, monitored by more robust contract management and the work of the Commissioning Boards.
- Risk to financial resilience –at the end of the year, the PCT achieved a surplus of £7.001m exceeding its financial control target £6.0m surplus. Pressure on costs of continuing healthcare and restitution payments was mitigated by holding back investment reserves. The existing continuing care action plan continued to be implemented, vacancies were recruited to, QIPP plans in addressing high cost packages and personal health budgets delivered savings. A turnaround plan was instigated by CCGs in Quarter 4.
- Risk of failure to achieve performance targets, specifically treating patients within 18 weeks from referral, inconsistent A&E performance, ambulance response targets and poor turnaround at acute hospitals. QIPP schemes, contract penalties and recovery action plans were implemented to improve performance; Serious Incidents and patient stories were closely monitored. A joint review of patient flows, Project Domino, had system-wide stakeholder support; work continues on improving urgent care, with new winter funding initiatives and help in A&E from the national Intensive Support Team. An East Anglia Quality Surveillance Group (attendees included commissioners, CQC, Monitor and Healthwatch) and a Regional Summit were held in March to better support East of England Ambulance Services Trust (EEAST) to improve performance and patient safety. The Board reviewed progress at each meeting.
- Risk to viability of CSU, regarding recruitment of permanent Managing Director and leadership team - an appointment process was agreed with the NHS England for interim support and both the Managing Director and Chief Financial Officer are now in post.

3.6. Outstanding risks at the end of year were formally passed on to the relevant successor bodies via the General and Quality Handover Documents.

3.7. Risks to data security were assessed according to Department of Health guidance, monitored by the Information Governance (IG) Committee and the Caldicott Guardian and reported as required to the Information Commissioner. Incident trends were reviewed and lessons learnt widely shared to prevent recurrence. The Senior Information Risk Owner (SIRO) and the Information Asset Owners (IAOs) were responsible for information systems and staff undertook mandatory IG training. NHS Norfolk submitted its cluster IG Toolkit assessment, using Internal Audit's feedback on their review of a sample of the PCT's evidence as further guidance. The IG Toolkit met level 2 (equating to Green, Satisfactory) for all requirements for 2012/13. The IG team supported transition, including Transfer Schemes, to ensure the emerging organisations complied with statutory requirements.

3.8. Lapses in data security were assessed according to the Department of Health Gateway 13177 guidance (where level 0 is the lowest level of impact and 5 is the most serious) and fully discussed at the Information Governance Committee. Only 4 incidents were reported in 2012/13 and these were low level (level 1).

3.9. There were no data security lapses that met the criteria for reporting to the Information Commissioner during 2012/13 (levels 3-5).

4. The risk and control framework

4.1. The Risk Framework

4.1.1. The PCT revised its governance structures and reporting processes for the 2012/13 transition year to facilitate the handover of responsibility to receiving organisations in line with the national NHS reforms.

4.1.2. The PCT followed a proactive, systematic process for identifying, evaluating, mitigating and escalating risk as outlined in the Risk Strategy and the Risk Management Framework. Risks were recorded, managed at the appropriate level and escalated as follows:-

4.1.3. The Board Assurance Framework (BAF) contained the PCT's significant risks against its four strategic priorities for 2012/13:

- Maintain and improve quality
- Financial control and operational grip (against national priorities set out in the NHS Operating Framework)
- QIPP
- Transition

4.1.4. The BAF was maintained by the Executive Team who agreed risk tolerance and risk appetite and was reported to each meeting of the public Board. Assurances on controls were provided by: internal audit reviews, performance reports, local counter fraud work, clinical audits, staff surveys, staff appraisals and training, incident and complaint investigations, IG toolkit evidence, Commissioning for Quality and Innovation (CQuIN) schemes, benchmarking, LINks, external regulators etc. The Audit Committee scrutinised the BAF and underlying risk management processes to provide further assurance to the Board.

4.1.5. The confidential Part 2 BAF contained significant clinical and quality risks of commissioned services, was scrutinised by the Quality & Patient Safety Committee and reported to the private Board meetings and regularly to the Audit Committee.

4.1.6. The Corporate Risk Register (CRR) contained significant operational risks and was managed by the Executive Team. In November, the Audit Committee approved the pragmatic merger of the BAF and Corporate Risk Register to better identify the main risks to the delivery of the PCT's priorities for 2012/13 and, as the CCGs had established an assurance framework reviewed at their Governing Bodies, reporting their risks to the PCT Board.

4.1.7. The Audit Committee challenged executives and senior managers on the effectiveness of their mitigation for supporting risk registers, including the CSU and CCGs and examined the development of risk strategies and assurance frameworks by the CCGs. The CCG Performance Committee provided further scrutiny of CCG risk management.

4.1.8. The CCG/PCT governance leads group provided an informal forum for sharing learning and rationalising resource for managing risk to CCG authorisation.

4.2. **Risk Prevention**

4.2.1. Learning from adverse events (such as serious incidents and complaints) was shared widely to prevent further occurrence.

4.2.2. There was a robust programme of counter fraud and anti-bribery activity, supported by the Local Counter Fraud Specialist (LCFS), reporting to the Director of Finance and whose annual programme of prevention, deterrence and detection was scrutinised by the Audit Committee.

4.2.3. The Primary Care Services Probity Group ensured payments to primary care contractors complied with regulations and were value for money.

4.2.4. The Scheme of Delegation, Standing Financial Instructions and Standing Orders were reviewed in year, specifically following the delegation of functions and budgets to CCGs.

4.2.5. Risks associated with the provision of services to patients were mitigated through robust contract management of provider services and the work of the Quality & Patient Safety team.

4.2.6. NHS Norfolk met all statutory and legal duties with regard to risk management, Health & Safety, IG, Equality & Diversity, Freedom of Information and sustainability during 2012/3. As an employer with staff entitled to membership of the NHS Pensions Scheme, control measures were in place throughout 2012/13 to ensure all employer obligations were complied with.

5. Effectiveness of Risk Management and Internal Control

5.1. As Accountable Officer, I am responsible for reviewing the effectiveness of the system of internal control. My review was informed in a number of ways:

- The work of the Board in ensuring sound systems of internal control, the regular update of governance arrangements to manage transition and monitoring of strategic risks via the BAF.
- The Executive Team managed operational risk to the delivery of strategic objectives, capturing of risk discussions via the BAF and the Corporate Risk Register. Membership included the CCG Chief Operating Officers for the whole year.
- The work of the Transition Leads Group, monitoring transition milestone progress, the closure plan, the transfer schemes of assets and liabilities and the development of the General and Quality handover documents.
- The work of Board committees, particularly the Audit Committee and CCG Performance Committee which scrutinised and challenged the executive and CCGs on governance and risk management and sought assurances on the effectiveness of controls.
- The work of the Executive Director of Nursing, Quality & Patient Safety team and CCG Chief Officer and Quality leads in carrying out unannounced visits, inspections, monitoring provider serious incidents and risks, and reviewing governance trend reports.
- Contract meetings with providers holding them to account for the quality of patient services.

- The Health & Safety Committee which reviewed health & safety risks and ensured the health & safety of the workforce and any persons working or visiting the premises.
- The IG Committee, SIRO and Caldicott Guardian who reviewed potential breaches of data security, IT security, the PCT's obligations under the Data Protection Act 1998 and progress with the IG Toolkit action plan.
- The work of regulatory bodies such as Monitor and the CQC whose inspection reports provided assurance to the Board on the quality and governance of our provider services and helped triangulate local information.
- Third party assurance (ISAE 3402) for Serco in relation to finance systems.
- The work of the Local Counter Fraud Specialist.
- Governance and performance reports on specialised commissioning.
- The external auditor's opinion and reports, including his conclusion of the PCT's value for money arrangements.
- The Serious Incident (SI) process for reporting and investigating serious incidents. Action plans were robustly monitored to ensure recommendations were actioned and risk mitigated.
- Regular performance reviews with the Strategic Health Authority. Positive feedback was received on the Annual Accountability Review and on the approach taken to directing the transition to clinical commissioning.
- The work of the Health Overview & Scrutiny Committee provided an independent view.
- Internal Audit, who provided an independent, objective opinion on the degree to which governance and risk management supported the achievement of the organisation's objectives.

5.2. **The work of Internal Audit**

5.2.1. The annual Head of Internal Audit Opinion (HoIA) contributed to the assurance available to the Accountable Officer and the Board and underpinned the Board's own assessment of the effectiveness of the organisation's system of internal control. The HoIA in turn assisted the Board in the completion of its Annual Governance Statement and was one of Significant Assurance for 2012/13. However, some weaknesses in the design and/or inconsistent application of controls put the achievement of particular objectives at risk, as detailed below. The Audit Committee received assurance at each meeting on progress to address these weaknesses. The Opinion was based solely on internal audit's assessment of whether the controls in place supported the achievement of management's objectives as set out in the Annual Internal Audit Risk Assessment and Plan and in individual assignment reports.

5.2.2. The review of the BAF and risk management was carried out as part of Internal Audit's annual plan and adequate assurance was received.

5.2.3. Internal Audit support was useful in assessing the impact on transition. Limited assurance opinion was given for:

- Business Continuity – revision of plans was on-going in 2012/13 due to re-structuring and movement of staff, however business continuity underpinned the transition work and was tested throughout e.g. with IT migration. The CSU and CCGs are using the recommendations to develop their own business continuity plans.
- QIPP – the QIPP target for 2012/13 was apportioned between the CCGs which were required to identify new schemes. Since the audit, the CCG Performance Committee was established to provide better scrutiny and challenge. CCGs are introducing standardised QIPP initiation processes.
- Transition Management – Contract Transfer – responsibility for the shift phase of contract transition was assigned to the CSU, capacity was addressed and the project plan finalised with CCG leads in December. Weekly monitoring was undertaken.
- Accounts Payable – issues with the Eros purchase order system, used for low value, non-medical supplies, were mitigated by controls for the approval of expenditure at invoice receipt stage. A new purchasing system was in place from the beginning of the new financial year which included the facility to perform electronic ordering.
- ITIL Service Desk – the PCT commissioned a gap analysis against aspirational standards to aid the introduction of formal service management process. Work is underway to address the gaps by the CSU.

5.3. Significant Issues

5.3.1. My review identified a number of other significant issues during 2012/13, which are summarised below:

- Failure to meet waiting times, mixed sex breaches, stroke, ambulance and A&E targets. QIPP schemes, robust contract management, Project Domino, and regional summits were used to support the providers to improve performance.
- As a result of problems with the Norfolk 111 service, as described in section 3, it was proposed to re-procure the service, whilst continuing to stabilise.
- The delay in signing the contract with the Norfolk & Norwich University Hospital due to disputes with performance targets was resolved by October. CCGs are leading the contract process this year and the majority have been signed.
- There were a number of clinical issues such as surgical Never Events (“serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented”, NPSA definition) and the high number of pressure ulcers which have been closely monitored through reporting, audit, unannounced visits, monitoring of the use of the WHO checklist and robust contract management.
- Patient Experience, as measured by the Friends and Family Test (Net Promoter), has been low at the Queen Elizabeth Hospital. The West Norfolk CCG has been working with them and has commissioned a more detailed patient feedback review to better understand patient concerns.

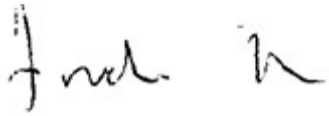
- There are a significant number of outstanding, high-cost continuing health care restitution claims and any accrual or provision entered into the accounts for these claims is expected to be based on estimation techniques and be significant and possibly material to the accounts.
- Transition and closedown risks were mitigated in year and monitored by the Director of Development and Transition Leads Group. The Closedown Report, Handover documents, Property Transfer Scheme Annexe A and Annexe 3 instructions and Generic Provisions were approved by the March Board. Finalisation of the Property Transfer Schemes is being managed by the Legacy team.

6. Conclusion

6.1. With the exception of the internal control issues that I have outlined in the Annual Governance Statement, to which appropriate action has been or is being taken by successor bodies, my review confirms that a sound system of internal control was in place in NHS Norfolk for the year ended 31 March 2013 and up to the date of approval of the annual report and accounts. This is supported by the Head of Internal Audit Opinion of Significant Assurance.

Accountable Officer: Andrew Reed

Organisation: NHS Norfolk



Signature ……

Date : 7th June 2013…..

INDEPENDENT AUDITORS' REPORT TO THE ACCOUNTABLE OFFICER FOR NORFOLK PRIMARY CARE TRUST

We have audited the financial statements of Norfolk Primary Care Trust for the year ended 31 March 2013 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 33. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

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

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

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

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

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

Scope of the audit of the financial statements

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

- whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the Trust; and
- the overall presentation of the financial statements.

In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

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

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

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

Opinion on other matters

In our opinion:

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

Matters on which we report by exception

We report to you if:

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

We have nothing to report in these respects

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

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

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

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 Norfolk Primary Care Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Neil Harris

for and on behalf of Ernst & Young LLP
400 Capability Green
Luton
Beds
LU1 3LU
7th June 2013

FOREWORD TO THE ACCOUNTS

Norfolk Primary Care Trust

These accounts for the year ended 31 March 2013 have been prepared by the Norfolk Primary Care Trust 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	**18,014**	15,223
Other costs	5.1	**1,262,079**	1,248,196
Income	4	**(33,340)**	(32,891)
Net operating costs before interest		**1,246,753**	1,230,528
Investment income	9	**(28)**	(29)
Other (Gains)/Losses	10	**0**	(7)
Finance costs	11	**1,025**	991
Net operating costs for the financial year		**1,247,750**	1,231,483
Of which:			
Administration Costs			
Gross employee benefits	7.1	**11,559**	11,696
Other costs	5.1	**14,153**	9,788
Income	4	**(2,691)**	(1,031)
Net administration costs before interest		**23,021**	**20,453**
Investment income	9	**(28)**	(29)
Other (Gains)/Losses	10	**0**	(7)
Finance costs	11	**0**	1
Net administration costs for the financial year		**22,993**	**20,418**
Programme Expenditure			
Gross employee benefits	7.1	**6,455**	3,527
Other costs	5.1	**1,247,926**	1,238,408
Income	4	**(30,649)**	(31,860)
Net programme expenditure before interest		**1,223,732**	**1,210,075**
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**1,025**	990
Net programme expenditure for the financial year		**1,224,757**	**1,211,065**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**517**	300
Net (gain) on revaluation of property, plant & equipment	**(1,228)**	(31)
Total comprehensive net expenditure for the year*	**1,247,039**	**1,231,752**

*This is the sum of the rows above plus net operating costs for the financial year.
The notes on pages 86 to 183 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	**78,200**	75,646
Intangible assets	13	**0**	0
Other financial assets	19	**204**	205
Total non-current assets		**78,404**	75,851
Current assets:			
Inventories	17	**11**	7
Trade and other receivables	18	**5,805**	12,673
Cash and cash equivalents	20	**192**	3
Total current assets		**6,008**	12,683
Non-current assets held for sale	21	**0**	0
Total current assets		**6,008**	12,683
Total assets		**84,412**	88,534
Current liabilities			
Trade and other payables	22	**(70,240)**	(69,535)
Provisions	27	**(12,253)**	(2,703)
Borrowings	23	**(122)**	(124)
Total current liabilities		**(82,615)**	(72,362)
Non-current assets plus/less net current assets/liabilities		**1,797**	16,172
Non-current liabilities			
Provisions	27	(1,045)	(2,051)
Borrowings	23	(11,347)	(11,470)
Total non-current liabilities		**(12,392)**	(13,521)
Total Assets Employed:		**(10,595)**	2,651
Financed by taxpayers' equity:			
General fund		(25,424)	(11,467)
Revaluation reserve		14,829	14,118
Total taxpayers' equity:		**(10,595)**	2,651

The notes on pages 72 to 109 form part of this account.

The financial statements on pages 1 to 4 were approved by the Audit Sub-Committee of the Department of Health Audit and Risk Committee on 7 June 2013 and signed on its behalf by

Signing Officer:

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	**(11,467)**	**14,118**	**0**	**2,651**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(1,247,750)	0	0	**(1,247,750)**
Net gain on revaluation of property, plant, equipment	0	1,228	0	**1,228**
Impairments and reversals	0	(517)	0	**(517)**
	(1,247,750)	**711**	**0**	**(1,247,039)**
Total recognised income and expense for 2012-13				
Net Parliamentary funding	1,233,793	0	0	**1,233,793**
Balance at 31 March 2013	**(25,424)**	**14,829**	**0**	**(10,595)**
Balance at 1 April 2011	**(2,817)**	**15607**	**0**	**12,790**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(1,231,483)	0	0	(1,231,483)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment	0	31	0	31
Impairments and Reversals	0	(300)	0	(300)
Transfers between reserves*	1,220	(1,220)	0	0
	(1,230,263)	(1,489)	0	(1,231,752)
Total recognised income and expense for 2011-12				
Net Parliamentary funding	1,221,613	0	0	1,221,613
Balance at 31 March 2012	**(11,467)**	**14,118**	**0**	**2,651**

Statement of cash flows for the year ended 31 March 2013

	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities		
Net Operating Cost Before Interest	**(1,246,753)**	(1,230,528)
Depreciation and Amortisation	**3,168**	3,161
Impairments and Reversals	**3,469**	372
Interest Paid	**(1,007)**	(991)
(Increase)/Decrease in Inventories	**(4)**	2
(Increase)/Decrease in Trade and Other Receivables	**6,614**	(4,604)
Increase/(Decrease) in Trade and Other Payables	**1,006**	8,612
Provisions Utilised	**(2,000)**	(1,961)
Increase/(Decrease) in Provisions	**10,521**	3,004
Net Cash Inflow/(Outflow) from Operating Activities	**(1,224,986)**	**(1,222,933)**
Cash flows from investing activities		
Interest Received	**30**	29
(Payments) for Property, Plant and Equipment	**(8,781)**	(2,518)
Proceeds of disposal of assets held for sale (PPE)	**254**	3,858
Loans Repaid in Respect of LIFT	**0**	1
Net Cash Inflow/(Outflow) from Investing Activities	**(8,497)**	**1,370**
Net cash inflow/(outflow) before financing	**(1,233,483)**	**(1,221,563)**
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**(121)**	(50)
Net Parliamentary Funding	**1,233,793**	1,221,613
Net Cash Inflow/(Outflow) from Financing Activities	**1,233,672**	**1,221,563**
Net increase/(decrease) in cash and cash equivalents	**189**	**0**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**3**	**3**
Cash and Cash Equivalents (and Bank Overdraft) at year end	**192**	**3**

1. Accounting policies

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

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

1.1 Accounting Conventions

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

Transforming Community Services (TCS) transactions

Services historically provided by by Norfolk PCT were transferred to Norfolk Community Health & Care NHS Trust in 2010-11 and accounts presented in 2010-11 were prepared under the principles of merger accounting. The 2011-12 accounts and the 2012-13 accounts are therefore prepared on a consistent basis with that adopted in 2010-11.

Acquisitions and Discontinued Operations

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

Critical accounting judgements and key sources of estimation uncertainty

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

Critical judgements in applying accounting policies

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

The PCT owns , leases or finances via LIFT schemes a range of community estate including hospitals and health centres. The PCT charges a rental to Norfolk Community Health & Care NHS Trust for the operational use of this estate. This rental agreement has not been formalised and is expected to expire at 31 March 2013, when property that has a majority operational use by Norfolk Community Health & Care NHS Trust will transfer to their ownership. Other property will transfer to NHS Property Services Ltd. a private limited company wholly owned by the Secretary of State for Health . The PCT considers the nature of the agreement with Norfolk Community Health & Care NHS Trust to be an operating lease.

As the PCT continued to retain ownership of community estate throughout 2012-13, all costs of backlog maintainance and statutory compliance works and completion of assets under construction at 31 March 2012, have been treated as additions to the PCT Property, Plant and Equipment account.

1.1 (Cont'd)

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

The PCT includes an estimate of the potential costs and timing of settlement of restitution and redress for continuing healthcare claims. Further details are given in the provisions note 27 to this account.

The PCT includes an estimate of the prescribing creditor outstanding as at 31.03.13. This estimate is based on forecast spend for the year advised by the NHS Prescription Pricing Authority less costs incurred to date and reflects that the pricing of scripts is up to two months in arrears.

Going concern

As a consequence of the Health and Social Care Act 2012, Norfolk PCT will be dissolved on 31 March 2013. Its functions will be transferred to various new or existing public sector entities. The Secretary of State has directed that , where Parliamentary funding continues to be voted to permit the relevant services to be carried out elsewhere in the public sector, this is normally sufficient evidence of going concern.

As a result the Board of Norfolk PCT have prepared these accounts on a going concern basis.

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 and will then be subject to the transitional arrangements adopted as a consequence of the Health and Social Care Act 2012 and the closure of the PCT on 31 March 2013.

1.3 Pooled budgets

The PCT has entered into a pooled budget with Norfolk County Council. Under the arrangement funds are pooled under S75 of the NHS Act 2006 for Medicine Management activities.
The pool is hosted by Norfolk County Council. As a commissioner of healthcare services, the PCT makes contributions to the pool, which are then used to purchase healthcare services. The PCT accounts for its share of the assets, liabilities, income and expenditure of the pool as determined by the pooled budget agreement, which comes to an end with the dissolution of the PCT on 31st March 2013.

1.4 Taxation

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

1.5 Administration and Programme Costs

Treasury has set performance targets in respect of non-frontline expenditure (administration expenditure).
From 2011-12, PCTs therefore analyse and report revenue income and expenditure by "admin and programme"
For PCTs, the Department has defined "admin and programme" in terms of running costs.
The broad definition of running costs includes any cost incurred that is not a direct payment for the provision of healthcare or healthcare related services.
Expense incurred under NHS transition redundancy programmes is however classed as "programme" under Treasury budgetary control arrangements and so is recorded as such in the financial statements.

1. Accounting policies (continued)

1.6 Property, Plant & Equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation

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

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

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

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

1.6 Property, Plant & Equipment (cont'd)
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)

1.7 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

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.

1.8 Other Financial Assets

Norfolk PCT is a stakeholder in a LIFT company, Norlife Ltd. The loan stock is carried at cost £203,977.

1.9 Depreciation, amortisation and impairments

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

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

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

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

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

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

1. Accounting policies (continued)

1.10 Donated assets

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

1.11 Government grants

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

1.12 Non-current assets held for sale

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

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

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

1.13 Inventories

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

1.14 Cash and cash equivalents

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

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

1. Accounting policies (continued)

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 27.

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

Retirement benefit costs

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

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

1.18 Research and Development

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

1.19 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.20 Grant making

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

1. Accounting policies (continued)

1.21 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.

1.22 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. Accounting policies (continued)

1.23 Foreign exchange

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

1.24 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.

1.25 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.

1. Accounting policies (continued)

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.

In the absence of a recognisable market for LIFT investments, fair value has been determined as equivalent to the cost of purchase.

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 discounted cash flow 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

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.

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.

1.26 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 therefore recognises the LIFTasset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

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

a) Services received
The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.
b) LIFT assets, liabilities, and finance costs

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

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

1. Accounting policies (continued)

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

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

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

c) Lifecycle replacement

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

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. The PCT considers that the actual profiling of lifecycle costs is not materially different to the LIFT profile.

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

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

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

2 Operating segments

The Chief Operating Decision Maker of the PCT is the Trust Board. The Board receives a detailed financial report to inform decision making at every monthly board meeting.

Prior to the operations of the clustering arrangement between Norfolk PCT and Great Yarmouth and Waveney PCT, operations were covered by the use of a single operating segment which covered the requirements of IFRS 8.

Following the clustering arrangements, the commissioning of healthcare services and other activities have been analysed as follows.

	Nth Norfolk CCG	Norwich CCG	Sth Norfolk CCG	West Norfolk CCG	Public Health	NCB	Total
	2012-13 £000	**2012-13 £000**	**2012-13 £000**	**2012-13 £000**	**2012-13 £000**	**2012-13 £000**	**2012-13 £000**
Expenditure	**218,502**	**220,802**	**247,366**	**215,986**	**45,823**	**298,274**	**1,246,753**
Surplus/(Deficit)							
Segment surplus/(deficit)	**(2,786)**	**2,163**	**34**	**(1,037)**	**563**	**9,063**	**8,000**
Common costs	**175**	**177**	**198**	**173**	**37**	**239**	**999**
Surplus/(deficit) before interest	**(2,961)**	**1,986**	**(164)**	**(1,210)**	**526**	**8,824**	**7,001**

The PCT did not analyse its Balance Sheet or assets as part of its segmental reporting and consequently net assets have not been assigned to any of the reporting segments shown above.

There are no comparative figures available for the segmental information for 2011-12 which was prior to the clustering arrangements taking effect and the structuring of the PCT reporting into the above segments.

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	**1,247,750**	1,231,483
Revenue Resource Limit	**1,254,751**	1,232,886
Under/(Over)spend Against Revenue Resource Limit (RRL)	7,001	1,403

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	**8,495**	(1,223)
Charge to Capital Resource Limit	**8,480**	(1,289)
(Over)/Underspend Against CRL	**15**	**66**

3.3 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**1,233,793**	1,221,613
Cash Limit	**1,255,793**	1,221,613
Under/(Over)spend Against Cash Limit	**22,000**	**0**

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

	2012-13 £000
Total cash received from DH (Gross)	1,096,056
Less: Trade Income from DH reported on AoB form 98 Inc Exp	(472)
Less/(Plus): movement in DH drs on AoB form 98 Cr Dr	(16)
Plus: cost of Dentistry Schemes (central charge to cash limits)	25,713
Plus: drugs reimbursement (central charge to cash limits)	112,512
Parliamentary funding credited to General Fund	**1,233,793**

4.0 Miscellaneous Revenue

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Dental Charge income from Contractor-Led GDS & PDS	**11,660**	0	11,660	11,501
Dental Charge income from Trust-Led GDS & PDS	**110**	0	110	110
Prescription Charge income	**1,627**	0	1,627	1,536
Strategic Health Authorities	**5,409**	57	5,352	5,055
NHS Trusts	**385**	235	150	298
NHS Foundation Trusts	**4,334**	168	4,166	3,353
Primary Care Trusts - Other	**2,363**	861	1,502	637
Primary Care Trusts - Lead Commissioning	**10**	0	10	0
English RAB Special Health Authorities	**0**	0	0	5
Department of Health - Other	**481**	0	481	1,548
Recoveries in respect of employee benefits	**799**	768	31	584
Local Authorities	**391**	153	238	1,140
Education, Training and Research	**30**	0	30	46
Non - NHS Private Patients	**105**	0	105	0
Other Non-NHS Patient Care Services	**0**	0	0	76
Rental revenue from operating leases	**4,878**	0	4,878	6,468
Other revenue	**758**	449	309	534
Total miscellaneous revenue	**33,340**	**2,691**	**30,649**	**32,891**

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	**103,526**	0	103,526	95,718
Non-Healthcare	**1,957**	1,942	15	1,020
Total	**105,483**	**1,942**	**103,541**	**96,738**
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	**132,461**	1,118	131,343	138,937
Goods and services (other, excl Trusts, FT and PCT))	**28**	27	1	9
Total	**132,489**	**1,145**	**131,344**	**138,946**
Goods and Services from Foundation Trusts	**543,409**	428	542,981	535,836
Purchase of Healthcare from Non-NHS bodies	**108,475**	0	108,475	95,917
Expenditure on Drugs Action Teams	**8,468**	0	8,468	5,208
Non-GMS Services from GPs	**6,869**	0	6,869	7,486
Contractor Led GDS & PDS (excluding employee benefits)	**37,103**	0	37,103	38,169
Salaried Trust-Led PDS & PCT DS (excluding employee benefits)	**3,345**	0	3,345	3,345
Chair, Non-executive Directors & PEC remuneration	**122**	122	0	68
Executive committee members costs	**251**	251	0	292
Consultancy Services	**1,042**	967	75	345
Prescribing Costs	**122,790**	0	122,790	126,841
G/PMS, APMS and PCTMS (excluding employee benefits)	**113,185**	0	113,185	109,261
Pharmaceutical Services	**10,008**	0	10,008	10,066
New Pharmacy Contract	**19,497**	0	19,497	19,649
General Ophthalmic Services	**6,870**	0	6,870	6,907
Supplies and Services - Clinical	**5,349**	0	5,349	5,681
Supplies and Services - General	**49**	37	12	24
Establishment	**2,178**	1,953	225	785
Transport	**9**	1	8	4
Premises	**2,294**	1,675	619	1,873
Impairments & Reversals of Property, plant and equipment	**3,469**	0	3,469	317
Impairments and Reversals of non-current assets held for sale	**0**	0	0	55
Depreciation	**3,168**	19	3,149	3,133
Amortisation	**0**	0	0	28
Impairment of Receivables	**(78)**	(78)	0	235
Audit Fees	**158**	158	0	279
Other Auditors Remuneration	**1**	1	0	0
Clinical Negligence Costs	**15**	15	0	10
Education and Training	**1,322**	324	998	934
Grants for capital purposes	**2,055**	0	2,055	1,559
Grants for revenue purposes	**1,490**	0	1,490	26,805
Other*	**21,194**	5,193	16,001	11,400
Total Operating costs charged to Statement of Comprehensive Net Expenditure	**1,262,079**	**14,153**	**1,247,926**	**1,248,196**

5. Operating Costs

5.1 Analysis of operating costs: (cont'd)

Employee Benefits (excluding capitalised costs)	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
PCT Officer Board Members	**587**	587	0	1,164
Other Employee Benefits	**17,427**	10,972	6,455	14,059
Total Employee Benefits charged to SOCNE	**18,014**	**11,559**	**6,455**	**15,223**
Total Operating Costs	**1,280,093**	**25,712**	**1,254,381**	**1,263,419**
Analysis of grants reported in total operating costs				
For capital purposes				
Grants to fund Capital Projects - GMS	**1,999**	0	1,999	683
Grants to Fund Capital Projects - Dental	**56**	0	56	804
Grants to Fund Capital Projects - Other	**0**	0	0	72
Total Capital Grants	**2,055**	**0**	**2,055**	**1,559**
Grants to fund revenue expenditure				
To Local Authorities	**1,490**	0	1,490	26,805
Total Revenue Grants	**1,490**	**0**	**1,490**	**26,805**
Total Grants	**3,545**	**0**	**3,545**	**28,364**

5.1 Analysis of operating costs (cont'd)

	Total	Commissionin Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**22,993**	20,772	2,221
Weighted population (number in units)**	**743,023**	743,023	743,023
Running costs per head of population (£ per head)	**31**	**28**	**3**
PCT Running Costs 2011-12			
Running costs (£000s)	**20,724**	18,861	1,863
Weighted population (number in units)	**743,023**	743,023	743,023
Running costs per head of population (£ per head)	**28**	**25**	**3**

*Other in Operating Costs includes an amount of £11524K for Continuing Care, £2743 for project expenditure, £1074K for Referral Centre Costs and the balance is made up of miscellaneous expenses.

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

Therefore, 2011-12 weighted populations have been used when calculated the Running Costs per head of population in 2012-13

5.2 Analysis of operating expenditure by expenditure classification

	2012-13	2011-12
	£000	£000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	113,185	109,261
Prescribing costs	122,790	126,841
Contractor led GDS & PDS	37,101	38,170
Trust led GDS & PDS	3,345	3,345
General Ophthalmic Services	6,870	6,907
Pharmaceutical services	10,008	10,066
New Pharmacy Contract	19,497	19,649
Non-GMS Services from GPs	4,211	5,311
Other	604	400
Total Primary Healthcare purchased	**317,611**	319,950
Purchase of Secondary Healthcare		
Learning Difficulties	5,866	10,597
Mental Illness	119,854	118,913
Maternity	28,465	27,988
General and Acute	522,439	511,816
Accident and emergency	15,133	15,177
Community Health Services	240,338	208,829
Total Secondary Healthcare Purchased	**932,095**	893,320
Grant Funding		
Grants for capital purposes	2,055	1,559
Grants for revenue purposes	1,490	26,805
Total Healthcare Purchased by PCT	**1,253,251**	**1,241,634**
Healthcare from NHS FTs included above	541,028	533,254

6. Operating Leases

6.1 PCT as lessee

	Land £000	Buildings £000	Other £000	2012-13 Total £000	2011-12 £000
Payments recognised as an expense					
Minimum lease payments				**825**	836
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**825**	**836**
Payable:					
No later than one year	**17**	**656**	**21**	**694**	798
Between one and five years	**69**	**2,345**	**13**	**2,427**	2,740
After five years	**162**	**2,736**	**0**	**2,898**	3,645
Total	**248**	**5,737**	**34**	**6,019**	**7,183**
Total future sublease payments expected to be received				825	980

The PCT uses a number of buildings under operating leases, in all cases the PCT is the head lease holder. The PCT also has operating leases for a small fleet of motor vehicles used for business purposes. The leases will novate in line with the provisions of the Health and Social Care Act onto successor bodies.

6.2 PCT as lessor

	2012-13 £000	2011-12 £000
Recognised as income		
Rental Revenue	**4,878**	6,468
Contingent rents	**0**	0
Total	**4878**	6,468
Receivable:		
No later than one year	**4,922**	6,468
Between one and five years	**446**	0
After five years	**528**	0
Total	**5,896**	6,468

The PCT owns community hospitals and other buildings which are the subject of a short term lease agreement with Norfolk Community Health & Care NHS Trust. It is intended to transfer ownership of the operational owned and leased estate to the Trust at 31/03/13 and the LIFT funded buildings and non-operational estate will transfer to an NHS Property Company.

At 31/03/11 it had been expected that all property other than those funded by LIFT would transfer ownership to Norfolk Community Health & Care NHS Trust early in 2011-12. Therefore income for the LIFT properties only was disclosed as receivable from the Trust for 2012-13.

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	**13,528**	9,463	4,065	**11,770**	8,035	3,735	**1,758**	1,428	330
Social security costs	**1,051**	854	197	**986**	801	185	**65**	53	12
Employer Contributions to NHS BSA - Pensions Division	**1,530**	1,242	288	**1,436**	1,166	270	**94**	76	18
Other pension costs	**354**	0	354	**354**	0	354	**0**	0	0
Termination benefits	**1,551**	0	1,551	**1,551**	0	1,551	**0**	0	0
Total employee benefits	**18,014**	**11,559**	**6,455**	**16,097**	**10,002**	**6,095**	**1,917**	**1,557**	**360**
Less recoveries in respect of employee benefits (table below)	**(799)**	(768)	(31)	**(799)**	**(768)**	**(31)**	**0**	**0**	**0**
Total - Net Employee Benefits including capitalised costs	**17,215**	**10,791**	**6,424**	**15,298**	**9,234**	**6,064**	**1,917**	**1,557**	**360**
Employee costs capitalised	**0**	0	0	**0**	0	0	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**18,014**	**11,559**	**6,455**	**16,097**	**10,002**	**6,095**	**1,917**	**1,557**	**360**
Recognised as:									
Commissioning employee benefits	**18,014**			**16,097**			**1,917**		
Provider employee benefits	**0**			**0**			**0**		
Gross Employee Benefits excluding capitalised costs	**18,014**			**16,097**			**1,917**		

	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	**671**	645	26	**671**	645	26	**0**	0	0
Social Security costs	**52**	50	2	**52**	50	2	**0**	0	0
Employer Contributions to NHS BSA - Pensions Division	**76**	73	3	**76**	73	3	**0**	0	0
Other pension costs	**0**	0	0	**0**	0	0	**0**	0	0
Termination Benefits	**0**	0	0	**0**	0	0	**0**	0	0
TOTAL excluding capitalised costs	**799**	**768**	**31**	**799**	**768**	**31**	**0**	**0**	**0**

7.1 (Cont'd)

Employee Benefits - Prior- year	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	**12,224**	11,108	1,116
Social security costs	**1,003**	982	21
Employer Contributions to NHS BSA - Pensions Division	**1,509**	1,477	32
Other pension costs	**2**	2	0
Termination benefits	**485**	485	0
Total gross employee benefits	**15,223**	**14,054**	**1,169**
Less recoveries in respect of employee benefits	**(584)**	(584)	0
Total - Net Employee Benefits including capitalised costs	**14,639**	**13,470**	**1,169**
Employee costs capitalised	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**15,223**	**14,054**	**1,169**
Recognised as:			
Commissioning employee benefits	**15,223**		
Provider employee benefits	**0**		
Gross Employee Benefits excluding capitalised costs	**15,223**		

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	**2**	2	0	**3**	3	0
Ambulance staff	**0**	0	0	**0**	0	0
Administration and estates	**242**	203	39	**260**	200	60
Healthcare assistants and other support staff	**0**	0	0	**1**	1	0
Nursing, midwifery and health visiting staff	**23**	20	3	**19**	15	4
Nursing, midwifery and health visiting learners	**0**	0	0	**0**	0	0
Scientific, therapeutic and technical staff	**23**	23	0	**27**	27	0
Social Care Staff	**0**	0	0	**0**	0	0
Other	**8**	4	4	**6**	3	3
TOTAL	**298**	**252**	**46**	**316**	**249**	**67**
Of the above - staff engaged on capital projects	**0**	0	0	**0**	0	0

7.4 Exit Packages agreed during 2012-13

	2012-13			2011-12		
Exit package cost band (including any special payment element)	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**
	Number	**Number**	**Number**	**Number**	**Number**	**Number**
Less than £10,000	**1**	**0**	**1**	4	2	**6**
£10,001-£25,000	**3**	**1**	**4**	7	1	**8**
£25,001-£50,000	**4**	**1**	**5**	5	0	**5**
£50,001-£100,000	**8**	**1**	**9**	3	0	**3**
£100,001 - £150,000	**2**	**0**	**2**	3	0	**3**
£150,001 - £200,000	**0**	**0**	**0**	0	0	**0**
>£200,000	**3**	**0**	**3**	0	0	**0**
Total number of exit packages by type (total cost	**21**	**3**	**24**	**22**	**3**	**25**
	£	**£**	**£**	**£**	**£**	**£**
Total resource cost	2,029,322	126,124	**2,155,446**	943,000	26,000	**969,000**

This note provides an analysis of Exit Packages agreed during the year. Compulsory redundancy and premature retirement costs have been paid in accordance with the provisions of the NHS pension scheme or the standard terms of Agenda for Change. 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.

The other departures relate to three staff who received ex-gratia payments in accordance with the HM Treasury approved Mutually Agreed Resignation Scheme (MARS).

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

7.5 Pension costs

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

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

a) Accounting valuation

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

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

b) Full actuarial (funding) valuation

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

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

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

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

c) Scheme provisions

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

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

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

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

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

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

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

8. Better Payment Practice Code

8.1 Measure of compliance	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**22,201**	**151,807**	20,314	166,125
Total Non-NHS Trade Invoices Paid Within Target	**19,515**	**131,876**	18,664	155,892
Percentage of NHS Trade Invoices Paid Within Target	87.90%	86.87%	91.88%	93.84%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**4,206**	**947,610**	4,214	876,655
Total NHS Trade Invoices Paid Within Target	**3,752**	**903,625**	3,942	868,296
Percentage of NHS Trade Invoices Paid Within Target	89.21%	95.36%	93.55%	99.05%

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	2011-12
	£000	£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

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Interest Income				
LIFT: loan interest receivable	**28**	**28**	**0**	29
Total investment income	**28**	**28**	**0**	29

10. Other Gains and Losses

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	**£000**	**£000**	£000
Gain/(Loss) on disposal of assets other than by sale (PPE)	**0**	**0**	**0**	7
Total	**0**	**0**	**0**	7

11. Finance Costs

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	**£000**	**£000**	£000
Interest				
Interest on obligations under finance leases	**69**	**0**	**69**	71
Interest on obligations under LIFT contracts:				
- main finance cost	**741**	**0**	**741**	743
- contingent finance cost	**197**	**0**	**197**	147
Total Interest Expense	**1,007**	**0**	**1,007**	961
Provisions - Unwinding of discount	**18**	**0**	**18**	30
Total	**1,025**	**0**	**1,025**	991

12 Property, Plant and equipment

12.1 Property, plant and equipment

2012-13	Land	Buildings excluding dwellings	Assets under construction and payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:							
At 1 April 2012	**13,396**	**64,221**	**306**	**1,014**	**3,505**	**11**	**82,453**
Additions of Assets Under Construction	0	0	8,480	0	0	0	**8,480**
Additions Purchased	127	2,887	(3,720)	219	487	0	**0**
Upward revaluation/positive indexation	0	1,228	0	0	0	0	**1,228**
Impairments/negative indexation	0	(517)	0	0	0	0	**(517)**
At 31 March 2013	**13,523**	**67,819**	**5,066**	**1,233**	**3,992**	**11**	**91,644**
Depreciation							
At 1 April 2012	**10**	**4,822**	**27**	**521**	**1,427**	**0**	**6,807**
Impairments	26	3,189	0	53	201	0	**3,469**
Charged During the Year	0	2,254	0	210	702	2	**3,168**
At 31 March 2013	**36**	**10,265**	**27**	**784**	**2,330**	**2**	**13,444**
Net Book Value at 31 March 2013	**13,487**	**57,554**	**5,039**	**449**	**1,662**	**9**	**78,200**
Purchased	13,351	56,592	5,039	449	1,662	9	**77,102**
Donated	136	679	0	0	0	0	**815**
Government Granted	0	283	0	0	0	0	**283**
Total at 31 March 2013	**13,487**	**57,554**	**5,039**	**449**	**1,662**	**9**	**78,200**
Asset financing:							
Owned	13,027	47,746	5,039	449	1,662	9	**67,932**
Held on finance lease	0	783	0	0	0	0	**783**
On-SOFP PFI contracts	460	9,025	0	0	0	0	**9,485**
Total at 31 March 2013	**13,487**	**57,554**	**5,039**	**449**	**1,662**	**9**	**78,200**

Note 12.1 (cont'd)

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Assets under construction & payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	**1,610**	**12,508**	**0**	**0**	**0**	**0**	**14,118**
Movements (specify)	0	711	0	0	0	0	**711**
At 31 March 2013	**1,610**	**13,219**	**0**	**0**	**0**	**0**	**14,829**

Additions to Assets Under Construction in 2012-13

	£000
Land	0
Buildings excl Dwellings	4,760
Dwellings	0
Plant & Machinery	0
Balance as at YTD	**4,760**

12.2 Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	Assets under construction and payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	**£000**
Cost or valuation:							
At 1 April 2011	**12,776**	**61,710**	**1,514**	**1,339**	**4,624**	**12**	**81,975**
Additions - purchased	0	0	2,820	0	0	0	**2,820**
Reclassifications	0	3,455	(3,831)	4	362	10	**0**
Reclassified as held for sale	620	1,789	(197)	0	(6)	0	**2,206**
Disposals other than by sale	0	(2,464)	0	(329)	(1,475)	(11)	**(4,279)**
Revaluation & indexation gains	0	31	0	0	0	0	**31**
Impairments	0	(300)	0	0	0	0	**(300)**
At 31 March 2012	**13,396**	**64,221**	**306**	**1,014**	**3,505**	**11**	**82,453**
Depreciation							
At 1 April 2011	**0**	**4,863**	**0**	**603**	**2,164**	**9**	**7,639**
Reclassifications as Held for Sale	0	0	0	0	(3)	0	**(3)**
Disposals other than for sale	0	(2,464)	0	(329)	(1,475)	(11)	**(4,279)**
Impairments	10	280	27	0	0	0	**317**
Charged During the Year	0	2,143		247	741	2	**3,133**
At 31 March 2012	**10**	**4,822**	**27**	**521**	**1,427**	**0**	**6,807**
Net Book Value at 31 March 2012	**13,386**	**59,399**	**279**	**493**	**2,078**	**11**	**75,646**
Purchased	13,250	57,403	279	493	2,078	11	**73,514**
Donated	136	1,175	0	0	0	0	**1,311**
Government Granted	0	821	0	0	0	0	**821**
At 31 March 2012	**13,386**	**59,399**	**279**	**493**	**2,078**	**11**	**75,646**
Asset financing:							
Owned	12,926	49,547	279	493	2,078	11	**65,334**
Held on finance lease	0	827	0	0	0	0	**827**
On-SOFP LIFT contracts	460	9,025	0	0	0	0	**9,485**
At 31 March 2012	**13,386**	**59,399**	**279**	**493**	**2,078**	**11**	**75,646**

13 Intangible assets

13.1 Intangible non-current assets

The PCT held no intangible assets at 31 March 2013.

13.2 Intangible non-current assets

2011-12	Software purchased	Total
	£000	£000
At 1 April 2011	**365**	**365**
Additions - purchased	0	**0**
Reclassified as held for sale	(134)	**(134)**
Disposals other than by sale	(231)	**(231)**
At 31 March 2012	**0**	**0**
Amortisation		
At 1 April 2011	**283**	**283**
Reclassified as held for sale	(80)	**(80)**
Disposals other than by sale	(231)	**(231)**
Charged during the year	28	**28**
At 31 March 2012	**0**	**0**
Net Book Value at 31 March 2012	**0**	**0**
Net Book Value at 31 March 2012 comprises		
Purchased	0	**0**
Total at 31 March 2012	**0**	**0**

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

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000
Property, Plant and Equipment impairments and reversals taken to SoCNE			
Unforeseen Obsolescence	254		254
Changes in market price	3,215		3,215
Total charged to Annually Managed Expenditure	**3,469**	**0**	**3,469**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Changes in market price	517		
Total Impairments of Property, Plant and Equipment charged to reserves	**517**	**0**	**0**
Non-current assets held for sale - impairments and reversals charged to SoCNE.			
Changes in market price	0		0
Total charged to Annually Managed Expenditure	**0**		**0**
Total impairments of non-current assets held for sale	**0**	**0**	**0**
Total Impairments charged to Revaluation Reserve	517	0	0
Total Impairments charged to SoCNE - DEL	0	0	0
Total Impairments charged to SoCNE - AME	3,469	0	3,469
Overall Total Impairments	**3,986**	**0**	**3,469**
Of which:			
Impairment on revaluation to "modern equivalent asset" basis	**0**	0	0

An impairment review identified the following impairments, total £517,000:

- Impairment on completing building works at Thorpe Health Centre £7,000
- Impairment on completing building works at Norwich Hospital £27,000
- Impairment on completing building works at Dereham Hospital £36,000
- Impairment on completing building works at Norwich Community Health £355,000
- Impairment on completing building works at Park View Centre £27,000
- Impairment on completing building works at St James Centre, Norwich £5,000
- Impairment on completing building works at Colman Hospital £47,000
- Impairment on completing building works at Ogden Court Centre £13,000

15 Commitments

15.1 Capital commitments

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

	31 March 2013 £000	31 March 2012 £000
Property, plant and equipment	**830**	40
Intangible assets	**0**	0
Total	**830**	40

16 Intra-Government and other balances

	Current receivables £000s	**Current payables £000s**
Balances with other Central Government Bodies	944	3,040
Balances with Local Authorities	229	2,903
Balances with NHS Trusts and Foundation Trusts	2,198	11,482
Balances with bodies external to government	2,434	52,815
At 31 March 2013	**5,805**	**70,240**
prior period:		
Balances with other Central Government Bodies	2,273	768
Balances with Local Authorities	414	2,494
Balances with NHS Trusts and Foundation Trusts	8,396	20,373
Balances with bodies external to government	1,590	45,900
At 31 March 2012	**12,673**	**69,535**

17 Inventories

	Total £000	Of which held at NBV
Balance at 1 April 2012	**7**	**0**
Additions	4	**0**
Inventories recognised as an expense in the period	0	**0**
Balance at 31 March 2013	**11**	**0**

18 Receivables

18.1 Trade and other receivables

	Current	
	31 March 2013 £000	31 March 2012 £000
NHS receivables - revenue	**3,133**	9,305
NHS receivables - capital	**0**	254
NHS prepayments and accrued income	**0**	1,109
Non-NHS receivables - revenue	**634**	584
Non-NHS prepayments and accrued income	**1,231**	1,257
Provision for the impairment of receivables	**0**	(235)
VAT	**702**	78
Other receivables	**105**	321
Total	**5,805**	12,673
Total current and non current	**5,805**	12,673
Included above:		
Prepaid pensions contributions	**0**	0

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

18.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	**277**	21
By three to six months	**93**	493
By more than six months	**87**	0
Total	**457**	514

18.3 Provision for impairment of receivables

	2012-13 £000	2011-12 £000
Balance at 1 April 2012	**(235)**	0
Amount written off during the year	**157**	0
Amount recovered during the year	**80**	0
(Increase)/decrease in receivables impaired	**(2)**	(235)
Balance at 31 March 2013	**0**	(235)

19 NHS LIFT investments

	Loan £000	Share capital £000	Total £000
Balance at 1 April 2012	**205**	**0**	**205**
Loan repayments	**(1)**	**0**	**(1)**
Balance at 31 March 2013	**204**	**0**	**204**
Balance at 1 April 2011	172	0	172
Loan repayments	(1)	0	(1)
Revaluations	34	0	34
Balance at 31 March 2012	**205**	**0**	**205**

20 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**3**	3
Net change in year	**189**	0
Closing balance	**192**	3
Made up of		
Cash with Government Banking Service	**192**	1
Commercial banks	**0**	0
Cash in hand	**0**	2
Cash and cash equivalents as in statement of financial position	**192**	3
Bank overdraft - Government Banking Service	**0**	3
Cash and cash equivalents as in statement of cash flows	**192**	6
Patients' money held by the PCT, not included above	**0**	0

21 Non-current assets held for sale

	Land	Buildings, excl. dwellings	Asset Under Construction and Payments on Account	Information Technology	Furniture and Fittings	Intangible Assets	Total
	£000	£000	£000	£000	£000	£000	£000
Balance at 1 April 2012	0	0	0	0	0	0	**0**
Balance at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**
							0
Balance at 1 April 2011	1,415	4,904	0	0	0	0	**6,319**
Plus assets classified as held for sale in the year	0	50	197	3	0	54	**304**
Less assets sold in the year	(795)	(3,060)	(197)	(3)	0	(54)	**(4,109)**
Less impairment of assets held for sale	0	(55)	0	0	0	0	**(55)**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	(620)	(1,839)	0	0	0	0	**(2,459)**
Balance at 31 March 2012	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2012	0	0	0	0	0	0	**0**

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

At 31 March 2012	0
At 31 March 2013	0

22 Trade and other payables

	Current	
	31 March 2013	31 March 2012
	£000	£000
NHS payables - revenue	**6,836**	14,470
NHS payables - capital	**0**	735
NHS accruals and deferred income	**7,686**	5,440
Family Health Services (FHS) payables	**22,895**	24,405
Non-NHS payables - revenue	**18,015**	4,104
Non-NHS payables - capital	**987**	553
Non_NHS accruals and deferred income	**13,791**	18,547
Social security costs	**4**	146
Tax	**7**	163
Payments received on account	**0**	772
Other	19	200
Total	**70,240**	69,535

23 Borrowings

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
LIFT liabilities:				
Main liability	**90**	94	**10,320**	10,411
Finance lease liabilities	**32**	30	**1,027**	1,059
Total	**122**	**124**	**11,347**	**11,470**
Total other liabilities (current and non-current)	**11,469**	**11,594**		

Payment of principal: Amounts falling Due

0 - 1 Years	122
1 - 2 Years	19
2 - 5 Years	276
Over 5 Years	11,052
TOTAL	**11,469**

24 Deferred income

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Opening balance at 1 April 2012	**3,439**	2,842	**0**	0
Deferred income addition	**0**	3,439	**0**	0
Transfer of deferred income	**(1,807)**	(2,842)	**0**	0
Current deferred Income at 31 March 2013	**1,632**	3,439	**0**	0
Total other liabilities (current and non-current)	**1,632**	**3,439**		

The PCT has received income for Research and Development, and for Public Health which will not be expended until 2013/14.

25 Finance lease obligations

Amounts payable under finance leases (Buildings)	**Minimum lease payments**		**Present value of minimum lease**	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Within one year	**99**	99	**32**	30
Between one and five years	**396**	396	**141**	123
After five years	**1,270**	1,369	**886**	936
Less future finance charges	**(706)**	(775)		
Present value of minimum lease payments	**1,059**	1,089	**1,059**	1,089
Included in:				
Current borrowings			**32**	30
Non-current borrowings			**1,027**	1,059
			1,059	1,089

Finance leases as lessee	**31 March 2013**	31 March 2012
	£000	£000
Future Sublease Payments Expected to be received	**958**	0
Contingent Rents Recognised as an Expense	**0**	0

26 PFI and LIFT - additional information

26.1 PFI and NHS LIFT schemes off-Statement of Financial Position

The PCT does not have any LIFT contracts deemed to be off-Statement of Financial Position and is not party to any PFI contracts.

26.2 PFI and NHS LIFT schemes on-Statement of Financial Position

The PCT was a party to LIFT schemes operated by Norlife Ltd. at three sites:

Norlife redeveloped the health centre at Sheringham and leased it to the PCT for a period of 25 years, from 1 August 2005 to 31 July 2030. The estimated capital

Norlife built a new Healthy Living Centre in Thetford which includes GPs, out-patient clinics, radiology, mental health, drug and alcohol services, dentistry, podiatry

Norlife purchased the former Turnstone Court building at Norwich Community Hospital and converted it into two theatre spaces primarily for Podiatric Surgery. The

All of the above arrangements are subject to standard NHS LIFT contracts, which obligate the LIFT company to provide uninterrupted services throughout the

Under IFRIC 12, the asset is treated as an asset of the trust and the substance of the contract is that the PCT has a finance lease. Payments comprise two

Under the provisions of the Health and Social Care Act 2012 calling for the closure of the PCT, the rights and
obligations under LIFT schemes will pass to sucessor bodies.

Total obligations for on-Statement of Financial Position PFI/NHS LIFT contracts due:

26.3 Charges to operating expenditure and future commitments in respect of on and off SOFP LIFT

	2012-13	2011-12
	£000	£000
Total Charge to Operating Expenses in year - OFF SOFP LIFT	0	0
Service element of on SOFP LIFT charged to operating expenses in year	397	290
Total	**397**	290

Payments committed to in respect of off SOFP LIFT and the service element of on SOFP LIFT.

No Later than One Year	326	376
Later than One Year, No Later than Five Years	1690	1,425
Later than Five Years	8062	8,957
Total	**10,078**	**10,758**

26.4 Imputed "finance lease" obligations for on SOFP LIFT Contracts due

No Later than One Year	824	766
Later than One Year, No Later than Five Years	3053	3,209
Later than Five Years	19991	21,494
Subtotal	**23,868**	25,469
Less: Interest Element	**(13,458)**	(14,942)
Total	**10,410**	10,527

27 Provisions

		Comprising:				
	Total	**Pensions Relating to Other Staff**	**Legal Claims**	**Continuing Care**	**Other**	**Redundancy**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Balance at 1 April 2012	**4,754**	32	1,607	1,043	1,857	215
Arising During the Year	**12,085**	0	139	11,524	175	247
Utilised During the Year	**(2,000)**	(32)	(1,260)	(421)	(122)	(165)
Reversed Unused	**(1,564)**	0	(21)	(427)	(1,116)	0
Unwinding of Discount	**18**	0	18	0	0	0
Change in Discount Rate	**5**	0	5	0	0	0
Transferred (to)/from otherPublic Sector bodies	**0**	0	0	0	0	0
Balance at 31 March 2013	**13,298**	**0**	**488**	**11,719**	**794**	**297**
Expected Timing of Cash Flows:						
No Later than One Year	**12,253**	**0**	**7**	**11,719**	**230**	**297**
Later than One Year and not later than Five Years	**319**	**0**	**30**	**0**	**289**	**0**
Later than Five Years	**726**	**0**	**451**	**0**	**275**	**0**

27 Provisions (cont'd)

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at 31 March 2013	37
As at 31 March 2012	176

i) The following movements took place on legal claims:

a) Back to back provisions totalling £1,072,445 provided in the accounts for 2011/12 under HSC 1999/146 for staff injury claims were settled in full in 2012/13.

b) A provision of £535,240 for abortive fees incurred in preparing a LIFT scheme for the West Norfolk area that did not proceed was settled in full during 2012/13.

c) A further provision of £107,746 was added to staff injury benefit provisions totalling £489,374 at 31.03.2013 (31.03.2012 £381,528). This resulted from a reassessment of the person's needs.

27 Provisions (cont'd)

c ii) The continuing care provision relates to the potential costs of restitution claims following the Coughlan judgement on responsibility for funding of continuing care. £11,719,084 (31.03.12 £1,041,881) potential cost of restitution

On 15 March 2012 the Department of Heath announced the introduction of deadlines for individuals to request an assessment of eligibility for NHS Continuing HealthCare. These were based on the period of care:

- For care received between 1 April 2004 and 31 March 2011, the deadline was 30 Sept 2012

- For care received since 1 April 2011, the deadline was 31 March 2013.

All restitution claims received are subject to a clinical assessment and are reviewed by a Continuing Care panel. The panel considers each assessment and decides whether the claimant should have received NHS funded continuing care according to the Coughlan judgement. The panels are chaired by a medical professional and membership includes other clinical staff and a non-executive director. In 2011/12, cases where a panel had decided that the claimant was eligible for continuing care were reflected accordingly as accruals or as provisions, depending on the progress with settlement of the claim.

This approach was changed in 2012/13 where the provision has been based on the population of cases considered to be ready for nurse assessment, which precedes cases being passed to panel for a final decision. This is on the assumption that the population of cases ready for full nurse assessment are more likely than not to result in an outflow of benefits across the population as a whole. At the point of nurse assessment there is sufficient review and evidence to determine the eligibility of the claim and each case can be passed to the review panel with either a recommendation for approval or a recommendation against approval. This revised approach provides an assumed 50% ultimate success rate of the population of cases considered to be ready for nurse assessment ie each case has a 50% chance of being forwarded to the panel with a recommendation for approval. The number of cases ready for full nurse assessment and panel review as at 31 March 2013 total 182

27 Provisions (cont'd)

The provision amount has been calculated by applying a number of variables as follows to the cases ready for full nurse assessment and panel review:

1) The average cost of the care home has been calculated as £650 per week based on care homes rates across the Norfolk and Waveney area.
2) The estimated number of years for each claim is 2.5. This is based on historical data relating to the average of previous claims that were judged to be eligible and for which funding is now in place.
3) An assumed interest rate of 8% based upon County Court rates as advised by the Department of Health.
4) 50% of the cases at the full nurse assessment stage will be eligible as described above

Outside of the provision there remains a balance of 816 cases that are not yet ready for assessment but present a potential contingent liability. In prior year accounts the PCT has produced an estimated figure for this liability but owing to the deadlines imposed by the Department of Health, the subsequent receipt of a large number of 'no win no fee' claims from solicitors on behalf of claimants which are judged to be unrealistic and the extremities of the variables impacting on the eligibility of the claims, it has not been possible to determine a figure that would be meaningful and add benefit to the accounts. As such, a contingent liability figure for the continuing care restitution claims has not been shown for 2012-13

iii) Other provisions relate to the following item:

The PCT has two contracts for long term finance leases of buildings for which it no longer has any practical use. Whilst the contracts have break clauses in 2015 and 2020, there were large penalties payable to exercise the breaks. In previous years the PCT established a provision for the unavoidable costs of meeting the outstanding rental obligations and exercising the break clause in 2015. However a renegotiation of the lease on one of the two properties concerned- Foregate Close, has meant that a provision in respect of this property has been substantially reduced.The total provision for onerous contracts, after adjusting for the SOFP entries required to remove the leased asset and borrowings from the SOFP, plus the provision for the costs of a business administration package which will not be used after 31 March 2013 now stands at £793,332. (31.03.12 £1,131,472)

28 Impact of IFRS treatment - 2012-13

	2012-13			2011-12		
	Total	Admin	Programme	Total	Admin	Programme
	£000	£000	£000	£000	£000	£000
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g LIFT/PFI)						
Depreciation charges	**0**	0	0	0	0	0
Interest Expense	**937**	0	937	743	0	743
Impairment charge - AME	**0**		0	0	0	0
Impairment charge - DEL	**0**	0	0	0	0	0
Other Expenditure	**316**	0	316	802	0	802
Revenue Receivable from subleasing	**(865)**	0	(865)	(1,232)	0	(1,232)
Total IFRS Expenditure (IFRIC12)	**388**	**0**	**388**	313	0	313
Revenue consequences of LIFT/PFI schemes under UK GAAP / ESA95 (net of any sublease income)	**(482)**	0	(482)	335	0	335
Net IFRS change (IFRIC12)	**(94)**	**0**	**(94)**	(22)	0	(22)
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12						
Capital expenditure 2012-13	0					
UK GAAP capital expenditure 2012-13 (Reversionary Interest)	0					

29 Financial Instruments

Financial risk management

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

Currency risk

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

Interest rate risk

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

Credit Risk

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

Liquidity Risk

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

30.1 Financial Assets

	Loans and receivables £000	Available for sale £000	Total £000
Receivables - NHS	3,133	0	**3,133**
Receivables - non-NHS	739	0	**739**
Cash at bank and in hand	192	0	**192**
Other financial assets	0	204	**204**
Total at 31 March 2013	**4,064**	**204**	**4,268**
Receivables - NHS	9,559	0	9,559
Receivables - non-NHS	905	0	905
Cash at bank and in hand	3	0	3
Other financial assets	0	205	205
Total at 31 March 2012	10,467	205	10,672

30.2 Financial Liabilities

	Other £000	Total £000
NHS payables	14,522	**14,522**
Non-NHS payables	41,897	**41,897**
PFI & finance lease obligations	11,469	**11,469**
Total at 31 March 2013	**67,888**	**67,888**
NHS payables	15,205	15,205
Non-NHS payables	29,062	29,062
PFI & finance lease obligations	11,594	11,594
Total at 31 March 2012	55,861	55,861

30 Related party transactions

Details of related party transactions with individuals are as follows:

Certain members of the Clinical Executive are also partners in GP practices. Payments to their practice are regarded as a related party transaction and are listed below. The payments relate to the practice as a whole for the provision of general primary medical and other services.

		2012-13		2011-12	
		Payments to Related Party	Amounts owed to Related Party	Payments to Related Party	Amounts owed to Related Party
		£000	£000	£000	£000
Name	**Practice**				
Dr. Cath Robinson	Oak Street Medical Practice, Norwich	1,113	0	986	0
Dr Alisdair Lennox	Cromer Medical Practice	1,771	6	1,599	0
Dr Antonio Penart	Theatre Royal Surgery, Dereham	1,034	0	987	0
Dr Hillary Byrne	Station Road Surgery, Attleborough	1,990	0	1,909	0
Dr Jon Bryson	School Lane Surgery, Thetford	1,281	0	1,237	0
Dr Tony Burgess	Gt Massingham & Docking Surgery	879	0	839	0
Dr Ian Mack	Watlington Medical Centre	842	0	822	0
Dr Victoria Holliday	Holt Medical Practice	243	0	0	0

Other related party transactions are:

30 Related party transactions (cont'd)

				2012-13		2011-12	
Name		**Related party**	**Payment purpose**	Payments to Related Party £000	Amounts owed to Related Party £000	Payments to Related Party £000	Amounts owed to Related Party £000
Sheila Childerhouse	Chair of PCT is also a trustee of	Keystone Development Trust	Supporting Thetford healthy Town initiatives	37	0	34	3
Louise Jordan-Hall	Cluster Vice Chair is also a trustee of	Affinity Trust	Disability support	289	0	0	0
	and is also a director of	Centre 81	Disability support	0	0	156	0
	and is also a director of	Props East	Health research and Innovati	0	0	0	0
Andrew Morgan	Cluster Chief Executive also Director of	Health Enterprise East Limited	Research	4	0	5	0
Dr. Alastair Lipp	Cluster Medical Director also member of	University of East Anglia	Patient research	551	0	51	0
	and is a member of	School of Public Health	Health Education and trainin	0	0	0	0
	and is a member of	Faculty of Public Health	Health Education and awarer	1	0	0	0
	and is a member of	National Institute of Health Research	Health Research	0	0	0	0
Adrian Marr	Cluster Interim Director of Finance is a director of	Cambridge and Peterborough PCT	Primary medical and other s	0	0	0	0
	and is a governor of	Holbrook High School Suffolk	School	0	0	0	0
	and is a director of	Cambridge and Peterborough PCT	Primary medical and other s	89	7	0	0
Sheila Bremner	Cluster Interim Chief Executive is also a director of	NHS Suffolk	Primary medical and other s	521	44	0	0
	and a director of	Cambridge and Peterborough PCT	Primary medical and other s	89	7	0	0
Jennie Harries	Joint Director of Public Health is also a director of	Movente Ltd	Consultancy	0	0	0	0
Sallie Mills-Lewis	Interim Director of Commissioning is also a partner of	Three Wishes Theatre Company	Theatrical Productions	0	0	0	0
	and a shareholder in	Balkerne Gardens Trust	Upkeep of Balkerne Gardens	0	0	0	0
Edward Libby	Non-Exec Director is also a director of	World Energy Solutions	Energy consultants	0	0	0	0
	and a non exec director of	Cambridgeshire and Peterborough PCT	Primary medical and other s	0	0	0	0
John Plaskett	Non Executive Director also a director of	Norlife Limited	LIFT company	4,666	0	528	0
Jeff Halliwell	Non Executive Director is also the chair of	Cafedirect PLC	Marketing Fairtrade products	0	0	0	0
	and a director of	Colborough Limited	Management consultancy	0	0	0	0
Marion Headicar	Non Executive Director is also the chair of	Healthwatch, Norfolk Shadow Board	Community Health awarenes	0	0	0	0

30 Related party transactions (cont'd)

					Payments to Related Party	Amounts owed to Related Party	Payments to Related Party	Amounts owed to Related Party
					£000	£000	£000	£000
Dr. Ian Mack	Chair of West Norfolk CCG	also a shareholder of	West Norfolk Health Ltd	Choose and Book Service	£000		£000	
		and an elected councillor of	Borough Council Kings Lynn and West Norfolk	Project Safehaven local MH service	50	0	88	0
		and a director of	Watlington Health	Medical and other services	11	0	0	0
Dr Tony Burgess	Chair of West Norfolk CCG	is also a shareholder	West Norfolk Health Ltd	Choose and Book Service	511	0	541	0
		and is a shareholder in	Universal Pharmacy Ltd	Medical Supplies	0	0	0	0
Dr Anoop Dhesi	Chair North Norfolk CCG	is also a director of	North Norfolk Healthcare CIC	Research Site Initiative Sche	1,030	0	1,100	0
		and is a member of	Stalham Staithe practice	medical practice	1,023	0	1,019	0
Dr Antonio Pennart	Clinical Executive member	also works for	NNUH(Norfolk and Norwich Hospital)	Primary medical and other s	311,287	5,109	333,639	0
		and is also employed by	NCH&C (Norfolk Community Health & C	Primary medical and other s	101,630	1	104,922	0
Mark Taylor	Chief Officer North Norfolk CCG	is also a director of	Julian Housing	Housing homeless people	176	0		
Adele Madin	Clinical Executive member	is a shareholder of	ECCH	Primary medical and other s	27,576	0	19,787	0
Rebecca Judge	is a non voting member of the Clinical Executive							
		and is a nurse at NCHC	NCH&C (Norfolk Community Health & C	Primary medical and other s	101,630	1	104,922	0
		and is a director of	Judge Pyschotherapy Service	Pyschotherapy servicesa	0	0	0	0
		and is a council member for	Downham Market Town Council		0	0	0	0

30 Related party transactions (cont'd)

The Department of Health is regarded as a related party. During the year Norfolk PCT has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are:

Norfolk and Norwich University Hospitals NHS F	East of England Ambulance Services NHS Trust
Queen Elizabeth Hospital King's Lynn NHS Fou	Cambridge University Hospital NHS Foundation Trust
Norfolk and Suffolk Foundation Trust	West Suffolk Hospitals NHS Trust
Norfolk and Waveney Mental Health NHS Foun	Cambridgeshire and Peterborough NHS Foundation Trust
Suffolk Mental Health Partnership	James Paget University Hospitals NHS Foundation Trust
Norfolk Community Health & Care Trust	Papworth Hospital NHS Foundation Trust
South East Essex PCT	East of England Strategic Health Authority
Great Yarmouth and Waveney PCT*	NHS Suffoilk

* Although the PCT operates in a cluster with Great Yarmouth and Waveney PCT, each of the entities remain separate statutory bodies.

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 Norfolk County Council in respect of joint enterprises.

31 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	156,513	37
Total losses	156,513	37
Total special payments	0	0
Total losses and special payments	156,513	37

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
Special payments - PCT management costs	4,000	2
Total losses	0	0
Total special payments	4,000	2
Total losses and special payments	4,000	2

No cases exceeded £250,000 during this year or last.

32 Third party assets

None

33 Events after the end of the reporting period

Norfolk PCT is closing at as 31/03/13, activities of the PCT will be shared between a range of successor bodies from 01/04/13, primarily four NHS Clinical Commissioning Groups, NHS England - East Anglia area office, Public Health activities managed by Norfolk County Council and Public Health England.

Norwich Clinical Commissioning Group, North Norfolk Clinical Commissioning Group, South Norfolk Clinical and West Norfolk Clinical Commissioning Group Commissioning Group are responsible for commissioning the following services (previously commissioned by the PCT).
Secondary and community healthcare from NHS and non NHS providers;
GP prescribing;
Primary care - local enhanced services;
Primary care - out of hours.

NHS England
NHS England is responsible for commissioning the following services (previously commissioned by the PCT):
Specialised services;
Prison healthcare;
GP services;
General dental services;
General ophthlamic services;
Pharmaceutical services;
Secondary dental care;
Public health (including health visiting and screening services).

Norfolk County Council
The County Council is responsible for commissioning the following services (previously commissioned by the PCT):
Public health (including sexual health, drug and alcohol misuse and school nursing services).

NHS Property Services Ltd.
NHS Property Services Ltd has taken over the management of the PCTs freehold and leasehold estate.
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.