Department
of Health

Wirral Primary Care Trust

2012-13 Annual Report and Accounts

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Wirral Primary Care Trust

2012-13 Annual Report

NHS WIRRAL
ANNUAL REPORT 2012/13

Working Together for a Healthier Future

Foreword

We are very pleased to introduce the Annual Report for the year 2012/13, a year which has been very challenging, not only for Primary Care Trusts but for the NHS as a whole.

We began the year finalising the arrangements for the fundamental changes to the NHS heralded in the NHS White Paper, and ended by transferring our statutory responsibilities to successor organisations.

As a result of the changes to the NHS architecture, NHS Cheshire, Warrington and Wirral was formed on 1st June 2011 as a single Cluster Primary Care Trust Board for each of the four Primary Care Trusts: NHS Central and Eastern Cheshire, NHS Warrington, NHS Western Cheshire and NHS Wirral. The Cluster Board comprises a senior management team which covers the four constituent PCTs and Non-Executive Directors from each Primary Care Trust.

In times of rapid change, it is those organisations with committed staff, effective management and robust systems and processes in place that are able to both adapt quickly and deliver their responsibilities. We believe that we have demonstrated this through 2012/13 as described in this Report.

Our legacy will be to ensure that the transition to the new NHS commissioning structures is managed smoothly for the benefit of the population of Cheshire, Warrington and Wirral.

It is important to recognise that we could not have achieved this rapid transformation without the loyalty and dedication of all our staff who work together tirelessly to ensure that our local people and visitors receive the best health care possible. Once again, we would like to take this opportunity to thank everyone in our Primary Care Trusts and Cluster for their commitment and hard work during a tough transitional period.

Kathy Cowell
Chair

Moira Dumma
Chief Executive

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Publication arrangements

The Annual Report and a full copy of the Annual Accounts will be published on the Department of Health website.

Paper copies (and alternative formats) of the Annual Report will also be available on request to members of the public free of charge through the Department.

INTRODUCTION

NHS Wirral provided services to people registered with general practices listed within the Primary Care Trust area covered by Wirral Borough Council which included a resident population of 310,000 people.

In 2012/13, NHS Wirral had 224 permanent and fixed term staff.

For 2012/13, NHS Wirral's revenue resource limit was £665,650,000.

We are responsible for the support and development of:

- 61 GP Practices
- 48 Dental Practices
- 33 Ophthalmic premises
- 90 Pharmacies

Our strategic vision was "*Working together for a Healthier Future*".

We aimed to:

- involve and empower people
- target inequalities through effective partnerships
- ensure excellence in our health services
- become a high performance, high reputation organisation.

Delivery of NHS Wirral's vision and strategic aspirations was based on the values set out in the NHS Constitution - a set of principles that were essential to ensure the delivery of world class services to the people of Wirral.

They were:

- Respect and Dignity
- Commitment to Quality of Care
- Compassion
- Improving Lives
- Working Together for Patients
- Everyone Counts
- Standards Framework.

Management Arrangements, NHS Cheshire, Warrington and Wirral

NHS Cheshire, Warrington and Wirral ("the Cluster") was formally constituted on 1st June 2011 and was a Primary Care Trust Cluster of four Primary Care Trusts comprising NHS Central and Eastern Cheshire, NHS Warrington, NHS Western Cheshire and NHS Wirral.

The Cluster covered the four Primary Care Trust areas as outlined above and was responsible for developing six Clinical Commissioning Groups (CCGs). Wirral has formed one Clinical Commissioning Group. The Cluster patch also encompassed eight NHS provider trusts and four local authority areas. The total population of the Cluster was 1.2 million and total budget was £3.3 billion.

The Statutory responsibilities of the Cluster were as follows:

- Commissioning:
  - Hospital Services
  - Community Services
  - Continuing Care
- Continuous Improvement
- Planning, Partnership, Cooperation

- Governance & Finance
- Public Engagement
- Equality & Human Resources
- Information Governance
- Resilience
- Health & Safety

Primary Care Trusts clustered to manage the transition to the new NHS system. This reduced the risk of individual organisational pressures, with a reducing management and financial management capacity, by creating a single Board and Executive Team. It also enabled emerging Clinical Commissioning Groups and Health & Wellbeing Boards to develop, as well as ensuring staff moved into new roles with CCGs, Commissioning Support, Local Authorities and NHS Commissioning Board. The Cluster also supported the provider element of the transition including progress to Foundation Trust status.

Individual Primary Care Trusts remained the statutory NHS bodies. The Cluster Chief Executive was the Accountable Officer for each of the four Primary Care Trusts (and all six CCGs).

The NHS Cheshire, Warrington and Wirral Board had a single governance structure with the CCG Boards/Executives as sub-committees as well as the Audit, Remuneration and Primary Care Committees.

The Cluster was also the host for the North West Specialised Commissioning Team and the Board received their minutes for assurance. A full copy of the NHS Cheshire, Warrington and Wirral Constitution and Governance Structure can be seen in the Corporate Governance Manual available on the Primary Care Trusts' websites.

Any risks from each of the Primary Care Trusts were escalated to the Board via the Assurance Framework and were reported at formal Board meetings. For further information about the Cluster Board Meetings please visit the Primary Care Trust website at www.wirral.nhs.uk.

The Cluster Board was responsible for implementing systems and processes to ensure that business was carried out in an appropriate manner, met statutory duties and managed risks. The Board was accountable for internal controls and, as the Accountable Officer, the Chief Executive was responsible for maintaining a sound system of internal control within which policies were implemented and objectives achieved.

Each year the Board prepared an Annual Governance Statement which set out how the Board discharged its responsibilities. This Statement is provided in full at Appendix 1.

The Cluster Board was the Board for each of the four PCTs and had common membership except for the Director of Public Health, where there was one per PCT. Current members are shown below. Full membership details and period of office are provided at Appendix 2.

Non Executive Directors:

Kathy Cowell - Chair
Farath Arshad
Sheryl Bailey
John Church
John Gartside
James Kay
Iain Purchase

Executive Directors:

Chief Executive	Kathy Doran/Moira Dumma
Director of Finance	Simon Holden/ Phillip Wadeson/Russell Favager
Director of Commissioning Development	Joanne Forrest/ Alison Tonge
Director of Human Resources	Michelle Chadwick
Director of Nursing, Performance and Quality	Cathy Maddaford
Chief Operating Officer, Cheshire and Merseyside Commissioning Support Unit	Neil Ryder

Director of Public Health: (on rotation from each Primary Care Trust-one vote)

Dr Heather Grimbaldeston
Fiona Johnstone
Dr Rita Robertson
Julie Webster/Caryn Cox

Medical Directors: (one vote)

Dr Bill Forsyth
Dr Shyamal Mukherjee
Dr Maureen Swanson

Non-voting member - Director of Communications and Engagement

Martin McEwan

A Declaration of Interests by the Board Members and Executive Team forms Appendix 3. Full details of remuneration of Board Members is provided at Appendix 4.

External scrutiny and accountability

We were scrutinised by Wirral Borough Council Health and Wellbeing Overview and Scrutiny Committees, our Local Involvement Network (LINk), the North West Strategic Health Authority/ Northern Region and the Department of Health.

Audit Committee

The Board had an Audit Committee which regularly reviewed the establishment and maintenance of an effective system of integrated governance, risk management and internal control that operates across the whole of the Cluster's activities and supported the organisation's goals. The Committee consisted of three Non-Executive Directors and was independent of the Chairman and Chief Executive. It reported directly to the Board.

NHS REFORM AND THE ROAD TO TRANSITION

During 2012/13 the Primary Care Trust, working through the Cluster, made preparations for the implementation of NHS reforms, subject to successful passage of the Health and Social Care Act which received Royal Assent on 27th March 2012.

On 31st March 2013, the Primary Care Trust was abolished. The new local health system will consist of the following organisations and remits:

NHS England: supports NHS services nationally and ensures that money spent on NHS services provides the best possible care for patients. It funds local CCGs to commission services for their communities and ensures that they do this effectively. Some specialist services will continue to be commissioned by NHS England centrally where this is most efficient. Working with leading health specialists, NHS England brings together expertise to ensure national standards are consistently in place across the country. Throughout its work it promotes the NHS Constitution and the Constitution's values and commitments. The local representative for NHS England is Cheshire, Warrington and Wirral Area Team.

Public Health England: provides national leadership and expert services to support public health and works with local government, the NHS and other key partners to respond to health protection emergencies.

The *NHS Trust Development Authority:* supports NHS trusts to improve so they can take advantage of the benefits of foundation trust status when they are ready.

Health Education England: makes sure the healthcare workforce has the right skills and training to improve the care patients receive. It supports a network of Local Education and Training Boards that plan education and training of the workforce to meet local and national needs.

Locally, *Health and Wellbeing Boards:* will bring together local organisations to work in partnership and Healthwatch will provide a powerful voice for patients and local communities.

Clinical Commissioning Groups (CCGs): made up of doctors, nurses and other professionals, will buy services for patients, while local councils formally take on their new roles in promoting public health.

The local CCG for Wirral Primary Care Trust is Wirral. Throughout 2012/13, the CCG has been working with full delegated authority and has been fully authorised as at April 2013. It is now a statutory body with an Accountable Officer and having statutory duties as outlined in the Health and Social Care Act 2012. Further information can be found on the website.

Emergency Planning, Response and Resilience

Throughout 2012/13 the PCT Cluster was the lead PCT responsible for emergency planning, response and resilience (EPRR). Towards the end of the financial year the PCT Cluster also had responsibility for working with the Cheshire, Warrington and Wirral Area Team of NHS England to hand over responsibility for EPRR from the PCT Cluster to the Area Team.

The PCT Cluster's EPRR responsibility consisted of two distinct roles:

(a) the statutory duties of each of the four PCTs as *Category 1 Responders* under the Civil Contingencies Act (2004), and those responsibilities for PCTs as outlined in *The NHS Emergency Planning Guidance 2005*[1] and its supporting guidance;

[1] Department of Health, October 2005 (Gateway Reference: 5638)

(b) the role as *Lead PCT* for EPRR across Cheshire, Halton and Warrington – the coordinating PCT for the strategic leadership of the whole of the NHS in Cheshire during an emergency/ adverse incident – which was undertaken by NHS Western Cheshire (now the PCT Cluster) under a memorandum of understanding with NHS North West (now NHS North of England).

During the transition PCT Clusters were charged with the following responsibilities:

(a) maintaining an effective response to emergencies/ adverse incidents. As such the Cluster's Chief Executive issued instructions to ensure that:
- each individual PCT maintained an on call rota,
- on call rotas for the Cheshire-wide NHS Strategic Commander and their Tactical Advisors were maintained;

(b) assisting the Cheshire, Warrington and Wirral Area Team in the establishment of its EPPR arrangements.

Guidance was also issued setting out the EPRR roles for the NHS Commissioning Board (together with its Regions and Area Teams) and CCGs from April 2013. Key documents include:

(a) *Health Emergency Preparedness, Resilience and Response from April 2013: Summary of the principal roles of health sector organisations* (Department of Health, July 2012);
(b) *Transitional Assurance Process for EPRR* (NHS Commissioning Board, October 2012);
(c) *The role of 'Accountable Emergency Officers' for EPPR* (NHS Commissioning Board, December 2012);
(d) *Command and Control Framework for the NHS during significant incidents and emergencies* (NHS Commissioning Board, January 2013);
(e) *Business Continuity Management Framework* (NHS Commissioning Board, January 2013);
(f) *Core Standards for EPRR* (NHS Commissioning Board, January 2013).

This guidance focuses on planning for emergencies/ major incidents and the ability of the NHS to respond to such incidents (i.e. for those incidents that only affect the NHS and those which affect all multi-agency partners). Selected tasks include:

(a) establishing Local Health Resilience Partnerships (LHRPs) which are to meet quarterly as a forum to facilitate NHS emergency preparedness and resilience with a membership drawn from local acute, ambulance, community and mental health providers, together with representatives from public health;
(b) training those Area Team senior managers who will be members of on call rotas to a national core standard;
(c) establishing new on call rotas to strategically manage the response of the NHS within each Area Team;
(d) establishing Area Team Incident Coordination Centres and developing Incident response Plans.

Supporting the Cluster's Chief Executive in her role as Accountable Officer for ensuring robust and effective EPRR arrangements are in place and have been maintained were:

(a) the Director of Nursing and Performance – who held executive responsibility on behalf of the PCT Cluster;
(b) the Head of NHS Resilience – who held managerial and operational responsibility.

As the Cheshire, Warrington and Wirral Area Team has started to appoint its own staff:

(a) Accountable Officer responsibility was transferred from the Cluster's Chief Executive to the Area Team Director (from 1 October 2012);
(b) executive responsibility for EPRR was transferred from the Cluster's Director of Nursing & Performance to the Area Team's Director of Operations & Delivery (from March 2013);
(c) managerial and operational responsibility was shared between the Cluster's Head of NHS resilience and the Area Team's Head of EPRR since mid-December 2012, with a formal transfer taking place to the Area Team's Head of EPRR at the beginning of March 2013.

In line with national guidance, a memorandum of understanding was prepared to delegate the PCT Cluster's EPRR responsibility to the Cheshire, Warrington and Wirral Area Team. This came into effect from 31st March 2013. However, in line with the Cluster PCT's responsibility to assist the Cheshire, Warrington and Wirral Area Team in the establishment of its EPPR arrangements, individual PCT and NHS Strategic Command on call rotas (including those for Tactical Advisors) were maintained until the end of March 2013. As a sign of the close cooperation between the PCT Cluster and the Cheshire, Warrington and Wirral Area Team, the Area Team Director and some of her fellow Directors have already been included on the Cheshire NHS Strategic Commander on call rota.

To ensure the robustness of local EPRR arrangements, since July 2012 the Cluster had undertaken the following audit and/ or reviews of:

(a) NHS provider major incident plans and arrangements;
(b) NHS provider business continuity plans and arrangements;
(c) Local health system (i.e. both NHS provider and emerging CCG) escalation plans.

Particularly through the work of the Cluster's Head of NHS Resilience, the PCT Cluster had also ensured that the NHS continued to be represented and actively involved in the work of the Cheshire Local Resilience Forum (LRF). Through the LRF the NHS continues to:

(a) contribute to the development and review of multi-agency emergency plans and processes;
(b) contribute the NHS perspective into post-incident debriefs;
(c) update multi-agency partners on the organisational changes to the NHS, especially the changing roles and responsibilities for EPRR;
(d) ensure the NHS is adequately represented at LRF-sponsored training and exercises, including Control of Major Accident Hazards (COMAH) exercises organised by local councils.

Since January 2013, as part of the transition from the PCT Cluster to the Cheshire, Warrington and Wirral Area Team, the Area Team's Head of EPRR increasingly took the place of representing the NHS at LRF/ multi-agency meetings from the Cluster's Head of NHS Resilience.

Whilst managing the transition, the PCT Cluster (and more recently the Cheshire, Warrington and Wirral Area Team), have been involved in preparations for the Olympics and Paralympics and in various incident / event responses including the Olympic Torch Relay, a chemical suicide and NHS winter escalation (including the activation of the Critical Care Plan in conjunction with Merseyside).

In addition, and in line with the NHS Commissioning Board's guidance – *Transitional Assurance Process for EPRR* (October 2012), regular '*EPRR Implementation Tracker*' returns on the progress of developing the new EPRR arrangements locally have been submitted to the NHS North of England Cluster/ NHS Commissioning Board North (as appropriate). Feedback to date has been positive, with no significant gap/ area of weakness identified in the local development of plans (although though it was recognised they are under development).

Part of this assurance process was an EPRR Impartial Review between representatives from the Cluster/ Area Team and NHS Commissioning Board North. Written evidence, prepared by the PCT Cluster/ Area Team was submitted for this review including:

(a) the Terms of Reference for the Cheshire, Warrington and Wirral LHRP together with the minutes of its first 2 meetings (held in November 2012 and January 2013);
(b) the Cheshire, Warrington and Wirral LRHP's *3-year Strategy*, its *Concept of Operations* and the latest version of the Area Team's/ LHRP's *Joint Annual EPRR Work Plan for Quarter 4 of 2012/3 and 2013/4* (all national requirements);
(c) correspondence to the Chair of the Cheshire LRF (Assistant Chief Constable McCormick from Cheshire Police) and briefing provided the LRF's General Working Group as to how the NHS will continue to be an effective and influential partner of the LRF;
(d) the arrangements for training on call staff and establishing on call rotas, together with a briefing on the proposal to establish a shared on call rota between the six CCGs in Cheshire, Warrington and Wirral (i.e., each CCG is required to have an on call rota in place, although it is permissible for this to be shared);
(e) an EPRR memorandum of understanding between the Cheshire, Warrington and Wirral Area Team, local NHS providers (i.e., acute, ambulance, community and mental health) and CCGs;
(f) the latest draft of the Cheshire, Warrington and Wirral Area Team's Incident Response Manual.

The outcome of this review was positive with NHS England (North) being assured of the arrangements being developed locally.

MANAGING RISK, INVESTIGATING EVENTS AND LEARNING FROM THE EXPERIENCE OF PATIENTS

Ensuring safe healthcare – managing risks

NHS health professionals will try to do everything possible to ensure people are treated properly and quickly. However, sometimes things can go wrong and patients can feel that their experience of healthcare could have been better. It is important that we are informed of any concerns or complaints so that improvements can be made.

A formal complaints system was in place and followed NHS procedures and good practice by adopting the Health Service Ombudsman's 'Principles of Good Complaints Handling' and 'Principles for Remedy'. A yearly report was presented to the Board detailing the number of complaints and the actions the PCT has taken.

Compliments and complaints

Treasury's Guidance on 'Managing Public Money' sets out the steps public bodies should take where they have caused injustice or hardship by maladministration or service failure. Revised Principles for Remedy, issued in May 2010, set out six principles that represent best practice and are directly applicable to NHS procedures.

The key principles were:
1. Getting it right
2. Being customer focused
3. Being open and accountable
4. Acting fairly and proportionately
5. Putting things right
6. Seeking continuous improvement

In 2012/13 the PCT received 24 formal complaints. It is through patient feedback that were able to learn from complaints to monitor and improve services where required, to ensure we met the needs of our patients in the future. As Commissioners of local Health Services we monitored the complaints received for trends and took appropriate action to reduce the risk of identified trends happening again.

Knowing when patients have had a good experience is as important as knowing when things have not gone well. A record of compliments was kept and feedback was given to the service in question.

The Patient Advice and Liaison Service

The Patient Advice and Liaison Service (PALS) is an informal way for patients to raise any concerns with their healthcare. The PALS team work on the patients behalf by liaising with healthcare staff, listening to concerns and providing information and advice. In 2012/13 there were 659 contacts made with the PALS team.

For further advice and help:

- The Complaints Department can provide advice and further information regarding the NHS complaints procedure
- The Independent Complaints Advocacy Service (ICAS) provides advice and support to people who want to complain about the NHS. Details are available at www.carersfederation.co.uk/icas
- The Department of Health's website also has information on the NHS complaints procedure www.dh.gov.uk/health/contact-dh/complaints

Looking after personal data

As technological advances multiply, so do people's concerns about the safety of their personal data. This concern was addressed at the highest level within the PCT. Staff received annual Information Governance training. Privacy Impact Assessments were also carried out before introducing a new project or changing a service involving person-identifiable information.

We continued to develop and agree Information Sharing Protocols, working in partnership with health, social care, other statutory bodies, commercial healthcare bodies and the voluntary sector.

The Primary Care Trust had to submit an information governance self assessment to the Department of Health each year and the Information Governance Group continued to monitor the work required. Our current compliance is 66%.

The work undertaken by the Primary Care Trust Cluster during 2012/13 as part of the information governance assurance programme, together with the annual compliance against the Information Governance Toolkit, achieved improved scores year on year, which demonstrated good performance in this area.

SUMMARY OF PERSONAL DATA INCIDENTS IN 2012/13 ACROSS THE CLUSTER		
Category	**Nature of Incident**	**Total**
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	0
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	1
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	6
V	Other	0

Disclosure of serious untoward incidents

The National Patient Safety Agency identified some incidents that were described as 'Never Events'. These are largely preventable events which should not occur if all the appropriate procedures are followed. There were 3 never events reported in 2012/13 which were investigated fully and appropriate action taken, as necessary.

For further information, please contact Sue McGorry, Quality and Safety Manager Cheshire, Warrington and Wirral Area Team on 01925 406076.

VALUING OUR STAFF: WORKFORCE AND ORGANISATIONAL DEVELOPMENT

Equality and Diversity

The New Equality Bill was passed in April 2010. All the sections of the new Act were in place which means that all statutory bodies (including the PCT) were required to produce a new equality document by the end of July 2011.

Consultation and Engagement was a key part of the duties. Information gained from the events was used to develop and improve services and to improve the patient experience. Disabled people were actively involved in the development of services including the Mystery Shopper project, website design and deaf awareness training and guidelines.

Community Development Workers were a key link to local communities including Black, Minority and Ethnic (BME) groups, Gypsy and Travellers and the Polish community. They fed back the main problems faced by local communities and helped the PCT develop positive solutions.

Staff Well Being and Engagement

Involving our staff

We actively encouraged and promoted staff involvement at all levels of activity. A number of formal and informal forums and committees were in place to ensure this happened. Commitment to working in partnership with our staff side colleagues was formally through the Partnership Forum. A Staff Forum was also developed for commissioning staff based at Universal House where there was limited staff side representation.

We kept our staff well informed through staff briefings, an e-bulletin and regular Intranet updates, in addition to events on specific topics, emails, and our website, all of which encourage feedback, we also included a staff support section designed to help staff cope with change, managing the transition and relieving stress.

Staff Support

NHS Wirral was fully committed to the health and positive wellbeing of its employees, the health and wellbeing of the workforce was crucial to the delivery of the improvements in patient care envisaged in the NHS Constitution. The Trust Health and Wellbeing Strategy was routinely monitored, reported and discussed with staff representatives via the staff forum. All staff had access to a comprehensive Occupational Health Service.

Targeted Health and Wellbeing interventions were delivered in line with the Health and Wellbeing strategy and action plan. Events held have included; mini health checks, complimentary therapy sessions, self-defence classes, yoga sessions, pre-retirement sessions to mention just a few.

Monitoring sickness absence

We proactively managed both short-term and long-term sickness absence in line with our Attendance Management policy. Sickness absence was monitored on a monthly basis and reported quarterly to the Board.

In terms of sickness absence, note 7.3 to the Accounts shows that the average working days lost for the year is 4.76 (2011/12: 8.61 days).

Caring for the environment

The NHS had a target to reduce carbon emissions by 26% by 2020. In 2012/13, work continued towards improving the efficiency of our buildings. This built on work done in previous years to help staff reduce their business miles by making video and teleconferencing available and promoting a "cycle to work" scheme. We also introduced staff briefings using live web casts to allow staff to see and be briefed by Directors without the need to travel across the Cluster footprint.

Sustainability Report

All NHS Trusts, Primary Care Trusts and strategic health authorities were required to produce a Sustainability Report in 2012/13 as part of their Annual Report. The Sustainability Report is provided at Appendix 5.

OPERATING AND FINANCIAL REVIEW 2012/13

Introduction

The PCT was responsible for commissioning health services for the population of Wirral, and worked in partnership with other NHS organisations, local government and the non-statutory sector to improve the quality of life that people could experience.

Following the Health & Social Care Act 2012, the PCT ceased to exist on 31 March 2013. In readiness for this, the PCT had already clustered with 3 other PCTs (Western Cheshire, Warrington, Central & Eastern Cheshire) and had established Wirral Clinical Commissioning Group as a Sub-Committee of the Board. The Act led to the establishment of the National Commissioning Board, Public Health England, Clinical Commissioning Groups, and the transfer of some public health functions to the Local Authority on the 1st April 2013.

KEY PERFORMANCE INDICATORS

Financial Performance

The financial statements included within this annual report demonstrated another successful year for the PCT. NHS Wirral met all of its statutory financial duties, as outlined below:

- **Revenue Resource Limit** – the PCT has a statutory duty to contain its revenue expenditure within the notified revenue resource limit of £665,650,000 (2011/12: £621,228,000). This was achieved with an underspend of £3,132,000 (2011/12: £2,001,000) which is in line with its agreed control total.

- **Capital Resource Limit** – there is a separate resource limit for capital expenditure, which also cannot be exceeded, of £4,950,000 (2011/12: £10,426,000). This target was achieved exactly (2011/12: £3,000 underspend).

- **Cash Limit** – the third financial target ensures that the PCT does not exceed its approved level of cash available. This target was achieved, with the PCT maximising its cash use by ending the financial year with a minimal cash balance of almost £0 (2011/12: £1,000)

Compliance with Better Payment Practice Code

In addition to the statutory duties, all NHS organisations were required to make payments to their creditors within 30 days (unless other terms have been agreed). The target is for PCTs to pay 95% of invoices within this timescale.

During 2012/13 the PCT achieved this target for three of the four indicators. For non NHS invoices 94.1% were paid in terms of number and 97.2% in terms of value (for 2011/12 the corresponding figures were 96.2% and 96.1% respectively).

For NHS invoices, actual invoices paid within 30 days were 96.4% in terms of number and 99.1% in terms of value (for 2011/12 the corresponding figures were 97.0% and 99.8% respectively).

The PCT was signed up to the Prompt Payment Code, whereby the PCT undertook to:

- Pay suppliers on time;
- Give clear guidance to suppliers; and
- Encourage good practice

Further information on the code can be found at www.Promptpaymentcode.org.uk

USE OF RESOURCES

Financial Resources

Overall, the PCT spent £681,030,000 on commissioning healthcare for Wirral residents during 2012/13 (£662,518,000 net of miscellaneous income). An analysis of the PCT gross expenditure is shown below.

The analysis shows that the majority of the PCT gross expenditure related to services commissioned for secondary healthcare. This was mainly provided by local NHS organisations, particularly Wirral University Teaching Hospital NHS Foundation Trust for acute services, Cheshire and Wirral Partnership NHS Foundation Trust for mental health and learning disability services, Wirral Community NHS Trust for community services, and Clatterbridge Centre for Oncology NHS Foundation Trust for specialist cancer services.

In addition, a large proportion of gross expenditure related to services delivered by GPs, including the cost of prescriptions.

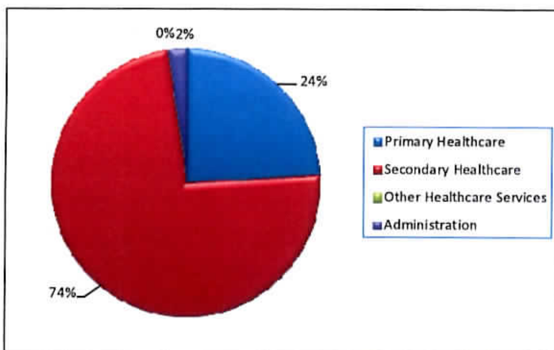
The running costs of the PCT totalled expenditure of £16,462,000 for 2012/13 (£16,079,000 in 2011/12).

Cash Resources

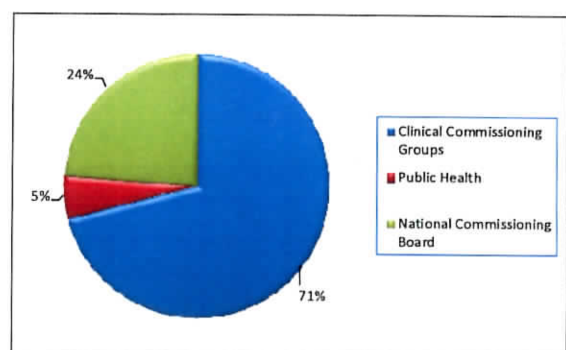
As mentioned above, the PCT had a cash limit against which all payments and receipts were monitored. The PCT needed to make the most effective use of this cash by appropriately managing its creditor payments in line with the Better Payments Practice Code, and also ensuring that income was correctly collected.

For 2012/13, the total cash spend was £660.6 million, which matched the cash limit allocated by the Department of Health.

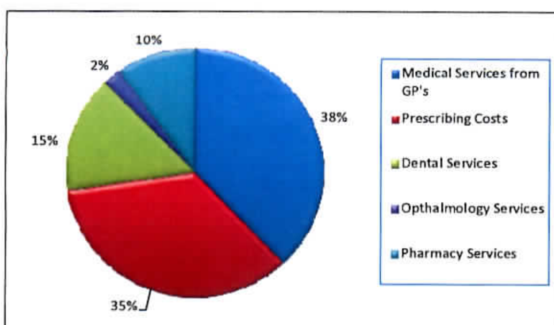
Local Health Services £662.5 million



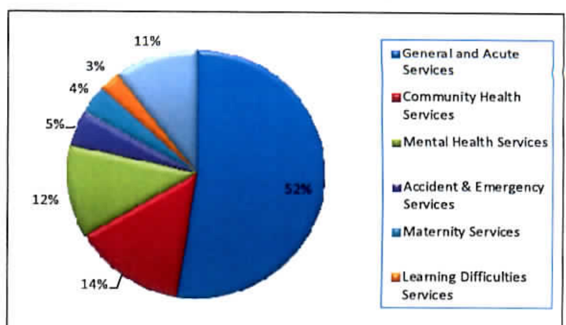
Services Commissioned By



Primary Healthcare



Secondary Healthcare



Staff Resources

The PCT employs staff across a range of disciplines:

Average Staff Numbers:	2012/13		2011/12
Medical and Dental Staff	3		5
Administration	195		203
Nursing Staff	13		11
Scientific, therapeutic & technical staff	21		21
Other staff	5		12
Total	**237**		**252**

In terms of sickness absence, note 7.3 to the Accounts shows that the average working days lost for the year was 4.76 (2011/12: 8.61 days).

Physical Resources

The PCT owned and leased a number of buildings across the Wirral, however the majority of these buildings are used to provide community services. All buildings and equipment owned or leased by the PCT transfer to successor bodies from 1 April 2013. The majority have transferred to Wirral Community Trust and NHS Property Services.

During 2012/13, the overall value of property, plant and equipment increased from £33.6 million to £34.7 million. The change is mainly due to the capital expenditure in year on the St Catherine's redevelopment scheme, offset by an impairment as the asset is brought into use.

Property assets were revalued by the District Valuer during the financial year 2012/13.

Value for Money

In order to obtain maximum benefit for patients from finite resources, the PCT regularly reviewed its expenditure to ensure that it achieves value for money. This was achieved by improving the procurement of supplies and services, and also by skill-mixing of staff to ensure that the most appropriate grade of staff was employed within each department.

In addition, benchmarking tools were used to compare costs with other organisations, and also by comparing costs of services commissioned against health outcomes. These tools helped us to improve the efficiency of the services provided to patients.

The PCT had a 'Value for Money Strategy' which aimed to embed a value for money culture across the whole organisation. Value for money doesn't mean the 'cheapest' service; it is about ensuring that the best combination of economy, efficiency and effectiveness is obtained from the use of resources.

In its Annual Audit Letter for 2011/12 the PCT received an unqualified Value for Money conclusion, reflecting adequate arrangements to secure economy, efficiency and effectiveness in use of resources.

Other Information of Public Interest In Relation to the Annual Report and Accounts:

Accounting policies

The only change to accounting policy relates to short-term employee benefits. Due to the demise of the PCT at 31 March 2013, all employees were expected to use all annual leave entitlement in the year and there was no accrual for leave not taken.

Auditors

The PCT's external audit was conducted by Grant Thornton UK LLP. The cost of the duties performed during the 2012/13 financial year was £119,880 (2011/12: £220,000). Internal audit services were provided by Mersey Internal Audit Agency at a cost of £59,061.

Contingent liabilities

The PCT has recognised a contingent liability of £18,000 in 2012/13 in respect of a number of claims to the National Health Service Litigation Authority (2011/12: £15,000), and £1,527,000 relating to claims for Continuing Healthcare restitution.

Events after the Reporting Period

As stated above, the PCT ceased to exist on 31 March 2013, with responsibilities for commissioning healthcare transferred in accordance with the Health and Social Care Act 2012.

International Financial Reporting Standards (IFRS)

The Accounts were prepared based on International Financial Reporting Standards (see accounting policy 1).

Losses and Special Payments

The PCT has recorded a total loss of £119,008 during the year (2011/12: £116,351), mainly relating to debt write-offs.

As part of its risk management processes, the PCT followed up all thefts of equipment and damage to buildings, and endeavours to minimise such incidents in the future.

Pension Liabilities

Note 7.5 to the accounts details the accounting for pension liabilities, covered by the provisions of the NHS Pension Scheme. Details of pension benefits of PCT senior managers are shown in the remuneration report, which is included as an appendix to this document.

There are no PCT employees who have stakeholder pensions in place of being a member of the NHS pension scheme.

Political and Charitable Contributions

There were no political or charitable contributions made by the PCT during the 2012/13 financial year.

Register of Directors Interests

The PCT are required to keep a Register of Directors Interests for the 2012/13 financial year. One of the Medical Directors who served during the year, namely Dr S Mukherjee, is a partner in GP

practices within Wirral. The GP practice received funding from the PCT for the delivery of services to their registered patients.

The Full Register of Interests is held at the CWW Area Team of NHS Commissioning Board and is available for public scrutiny. The register of Cluster Board interests is at Appendix 3.

Senior Officer Remuneration

As a public body, the PCT was required to make public the remuneration of those persons in senior positions having authority or responsibility for directing or controlling the major activities. For NHS Wirral, we have deemed these persons were the executive and non-executive directors of the clustered PCT, NHS Cheshire Warrington & Wirral.

The remuneration details are included at Appendix 4 to the annual report. The Remuneration for Directors is in accordance with the guidance issued by the Department of Health.

Serious Untoward Incidents

There were no serious untoward incidents involving data loss or confidentiality breaches.

Severance payments

There were a number of exit packages agreed during 2012/13. The majority of packages were agreed under the NHS Voluntary Redundancy Scheme (VRS) or Retention and Exit Terms Scheme (RETS), with some staff leaving through compulsory redundancy. Overall, there were 42 departures under these schemes at a cost of £2,596,000 (2011/12: £804,000 for 5 employees).

Staff Pay Awards

The PCT increased staff pay in line with the nationally agreed pay awards.

REMUNERATION REPORT

Terms of Reference for the Remuneration Committee

The Remuneration Committees of Primary Care Trusts made recommendations to their Boards on remuneration and on terms of service for the Chief Executive and very senior managers to ensure they are fairly rewarded for their individual contribution to the organisation within the requirements of the nationally developed Framework for Very Senior Managers. Advice to Boards on such remuneration includes all aspects of salary, provisions for other benefits including pensions and cars as well as arrangements for termination of employment and other contractual terms. Additionally, the Remuneration Committee:

- Made recommendations to the Board on the remuneration, allowances and terms of service of other officer members to ensure they were fairly rewarded for their individual contribution to the organisation.

- Monitored and evaluated the performance of individual and other senior officer members.

- Advised on and oversaw appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

Composition of the Committee

The Committee comprised the Board Chairman and at least two other non-officer members.

Remuneration Committee membership

Three Non-Executive Directors were members of the Remuneration Committee.

Remuneration of senior managers – current/ previous financial year

The Remuneration Committee determined the salaries of the following Directors' and senior managers' posts: Chief Executive, Directors, senior managers (on local contracts). The remuneration packages for these senior posts comprised base salary in the light of the requirements of the national Very Senior Managers policy.

On the inception of the consolidated PCT Cluster Board on 1st June 2011, Cluster Executive and Non-Executive Directors were appointed to all four PCTs hence we have shown remuneration shared equally between the four constituent PCTs. The remuneration report shown here relates to this PCT's share of the total remuneration. Directors of Public Health relate to one PCT each and they share Board level responsibility.

A consolidated report for the entire Cluster can be found in Appendix 4.

Pay scales and benefits

Executive Directors may receive taxable benefits from the Primary Care Trust's lease car scheme as part of their remuneration.

Pensions

All Directors for the Primary Care Trust have access to the NHS Pension Scheme which provides pensions on a final salary basis. Employees are entitled to join the NHS Pensions Scheme. Further details are provided in the Annual Accounts and in Appendix 4 of this annual report.

Performance management

ationally an annual appraisal system for all of its employees. The ittee's minutes state that the current organisation's objectives and appraisal nue to be the method by which performance and achievement of corporate d be measured.

reements Appointment - Chief Executive and Directors

r Executive and Directors have contractual status which expired on 31st March2013 when T ceased or earlier for those who have ceased to act during the year.

Termination of appointment – Chief Executive and Directors

Other than in circumstances where the contract is being terminated by summary dismissal, the employee shall be entitled to receive six months' notice of termination. The employee is required to give the Primary Care Trust six months' notice of their intention to terminate this employment.

Contractual Information - Year ended 31st March 2013

As part of NHS reforms, PCTs have been abolished from 31st March 2013. As such, the employment contracts of all CWW Cluster Board members will end on that date unless stated as earlier. Details of period of office of members is provided at Appendix 2.

Department of Health

WIRRAL PRIMARY CARE TRUST

CLUSTER OF NHS CHESHIRE, WARRINGTON AND WIRRAL PRIMARY CARE TRUSTS

ANNUAL GOVERNANCE STATEMENT 2012/13

My review confirms that each Primary Care Trust had a generally sound system of internal control that supported the achievement of its policies, aims and objectives. The Primary Care Trust Cluster was established on 1st June 2011.

Scope of responsibility

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

There was regular contact between the Strategic Health Authority and the Primary Care Trust which allows for any concerns to be addressed

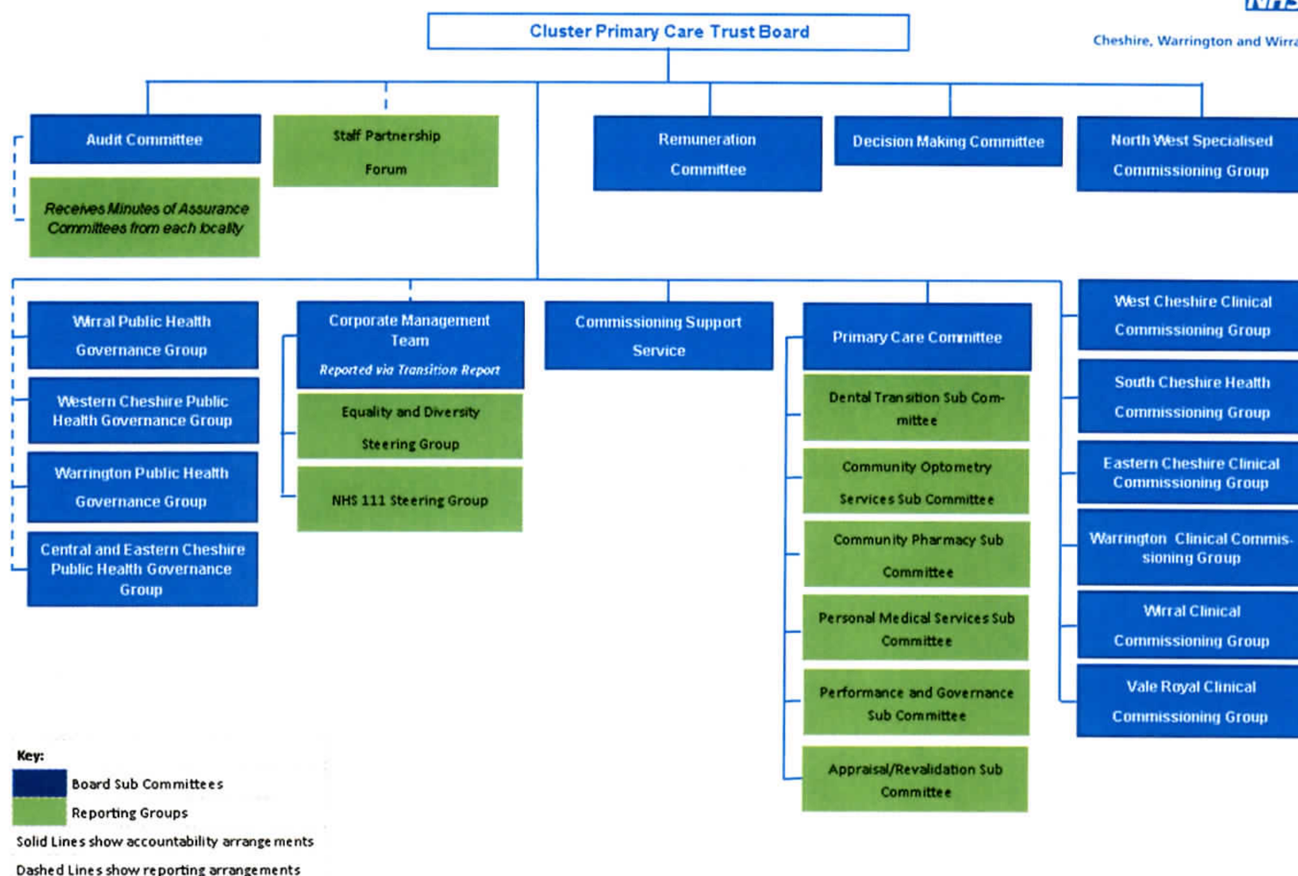
With respect to partnership working across the Local Health Economy, I met regularly with the Local Authority Chief Executives and as necessary with the Chief Executives of the providers within the Primary Care Trust area. The Primary Care Trust participates in partnership arrangements for children's services, adult services and health and well-being. The post of Joint Director of Public Health is jointly accountable to the Local Authority and the Primary Care Trust. There are a range of joint commissioning appointments across different organisations.

The governance framework of the organisation

The NHS Cheshire, Warrington and Wirral Board was established on 6th June 2011 by the Establishment Agreement contained in Section A of the Standing Financial Instructions/Standing Orders (initially approved by Board on 6th June and updated and approved on 2nd November 2011). A diagram of the Governance Structure for the Cluster is shown below.

The Board has the following Sub-Committees which have delegated responsibilities as part of the Scheme of Reservation and Delegation.

- Audit Committee
- Remuneration Committee
- Decision Making Committee
- Primary Care Committee
- West Cheshire Clinical Commissioning Group
- South Cheshire Clinical Commissioning Group
- Eastern Cheshire Clinical Commissioning Group
- Warrington Clinical Commissioning Group
- Wirral Clinical Commissioning Group
- Vale Royal Clinical Commissioning Group
- North West Specialised Commissioning Group



The Board Sub-Committees all have terms of reference which have been approved by the Board. The Board also had a number of reporting groups from whom they receive minutes as part of the assurance process. These groups included:

- Public Health Governance Groups/Steering Groups for each Primary Care Trust (reported via the Transition Update Board Papers)
- Corporate Management Team (reported via the Transition Update Board Papers)
- Staff Partnership Forum

The Board met regularly either formally where meetings were held in public or informally for the Board's own development. Copies of the Formal Board agendas and papers are available on each of the Primary Care Trust websites and were published 5 working days in advance of the meeting. The minutes of the Board meetings and minutes of supporting groups as outlined below contain details of the attendance of members and any apologies received. The Board developed the following vision and values:

- Honesty and Integrity - by showing respect, fairness and trust to all our staff during a period of major change;
- Clear leadership - to develop positive attitudes and actions recognising the potential for people to make a difference; and by having the courage to take necessary tough decisions in order to successfully deliver the new NHS;
- Collaborative support - to all staff and teams to secure success with Clinical Commissioning, Commissioning Support and Public Health;
- Working creatively - with partners based on the common objective to keep our population at the centre of all we do.

These values were developed to provide focus for the Board in their role as a Cluster Primary Care Trust Board during the transitional period for the NHS. The Board fully complied with the UK Corporate Governance Code and was effective in discharging it roles and responsibilities.

The Audit Committee was responsible for ensuring compliance with statutory requirements and provided assurance to the Board on internal control and governance matters (both clinical and non-clinical), that supported the achievement of the organisation's objectives. The Audit Committee highlights have included:

- Monitoring the impact of wider NHS transition on the Cluster, including commissioning support arrangements, CCG development and the establishment of the NHS Commissioning Board. This included consideration of the impacts on areas of corporate priority including HR and Information Technology. The Committee also considered specific guidance on financial closedown of PCTs;
- Review of areas of financial focus including key aspects of the financial statements such as final accounts timetables, segmental reporting requirements and review of accounting policies. The Committee also reviewed tender waivers, progress against QIPP and losses & special payments;
- Regular updates from internal auditors including plans, progress reports, final reports issued and the Director of Internal Audit annual opinion; the Committee also tracked audit recommendations to ensure these were implemented. The outstanding recommendations have been transferred to the Clinical Commissioning Groups and this process is embedded as part of their governance frameworks;
- Regular updates from external auditors including plans, progress reports, annual governance reports and annual audit letters. The external auditors also provided updates on the transfer of responsibilities to the new external audit provider;
- Review of the Board Assurance Framework as part of the Committee's role to oversee the establishment and maintenance of an effective system of integrated governance, risk management and internal control;
- Updates from each of the PCT/localities and the hosted North West Specialised Commissioning Team focussing on local performance and transition issues; and,
- Review of counter fraud progress reports.

Throughout the year the Board has received copies of the Clinical Commissioning Group Board minutes. These have provided assurances of their delegated responsibilities which include the majority of commissioning budgets and performance of providers. Risk is an agenda item for all Clinical Commissioning Groups and mechanisms are in place to escalate risks for Board attention, where appropriate. Key points reported via these Sub-Committees have included:

- Monitoring of the Clinical Commissioning Group Financial Position;
- Finalising the Clinical Commissioning Group Staffing Structure and developing the organisational development plan;
- Development of a Planning Framework including contracts and the strategic plan for 2012/13;
- Preparing for Formal Board Meetings in public and undertaking Board development programmes;
- Reviewing commissioned services and preparing to implement any willing provider;
- Developing assurance frameworks for managing risk and reporting to the Primary Care Trust Cluster Board;

The NHS Cheshire, Warrington and Wirral Scheme of Reservation and Delegation clearly states that Quality is delegated to the Clinical Commissioning Groups to oversee for their respective providers.

In addition to regular reporting to Clinical Commissioning Group Boards, any exceptions including serious incidents are reported to the Primary Care Trust Cluster. Clinical Commissioning Groups are responsible for ensuring that exceptions are reported in a timely manner to the Primary Care Trust Cluster and that actions

are taken by the providers and themselves to address the exceptions. These exceptions are also included in the Quality Accounts for providers on an annual basis.

At its last formal Board Meeting in March 2013, the corporate handover document for NHS Cheshire Warrington & Wirral (NHS CWW) Cluster was presented. It is intended that this document will signpost all new NHS organisations who take responsibility for Primary Care Trust functions from 1 April 2013 to the key risks, issues and areas of concern of which those new bodies need to be aware as they assume responsibility for the discharge of their functions.

The Corporate Handover document should be read in conjunction with the Quality Handover document which sets out the key quality and safety issues for NHS Cheshire Warrington & Wirral Cluster. This was also presented to the Primary Care Trust Cluster Board in March 2013. Both documents are available on the Primary Care Trust websites as part of the Board papers.

From 1 April 2013 when PCTs were abolished, Area Team Directors continued to discharge the responsibilities associated with the financial closedown of PCTs. The production of the accounts for 2012/13 was supported by LAT Directors of Finance (DoFs). This has included:

- preparation and sign off of PCT accounts for 2012/13;
- support for the completion of the Department's resource account;
- designation of closing balances to residual organisations;
- management of local discharge of balances transferred to the Department; and
- management of payroll queries and other related payroll issues.

However, when PCTs ceased to be statutory bodies on 1 April 2013, the statutory status of the essential scrutiny and governance function provided by Audit Committees has been lost. To maintain rigour in the process, we have established an Audit Sub-Committee of the Department of Health Audit & Risk Committee, to support the final accounts process. This approach will draw on the expertise of current Audit Committee members when forming the Sub-Committee. This arrangement will provide a mechanism with the appropriate status to discharge the function.

The non-executive directors (NEDs) that form the Sub-Committee have been identified locally and include the previous chair of the PCT Cluster. They have been appointed by the Department's Permanent Secretary following local nomination. The Cluster Audit Sub-Committees took place in May and June 2013 to agree the accounts in line with national timescales.

<u>Risk assessment</u>

The Corporate Risk Register enabled the Cluster to understand its comprehensive risk profile. It records dependencies between risks and links between risks on the Board Assurance Framework and the risk registers of individual functions.

The Corporate Risk Register is derived from a number of sources:

- escalation from Risk Registers held by:
  - Clinical Commissioning Groups
  - Commissioning Support Service
  - Public Health Departments
  - Primary Care
  - Cluster wide e.g. Emergency Planning.
- the business planning system, which determined the Primary Care Trusts' principle objectives, corporate activities such as the planning process or business case development, external inspections (e.g. Health and Safety Executive) complaints/ incidents and litigation.

Items for the Risk Register which were a standing item on agendas of:

- The Board
- Audit Committee
- Remuneration and Terms of Service Committee
- Clinical Commissioning Group Boards
- Public Health Governance Committees
- Commissioning Support Service Board
- Primary Care Committee.

The Corporate Risk Register is a dynamic document, held by the Cluster Office. It forms part of the legacy document for when the Primary Care Trusts are abolished. Risks identified as significant or complex were entered on to the Corporate Risk Register, quality assured by the Corporate Management Team before escalation to the Board.

The Assurance Framework was developed in accordance with guidelines provided by the Department of Health.

This is a high level document that recorded the principal risks that could have impacted on the Cluster achieving its strategic objectives. It provided a framework for reporting key information to the Board. It provided assurance that risks were managed effectively and objectives were delivered and also identified which of the Primary Care Trusts' objectives were at risk because of gaps in controls or assurance about them.

During 2012/13 the following risks were highlighted to the Cluster Board:

- Ensuring a robust PCT closedown as part of NHS transition arrangements, including the need to successfully identify and transfer assets and liabilities;
- Assurances need to be in place that commissioned services are safe and of good quality. This risk has been mitigated through inclusion of quality and safety aspects in all contracts and robust contract monitoring arrangements;
- The need to successfully implement the NHS '111' programme. The Cluster has established a Steering Group with representation across all CCGs to implement and monitor progress against key milestones; and,
- The need to support CCGs engagement in the QIPP agenda – this has been mitigated through each CCG having approved, individual QIPP plans and securing GP involvement in QIPP projects.

Principal risks were not considered in isolation, but derived from the prioritisation of risks fed upwards through the whole organisation, including Risk Registers and Assurance Frameworks held and managed by Clinical Commissioning Groups, Public Health Departments, Commissioning Support Service and Primary Care. In this way the Risk Registers will contribute to the Board Assurance Framework and ensure that system risks are identified and monitored.

All Clinical Commissioning Groups/Public Health/Primary Care/Commissioning Support Service minutes are submitted to every formal Cluster Board and each of the groups attends the Board on a rolling basis or when there is a specific item which requires Board approval. The Cluster has a Single Audit Committee which is enabling and supporting the development of local governance groups (inc QIPP governance). Regular quality meetings are held with providers (see further detail below) and Clinical Commissioning Groups. The Chief Executive meets formally with Clinical Commissioning Group Chairs and Chief Officers bi-monthly and with Directors of Public Health also monthly. The Cluster is part of the Regional Management Board in Cheshire and Warrington and the Health and Local Government meetings in Wirral. There is also

senior Cluster attendance at all Health & Wellbeing Boards. Delegated arrangements are detailed in Standing Orders and Financial Instructions

During 2012/13 there were no lapses of data security. Therefore no incidents were reported to the information commissioner relating to any of the Primary Care Trusts.

The risk and control framework

The Risk Management Strategy sets out the responsibility and role of the Chief Executive in relation to Risk Management. The Board took direct responsibility for the monitoring of the assurance framework and for risk management.

Board committees were supported by the governance structure and have received reports from a number of other Trust and locality-wide groups, to ensure that all significant risks were highlighted to the Board.

The Assurance Framework identified those risks deemed as strategically significant to the objectives of the organisation. Risk Management was embedded within the organisation and the process was been cascaded to service areas to assist with the development of an organisation-wide risk awareness culture. This was supported by operational risk registers which enabled risk management decision-making to occur as near as practicable to the risk source, and for those risks that cannot be dealt with locally to be passed upwards to the appropriate level within the organisation.

The Primary Care Trust Assurance Framework, Corporate Risk Register and Top Risks were reviewed and updated regularly. Risks were identified via a number of routes, including reports from staff and senior managers, incidents, complaints and Primary Care Trust Committees. The Cluster Team was responsible for ensuring all risks were appropriately graded and that action plans were regularly monitored.

The Primary Care Trust undertook a wide range of mandatory and statutory training for all staff and there was a greater emphasis on staff training during 2012/13 following the introduction of e-learning. Staff were required to undertake training in relation to Counter Fraud, Equality and Diversity, Fire Safety, Infection Control, Information Governance, Safeguarding Children and Adults as well as Health and Safety. This training was mandatory for all staff and was a key part of the organisation's core induction. This ensured that risk management, risk assessment and incident reporting were highlighted together with key Trust strategies, policies and procedures. These included risk management strategy, infection control, and complaints.

Statutory & Mandatory training compliance rates across the Cluster were taken as at January 2013. Overall the Cluster was 70.6% compliant across the 8 core courses, which was an increase of 1.6% on the October figure. However, training compliance reduced in comparison to the previous year as a result of the NHS Transition. Compliance reports were sent out to the locality HR Teams so that discussion with line managers about ongoing compliance action could be undertaken. Two out of the eight courses are achieving the National compliance rates of 85% or higher".

The Trust has ensured:

- Director objectives were aligned with key Corporate Objectives.
- The Primary Care Trust is committed to engaging local independent contractors to facilitate the development of good governance and risk management processes.
- The Primary Care Trust seeks independent assurances from third party providers of services to the Primary Care Trust over the effectiveness of internal controls in place. Relevant reports covering the review of third party provider controls are presented to the Audit Committee during the year.
- Control measures are in place to ensure that all the organisations' obligations under equality, diversity and human rights legislation are complied with.

Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of Internal Audit's work. The overall level of the Head of Internal Audit Opinion is one of significant assurance. Significant assurance can be given that there was a generally sound system of internal control designed to meet the organisation's objectives and that controls were generally being applied consistently. However some weaknesses in the design or inconsistent application of controls put the achievement of particular objectives at risk. Executive managers within the organisation who had responsibility for the development and maintenance of the system of internal control provided me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that managed the risks to the organisation achieving its principal objectives have been reviewed.

My review is also informed by:

- Attendance and debate at the Corporate Management Team Meetings, Primary Care Trust Board, and reports from the Audit Committee.
- The achievement of financial duties and the financial position of the Primary Care Trust.

Assessments from Mersey Internal Audit which report:

- Classified the Assurance Framework at the highest level 'A': 'An Assurance Framework has been established which is designed and operating to meet the requirements of the Annual Governance Statement and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation'.
- Responses to staff and patient surveys and other external reviews.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control.

In addition I am aware of the importance of the roles of the following:

- The Board, The Board's role is to provide active leadership of the Trust within a framework of prudent and effective controls that enable risk to be assessed and managed
- The Audit Committee, as part of an integrated committee structure, is pivotal in advising the Board on the effectiveness of the system of internal control. Any significant internal control issues would be reported to the Board via the Audit Committee. An Audit Committee report has been produced outlining how the Committee complied with its duties delegated to it by the Primary Care Trust Board in its Terms of Reference.
- Executive Directors' roles and responsibilities in ensuring systems of internal control are in place and implemented effectively.
- Internal Audit provides reports to each meeting of the Audit Committee and full reports to the Director of Finance and key officers. The Audit Committee also receives details of any actions that remain outstanding from the follow up of previous audit work. The Director of Finance also meets regularly with the Audit Manager.
- External Audit – provides external audit annual management letter and progress reports to the Audit Committee.

Significant Issues

Financial Position at Year End for NHS Cheshire, Warrington and Wirral

The Cluster Plans were for an overall budget of £3.3 billion, which includes £1.1 billion in respect of the North West wide Specialist Commissioning function. The total surplus planned and delivered for the year is £10.3 million, excluding impairments. In addition, it is worth noting the challenging Quality, Innovation, Productivity and Prevention savings of £107.4 million, of which £55.7 million was cash releasing.

NHS 111 Programme

The 111 Programme had an established governance process for mobilisation actions which were required along with an established, and now on-going clinical governance assurance process since the "go live" of the service at the end of March. The Cluster role was to ensure that the mobilisation requirements were fulfilled and any outstanding actions were managed by way of a risk register as part of the joint mobilisation arrangements with Merseyside. This was due to the contract for the 111 programme being provided on a joint Cheshire and Mersey footprint.

The Cluster also ensured that the clinical governance arrangements were implemented and a structure of local clinical advisory groups (LCAG) established. Each LCAG (based around Out of Hours Services) will be led by a Clinical Commissioning Group, who will be responsible for co-ordinating and establishing the LCAGs, who will report through the 'county' specific clinical governance groups and ultimately via a clinical lead to the North West Clinical advisory group.

Financial Position

The surplus for 2012/13 is £3.132 million and is in line with the planned surplus for 2012/13 of £3.088m. It reflects an underlying recurrent surplus of £15.483 million offset by non recurrent commitments of £12.351 million, primarily on initiatives to deliver longer term QIPP savings, redundancy costs and pump priming the new health system. Planned QIPP savings are reported by ten key themes, delivering planned savings of £6.414 million.

Performance Issues

Wirral University Teaching Hospital NHS Foundation Trust struggled to deliver the accident and emergency 4 hour standard in both Quarter 3 and Quarter 4 of 2012/13 and as a result of this failed to deliver the required overall year to date standard. The Trust is working closely with commissioners to identify reasons for this and to put in place robust action plans to ensure performance against this standard for 2013/14 is delivered. Pressure remains for the Trust in delivering both the elective 18 week pathway and the diagnostic tests standard however the Trust is working with the commissioner to ensure any issues are highlighted and mitigating actions put in place.

Conclusion

To the best of my knowledge, the governance arrangements in place are effective with the exception of the significant issues reported above.

Accountable Officer: Moira Dumma

Organisation: Wirral Primary Care Trust

Signature:

Date: 3.6.2013

APPENDIX 2

BOARD MEMBERS

Current Board Members and Period of Office

Name	Position	Start Date
Moira Dumma	Chief Executive	1st October 2012
Michelle Chadwick	Executive Director of Human Resources	
Russell Favager	Executive Director of Finance	14th January 2013
Cathy Maddaford	Executive Director of Quality & Performance/ Executive Nurse	
Shayamal Mukherjee	Medical Director	
Maureen Swanson	Medical Director	
Neil Ryder	Chief Operating Officer – Cheshire and Merseyside Commissioning Support Unit	
Fiona Johnstone	Executive Director of Public Health (Wirral)	
Heather Grimbaldeston	Executive Director of Public Health (Central and Eastern Cheshire)	
Rita Robertson	Executive Director of Public Health (Warrington)	
Caryn Cox	Executive Director of Public Health (Western Cheshire)	1st December 2012
Martin McEwan	Director of Communications and Engagement	
Alison Tonge	Executive Director of Commissioning Development	1st November 2012
Kathy Cowell	Chair	
James Kay	Non-Executive Director –Vice Chair	
John Gartside	Non-Executive Director-Vice Chair	
John Church	Non-Executive Director-Vice Chair	
Farath Arshad	Non-Executive Director	
Iain Purchase	Non-Executive Director	
Sheryl Bailey	Non-Executive Director	

Former Serving Board Members and Period of Office

Name	Position	End Date
Kathy Doran	Chief Executive	1st October 2012
Julie Webster	Executive Director of Public Health (Western Cheshire)	30th November 2012
Phil Wadeson	Executive Director of Finance	1st September 2012 to 11th January 2013
Simon Holden	Executive Director of Finance	3rd August 2012
Joanne Forrest	Executive Director of Commissioning Development	30th November 2012
Bill Forsyth	Medical Director	31st May 2012

Appendix 3 – Register of Cluster Board Interests

NAME	POSITION	INTERESTS DECLARED	DATE REVIEWED
Farath Arshad	Non-Executive Director	• Research Active Academic with collaboration involving NHS Partners (NMHIS, Trafford NHS Trust, RLBUHT, Mersey Care, Alder Hey) • Advisor on Board of Informatics, Merseyside	March 2013
Sheryl Bailey	Non-Executive Director	• NIL	March 2013
Michelle Chadwick	Director of Human Resources and Organisational Development	• NIL	March 2013
Kathy Cowell	Chair	• Chairman – Your Housing Group (Housing Association), 2012 - 2015 • Member - East Cheshire Hospice Strategic Growth Committee, 2009 - • Board Member - Cheshire Community Foundation, 2011 – • Deputy Lieutenant of Cheshire	March 2013
John Church	Vice Chair / Non-Executive Director (Western Cheshire Locality Chair)	• Public Member of Wirral University Teaching Hospital NHS Foundation Trust • Public Member of Countess of Chester NHS Foundation Trust • Public Member of Cheshire and Wirral Partnership NHS Foundation Trust • Church Warden at St Nicholas Church, Burton-in-Wirral • Board Member of NHS North West Social Value Foundation • Trustee Board Director of Save the Family • PCC Secretary of St Nicholas Church, Burton	March 2013
Kathy Doran	Chief Executive	• Trustee - Reader Organisation (Sept 2011) • Member of NIHR Advisory Board and NIHR Public Health Advisory Board • Involved with a range of voluntary sector organisations in contract with NHS Wirral	March 2013

NAME	POSITION	INTERESTS DECLARED	DATE REVIEWED
Joanne Forrest	Managing Director (Warrington)	• NIL	Left November 2013
John Gartside	Non-Executive Director (Warrington Locality Chair)	• Board Member – Big Lottery • Vice Chair - Big Lottery Fund England Committee • Magistrate – Warrington Bench (JP) • Deputy Lieutenant for Cheshire • Freeman of the Warrington Borough • Trustee and Company Secretary of the Tim Parry Jonathan Ball Foundation for Peace • Trustee of Warrington Wolves Foundation • Daughter (Lucy Gartside) is a Consultant in Organisational Development, Human Resources and Commissioning • Trustee of 'Spirit of 2012' – Olympic Legacy Fund	March 2013
Heather Grimbaldeston	Director of Public Health (Central & Eastern Cheshire)	• NIL	April 2012
Simon Holden	Director of Finance	• Chairman of Governors, Pear Tree School • Treasurer, Cheshire Centre for Independent Living • Business Mentor, Princes Trust	Left in September 2013
Fiona Johnstone	Director of Public Health (Wirral)	• Post of Director of Public Health (Wirral) is a joint appointment with Wirral Borough Council	March 2013
James Kay	Non-Executive Director (Wirral Locality Chair)	• Public Member of Wirral University Teaching Hospital NHS Foundation Trust • Productions Director of Riverside Players (Registered Charity and Community Theatre Group)	March 2013
Cathy Maddaford	Director of Nursing, Performance and Quality	• Non Foundation Council Member of Chester University • Magistrate on the West Cheshire Nech	March 2013

NAME	POSITION	INTERESTS DECLARED	DATE REVIEWED
Martin McEwan	Director of Communications and Engagement	• Wirral University Teaching Hospital NHS Foundation Trust Stakeholder Governor • Trustee (Board Member) of Greater Merseyside Connexions • Interim Director of Marketing and Communications, Alder Hey NHS Foundation Trust	March 2013
Dr Shyamal Mukherjee	Medical Director (Wirral)	• Partner of Central Park Medical Centre, Wirral • Member/Past President Rotary club of Wallasey • Trustee Reader's Organisation -Charity Voluntary Sector • Trustee Inspire - Respiratory Charity • Chair – Wirral Ethnic Health and Social Care Advisory Group • Board Member - Wirral Multicultural Organisation • Board Member/ex officio - CCG Group, Wirral • Wife (Dr A Mukherjee) is partner of Central Park Medical Centre, Wirral • Daughter (Dr R Mukherjee) is partner of Central Park Medical Centre, Wirral	March 2013
Iain Purchase	Non-Executive Director	• NIL	April 2012
Rita Robertson	Director of Public Health (Warrington)	• NIL	March 2013
Neil Ryder	Managing Director (Western Cheshire)	• Trustee – Cartrenfi (Charitable Trust)	April 2012
Dr Maureen Swanson	Medical Director (Western Cheshire)	• NIL	March2013
Julie Webster	Director of Public Health (Western Cheshire)	• Director – Cheshire and Warrington Sports Partnership • Class B Director – Leisure Community Interest Company, Cheshire West and Chester • Public Member of Cheshire and Wirral Partnership NHS Foundation Trust • Public Member of Countess of Chester Hospital NHS Foundation Trust	Left November 2012

NAME	POSITION	INTERESTS DECLARED	DATE REVIEWED
Moira Dumma	Chief Executive /Local Area Team Director	• Self appointed as Area Team Director, Cheshire Warrington and Wirral in NHS Commissioning Board	March 2013
Alison Tonge	Director of Commissioning/Local Area Team Director of Commissioning	• NIL	March 2013
Russell Favager	Director of Finance/Local Area Team Director of Finance	• NIL	January 2013
Caryn Cox	Director of Public Health, Western Cheshire	• NIL	December 2012
Phil Wadeson	Finance Director	• Nil	May 2013

Appendix 4 - Wirral PCT - Audited

Cluster arrangements came into effect from 1 June 2011. At that date a number of directors from the 4 PCTs within the Cluster took on senior roles working across the Cluster as part of the new Cluster working arrangements. NHS guidance states that the remuneration costs of these individuals can be apportioned across the individual PCTs. The CWW Cluster has decided to notionally apportion these costs equally across the 4 PCTs and the notional costs for Wirral PCT are set out in the table below. The full costs to the CWW Cluster are also provided within the following tables.

Salaries & Allowances for Senior Employees of NHS Cheshire, Wirral & Warrington (from 1st April 2012 - 31st March 2013)

The comparative remuneration costs for 2011/12 relate to the 10 months from the start of Cluster arrangements. The amounts for the two month period prior to the Cluster formation are on the final page. The PCTs responsible for paying individual directors remuneration are highlighted in the notes at the foot of the tables.

	2012/13				2011/12		
Name & Title	**Salary (bands of £5,000)**	**Other Remuneration (bands of £5,000)** 9	**Bonus Payments (bands of £5,000)**	**Benefits in Kind (to nearest £100)**	Salary (bands of £5,000)	Other Remuneration (bands of £5,000	Benefits in Kind (to nearest £100)
Cluster Staff (Notional Apportionment)							
Primary Care Trust Cluster Board							
Moira Dumma - Chief Executive 6 Commenced October 1st 2012	0	0	0	0	0	0	0
Russell Favager- Director of Finance 6 Commenced January 14th 2013	0	0	0	0	0	0	0
Phil Wadeson- Director of Finance 5 Commenced September 1st 2012 – Ceased January 11th 2013	5-10	0	0	0	0	0	0
Cathy Maddaford - Director of Nursing Quality & Performance 3	20-25	45-50	0	7	20-25	0	5
Michelle Chadwick - Director of Human Resources & Organisational Development 4	25-30	0	0	6	15-20	0	0
Martin McEwan - Director of Communications & Engagement (non voting) 1	20-25	5-10	0	12	15-20	0	9
Kathy Doran - Chief Executive 1 Ceased October 1st 2012	15-20	15-20	0	8	30-35	0	6
Simon Holden - Director of Finance 2 Ceased August 31st 2012	10-15	0	0	0	20-25	0	0
Cathy Gritzner - Director of Commissioning Development 1 Ceased March 31st 2012	0	0	0	0	20-25	0	1
Joanne Forrest - Director of Commissioning Development- Commenced April 1st 2012 – Ceased November 30th 2012 3/4	15-20 4	55-60 3	0	0	0	0	0
Alison Tonge - Director of Commissioning Development- Commenced November 1st 2012 6	0	0	0	0	0	0	0
Neil Ryder – Chief Operating Officer – Cheshire and Merseyside Commissioning Support Unit/ MD W Cheshire PCT 3	25-30	0	0	8	15-20	0	7

Medical Directors (One shared vote)

Bill Forsyth - Medical Director - Central & Eastern Cheshire PCT Ceased May 31st 2012 [2]	0-5	0	0	0	20-25	0	0
Maureen Swanson - Medical Director – Warrington PCT & Western Cheshire PCT [3/4]	25-30	55-60	0	0	20-25	0	0
Shyamal Mukherjee - Medical Director - Wirral PCT [1]	5-10	5-10	0	0	5-10	0	0

Non Executives

Kathy Cowell - Chair [2]	10-15	0	0	0	5-10	0	0
Melinda Acutt - Non Executive Director (until 30 January 2012) [1]	0	0	0	0	0-5	0	0
Fareth Arshad - Non Executive Director [4]	0-5	0	0	0	0-5	0	0
Sheryl Bailey - Non Executive Director [3]	0-5	0	0	0	0-5	0	0
John Gartside - Non Executive Director [4]	5-10	0	0	0	5-10	0	0
James Kay - Non Executive Director [1]	5-10	0	0	0	5-10	0	0
Iain Purchase - Non Executive Director [2]	0-5	0	0	0	0-5	0	0
John Church - Non Executive Director [3]	5-10	0	0	0	5-10	0	0

Other Primary Care Trust Senior Staff (Full Costs)

Director of Public Health (One shared vote)

Fiona Johnstone - Director of Public Health - Wirral PCT [1]	85-90	0	0	57	75 - 80	0	48

Cluster Board – Remuneration in Full

Name & Title	2012/13 Salary (bands of £5,000) £000	2012/13 Other Remuneration (bands of £5,000) [9] £000	2012/13 Bonus Payments (bands of £5,000) £000	2012/13 Benefits in Kind (rounded to nearest £00) £00	2011/12 Salary (bands of £5,000) £000	2011/12 Other Remuneration (bands of £5,000) £000	2011/12 Benefits in Kind (rounded to nearest £00) £00
Primary Care Trust Cluster Board (Remuneration in full)							
Kathy Doran - Chief Executive [1] Ceased October 1st 2012	70-75	70-75	0	30	125 - 130	0	24
Simon Holden - Director of Finance [2] Ceased September 1st 2012	45 - 50	0	0	0	95 - 100	0	0
Joanne Forrest - Director of Commissioning Development Ceased November 30th 2012 [3/4]	65-70 [4]	220-225 [3]	0	0	0	0	0
Cathy Maddaford - Director of Nursing Quality & Performance [3]	95 - 100	190-195	0	28	80 - 85	0	21
Michelle Chadwick - Director of Human Resources & Organisational Development [4]	105-110	0	0	25	70 - 75	0	0
Martin McEwan - Director of Communications & Engagement (non voting) [1]	80 - 85	25-30	0	46	65 - 70	0	35
Neil Ryder – Chief Operating Officer – Cheshire and Merseyside Commissioning Support Unit/ Managing Director Western Cheshire PCT [3]	100-105	0	0	31	65-70	0-5	28
Phil Wadeson - Director of Finance Appointed September 1st 2012 to January 11th 2013 [5]	25-30	0	0	0	0	0	0
Medical Directors (One shared vote)							
Bill Forsyth - Medical Director - Central & Eastern Cheshire PCT [2]	15-20	0	0	0	85-90	0	0
Maureen Swanson - Medical Director - Warrington PCT & Western Cheshire PCT [3/4]	115-120	225-230	0	0	95-100	0	0
Shyamal Mukherjee - Medical Director - Wirral PCT [1]	25 - 30	20-25	0	0	20 - 25	0	0

Non-Executive Directors

Kathy Cowell - Chair [2]	40 - 45	0	0	0	35 - 40	0	0
Melinda Acutt - Non Executive Director (until 30th January 2012) [1]	0	0	0	0	5 - 10	0	0
Fareth Arshad - Non Executive Director [4]	5 - 10	0	0	0	5 - 10	0	0
Sheryl Bailey - Non Executive Director [3]	10 - 15	0	0	0	10 - 15	0	0
John Gartside - Non Executive Director [4]	30 - 35	0	0	0	25 - 30	0	0
James Kay - Non Executive Director [1]	35 - 40	0	0	0	30 - 35	0	0
Iain Purchase - Non Executive Director [2]	5 -10	0	0	0	5 - 10	0	0
John Church - Non Executive Director [3]	30 - 35	0	0	0	25 - 30	0	0

Pension Benefits for Senior Employees at NHS Cheshire, Wirral & Warrington 2012/13

Name	Real increase (decrease) in pension at 60 (bands of £2,500) £000	Real increase (decrease) in pension lump sum at 60 (bands of £2,500) £000	Total accrued pension at 60 as 31/03/2013 (bands of £5,000) £000	Lump sum at 60 to accrued pension at 31/03/13 (bands of £5,000) £000	Cash Equivalent Transfer Value as at 31/03/2013 £000	Cash Equivalent Transfer Value as at 31/03/2012 £000	Real increase (decrease) in Cash Equivalent Transfer Value £000
Primary Care Trust Cluster Board							
Kathy Doran - Chief Executive 1/10	(2.5 – 0)	2.5 – 5.0	55 - 60	165 - 170	0	1,068	0
Simon Holden - Director of Finance 2	5 - 7.5	17.5 - 20	45 - 50	140 - 145	786	637	117
Joanne Forrest - Director of Commissioning Development to November 30th 2012 3/4/10	(2.5 – 0)	(5.0 – 2.5)	35-40	115 - 120	0	730	0
Cathy Maddaford - Director of Nursing Quality & Performance 3	0 - 2.5	0 – 2.5	40 - 45	120 - 125	0	0	0
Michelle Chadwick - Director of Human Resources & Organisational Development 4	0 – 2.5	0- 2.5	5 - 10	20 - 25	136	96	35
Martin McEwan - Director of Communications & Engagement (non-voting) 1	0 - 2.5	0	5 - 10	0	66	48	11
Medical Directors (One shared vote)							
Bill Forsyth - Medical Director - Central & Eastern Cheshire PCT 2/10	0 – 2.5	2.5 – 5.0	70 - 75	210 - 215	0	1,546	0
Maureen Swanson - Medical Director - Warrington PCT & Western Cheshire PCT 3/10/11	(2.5 - 0)	(7.5 - 5)	60 - 65	180 - 185	0	711	0
Shyamal Mukherjee - Medical Director - Wirral PCT 1/7	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Directors of Public Health (One vote)							
Fiona Johnstone - Director of Public Health - Wirral PCT 1	0 – 2.5	0 – 2.5	15 -20	55 - 60	344	315	13
Other Senior Officers							
Neil Ryder – Chief Operating Officer – Cheshire and Merseyside Commissioning Support Unit / Managing Director Western Cheshire PCT 3	0 - 5	10-15	30-35	90-95	519	401	97

Notes

1 - Indicates staff employed in a role in the PCT Cluster but are ultimately employed and paid by Wirral PCT
2 - Indicates staff employed in a role in the PCT Cluster but are ultimately employed and paid by Central & Eastern Cheshire PCT
3 - Indicates staff employed in a role in the PCT Cluster but are ultimately employed and paid by Western Cheshire PCT
4 - Indicates staff employed in a role in the PCT Cluster but are ultimately employed and paid by Warrington PCT
5- Indicates a member of staff employed in a role in the PCT Cluster but ultimately employed and paid by Liverpool PCT
6 - Indicates staff employed in a role in the PCT Cluster but are ultimately employed and paid by NHS bodies outside the local NHS community at no cost to the Cluster. Russell Favager and Alison Tonge were remunerated by NHSCB and Moira Dumma was remunerated by NHS South Birmingham.
7 - Not a member of the NHS Pension Scheme.
8 - Non-Executive Directors do not receive pensionable remuneration at the Cluster and no pension benefits accrue to the positions they hold.
9 - Other remuneration amounts include exit packages for Cluster Board Directors.
10.The Cash Equivalent Transfer Values (CETV) at 31st March 2013 are nil for these directors due to the fact that they are in receipt of pension benefits during 2012/13
11. The opening CETV value at 31st March 2012 for M Swanson has been altered from £1,357 due to receipts of pension benefits in 2012/13

The above roles within the PCT Cluster are considered to be split equally between each of the PCTs.
In the interest of reducing bureaucracy and limiting the complexity and volume of these transactions, the PCT Cluster has agreed not to recharge the notional costs between respective organisations. However Western Cheshire PCT has recharged the full salary of Joanne Forrest and a portion of the salary of Maureen Swanson (35-40 band) to Warrington PCT. A portion of the salary of Julie Webster (30-35 band) has also been recharged to Wirral PCT.

The roles of those within the emerging clinical commissioning groups have not been included within the disclosures for 2012/13. These roles do not meet the NHS reporting requirements as having responsibility for directing or controlling the major activities of this NHS body.

Wirral Primary Care Trust Pay Multiples

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

The banded remuneration of the highest paid director in Wirral PCT in the financial year 2012/13 was £149,652 (2011/12 £148,296). This was 4.35 times the median remuneration of the work force which was £34,411 (2011/12 – 4.55 times and £32,568)

In 2012/13, 5 employees received remuneration in excess of the highest-paid director (2011/12 – 6)

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include employer pension contributions and the cash equivalent transfer value of pensions. Salaries used in the calculations were annualised.

The table on the following page relates to senior managers for the two months prior to the formation of Cluster arrangements on 1st June 2011 and are for 2011/12 comparative purposes only.

Salaries & Allowances for Senior Employees of Wirral PCT (from 1st April 2011 - 31st May 2011)

This table shows the remuneration costs attributable to the PCT up to the date of the start of Cluster arrangements

	2011/12				2010/11			
Name & Title	**Salary (bands of £5,000)**	**Perforance Related Bonus (bands of £5,000)**	**Other Remuneration (bands of £5,000**	**Benefits in Kind (rounded to nearest £00)**	Salary (bands of £5,000)	Perforance Related Bonus (bands of £5,000)	Other Remuneration (bands of £5,000	Benefits in Kind (rounded to nearest £00)
Wirral PCT staff who work in roles in the PCT Cluster								
Kathy Doran - Chief Executive	20 - 25	0	0	4.9	130 - 135	0 - 5	0	2.9
Cathy Gritzner - Director of Commissioning Development	10 - 15	0	0	0	85 -90	0 - 5	0	0
Martin McEwan - Director of Communications & Engagement	10 - 15	0	0	7	75 - 80	0 - 5	0	4.2
Dr Shyamal Mukherjee - Medical Director	0 - 5	0	0	0	55 - 60	0	0	0
Fiona Johnstone - Joint Director of Public Health	10 - 15	0	0	4.9	45 -50	0	0	0
Melinda Acutt - Non Executive Director	0 - 5	0	0	0	5 -10	0	0	0
James Kay - Non Executive Director	5 - 10	0	0	0	20 - 25	0	0	0
Dr Philip Jennings - Wirral Health Commissioning Consortia	10 - 15	0	0	0	10 - 15	0	0	0
Dr Peter Naylor - Wirral Health Commissioning Consortia	5 - 10	0	0	0	10 - 15	0	0	0
Wirral PCT staff								
Alan Howgate - Director of Finance	15 - 20	0	0	0	30 -35	0	0	0.5
Dr Abinandan Mantgani - Medical Director	5 - 10	0	0	0	50 - 55	0	0 - 5	0
Dr Shanila Roohi - Medical Director	5 - 10	0	0	0	55 - 60	0	0	0
Michael Roach - Audit Committee Member	0 - 5	0	0	0	10 - 15	0	0	0
Phillip Davies - Remuneration Committee Member	0 - 5	0	0	0	5 -10	0	0	0
John Callcott - Audit Committee Member	0 - 5	0	0	0	5 -10	0	0	0
Dr Andrew Lee - PEC Member	0	0	0	0	10 - 15	0	0	0
Frances Street - Chairman (left 31 December 2010)	0	0	0	0	15 - 20	0	0	0
Russell Favager - Director of Finance (left 26 November 2010)	0	0	0	0	65 - 70	0 - 5	0	1.8
John South - Director of Primary Care & Provider Services (left 31 January 2011)	0	0	0	0	65 - 70	0	0	2.2
Marie Armitage - Joint Director of Public Health (left 31 August 2010)	0	0	0	0	35 - 40	0 - 5	0	0
Marianne O'Hanlon - Acting Director of Human Resources (left 5 April 2010)	0	0	0	0	0 - 5	0 - 5	0	0
Tina Long - Director of Strategic Partnerships (left 17 September 2010)	0	0	0	0	35 - 40	0 - 5	0	0.7
Garry Gray (left 31 December 2010)	0	0	0	0	5 - 10	0	0	0
Christine Allen (left 31 December 2010)	0	0	0	0	5 - 10	0	0	0
Margaret Johnson (left 31 January 2011)	0	0	0	0	10 - 15	0	45 - 50	0

APPENDIX 5 - Sustainability Report

What is your Trust identification code? 5NK

What is your Trust name? Wirral PCT

What was your total expenditure on energy in each of the last five financial years?

	2008/09	2009/10	2010/11	2011/12	2012/13	% Reduction	£ Reduction	Hip Operations
Energy Cost £	645,778	805,282	657,994	78,353	103,665	-32	25,312	4
					32%		25312	

What is the NPV of the savings expected as as a result of your plans to change your organisation to make it more sustainable. What length of time does this assessment cover?

NPV

Time period

Nurses: 0

What weight of the waste you generate is recycled, and what does this represent as a proportion of total waste?

	2012/13	Proportion	Percentage
Total Waste	3.75		
Recycled waste	2.44	0.650666667	65

What was your total consumption of energy in each of the last five years (MWh), what was your floor area (in order to calculate energy intensity), what proportion of your energy comes form renewable sources and how much of your energy is generated on site?

	2008/09	2009/10	2010/11	2011/12	2012/13
Oil	154.7	154.7	2.1	0	0
Gas	10182.5	9521.9	7923.6	509.9	937
Coal					
Renewables					
Other					
Electricity				679.5	825.4
TOTAL	10337.2	9676.6	7925.7	1189.4	1762.4

0

Risen/Fallen: risen

	2011/12	2012/13
Floor Area (m2)	7,350	7,350
	0.16	0.24

Proportion of Energy Generated on site: 0.34

In addition, we generate 0.34% of our energy on site

Is the tariff which you pay for electricity a "green" or "renewable" tariff?

What was your Operating Expenditure (per the financial statements) in the last 2 financial years?

2011/12	2012/13
639,519,000	663,106,000

Energy as a proportion of costs

2011/12	2012/13
0.01	0.02

What were your gross scope 1-3 carbon emissions over the last 5 years, and how were they constituted?

	UNIT		2008/09	2009/10	2010/11	2011/12	2012/13
Emissions as a result of Electricity Consumption	kWh	Electricity	15468414	2145.177	1793.112	356.5	433
Emissions as a result of Gas Consumption	kWh	Gas	1869.507	1748.229	1454.775	93.6	172
Emissions as a result of Business Travel - Air	km	Air			0.553		
Emissions as a result of Business Travel - Road	miles	Road			645.98		
Emissions as a result of Business Travel - Rail	miles	Rail					
Emissions as a result of Other activities	tonnes Co2	Other					

CONVERSION FACTORS

2008/09	2009/10	2010/11	2011/12	2012/13
0.60815	0.59668	0.58982	0.58982	0.58982
0.20435	0.20435	0.20435	0.20435	0.20435
0.20124	0.20124	0.20124	0.20124	0.20124
0.37604	0.37604	0.37604	0.37604	0.37604
0.06715	0.06715	0.06715	0.06715	0.06715

2008/09	2009/10	2010/11	2011/12	2012/13	INCLUSION
9407116	1279.984	1057.613	210.2708	255.3921	45.1212
382.0338	357.2506	297.2833	19.12716	35.1482	16.021
0	0	0.111286	0	0	0
0	0	242.9143	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0

Change in Emissions 61.1423 increased 61.1423

Scope 3 0

If you gather data on your Other (Scope 3) emissions, please enter details as to what this assessment includes in the form of the sentence

"Our Other emissions value includes healthcare purchased from non NHS organisations, emissions arising from water and waste use, purchased pharaceuticals and medical instruments, staff, patient and visitor travel."

What was your water consumption in m3 in the last 4 financial years?

	2008/09	2009/10	2010/11	2011/12	2012/13	Gross reduction		
Water consumption	22,985	22347	16349	8273	1398.2	-6876.8	reduced	6876.8

What was your total expenditure on water in the last financial year? £2,980

What was your gross expenditure on the CRC Energy Efficiency Scheme in 2012/13? £0 Incomplete

What was your expenditure on official business travel in 2012/13? £240,199 Complete

What was your expenditure on waste disposal in the following categories:

	2011/12	2012/13
Total Waste arising		
Waste sent to landfill	2040	587
Waste recycled/reused	4334	1247
Waste incinerated/energy from waste	2510	722

If you have consumed finite resources, and in in doing so incurred material expenditure, then please complete the following boxes

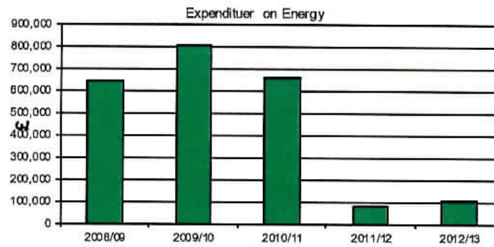
Expenditure	
Nature of resource	

	Yes/No	
Has your Board approved a Sustainable Development Management Plan in the last 12 months?	No	1
Has your board approved plans which address the potential need to adapt the organisation's activities (models of care) as a result of climate change?	Yes	2
Has your board approved plans which address the potential need to adapt the organisation's buildings or estates as a result of climate change?	Yes	3
Does your board consider sustainability issues as part of its risk management process?	Yes	4
Have you developed policies on sustainable procurement?	Yes	5
Have you begun to calculate carbon emissions related to procurement of goods and services?		
Is there a Board Level lead for Sustainability on your Board?	Yes	6
If Yes - What is their name?	Alan Howgate	
Are sustainability issues, such as carbon reduction, included in the job descriptions of all staff?	No	7
When was your last staff energy awareness campaign? (10th October)	2010	8
If it is an ongoing process please enter yes into the orange box on this line	No	
If you have not conducted an energy awareness campaign, please enter No into the box on this line		
Do you have a Sustainable Transport Plan?	Yes	9

If you have used estimation, please indicate what quarters this estimation applies to:

Q1	Yes
Q2	Yes
Q3	Yes
Q4	Yes

-32%



The NHS aims to reduce its carbon footprint by 10% between 2009 and 2015. Reducing the amount of energy used in our organisation contributes to this goal

There is also a financial benefit which comes from reducing our energy bill.

Our energy costs have increased by 32% in 2012/13, the equivalent of 4 hip operations.

£0,000

We have not yet quantified our plans to reduce carbon emissions and improve our environmental sustainability

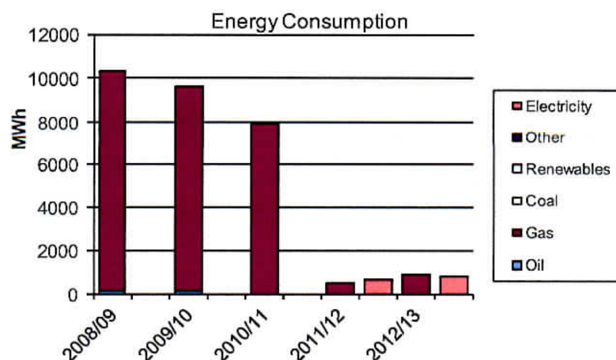
2 tonnes

Percentage of Waste Recycled

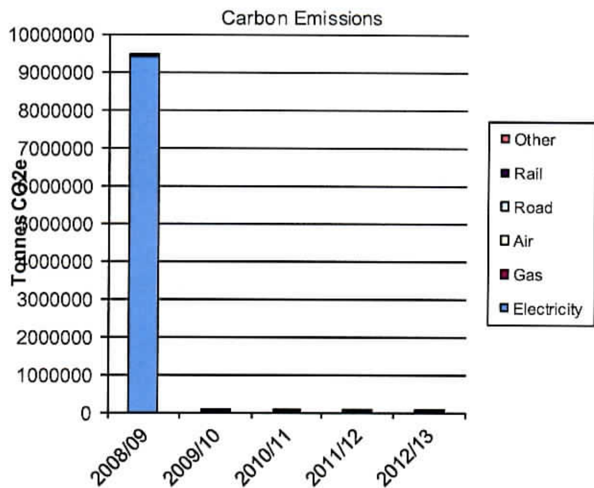
We recover or recycle 2.44 tonnes of waste, which is 65% of the total waste we produce.

Our total energy consumption has risen during the year, from 1,189 to 1,762 MWh

Our relative energy consumption has changed during the year, from 0.16 to 0.24 MWh/square metre.

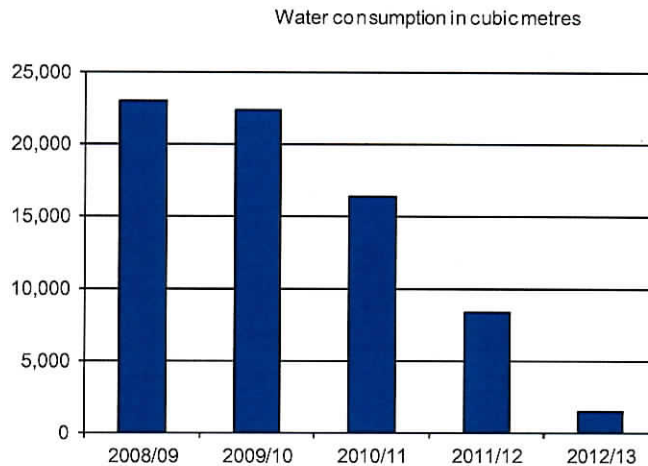


Renewable energy represents 0.0% of our total energy use. In addition, we generate 0.34% of our energy on site We have not made arrangements to purchase electricity generated from renewable sources



Our measured greenhouse gas emissions have increased by 0,061 tonnes this year.

0



Our water consumption has reduced by 6,877 cubic meters in the recent financial year.

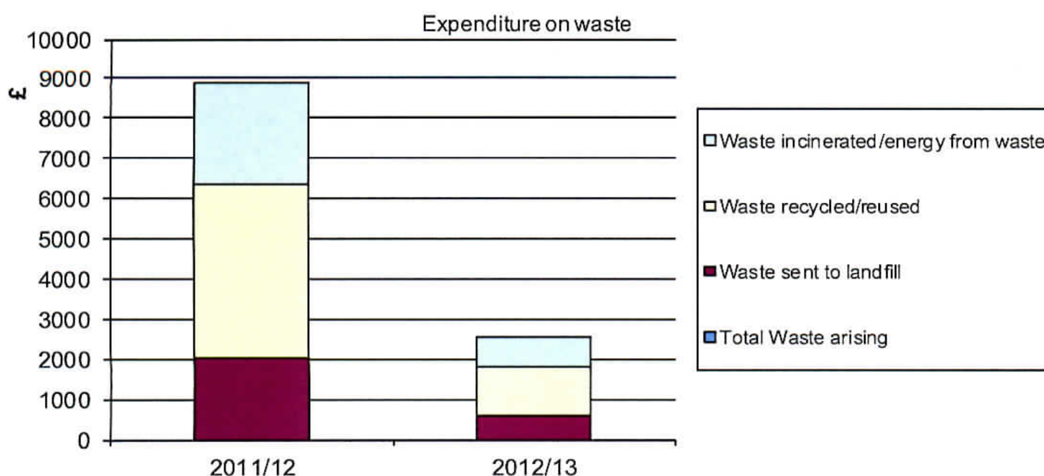
In 2012/13 we spent £2,980 on water.

During 2012/13 our gross expenditure on the CRC Energy Efficiency Scheme was £0

The CRC Energy Efficiency Scheme is a mandatory scheme aimed at improving energy efficiency and cutting emissions in large public and private sector organisations.

During 2012/13 our total expenditure on business travel was £240,199.

Our expenditure on waste in the last two years was incurred as follows:



Our organisation has an up to date Sustainable Development Management Plan. Having an up to date Sustainable Development Management plan is a good way to ensure that an NHS organisation fulfils its commitment to conducting all aspects of its activities with due consideration to sustainability, whilst providing high quality patient care. The NHS Carbon Reduction Strategy asks for the boards of all NHS organisations to approve such a plan.

We consider neither the potential need to adapt the organisation's activities nor its buildings and estates as a result of climate change.

Adaptation to climate change will pose a challenge to both service delivery and infrastructure in the future. It is therefore appropriate that we consider it when planning how we will best serve patients in the future.

Sustainability issues are not included in our analysis of risks facing our organisation. NHS organisations have a statutory duty to assess the risks posed by climate change. Risk assessment, including the quantification and prioritisation of risk, is an important part of managing complex organisations.

We plan to start work on calculating the carbon emissions associated goods and services we procure. In addition to our focus on carbon, we are also committed to reducing wider environmental and social impacts associated with the procurement of goods and services. This will be set out within our policies on sustainable procurement.

There is no Board Level lead for Sustainability. A Board Level lead for Sustainability ensures that sustainability issues have visibility and ownership at the highest level of the organisation.

Sustainability issues, such as carbon reduction, are not currently included in the job descriptions of all staff. Our last staff awareness campaign was conducted on the 1st May 2011. "A sustainable NHS can only be delivered through the efforts of all staff". Staff awareness campaigns have been shown to deliver cost savings and associated reductions in carbon emissions.

Our organisation does not have a Sustainable Transport Plan. The NHS places a substantial burden on the transport infrastructure, whether through patient, clinician or other business activity. This generates an impact on air quality and greenhouse gas emissions. It is therefore important that we consider what steps are appropriate to reduce or change travel patterns.

Appendix 6 - Off-payroll engagements

Table 1: For off-payroll engagements at a cost of over £58,200 per annum that were in place as of 31st January 2012

	NHS Wirral
No. In place on 31st January 2012	2
Of which:	
No. that have since come onto the Organisation's payroll	0
Of which:	
No. that have since been re-negotiated/re-engaged to include to include contractual clauses allowing the (department) to seek assurance as to their tax obligations	0
No. that have not been successfully re-negotiated, and therefore continue without contractual clauses allowing the (department) to seek assurance as to their tax obligations	0
No that have come to an end	2
Total at 31st March 2013	0

Table 2: For all new off-payroll engagements between 23rd August 2012 and 31st March 2013, for more than £220 per day and more than 6 months

	NHS Wirral
No. of new engagements	1
Of which:	
No. of new engagements which include contractual clauses giving the department the right to request assurance in relation to income tax and National Insurance obligations	0
Of which:	
No. for whom assurance has been accepted and received	0
No. for whom assurance has been accepted and not received	0
No. that have been terminated as a result of assurance not being received	0
Total at 31st March 2013	1

Wirral Primary Care Trust

2012-13 Accounts

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Wirral Primary Care Trust

2012-13 Accounts

Department of Health

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: MOIRA DUNN

Date 3.6.2013

Department
of Health

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

3.6.2013 Date .... Signing Officer

3/6/13 Date .... Finance Signing Officer

Grant Thornton

INDEPENDENT AUDITOR'S REPORT TO THE DEPARTMENT OF HEALTH'S ACCOUNTING OFFICER IN RESPECT OF WIRRAL PRIMARY CARE TRUST

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

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

- the table of salaries and allowances of senior managers and related narrative notes on pages 39 to 42;
- the table of pension benefits of senior managers and related narrative notes on pages 43 to 44; and
- the disclosure of pay multiples and related narrative notes on pages 45 to 46.

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

Respective responsibilities of the signing officer, finance signing officer and auditor

As explained more fully in the Statement of Responsibilities, 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 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 Wirral Primary Care Trust as at 31 March 2013 and of its net operating costs for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters

In our opinion:

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

Matters on which we report by exception

We report to you if:

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

We have nothing to report in these respects.

Other matters on which we are required to conclude

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are also required by the Audit Commission's Code of Audit Practice to report any matters that prevent us being satisfied that the audited body has put in place such arrangements.

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

- our review of the annual governance statement;
- the work of other relevant regulatory bodies or inspectorates, to the extent the results of the work have an impact on our responsibilities; and
- our locally determined risk-based work on the transition arrangements for the demising Primary Care 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 financial statements of Wirral 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.

Robin Baker
Senior Statutory Auditor, for and on behalf of Grant Thornton UK LLP
Royal Liver Building
Liverpool
L3 1PS

7 June 2013

Statement of Comprehensive Net Expenditure for year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure			
Gross employee benefits	7.1	**13,445**	13,240
Other costs	5.1	**667,585**	626,277
Income	4	**(18,551)**	(20,293)
Net operating costs before interest		**662,479**	619,224
Investment income	9	**0**	0
Other (Gains)/Losses	10	**39**	0
Finance costs	11	**0**	3
Net operating costs for the financial year		**662,518**	619,227
Transfers by absorption -(gains)		**0**	0
Transfers by absorption - losses		**0**	0
Net (gain)/loss on transfers by absorption		**0**	0
Net Operating Costs for the Financial Year including absorption transfers		**662,518**	**619,227**
Of which:			
Administration Costs			
Gross employee benefits	7.1	**9,513**	9,803
Other costs	5.1	**8,662**	9,270
Income	4	**(1,752)**	(3,086)
Net administration costs before interest		**16,423**	**15,987**
Investment income	9	**0**	0
Other (Gains)/Losses	10	**39**	0
Finance costs	11	**0**	0
Net administration costs for the financial year		**16,462**	**15,987**
Programme Expenditure			
Gross employee benefits	7.1	**3,932**	3,437
Other costs	5.1	**658,923**	617,007
Income	4	**(16,799)**	(17,207)
Net programme expenditure before interest		**646,056**	**603,237**
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**0**	3
Net programme expenditure for the financial year		**646,056**	**603,240**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**82**	0
Net (gain) on revaluation of property, plant & equipment	**0**	0
Net (gain) on revaluation of intangibles	**0**	0
Net (gain) on revaluation of financial assets	**0**	0
Net (gain)/loss on other reserves	**0**	0
Net (gain)/loss on available for sale financial assets	**0**	0
Net (gain) /loss on Assets Held for Sale	**0**	0
Release of Reserves to Statement of Comprehensive Net Expenditure	**0**	0
Net actuarial (gain)/loss on pension schemes	**0**	0
Reclassification Adjustments		
Reclassification adjustment on disposal of available for sale financial assets	**0**	0
Total comprehensive net expenditure for the year	**662,600**	**619,227**

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	**34,721**	33,618
Intangible assets	13	**61**	76
Other financial assets	20	**0**	0
Trade and other receivables	18	**0**	0
Total non-current assets		**34,782**	33,694
Current assets:			
Inventories	17	**0**	0
Trade and other receivables	18	**4,810**	8,308
Other financial assets	20	**0**	0
Other current assets	21	**0**	0
Cash and cash equivalents	22	**0**	1
Total current assets		**4,810**	8,309
Non-current assets held for sale	23	**0**	0
Total current assets		**4,810**	8,309
Total assets		**39,592**	42,003
Current liabilities			
Trade and other payables	24	**(32,738)**	(34,616)
Other liabilities	25	**0**	0
Provisions	30	**(2,526)**	(1,084)
Borrowings	26	**0**	0
Other financial liabilities	27	**0**	0
Total current liabilities		**(35,264)**	(35,700)
Non-current assets plus/less net current assets/liabilities		**4,328**	6,303
Non-current liabilities			
Trade and other payables	24	0	0
Other Liabilities	25	0	0
Provisions	30	0	0
Borrowings	26	0	0
Other financial liabilities	27	0	0
Total non-current liabilities		**0**	0
Total Assets Employed:		**4,328**	6,303
Financed by taxpayers' equity:			
General fund		(1,707)	(1,861)
Revaluation reserve		6,035	8,164
Other reserves		0	0
Total taxpayers' equity:		**4,328**	6,303

The notes on pages 5 to 36 form part of this account.

The financial statements on pages 1 to 36 were approved by the Audit Sub Committee of the Department of Health on and signed on its behalf by

Designated Signing Officer: Date: 3.6.2013

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	**(1,861)**	**8,164**	**0**	**6,303**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(662,518)			**(662,518)**
Net gain on revaluation of property, plant, equipment		0		**0**
Net gain on revaluation of intangible assets		0		**0**
Net gain on revaluation of financial assets		0		**0**
Net gain on revaluation of assets held for sale		0		**0**
Impairments and reversals		(82)		**(82)**
Movements in other reserves			0	**0**
Transfers between reserves	2,047	(2,047)		**0**
Release of Reserves to Statement of Comprehensive Net Expenditure		0		**0**
Reclassification Adjustments				
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0		**0**
Net actuarial gain/(loss) on pensions	0		0	**0**
Total recognised income and expense for 2012-13	**(660,471)**	**(2,129)**	**0**	**(662,600)**
Net Parliamentary funding	660,625			**660,625**
Balance at 31 March 2013	**(1,707)**	**6,035**	**0**	**4,328**
Balance at 1 April 2011	**(12,148)**	**8,164**	**0**	**(3,984)**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(619,227)			(619,227)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment		0		0
Net Gain / (loss) on Revaluation of Intangible Assets		0		0
Net Gain / (loss) on Revaluation of Financial Assets		0		0
Net Gain / (loss) on Assets Held for Sale		0		0
Impairments and Reversals		0		0
Movements in other reserves			0	0
Transfers between reserves*	0	0		0
Release of Reserves to Statement of Comprehensive Net Expenditure		0		0
Reclassification Adjustments				
Transfers to/(from) Other Bodies within the Resource Account Boundary	463	0	0	463
On disposal of available for sale financial assets	0	0	0	0
Net actuarial gain/(loss) on pensions	0		0	0
Total recognised income and expense for 2011-12	(618,764)	0	0	(618,764)
Net Parliamentary funding	629,051			629,051
Balance at 31 March 2012	**(1,861)**	**8,164**	**0**	**6,303**

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	**(662,479)**	(619,224)
Depreciation and Amortisation	**887**	2,601
Impairments and Reversals	**2,893**	0
Other Gains / (Losses) on foreign exchange	**0**	0
Donated Assets received credited to revenue but non-cash	**0**	0
Government Granted Assets received credited to revenue but non-cash	**0**	0
Interest Paid	**0**	(3)
Release of PFI/deferred credit	**0**	0
(Increase)/Decrease in Inventories	**0**	88
(Increase)/Decrease in Trade and Other Receivables	**2,370**	(2,323)
(Increase)/Decrease in Other Current Assets	**0**	0
Increase/(Decrease) in Trade and Other Payables	**(1,232)**	(730)
(Increase)/Decrease in Other Current Liabilities	**0**	0
Provisions Utilised	**(1,084)**	(750)
Increase/(Decrease) in Provisions	**2,526**	666
Net Cash Inflow/(Outflow) from Operating Activities	**(656,119)**	(619,675)
Cash flows from investing activities		
Interest Received	**0**	0
(Payments) for Property, Plant and Equipment	**(8,020)**	(16,140)
(Payments) for Intangible Assets	**0**	(16)
(Payments) for Other Financial Assets	**0**	0
(Payments) for Financial Assets (LIFT)	**0**	0
Proceeds of disposal of assets held for sale (PPE)	**0**	0
Proceeds of disposal of assets held for sale (Intangible)	**0**	0
Proceeds from Disposal of Other Financial Assets	**0**	0
Proceeds from the disposal of Financial Assets (LIFT)	**0**	0
Loans Made in Respect of LIFT	**0**	0
Loans Repaid in Respect of LIFT	**0**	0
Rental Revenue	**0**	0
Net Cash Inflow/(Outflow) from Investing Activities	**(8,020)**	**(16,156)**
Net cash inflow/(outflow) before financing	**(664,139)**	**(635,831)**
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**0**	(32)
Net Parliamentary Funding	**660,625**	629,051
Capital Receipts Surrendered	**0**	0
Capital grants and other capital receipts	**3,513**	6,810
Cash Transferred (to)/from Other NHS Bodies (free text note required)	**0**	0
Net Cash Inflow/(Outflow) from Financing Activities	**664,138**	**635,829**
Net increase/(decrease) in cash and cash equivalents	**(1)**	**(2)**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**1**	**3**
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies	**0**	0
Cash and Cash Equivalents (and Bank Overdraft) at year end	**0**	**1**

1. Accounting policies

As a consequence of the Health and Social Care Act 2012, Wirral Primary Care Trust was dissolved on 31 March 2013. Its functions were transferred to various new or exisitng 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 Wirral Primary Care Trust have prepared these financial statements on a going concern basis.

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

The Secretary of State for Health has directed that the financial statements of 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.

For 2011/12 and 2012/13, in accordance with the directed accounting policy from the Secretary of State, the PCT does not consolidate the NHS charitable funds for which it is the corporate trustee.

1.1 Accounting Conventions

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

Transforming Community Services (TCS) transactions

Under the TCS initiative, services historically provided by the PCT transferred to Wirral Community NHS Trust in 2011-12 and were accounted for under merger accounting. For 2012-13 such transfers fall to be accounted for by use of absorption accounting in line with the Treasury FReM. However, the FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCNE, and is disclosed separately from operating costs.

Acquisitions and Discontinued Operations

Activities are considered to be 'acquired' only if they are acquired from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one NHS body to another. During 2012-13 no activities are deemed to have discontinued.

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

Wirral PCT did not make any critical judgements in 2012/13, apart from those involving estimations (see below) that management has made in the process of applying the entity's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

1. Accounting policies (continued)

PPE and Valuations

The PCT has a full revaluation exercise done every five years. During the intervening years a desktop valuation is carried out. All valuations are performed by a senior officer of the District Valuation Office, using recognised measurement techniques and based on professional expertise.

Since valuations are compiled by an expert using recognised measurement techniques and based on professional guidance, the underlying data is considered to be reliable and the scope to use judgement and change assumptions limited. As such, the degree of estimation uncertainty is not considered to be high.

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

Provisions

Provisions are made when an event has taken place that gives the PCT a legal or constructive obligation that probably requires settlement, and a reliable estimate can be made of the amount of the obligation.

Continuing Health Care (CHC) restitution claims have been subject to a closing deadline for claims prior to 31st March 2012. This has resulted in a large number of claims that have not been finalised or agreed for settlement as at 31st March 2013. The amount contained in these accounts as a provision has been subject to the estimation of a specialist team based on experience of prior claim settlements. £2.495m was provided at 31st March 2013 for settlement of these claims.

1.2 Revenue and Funding

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

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

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

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

1.3 Pooled budgets

The PCT had previously entered into a pooled budget with Wirral Metropolitan Borough Council, under the arrangement the funds were pooled under S75 of the NHS Act 2006 for Community Equipment activities. This pool ended on 31st March 2011.

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 arrrangements 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.

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 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)

1.9 Donated assets
The PCT does not hold any Donated Assets.

1.10 Government grants
The PCT does not hold any Government Granted Assets.

1.11 Non-current assets held for sale
The PCT does not have any Non-current assets held for sale.

1.12 Inventories
Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula.

1.13 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.

1.14 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).

1.15 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 30.

1. Accounting policies (continued)

1.16 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.

However, due to the demise of the PCT at 31 March 2013 all employees are expected to use all leave entitlement in the year and there will be no accrual for leave earned not taken.

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.

1.17 Research and Development

The PCT has not incurred any expenditure on research and development during the year (2011/12: £0).

1.18 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.

1.19 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.

1.20 EU Emissions Trading Scheme

The PCT is not a participant in the trading scheme.

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.

1.23 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 minus 1.8% for short term (0-5 years), minus 1% for medium term (6-10 years) and 2.2% for long term provisions (over 10 years). The rate applicable for post employment benefits is 2.35%.

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

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

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

1. Accounting policies (continued)

1.25 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. The PCT holds financial assets under the 'loans and receivables' category.

Loans and receivables

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

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

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

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

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

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

1. Accounting policies (continued)

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

Financial liabilities are initially recognised at fair value.

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

The PCT does not have any Private Finance Initiatives (PFI) Schemes or any NHS LIFT transactions.

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

1.28 Going Concern

As a consequence of the Health and Social Care Act 2012, Wirral PCT was dissolved on 31 March 2013. Its functions have 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 Wirral PCT have prepared these financial statements on a going concern basis.

2 Operating segments

Wirral PCT has applied IFRS 8 in determining its operating segments. An operating segment represents a component that offers different services, for which financial information is reported to the Board and is used to assess performance and allocate resources.

On 1 April 2011, the provider arm which provided a range of primary care and community services was established as an autonomous NHS Trust (Wirral Community NHS Trust) and from the start of this financial year the PCT has been operating as one segment.

Wirral PCT incurred significant expenditure, which is defined as being greater than 10% of total expenditure, with Wirral University Teaching Hospital NHS Foundation Trust. This amounted to £230,793k (2011/12: £218,017k) during the financial year.

3. Financial Performance Targets

3.1 Revenue Resource Limit

	2012-13	2011-12
	£000	£000
The PCTs' performance for the year ended 2012-13 is as follows:		
Total Net Operating Cost for the Financial Year	**662,518**	619,227
Adjusted for prior period adjustments in respect of errors	**0**	0
Revenue Resource Limit	**665,650**	621,228
Under/(Over)spend Against Revenue Resource Limit (RRL)	3,132	2,001

3.2 Capital Resource Limit

The PCT is required to keep within its Capital Resource Limit.

	2012-13	2011-12
	£000	£000
Capital Resource Limit	**4,950**	10,426
Charge to Capital Resource Limit	**4,950**	10,423
(Over)/Underspend Against CRL	**0**	**3**

3.3 Under/(Over)spend against cash limit

	2012-13	2011-12
	£000	£000
Total Charge to Cash Limit	**660,625**	629,051
Cash Limit	**660,625**	629,051
Under/(Over)spend Against Cash Limit	**0**	**0**

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

	2012-13
	£000
Total cash received from DH (Gross)	576,740
Less: Trade Income from DH	(20)
Less/(Plus): movement in DH working balances	(26)
Sub total: net advances	**576,694**
(Less)/plus: transfers (to)/from other resource account bodies (free text note required)	(4)
Plus: cost of Dentistry Schemes (central charge to cash limits)	16,969
Plus: drugs reimbursement (central charge to cash limits)	66,966
Parliamentary funding credited to General Fund	**660,625**

4 Miscellaneous Revenue

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Fees and Charges	**0**	0	0	0
Dental Charge income from Contractor-Led GDS & PDS	**4,750**		4,750	4,814
Dental Charge income from Trust-Led GDS & PDS	**0**		0	0
Prescription Charge income	**3,436**		3,436	3,321
Strategic Health Authorities	**1,198**	0	1,198	1,285
NHS Trusts	**670**	572	98	1,513
NHS Foundation Trusts	**1,031**	523	508	323
Primary Care Trusts Contributions to DATs	**0**		0	0
Primary Care Trusts - Other	**1,328**	8	1,320	690
Primary Care Trusts - Lead Commissioning	**3,544**	0	3,544	4,084
English RAB Special Health Authorities	**0**	0	0	0
NDPBs and Others (CGA)	**0**	0	0	0
Department of Health - SMPTB	**0**	0	0	0
Department of Health - Other	**20**	20	0	48
Recoveries in respect of employee benefits	**0**	0	0	0
Local Authorities	**161**	87	74	202
Patient Transport Services	**0**		0	0
Education, Training and Research	**1,864**	14	1,850	1,865
Non-NHS: Private Patients	**0**		0	0
Non-NHS: Overseas Patients (Non-Reciprocal)	**0**		0	0
NHS Injury Costs Recovery	**0**		0	0
Other Non-NHS Patient Care Services	**0**	0	0	29
Charitable and Other Contributions to Expenditure	**0**		0	0
Receipt of donated assets	**0**		0	0
Receipt of Government granted assets	**0**		0	0
Rental revenue from finance leases	**0**	0	0	0
Rental revenue from operating leases	**402**	402	0	1,392
Other revenue	**147**	126	21	727
Total miscellaneous revenue	**18,551**	**1,752**	**16,799**	**20,293**

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	**62,646**		62,646	57,579
Non-Healthcare	**3,728**	3,009	719	1,148
Total	**66,374**	**3,009**	**63,365**	**58,727**
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	**63,790**	194	63,596	62,752
Goods and services (other, excl Trusts, FT and PCT))	**0**	0	0	716
Total	**63,790**	**194**	**63,596**	**63,468**
Goods and Services from Foundation Trusts	**294,945**	(40)	294,985	280,998
Purchase of Healthcare from Non-NHS bodies	**65,881**		65,881	53,897
Social Care from Independent Providers	**0**		0	0
Expenditure on Drugs Action Teams	**0**		0	3,485
Non-GMS Services from GPs	**5,166**	0	5,166	2,939
Contractor Led GDS & PDS (excluding employee benefits)	**22,071**		22,071	21,880
Salaried Trust-Led PDS & PCT DS (excluding employee benefits)	**1,898**		1,898	1,924
Chair, Non-executive Directors & PEC remuneration	**84**	84	0	41
Executive committee members costs	**0**	0	0	0
Consultancy Services	**1,712**	620	1,092	1,297
Prescribing Costs	**55,245**		55,245	58,965
G/PMS, APMS and PCTMS (excluding employee benefits)	**55,815**	0	55,815	50,042
Pharmaceutical Services	**0**		0	0
Local Pharmaceutical Services Pilots	**0**		0	0
New Pharmacy Contract	**16,025**		16,025	15,713
General Ophthalmic Services	**3,586**		3,586	3,392
Supplies and Services - Clinical	**321**	0	321	342
Supplies and Services - General	**141**	139	2	49
Establishment	**2,148**	1,475	673	1,487
Transport	**12**	12	0	96
Premises	**3,944**	2,150	1,794	1,571
Impairments & Reversals of Property, plant and equipment	**2,893**	0	2,893	0
Impairments and Reversals of non-current assets held for sale	**0**	0	0	0
Depreciation	**872**	245	627	2,577
Amortisation	**15**	0	15	24
Impairment & Reversals Intangible non-current assets	**0**	0	0	0
Impairment and Reversals of Financial Assets	**0**	0	0	0
Impairment of Receivables	**(25)**	(1)	(24)	(66)
Inventory write offs	**0**	0	0	0
Research and Development Expenditure	**0**	0	0	0
Audit Fees	**120**	120	0	183
Other Auditors Remuneration	**60**	60	0	37
Clinical Negligence Costs	**0**	0	0	20
Education and Training	**683**	118	565	737
Grants for capital purposes	**0**	0	0	0
Grants for revenue purposes	**0**	0	0	0
Impairments and reversals for investment properties	**0**	0	0	0
Other	**3,809**	477	3,332	2,452
Total Operating costs charged to Statement of Comprehensive Net Expenditure	**667,585**	**8,662**	**658,923**	**626,277**
Employee Benefits (excluding capitalised costs)				
Employee Benefits associated with PCTMS	**0**	0	0	89
Trust led PDS and PCT DS	**0**	0	0	0
PCT Officer Board Members	**854**	854	0	972
Other Employee Benefits	**12,591**	8,659	3,932	12,179
Total Employee Benefits charged to SOCNE	**13,445**	**9,513**	**3,932**	**13,240**
Total Operating Costs	**681,030**	**18,175**	**662,855**	**639,517**
Analysis of grants reported in total operating costs				
For capital purposes				
Grants to fund Capital Projects - GMS	**0**	0	0	0
Grants to Local Authorities to Fund Capital Projects	**0**	0	0	0
Grants to Private Sector to Fund Capital Projects	**0**	0	0	0
Grants to Fund Capital Projects - Dental	**0**	0	0	0
Grants to Fund Capital Projects - Other	**0**	0	0	0
Total Capital Grants	**0**	**0**	**0**	**0**
Grants to fund revenue expenditure				
To Local Authorities	**0**	0	0	0
To Private Sector	**0**	0	0	0
To Other	**0**	0	0	0
Total Revenue Grants	**0**	**0**	**0**	**0**
Total Grants	**0**	**0**	**0**	**0**

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**16,462**	13,906	2,556
Weighted population (number in units)*	**357,749**	357,749	357,749
Running costs per head of population (£ per head)	**46**	**39**	**7**
PCT Running Costs 2011-12			
Running costs (£000s)	**16,079**	13,633	2,446
Weighted population (number in units)	**357,749**	357,749	357,749
Running costs per head of population (£ per head)	**45**	**38**	**7**

5.2 Analysis of operating expenditure by expenditure classification

	2012-13	2011-12
	£000	£000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	55,815	50,131
Prescribing costs	55,245	58,965
Contractor led GDS & PDS	22,071	21,880
Trust led GDS & PDS	1,898	1,924
General Ophthalmic Services	3,586	3,392
Department of Health Initiative Funding	0	0
Pharmaceutical services	0	0
Local Pharmaceutical Services Pilots	0	0
New Pharmacy Contract	16,025	15,713
Non-GMS Services from GPs	4,367	2,464
Other	0	0
Total Primary Healthcare purchased	**159,007**	154,469
Purchase of Secondary Healthcare		
Learning Difficulties	12,725	12,280
Mental Illness	57,996	54,648
Maternity	17,635	17,523
General and Acute	255,390	249,162
Accident and emergency	22,760	21,588
Community Health Services	69,342	65,870
Other Contractual	51,658	35,416
Total Secondary Healthcare Purchased	**487,506**	456,487
Grant Funding		
Grants for capital purposes	0	0
Grants for revenue purposes	0	0
Total Healthcare Purchased by PCT	**646,513**	**610,956**
PCT self-provided secondary healthcare included above	0	0
Social Care from Independent Providers	0	0
Healthcare from NHS FTs included above	286,990	280,033

6. Operating Leases

6.1 PCT as lessee

	Land	Buildings	Other	2012-13 Total	2011-12
	£000	£000	£000	£000	£000
Payments recognised as an expense					
Minimum lease payments				**6,375**	4,783
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**6,375**	**4,783**
Payable:					
No later than one year	**0**	**1,336**	**39**	**1,375**	482
Between one and five years	**0**	**4,260**	**29**	**4,289**	1,117
After five years	**0**	**17,650**	**0**	**17,650**	49
Total	**0**	**23,246**	**68**	**23,314**	**1,648**

NHS Wirral has entered into certain financial arrangements involving the use of GP Premises, under:

IAS 17 Leases
SIC 27 Evaluating the substance of transactions involving the legal form of a lease
IFRIC 4 Determining whether an arrangement contains a lease

The PCT has determined those operating leases must be recognised, but, as there is no defined term in the arrangements entered into, it is not possible to analyse the arrangements over financial years. The financial value included in the Operating Cost Statement for 2012/13 is £6,375k (2011/12: £4,249k).

6.2 PCT as lessor

	2012-13	2011-12
	£000	£000
Recognised as income		
Rental Revenue	**402**	1,392
Contingent rents	**0**	0
Total	**402**	1,392
Receivable:		
No later than one year	**536**	1,324
Between one and five years	**267**	0
After five years	**0**	0
Total	**803**	1,324

7. Employee benefits and staff numbers

7.1 Employee benefits

	Total	Admin	Programme	Permanently employed Total	Permanently employed Admin	Permanently employed Programme	Other Total	Other Admin	Other Programme
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Employee Benefits 2012/13 - gross expenditure									
Salaries and wages	**9,935**	8,268	1,667	**9,352**	7,730	1,622	**583**	538	45
Social security costs	**728**	516	212	**728**	516	212	**0**	0	0
Employer Contributions to NHS BSA - Pensions Division	**1,111**	787	324	**1,111**	787	324	**0**	0	0
Other pension costs	**7**	7	0	**7**	7	0	**0**	0	0
Other post-employment benefits	**0**	0	0	**0**	0	0	**0**	0	0
Other employment benefits	**0**	0	0	**0**	0	0	**0**	0	0
Termination benefits	**1,729**	0	1,729	**1,729**	0	1,729	**0**	0	0
Total employee benefits	**13,510**	**9,578**	**3,932**	**12,927**	**9,040**	**3,887**	**583**	**538**	**45**
Less recoveries in respect of employee benefits (table below)	**0**	0	0	**0**	**0**	**0**	**0**	**0**	**0**
Total - Net Employee Benefits including capitalised costs	**13,510**	**9,578**	**3,932**	**12,927**	**9,040**	**3,887**	**583**	**538**	**45**
Employee costs capitalised	**65**	65	0	**65**	65	0	**0**	0	0
Net Employee Benefits excluding capitalised costs	**13,445**	**9,513**	**3,932**	**12,862**	**8,975**	**3,887**	**583**	**538**	**45**
Recognised as:									
Commissioning employee benefits	**13,445**			**12,862**			**583**		
Provider employee benefits	**0**			**0**			**0**		
Net Employee Benefits excluding capitalised costs	**13,445**			**12,862**			**583**		

	Total	Admin	Programme	Permanently employed Total	Permanently employed Admin	Permanently employed Programme	Other Total	Other Admin	Other Programme
Employee Benefits 2012/13 - income									
Salaries and wages	**0**	0	0	**0**	0	0	**0**	0	0
Social Security costs	**0**	0	0	**0**	0	0	**0**	0	0
Employer Contributions to NHS BSA - Pensions Division	**0**	0	0	**0**	0	0	**0**	0	0
Other pension costs	**0**	0	0	**0**	0	0	**0**	0	0
Other Post Employment Benefits	**0**	0	0	**0**	0	0	**0**	0	0
Other Employment Benefits	**0**	0	0	**0**	0	0	**0**	0	0
Termination Benefits	**0**	0	0	**0**	0	0	**0**	0	0
TOTAL excluding capitalised costs	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

	Total	Permanently employed	Other
	£000	£000	£000
Net expenditure - 2011-12			
Salaries and wages	**9,822**	9,463	359
Social security costs	**709**	709	0
Employer Contributions to NHS BSA - Pensions Division	**1,125**	1,125	0
Other pension costs	**544**	544	0
Other post-employment benefits	**0**	0	0
Other employment benefits	**0**	0	0
Termination benefits	**1,163**	1,163	0
Total employee benefits	**13,363**	**13,004**	**359**
Employee costs capitalised	**123**	123	0
Net Employee Benefits excluding capitalised costs	**13,240**	**12,881**	**359**
Recognised as:			
Commissioning employee benefits	**13,240**		
Provider employee benefits	**0**		
TOTAL - excluding capitalised costs	**13,240**		

7.2 Staff Numbers

	2012-13 Total	2012-13 Permanently employed	2012-13 Other	2011-12 Total	2011-12 Permanently employed	2011-12 Other
	Number	Number	Number	Number	Number	Number
Average Staff Numbers						
Medical and dental	**3**	2	1	**5**	3	2
Ambulance staff	**0**	0	0	**0**	0	0
Administration and estates	**195**	184	12	**203**	196	7
Healthcare assistants and other support staff	**0**	0	0	**0**	0	0
Nursing, midwifery and health visiting staff	**13**	13	0	**11**	11	0
Nursing, midwifery and health visiting learners	**0**	0	0	**0**	0	0
Scientific, therapeutic and technical staff	**21**	21	0	**21**	21	0
Social Care Staff	**0**	0	0	**0**	0	0
Other	**5**	5	0	**12**	12	0
TOTAL	**237**	**224**	**13**	**252**	**243**	**9**
Of the above - staff engaged on capital projects	**2**	2	0	**2**	2	0

7.3 Staff Sickness absence and ill health retirements

	2012-13	2011-12
	Number	Number
Total Days Lost	**1,089**	9,906
Total Staff Years	**229**	1,150
Average working Days Lost	4.76	8.61

	2012-13	2011-12
	Number	Number
Number of persons retired early on ill health grounds	**0**	3
	£000s	£000s
Total additional pensions liabilities accrued in the year	**0**	98

7.4 Exit Packages agreed during 2012-13

	2012-13			2011-12		
Exit package cost band (including any special payment element)	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**
	Number	**Number**	**Number**	**Number**	**Number**	**Number**
Lees than £10,000	**1**	**3**	**4**	0	0	**0**
£10,001-£25,000	**1**	**11**	**12**	0	1	**1**
£25,001-£50,000	**3**	**4**	**7**	0	1	**1**
£50,001-£100,000	**1**	**9**	**10**	0	0	**0**
£100,001 - £150,000	**0**	**3**	**3**	0	0	**0**
£150,001 - £200,000	**0**	**5**	**5**	0	0	**0**
>£200,000	**0**	**1**	**1**	0	3	**3**
Total number of exit packages by type (total cost	**6**	**36**	**42**	**0**	**5**	**5**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Total resource cost	213	2,382	**2,596**	0	804	**804**

This note provides an anaysis of Exit Packages agreed during the year. Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Voluntary Redundancy Scheme (VRS). 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 pension scheme and are not included in the table.

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”.

Pensions Indexation

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).

Ill-Health Retirement

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.

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.

Death Benefits

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.

Additional Voluntary Contributions (AVCs)

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.

Transfer between Funds

Scheme members have the option to transfer their pension between the NHS Pension Scheme and another scheme when they move into or out of NHS employment.

Preserved Benefits

Where a scheme member ceases NHS employment with more than two years service they can preserve their accrued NHS pension for payment when they reach retirement age.

Compensation for Early Retirement

Where a member of the Scheme is made redundant they may be entitled to early receipt of their pension plus enhancement, at the employer’s cost.

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	**11,671**	**69,080**	11,759	65,446
Total Non-NHS Trade Invoices Paid Within Target	**10,977**	**67,163**	11,311	62,892
Percentage of Non-NHS Trade Invoices Paid Within Target	94.05%	97.23%	96.19%	96.10%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3,605**	**457,958**	3,255	453,468
Total NHS Trade Invoices Paid Within Target	**3,475**	**454,026**	3,156	452,430
Percentage of NHS Trade Invoices Paid Within Target	96.39%	99.14%	96.96%	99.77%

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

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

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

9. Investment Income

The PCT did not receive any Investment Revenue during the year (2011/12: £0)

10. Other Gains and Losses

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Gain/(Loss) on disposal of assets other than by sale (PPE)	**(39)**	**(39)**	**0**	0
Gain/(Loss) on disposal of assets other than by sale (intangibles)	**0**	**0**	**0**	0
Gain/(Loss) on disposal of Financial Assets - other than held for sale	**0**	**0**	**0**	0
Gain (Loss) on disposal of assets held for sale	**0**	**0**	**0**	0
Gain/(loss) on foreign exchange	**0**	**0**	**0**	0
Change in fair value of financial assets carried at fair value through the SoCNE	**0**	**0**	**0**	0
Change in fair value of financial liabilities carried at fair value through the SoCNE	**0**	**0**	**0**	0
Change in fair value of investment property	**0**	**0**	**0**	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	**0**	**0**	**0**	0
Total	**(39)**	**(39)**	**0**	0

11. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest				
Interest on obligations under finance leases	**0**	**0**	**0**	3
Provisions - unwinding of discount				
Interest on obligations under PFI contracts:	**0**	**0**	**0**	0
- main finance cost	**0**	**0**	**0**	0
- contingent finance cost				
Interest on obligations under LIFT contracts:	**0**	**0**	**0**	0
- main finance cost	**0**	**0**	**0**	0
- contingent finance cost	**0**	**0**	**0**	0
Interest on late payment of commercial debt	**0**	**0**	**0**	**0**
Other interest expense	**0**	**0**	**0**	**3**
Total interest expense	**0**	**0**	**0**	0
Other finance costs	**0**	**0**	**0**	0
Total	**0**	**0**	**0**	**3**

12.1 Property, plant and equipment

2012-13	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:									
At 1 April 2012	**5,677**	**19,639**	**0**	**17,957**	**2,410**	**83**	**3,704**	**52**	**49,522**
Additions of Assets Under Construction	0	0	0	3,868	0	0	0	0	**3,868**
Additions Purchased	0	508	0		0	0	272	341	**1,121**
Additions Donated	0	0	0	0	0	0	0	0	**0**
Additions Government Granted	0	0	0	0	0	0	0	0	**0**
Additions Leased	0	0	0		0	0	0	0	**0**
Reclassifications	0	21,886	0	(21,825)	(61)	0	0	0	**0**
Reclassifications as Held for Sale	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	(92)	0	(7)	0	**(99)**
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	**0**
Impairments/negative indexation	(123)	(26)	0	0	(15)	0	0	0	**(164)**
Reversal of Impairments	0	82	0	0	0	0	0	0	**82**
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	**0**
At 31 March 2013	**5,554**	**42,089**	**0**	**0**	**2,242**	**83**	**3,969**	**393**	**54,330**
Depreciation									
At 1 April 2012	**0**	**11,195**	**0**	**0**	**1,502**	**26**	**3,146**	**35**	**15,904**
Reclassifications	0	21	0	0	(21)	0	0	0	**0**
Reclassifications as Held for Sale	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	(59)	0	(1)	0	**(60)**
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	**0**
Impairments	0	2,883	0	0	6	0	4	0	**2,893**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Charged During the Year	32	532	0		131	12	164	1	**872**
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	**0**
At 31 March 2013	**32**	**14,631**	**0**	**0**	**1,559**	**38**	**3,313**	**36**	**19,609**
Net Book Value at 31 March 2013	**5,522**	**27,458**	**0**	**0**	**683**	**45**	**656**	**357**	**34,721**
Purchased	5,522	27,458	0	0	683	45	656	357	**34,721**
Donated	0	0	0	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2013	**5,522**	**27,458**	**0**	**0**	**683**	**45**	**656**	**357**	**34,721**
Asset financing:									
Owned	4,304	27,458	0	0	683	45	656	357	**33,503**
Held on finance lease	1,218	0	0	0	0	0	0	0	**1,218**
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2013	**5,522**	**27,458**	**0**	**0**	**683**	**45**	**656**	**357**	**34,721**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	**2,885**	**5,213**	**0**	**0**	**40**	**0**	**0**	**26**	**8,164**
Movements	(123)	(1,991)	0	0	(15)	0	0	0	**(2,129)**
At 31 March 2013	**2,762**	**3,222**	**0**	**0**	**25**	**0**	**0**	**26**	**6,035**

12.2 Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	**£000**
Cost or valuation:									
At 1 April 2011	**5,332**	**19,404**	**0**	**8,224**	**2,410**	**83**	**3,611**	**51**	**39,115**
Additions - purchased	0	580	0	9,733	0	0	93	1	**10,407**
Additions - donated	0	0	0	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	0	0	0	**0**
Reclassifications	345	(345)	0	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	0	0	0	**0**
Revaluation & indexation gains	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
Reversals of impairments	0	0	0	0	0	0	0	0	**0**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluatic	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**5,677**	**19,639**	**0**	**17,957**	**2,410**	**83**	**3,704**	**52**	**49,522**
Depreciation									
At 1 April 2011	**0**	**9,229**	**0**	**0**	**1,364**	**14**	**2,685**	**35**	**13,327**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassifications as Held for Sale	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	0	0	0	0	**0**
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Charged During the Year	0	1,966	0	0	138	12	461	0	**2,577**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluatic	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**0**	**11,195**	**0**	**0**	**1,502**	**26**	**3,146**	**35**	**15,904**
Net Book Value at 31 March 2012	**5,677**	**8,444**	**0**	**17,957**	**908**	**57**	**558**	**17**	**33,618**
Purchased	5,677	8,444	0	17,957	908	57	558	17	**33,618**
Donated	0	0	0	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**5,677**	**8,444**	**0**	**17,957**	**908**	**57**	**558**	**17**	**33,618**
Asset financing:									
Owned	4,427	8,444	0	17,957	908	57	558	17	**32,368**
Held on finance lease	1,250	0	0	0	0	0	0	0	**1,250**
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**5,677**	**8,444**	**0**	**17,957**	**908**	**57**	**558**	**17**	**33,618**

12.3 Property, plant and equipment

Land and Buildings were revalued by the District Valuer at 31 March 2013 on a modern equivalent asset basis.
During 2012/13 Buildings have been depreciated on a straight-line basis over their useful economic lives.

Until 31 March 2008, the depreciated replacement cost of specialised buildings had 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.

Economic Lives of Fixed Assets

Assets are depreciated over their useful economic lives. These are specific to the PCT and may be shorter than the physical life of the asset itself.

	Minimum Life (years)	Maximum Life (years)
Software Licences	1	5
Licences and Trademarks	0	0
Patents	0	0
Development Expenditure	0	0
Buildings excl. Dwellings	15	50
Dwellings	0	0
Plant and Machinery	5	15
Transport Equipment	7	7
Information Technology	5	5
Furniture and Fittings	5	10

13.1 Intangible non-current assets

2012-13	Software internally generated	Software purchased	Licences & trademarks	Patents	Development expenditure	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2012	**0**	**187**	**0**	**0**	**0**	**187**
Additions - purchased	0	0	0	0	0	**0**
Additions - internally generated	0	0	0	0	0	**0**
Additions - donated	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	**0**
Additions Leased	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation & indexation gains	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	**0**
In-year transfers to/from NHS bodies	0	0	0	0	0	**0**
At 31 March 2013	**0**	**187**	**0**	**0**	**0**	**187**
Amortisation						
At 1 April 2012	**0**	**111**	**0**	**0**	**0**	**111**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation or indexation gains	0	0	0	0	0	**0**
Impairments charged to operating expenses	0	0	0	0	0	**0**
Reversal of impairments charged to operating expenses	0	0	0	0	0	**0**
Charged during the year	0	15	0	0	0	**15**
In-year transfers to NHS bodies	0	0	0	0	0	**0**
At 31 March 2013	**0**	**126**	**0**	**0**	**0**	**126**
Net Book Value at 31 March 2013	**0**	**61**	**0**	**0**	**0**	**61**
Net Book Value at 31 March 2013 comprises						
Purchased	0	61	0	0	0	**61**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	**0**
Total at 31 March 2013	**0**	**61**	**0**	**0**	**0**	**61**

Revaluation reserve balance for intangible non-current assets

	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	**0**	**0**	**0**	**0**	**0**	**0**
Movements (specify)	0	0	0	0	0	**0**
At 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**

13.2 Intangible non-current assets

2011-12	Software internally generated £000	Software purchased £000	Licences & trademarks £000	Patents £000	Development expenditure £000	Total £000
At 1 April 2011	**0**	**171**	**0**	**0**	**0**	**171**
Additions - purchased	0	16	0	0	0	**16**
Additions - internally generated	0	0	0	0	0	**0**
Additions - donated	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation & indexation gains	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	**0**
In-year transfers to/from NHS bodies	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluation	0	0	0	0	0	**0**
At 31 March 2012	**0**	**187**	**0**	**0**	**0**	**187**
Amortisation						
At 1 April 2011	**0**	**87**	**0**	**0**	**0**	**87**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation or indexation gains	0	0	0	0	0	**0**
Impairments charged to operating expenses	0	0	0	0	0	**0**
Reversal of impairments charged to operating expenses	0	0	0	0	0	**0**
Charged during the year	0	24	0	0	0	**24**
In-year transfers to NHS bodies	0	0	0	0	0	**0**
Less cumulative dep written down on revaluation	0	0	0	0	0	**0**
At 31 March 2012	**0**	**111**	**0**	**0**	**0**	**111**
Net Book Value at 31 March 2012	**0**	**76**	**0**	**0**	**0**	**76**
Net Book Value at 31 March 2012 comprises						
Purchased	0	76	0	0	0	**76**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	**0**
Total at 31 March 2012	**0**	**76**	**0**	**0**	**0**	**76**

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

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000
Property, Plant and Equipment impairments and reversals taken to SoCNE			
Loss or damage resulting from normal operations	60	0	60
Over-specification of assets	0	0	0
Abandonment of assets in the course of construction	0	0	0
Total charged to Departmental Expenditure Limit	**60**	**0**	**60**
Unforeseen obsolescence	0	0	0
Loss as a result of catastrophe	0	0	0
Other	0	0	0
Changes in market price	2,833	0	2,833
Total charged to Annually Managed Expenditure	**2,833**	**0**	**2,833**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Loss or damage resulting from normal operations	0	0	0
Over Specification of Assets	0	0	0
Abandonment of assets in the course of construction	0	0	0
Unforeseen obsolescence	15	0	0
Loss as a result of catastrophe	0	0	0
Other	0	0	0
Changes in market price	67	0	0
Total impairments for PPE charged to reserves	**82**	0	0
Total Impairments of Property, Plant and Equipment	**2,975**	**0**	**2,893**
Intangible assets impairments and reversals charged to SoCNE			
Loss or damage resulting from normal operations	0	0	0
Over-specification of assets	0	0	0
Abandonment of assets in the course of construction	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen obsolescence	0	0	0
Loss as a result of catastrophe	0	0	0
Other	0	0	0
Changes in market price	0	0	0
Total charged to Annually Managed Expenditure	**0**	0	**0**
Intangible Assets impairments and reversals charged to the Revaluation Reserve			
Loss or damage resulting from normal operations	0	0	0
Over-specification of assets	0	0	0
Abandonment of assets in the course of construction	0	0	0
Unforeseen obsolescence	0	0	0
Loss as a result of catastrophe	0	0	0
Other	0	0	0
Changes in market price	0	0	0
Total impairments for Intangible Assets charged to Reserves	**0**	0	0
Total Impairments of Intangibles	**0**	**0**	**0**
Financial Assets charged to SoCNE			
Loss or damage resulting from normal operations	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Loss as a result of catastrophe	0	0	0
Other	0	0	0
Total charged to Annually Managed Expenditure	**0**	**0**	**0**
Financial Assets impairments and reversals charged to the Revaluation Reserve			
Loss or damage resulting from normal operations	0	0	0
Loss as a result of catastrophe	0	0	0
Other	0	0	0
TOTAL impairments for Financial Assets charged to reserves	**0**	**0**	**0**
Total Impairments of Financial Assets	**0**	**0**	**0**
Non-current assets held for sale - impairments and reversals charged to SoCNE.			
Loss or damage resulting from normal operations	0	0	0
Abandonment of assets in the course of construction	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**

Unforeseen obsolescence	0	0	0
Loss as a result of catastrophe	0	0	0
Other	0	0	0
Changes in market price	0	0	0
Total charged to Annually Managed Expenditure	**0**	**0**	**0**
Total impairments of non-current assets held for sale	**0**	**0**	**0**
Inventories - impairments and reversals charged to SoCNE			
Loss or Damage Resulting from Normal Operations	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen Obsolescence	0	0	0
Loss as a Result of a Catastrophe	0	0	0
Other (Free text note required)*	0	0	0
Changes in Market Price	0	0	0
Total charged to Annually Managed Expenditure	**0**	**0**	**0**
Total impairments of Inventories	**0**	**0**	**0**
Investment Property impairments charged to SoCNE			
Loss or Damage Resulting from Normal Operations	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen Obsolescence	0	0	0
Loss as a Result of a Catastrophe	0	0	0
Other (Free text note required)*	0	0	0
Changes in Market Price	0	0	0
Total charged to Annually Managed Expenditure	**0**	**0**	**0**
Total Investment Property impairments charged to SoCNE	**0**	**0**	**0**
Investment Property impairments and reversals charged to the Revaluation Reserve			
Loss or Damage Resulting from Normal Operations	0	0	0
Over Specification of Assets	0	0	0
Abandonment of Assets in the Course of Construction	0	0	0
Unforeseen Obsolescence	0	0	0
Loss as a Result of a Catastrophe	0	0	0
Other (Free text note required)*	0	0	0
Changes in Market Price	0	0	0
TOTAL impairments for Investment Property charged to Reserves	**0**	0	0
Total Investment Property Impairments	**0**	**0**	**0**
Total Impairments charged to Revaluation Reserve	82	0	0
Total Impairments charged to SoCNE - DEL	60	0	60
Total Impairments charged to SoCNE - AME	2,833	0	2,833
Overall Total Impairments	**2,975**	**0**	**2,893**
Of which:			
Impairment on revaluation to "modern equivalent asset" basis	**0**	0	0
Donated and Gov Granted Assets, included above			
Donated and Government Granted Asset Impairments: amount charged to SoCNE -DEL	0	0	0
Donated and Government Granted Asset Impairments: amount charged to SoCNE -AME	0	0	0
Donated Asset Impairments: amount charged to revaluation reserve	0	0	0
Total Donated Asset Impairments	0	0	0
Government Granted Asset Impairments: amount charged to SoCNE - DEL	0	0	0
Government Granted Asset Impairments: amount charged to SoCNE - AME	0	0	0
Government Granted Asset Impairments: amount charged to revaluation reserve	0	0	0
Total Gov Granted asset Impairments	0	0	0
TOTAL DONATED/GOVERNMENT GRANTED ASSET IMPAIRMENTS	0	0	0

15 Commitments

15.1 Capital commitments

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

	31 March 2013	31 March 2012
	£000	£000
Property, plant and equipment	**0**	4,032
Intangible assets	**0**	0
Total	**0**	4,032

15.2 Other financial commitments

The PCT does not have any other financial commitments (31 March 2012: £0).

16 Intra-Government and other balances

	Current receivables £000s	**Non-current receivables £000s**	**Current payables £000s**	**Non-current payables £000s**
Balances with other Central Government Bodies	1,653	0	811	0
Balances with Local Authorities	328	0	3,712	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	550	0	4,798	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	2,279	0	23,417	0
At 31 March 2013	**4,810**	**0**	**32,738**	**0**
prior period:				
Balances with other Central Government Bodies	865	0	1,371	0
Balances with Local Authorities	526	0	5,346	0
Balances with NHS Trusts and Foundation Trusts	2,063	0	3,785	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	4,834	0	24,050	0
At 31 March 2012	**8,288**	**0**	**34,552**	**0**

17 Inventories

The PCT did not hold any inventory during 2012/13 (31 March 2012: £0).

18.1 Trade and other receivables

	Current		**Non-current**	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
NHS receivables - revenue	**2,102**	2,403	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**0**	0	**0**	0
Non-NHS receivables - revenue	**699**	1,102	**0**	0
Non-NHS receivables - capital	**0**	1,128	**0**	0
Non-NHS prepayments and accrued income	**1,978**	3,428	**0**	0
Provision for the impairment of receivables	**(93)**	(124)	**0**	0

VAT	**101**	268	**0**	0
Current part of PFI and other PPP arrangements prepayments and accrue	**0**	0	**0**	0
Interest receivables	**0**	0	**0**	0
Finance lease receivables	**0**	0	**0**	0
Operating lease receivables	**0**	0	**0**	0
Other receivables	**23**	103	**0**	0
Total	**4,810**	8,308	**0**	0
Total current and non current	**4,810**	8,308		
Included above:				
Prepaid pensions contributions	**0**	0		

18.2 Receivables past their due date but not impaired

	31 March 2013	31 March 2012
	£000	£000
By up to three months	**497**	761
By three to six months	**93**	418
By more than six months	**64**	117
Total	**654**	1,296

18.3 Provision for impairment of receivables

	2012-13	2011-12
	£000	**£000**
Balance at 1 April 2012	**(124)**	(302)
Amount written off during the year	**6**	112
Amount recovered during the year	**107**	110
(Increase)/decrease in receivables impaired	**(82)**	(44)
Balance at 31 March 2013	**(93)**	(124)

Provisions for impairments of receivables are made against amounts that have been individually determined not to be collectible in full, because of known financial difficulties of the debtor or evidence of default or delinquency in payment.

19 NHS LIFT investments

The PCT does not have any NHS LIFT Schemes (31 March 2012: £0).

20 Other financial assets

The PCT does not have any other financial assets (31 March 2012: £0).

21 Other current assets

The PCT does not have any other current assets (31 March 2012: £0).

22 Cash and Cash Equivalents

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

23 Non-current assets held for sale

There were no Non-current assets held for sale (31 March 2012: £0).

24 Trade and other payables

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Interest payable	**0**	0	**0**	0
NHS payables - revenue	**5,353**	4,696	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**0**	0	**0**	0
Family Health Services (FHS) payables	**9,276**	8,093	0	0
Non-NHS payables - revenue	**3,799**	6,988	**0**	0
Non-NHS payables - capital	**135**	781	**0**	0
Non_NHS accruals and deferred income	**13,474**	13,617	**0**	0
Social security costs	**24**	115	**0**	0
VAT	**0**	0	**0**	0
Tax	**225**	134	**0**	0
Payments received on account	**0**	0	**0**	0
Other	452	192	0	0
Total	**32,738**	34,616	**0**	0
Total payables (current and non-current)	**32,738**	**34,616**		

Other payables at 31 March 2013 do not include any amounts in respect of payments due in future years under arrangements to buy out the liability for early retirements over 5 instalments (2011-12: £0) or for any outstanding pensions contributions. (31 March 2012: £0).

25 Other liabilities

The PCT does not have any other liabilities (31 March 2012: £0).

26 Borrowings

The PCT does not have any borrowings (31 March 2012: £0).

27 Other financial liabilities
The PCT does not have any other financial liabilities (31 March 2012: £0).

28 Deferred income
The PCT does not have any deferred income (31 March 2012: £0).

29 Finance lease obligations
The PCT does not have any finance lease obligations (31 March 2012: £0).

30 Provisions

Comprising:

	Total £000s	Pensions to Former Directors £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Restructuring £000s	Continuing Care £000s	Equal Pay £000s	Agenda for Change £000s	Other £000s	Redundancy £000s
Balance at 1 April 2012	**1,084**	0	0	18	0	0	0	0	184	882
Arising During the Year	**2,526**	0	0	31	0	2,495	0	0	0	0
Utilised During the Year	**(1,084)**	0	0	(18)	0	0	0	0	(184)	(882)
Reversed Unused	**0**	0	0	0	0	0	0	0	0	0
Unwinding of Discount	**0**	0	0	0	0	0	0	0	0	0
Change in Discount Rate	**0**	0	0	0	0	0	0	0	0	0
Transferred (to)/from otherPublic Sector bodies	**0**	0	0	0	0	0	0	0	0	0
Balance at 31 March 2013	**2,526**	**0**	**0**	**31**	**0**	**2,495**	**0**	**0**	**0**	**0**
Expected Timing of Cash Flows:										
No Later than One Year	**2,526**	**0**	**0**	**31**	**0**	**2,495**	**0**	**0**	**0**	**0**
Later than One Year and not later than Five Years	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Later than Five Years	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at 31 March 2013	209
As at 31 March 2012	3,350

The PCT was not able to fully investigate all of the large number of claims received during the year prior to its demise. It used a model based on the judgement of officers with experience of investigating claims to estimate the probability of claims progressing through the various identified stages in the model to establish the number of claims to be provided for. A sample of 20 cases across the Cluster was used to support one of the stages - for the estimate of success for patients in residential care homes. This approach provided an estimate of the conversion rate for successful claims, which fell within a range of between 13.3% and 15.0% with an average of 14.3% across the cluster. The estimated cost per claim and average weeks were based on historic data to produce the likely overall liability.

The calculation of the provisions for closedown claims has required a significant degree of judgement and estimation. Within the cluster, the approach adopted has been consistent whilst also building in local influencing factors. Local intelligence has been applied in relation to average claim period and local rates paid per bed per week.

All provisions are expected to be utilised by 31 March 2014.

31 Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities		
Equal Pay	**0**	0
CHC Restitution	**(1,527)**	0
NHSLA Claims	**(18)**	(15)
Amounts Recoverable Against Contingent Liabilities	**0**	0
Net Value of Contingent Liabilities	**(1,545)**	(15)
Contingent Assets		
Contingent Assets	**0**	0
Net Value of Contingent Assets	**0**	0

32 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.

32.1 Financial Assets	**At 'fair value through profit and loss'**	**Loans and receivables**	**Available for sale**	**Total**
	£000	**£000**	**£000**	**£000**
Embedded derivatives	0	0	0	**0**
Receivables - NHS	0	2,102	0	**2,102**
Receivables - non-NHS	0	730	0	**730**
Cash at bank and in hand	0	0	0	**0**
Other financial assets	0	0	0	**0**
Total at 31 March 2013	**0**	**2,832**	**0**	**2,832**
Embedded derivatives	0	0	0	0
Receivables - NHS	0	2,403	0	2,403
Receivables - non-NHS	0	2,477	0	2,477
Cash at bank and in hand	0	1	0	1
Other financial assets	0	0	0	0
Total at 31 March 2012	0	4,881	0	4,881

32.2 Financial Liabilities	**At 'fair value through profit and loss'**	**Other**	**Total**
	£000	**£000**	**£000**
Embedded derivatives	0	0	**0**
NHS payables	0	5,353	**5,353**
Non-NHS payables	0	4,635	**4,635**
Other borrowings	0	0	**0**
PFI & finance lease obligations	0	0	**0**
Other financial liabilities	0	0	**0**
Total at 31 March 2013	**0**	**9,988**	**9,988**
Embedded derivatives	0	0	0
NHS payables	0	4,696	4,696
Non-NHS payables	0	8,210	8,210
Other borrowings	0	0	0
PFI & finance lease obligations	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2012	**0**	12,906	12,906

33 Related party transactions

Wirral Primary Care Trust is a corporate body established by order of the Secretary of state for Health. In accordance with the national policy of the 'clustering' of primary care trusts, with effect from 1 June 2011, NHS Cheshire, Warrington and Wirral (primary care trust cluster) assumed responsibility as the corporate body with the PCTs in the cluster operating under a single board. During financial year 2012-13 the following transactions took place between Wirral Primary Care Trust and organisations that have a related party relationship with board members of the PCT cluster. For 2012-13 related party transactions are based on interests disclosed by members of the cluster board and key individuals in Wirral CCG, as these persons have control and significant influence over the organisation.

Related Party Transaction during 2012-2013

				2012-2013			
	Role with PCT	**Role within related party**	**Related party**	**Payments to Related Party £**	**Receipts from Related Party £**	**Amounts owed to Related Party £**	**Amounts due from Related Party £**
Cluster Board							
John Church	Vice Chair / Non-Executive Director	Member	Wirral University Teaching Hospital NHS Foundation Trust	Department of Health related party - see note below			
		Member	Countess of Chester NHS Foundation Trust	Department of Health related party - see note below			
		Member	Cheshire and Wirral Partnership NHS Foundation Trust	Department of Health related party - see note below			
James Kay	Non Executive Director	Member	Wirral University Teaching Hospital NHS Foundation Trust	Department of Health related party - see note below			
Martin McEwan	Director of Communications and Engagement	Stakeholder Governor	Wirral University Teaching Hospital NHS Foundation Trust	Department of Health related party - see note below			
		Interim Director, Marketing & Communications	Alder Hey Childrens NHS Foundation Trust	Department of Health related party - see note below			
Cathy Maddaford	Director of Nursing, Performance and Quality	Member of Non Foundation Council	University of Chester	5,607	250	0	0
Fiona Johnstone	Director of Public Health	Director of Public Health (joint appointment)	Wirral MBC	Other Government Department - see note below			
Dr Shyamal Mukherjee	Medical Director	Partner	Central Park Medical Centre	1,545,131	0	0	0

Phil Wadeson was appointed as the joint Director of Finance for NHS Merseyside Cluster and the NHS Cheshire, Warrington and Wirral (CWW) Cluster for the period 1 September 2012 to 10 January 2013 and continued to support the NHS CWW Cluster to the end of January 2013. He is deemed to have a related party interest in all four of the NHS Merseyside Cluster PCTs.

WIRRAL CCG							
Dr A Mantgani	Chief Clinical Officer		Miriam Medical Centre	2,195,637	0	0	0
			Earlston Road Surgery	810,082	0	0	0
			Seabank Medical Centre	5,473	0	0	0

Dr P Jennings	Chair	West Wirral GPP	2,258,597	0	0	0

Related Party Transaction during 2011-12

	Role with PCT	Related party	2011-12 Payments to Related Party £	Receipts from Related Party £	Amounts owed to Related Party £	Amounts due from Related Party £
Wirral PCT Related Parties from 1st April 2011 - 31st May 2011						
Dr A Mantgani	Medical Director	Miriam Medical Centre	155,714	0	0	0
Dr A Mantgani	Medical Director	Earlston Road Surgery	57,633	0	0	0
Dr A Mantgani	Medical Director	Seabank Medical Centre	35,583	0	0	0
Dr A Mantgani	Medical Director	Central Park MC	209,163	0	0	0

From 1 June 2011 a new Cluster Board was formed

Some of the Cluster Board Members or members of the key management staff or parties related to them have undertaken material transactions with the PCT as follows:

	Role with PCT	Related party	Payments to Related Party £	Receipts from Related Party £	Amounts owed to Related Party £	Amounts due from Related Party £
Medical Directors (One shared vote)						
Shyamal Mukherjee	Medical Director	Central Park Medical Centre	1,177,093	0	0	0
Non Executives						
Fareth Arshad	Non Executive Director	Liverpool John Moores University	9,580	0	0	0
John Gartside	Non Executive Director	Warrington Collegiate Institute	-			
Emerging Clinical Commissioning Groups Chairs						
Dr Andrew Davies	Warrington Health Consortium	Greenbank Surgery	970,084	0	0	0
Dr John Oates	Wirral Consortium	Parkfield Medical Centre	857,392	0	0	0
Dr John Oates	Wirral Consortium	Dr Hawthornthwaite & Partners	26,520	0	0	0
Dr Philip Jennings	Wirral Health Commissioning Consortia	West Wirral Group Practice	1,756,612	0	0	0
Dr Peter Naylor	Wirral Health Commissioning Consortia	St George's Medical Centre	1,487,685	0	0	0
Dr Gillian Frances	Wirral NHS Alliance	Spital Surgery - Dr G Francis & Partners	565,093	0	0	0
Dr Sarah Baker	Warrington Health Consortium	Warrington Disability Partnership	62,251	0	0	0
Non NHS Cheshire, Wirral & Warrington Senior Staff with Significant Influence						
Dr Abinandan Mantgani (Executive Clinical Lead)	Wirral GP Commissioning Consortia	Miriam Medical Centre	1,226,406	0	0	0
Dr Abinandan Mantgani (Executive Clinical Lead)	Wirral GP Commissioning Consortia	Earlston Road Surgery	391,583	0	0	0
Dr Abinandan Mantgani (Executive Clinical Lead)	Wirral GP Commissioning Consortia	Seabank Medical Centre	186,992	0	0	0

In 2012/13 the Department of Health is regarded as a related party. During the year the 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 listed below:

NHS Northwest

Primary Care Trusts
Blackpool PCT
Central and Eastern Cheshire PCT
Halton and St Helens PCT
Knowsley PCT
Liverpool PCT
Sefton PCT
Warrington PCT
Knowsley PCT
Western Cheshire PCT

NHS Trusts
Royal Liverpool Broadgreen Hospitals NHS Trust
Southport And Ormskirk Hospital NHS Trust
Mersey Care NHS Trust
North West Ambulance Service NHS Trust
Liverpool Community Health NHS Trust
Bridgewater Community Healthcare NHS Trust
The Wirral Community NHS Trust

NHS Business Services Authority
Dental Practices Board
Prescription Prescribing Authority

Foundation Trusts
Wirral University Teaching Hospital NHS Foundation Trust
St Helens And Knowsley Hospitals NHS Trust
Liverpool Heart And Chest NHS Foundation Trust
Alder Hey Childrens NHS Foundation Trust
Aintree University Hospitals NHS Foundation Trust
Clatterbridge Centre For Oncology NHS Foundation Trust
Liverpool Womens Hospital NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust
Countess Of Chester Hospital NHS Foundation Trust
Robert Jones and Agnes Hunt Orthopaedic NHS Foundation Trust
University Hospital Of South Manchester NHS Foundation Trust
Salford Royal NHS Foundation Trust
South Staffordshire Healthcare NHS Foundation Trust
Wrightington, Wigan And Leigh NHS Foundation Trust
5 Boroughs Partnership NHS Foundation Trust
Central Manchester University Hospitals NHS Foundation Trust
Warrington And Halton Hospitals NHS Foundation Trust
Cheshire And Wirral Partnership NHS Foundation Trust
Greater Manchester West MH NHS Foundation Trust

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 Wirral Metropolitan Borough Council, and HM Revenue and Customs.

34 Losses and special payments

There were 8 cases in 2012/13 involving a total loss of £119,008 (2011/12: 10 cases and £116,351).

There were no special payments in 2012/13 (2011/12: £0).

There were no individual cases where the payment exceeded £250,000 (2011/12: £0).

35 Third party assets

The PCT did not hold any cash at bank and in hand at 31 March 2013 which relates to monies held on behalf of patients (31 March 2012: £0).

36 Pooled budget

From 1 April 2011 the PCT no longer hosts the pooled budget arrangement with Wirral Metropolitan Borough Council.

37 Cashflows relating to exceptional items

There have been no exceptional items relating to cashflow during 2012/13 (2011/12: £0).

38 Events after the end of the reporting period

These accounts have been completed on a going concern basis in line with NHS guidance. As part of the changes to the NHS brought about by the Health and Social Care Act 2012, NHS Wirral PCT ceased to exist on 31 March 2013. . This Act also established Clinical Commissioning Groups and the National Commissioning Board from the 1st April 2013 as the main commissioners of acute and community care. NHS Wirral PCT's responsibility for commissioning these services has been taken over by Wirral CCG.

In addition the primary care commissioning responsibility has been taken over by the NHS Commissioning Board and Public Health commissioning by the local authority.

WIRRAL PRIMARY CARE TRUST

CLUSTER OF NHS CHESHIRE, WARRINGTON AND WIRRAL PRIMARY CARE TRUSTS

ANNUAL GOVERNANCE STATEMENT 2012/13

My review confirms that each Primary Care Trust had a generally sound system of internal control that supported the achievement of its policies, aims and objectives. The Primary Care Trust Cluster was established on 1st June 2011.

Scope of responsibility

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

There was regular contact between the Strategic Health Authority and the Primary Care Trust which allows for any concerns to be addressed

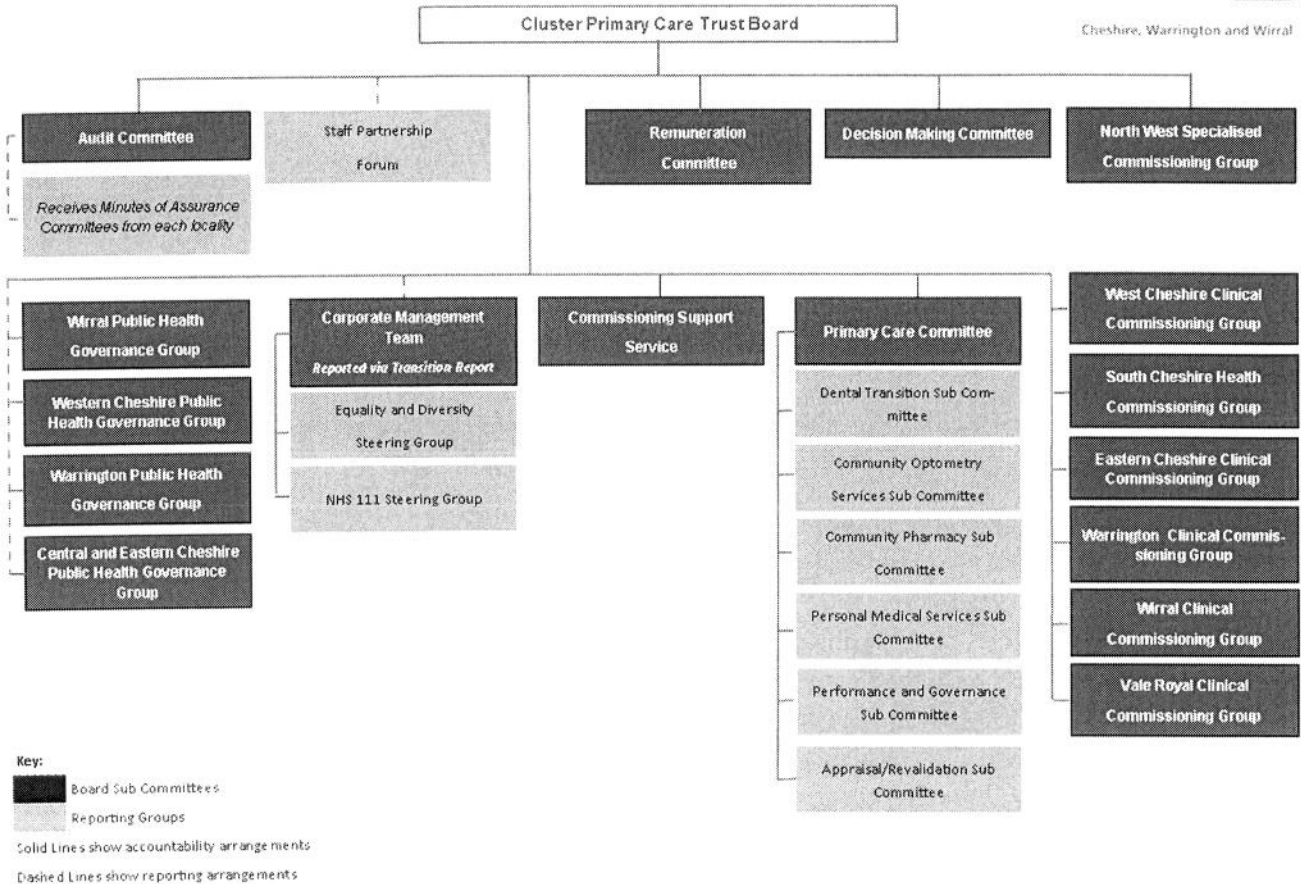
With respect to partnership working across the Local Health Economy, I met regularly with the Local Authority Chief Executives and as necessary with the Chief Executives of the providers within the Primary Care Trust area. The Primary Care Trust participates in partnership arrangements for children's services, adult services and health and well-being. The post of Joint Director of Public Health is jointly accountable to the Local Authority and the Primary Care Trust. There are a range of joint commissioning appointments across different organisations.

The governance framework of the organisation

The NHS Cheshire, Warrington and Wirral Board was established on 6th June 2011 by the Establishment Agreement contained in Section A of the Standing Financial Instructions/Standing Orders (initially approved by Board on 6th June and updated and approved on 2nd November 2011). A diagram of the Governance Structure for the Cluster is shown below.

The Board has the following Sub-Committees which have delegated responsibilities as part of the Scheme of Reservation and Delegation.

- Audit Committee
- Remuneration Committee
- Decision Making Committee
- Primary Care Committee
- West Cheshire Clinical Commissioning Group
- South Cheshire Clinical Commissioning Group
- Eastern Cheshire Clinical Commissioning Group
- Warrington Clinical Commissioning Group
- Wirral Clinical Commissioning Group
- Vale Royal Clinical Commissioning Group
- North West Specialised Commissioning Group



The Board sub-committees all have terms of reference which have been approved by the Board. The Board also had a number of reporting groups from whom they receive minutes as part of the assurance process. These groups included:

- Public Health Governance Groups/Steering Groups for each Primary Care Trust (reported via the Transition Update Board Papers)
- Corporate Management Team (reported via the Transition Update Board Papers)
- Staff Partnership Forum

The Board met regularly either formally where meetings were held in public or informally for the Board's own development. Copies of the Formal Board agendas and papers are available on each of the Primary Care Trust websites and were published 5 working days in advance of the meeting. The minutes of the Board meetings and minutes of supporting groups as outlined below contain details of the attendance of members and any apologies received. The Board developed the following vision and values:

- Honesty and Integrity - by showing respect, fairness and trust to all our staff during a period of major change;
- Clear leadership - to develop positive attitudes and actions recognising the potential for people to make a difference; and by having the courage to take necessary tough decisions in order to successfully deliver the new NHS;
- Collaborative support - to all staff and teams to secure success with Clinical Commissioning, Commissioning Support and Public Health;
- Working creatively - with partners based on the common objective to keep our population at the centre of all we do.

These values were developed to provide focus for the Board in their role as a Cluster Primary Care Trust Board during the transitional period for the NHS. The Board fully complied with the UK Corporate Governance Code and was effective in discharging it roles and responsibilities.

The Audit Committee was responsible for ensuring compliance with statutory requirements and provided assurance to the Board on internal control and governance matters (both clinical and non-clinical), that supported the achievement of the organisation's objectives. The Audit Committee highlights have included:

- Monitoring the impact of wider NHS transition on the Cluster, including commissioning support arrangements, CCG development and the establishment of the NHS Commissioning Board. This included consideration of the impacts on areas of corporate priority including HR and Information Technology. The Committee also considered specific guidance on financial closedown of PCTs;
- Review of areas of financial focus including key aspects of the financial statements such as final accounts timetables, segmental reporting requirements and review of accounting policies. The Committee also reviewed tender waivers, progress against QIPP and losses & special payments;
- Regular updates from internal auditors including plans, progress reports, final reports issued and the Director of Internal Audit annual opinion; the Committee also tracked audit recommendations to ensure these were implemented. The outstanding recommendations have been transferred to the Clinical Commissioning Groups and this process is embedded as part of their governance frameworks;
- Regular updates from external auditors including plans, progress reports, annual governance reports and annual audit letters. The external auditors also provided updates on the transfer of responsibilities to the new external audit provider;
- Review of the Board Assurance Framework as part of the Committee's role to oversee the establishment and maintenance of an effective system of integrated governance, risk management and internal control;
- Updates from each of the PCT/localities and the hosted North West Specialised Commissioning Team focussing on local performance and transition issues; and,
- Review of counter fraud progress reports.

Throughout the year the Board has received copies of the Clinical Commissioning Group Board minutes. These have provided assurances of their delegated responsibilities which include the majority of commissioning budgets and performance of providers. Risk is an agenda item for all Clinical Commissioning Groups and mechanisms are in place to escalate risks for Board attention, where appropriate. Key points reported via these Sub-Committees have included:

- Monitoring of the Clinical Commissioning Group Financial Position;
- Finalising the Clinical Commissioning Group Staffing Structure and developing the organisational development plan;
- Development of a Planning Framework including contracts and the strategic plan for 2012/13;
- Preparing for Formal Board Meetings in public and undertaking Board development programmes;
- Reviewing commissioned services and preparing to implement any willing provider;
- Developing assurance frameworks for managing risk and reporting to the Primary Care Trust Cluster Board;

The NHS Cheshire, Warrington and Wirral Scheme of Reservation and Delegation clearly states that Quality is delegated to the Clinical Commissioning Groups to oversee for their respective providers.

In addition to regular reporting to Clinical Commissioning Group Boards, any exceptions including serious incidents are reported to the Primary Care Trust Cluster. Clinical Commissioning Groups are responsible for ensuring that exceptions are reported in a timely manner to the Primary Care Trust Cluster and that actions

are taken by the providers and themselves to address the exceptions. These exceptions are also included in the Quality Accounts for providers on an annual basis.

At its last formal Board Meeting in March 2013, the corporate handover document for NHS Cheshire Warrington & Wirral (NHS CWW) Cluster was presented. It is intended that this document will signpost all new NHS organisations who take responsibility for Primary Care Trust functions from 1 April 2013 to the key risks, issues and areas of concern of which those new bodies need to be aware as they assume responsibility for the discharge of their functions.

The Corporate Handover document should be read in conjunction with the Quality Handover document which sets out the key quality and safety issues for NHS Cheshire Warrington & Wirral Cluster. This was also presented to the Primary Care Trust Cluster Board in March 2013. Both documents are available on the Primary Care Trust websites as part of the Board papers.

From 1 April 2013 when PCTs were abolished, Area Team Directors continued to discharge the responsibilities associated with the financial closedown of PCTs. The production of the accounts for 2012/13 was supported by LAT Directors of Finance (DoFs). This has included:

- preparation and sign off of PCT accounts for 2012/13;
- support for the completion of the Department's resource account;
- designation of closing balances to residual organisations;
- management of local discharge of balances transferred to the Department; and
- management of payroll queries and other related payroll issues.

However, when PCTs ceased to be statutory bodies on 1 April 2013, the statutory status of the essential scrutiny and governance function provided by Audit Committees has been lost. To maintain rigour in the process, we have established an Audit Sub-Committee of the Department of Health Audit & Risk Committee, to support the final accounts process. This approach will draw on the expertise of current Audit Committee members when forming the Sub-Committee. This arrangement will provide a mechanism with the appropriate status to discharge the function.

The non-executive directors (NEDs) that form the Sub-Committee have been identified locally and include the previous chair of the PCT Cluster. They have been appointed by the Department's Permanent Secretary following local nomination. The Cluster Audit Sub-Committees took place in May and June 2013 to agree the accounts in line with national timescales.

Risk assessment

The Corporate Risk Register enabled the Cluster to understand its comprehensive risk profile. It records dependencies between risks and links between risks on the Board Assurance Framework and the risk registers of individual functions.

The Corporate Risk Register is derived from a number of sources:

- escalation from Risk Registers held by:
  - Clinical Commissioning Groups
  - Commissioning Support Service
  - Public Health Departments
  - Primary Care
  - Cluster wide e.g. Emergency Planning.
- the business planning system, which determined the Primary Care Trusts' principle objectives, corporate activities such as the planning process or business case development, external inspections (e.g. Health and Safety Executive) complaints/ incidents and litigation.

Items for the Risk Register which were a standing item on agendas of:

- The Board
- Audit Committee
- Remuneration and Terms of Service Committee
- Clinical Commissioning Group Boards
- Public Health Governance Committees
- Commissioning Support Service Board
- Primary Care Committee.

The Corporate Risk Register is a dynamic document, held by the Cluster Office. It forms part of the legacy document for when the Primary Care Trusts are abolished. Risks identified as significant or complex were entered on to the Corporate Risk Register, quality assured by the Corporate Management Team before escalation to the Board.

The Assurance Framework was developed in accordance with guidelines provided by the Department of Health.

This is a high level document that recorded the principal risks that could have impacted on the Cluster achieving its strategic objectives. It provided a framework for reporting key information to the Board. It provided assurance that risks were managed effectively and objectives were delivered and also identified which of the Primary Care Trusts' objectives were at risk because of gaps in controls or assurance about them.

During 2012/13 the following risks were highlighted to the Cluster Board:

- Ensuring a robust PCT closedown as part of NHS transition arrangements, including the need to successfully identify and transfer assets and liabilities;
- Assurances need to be in place that commissioned services are safe and of good quality. This risk has been mitigated through inclusion of quality and safety aspects in all contracts and robust contract monitoring arrangements;
- The need to successfully implement the NHS '111' programme. The Cluster has established a Steering Group with representation across all CCGs to implement and monitor progress against key milestones; and,
- The need to support CCGs engagement in the QIPP agenda – this has been mitigated through each CCG having approved, individual QIPP plans and securing GP involvement in QIPP projects.

Principal risks were not considered in isolation, but derived from the prioritisation of risks fed upwards through the whole organisation, including Risk Registers and Assurance Frameworks held and managed by Clinical Commissioning Groups, Public Health Departments, Commissioning Support Service and Primary Care. In this way the Risk Registers will contribute to the Board Assurance Framework and ensure that system risks are identified and monitored.

All Clinical Commissioning Groups/Public Health/Primary Care/Commissioning Support Service minutes are submitted to every formal Cluster Board and each of the groups attends the Board on a rolling basis or when there is a specific item which requires Board approval. The Cluster has a Single Audit Committee which is enabling and supporting the development of local governance groups (inc QIPP governance). Regular quality meetings are held with providers (see further detail below) and Clinical Commissioning Groups. The Chief Executive meets formally with Clinical Commissioning Group Chairs and Chief Officers bi-monthly and with Directors of Public Health also monthly. The Cluster is part of the Regional Management Board in Cheshire and Warrington and the Health and Local Government meetings in Wirral. There is also

senior Cluster attendance at all Health & Wellbeing Boards. Delegated arrangements are detailed in Standing Orders and Financial Instructions

During 2012/13 there were no lapses of data security. Therefore no incidents were reported to the information commissioner relating to any of the Primary Care Trusts.

The risk and control framework

The Risk Management Strategy sets out the responsibility and role of the Chief Executive in relation to Risk Management. The Board took direct responsibility for the monitoring of the assurance framework and for risk management.

Board committees were supported by the governance structure and have received reports from a number of other Trust and locality-wide groups, to ensure that all significant risks were highlighted to the Board.

The Assurance Framework identified those risks deemed as strategically significant to the objectives of the organisation. Risk Management was embedded within the organisation and the process was been cascaded to service areas to assist with the development of an organisation-wide risk awareness culture. This was supported by operational risk registers which enabled risk management decision-making to occur as near as practicable to the risk source, and for those risks that cannot be dealt with locally to be passed upwards to the appropriate level within the organisation.

The Primary Care Trust Assurance Framework, Corporate Risk Register and Top Risks were reviewed and updated regularly. Risks were identified via a number of routes, including reports from staff and senior managers, incidents, complaints and Primary Care Trust Committees. The Cluster Team was responsible for ensuring all risks were appropriately graded and that action plans were regularly monitored.

The Primary Care Trust undertook a wide range of mandatory and statutory training for all staff and there was a greater emphasis on staff training during 2012/13 following the introduction of e-learning. Staff were required to undertake training in relation to Counter Fraud, Equality and Diversity, Fire Safety, Infection Control, Information Governance, Safeguarding Children and Adults as well as Health and Safety. This training was mandatory for all staff and was a key part of the organisation's core induction. This ensured that risk management, risk assessment and incident reporting were highlighted together with key Trust strategies, policies and procedures. These included risk management strategy, infection control, and complaints.

Statutory & Mandatory training compliance rates across the Cluster were taken as at January 2013. Overall the Cluster was 70.6% compliant across the 8 core courses, which was an increase of 1.6% on the October figure. However, training compliance reduced in comparison to the previous year as a result of the NHS Transition. Compliance reports were sent out to the locality HR Teams so that discussion with line managers about ongoing compliance action could be undertaken. Two out of the eight courses are achieving the National compliance rates of 85% or higher".

The Trust has ensured:

- Director objectives were aligned with key Corporate Objectives.
- The Primary Care Trust is committed to engaging local independent contractors to facilitate the development of good governance and risk management processes.
- The Primary Care Trust seeks independent assurances from third party providers of services to the Primary Care Trust over the effectiveness of internal controls in place. Relevant reports covering the review of third party provider controls are presented to the Audit Committee during the year.
- Control measures are in place to ensure that all the organisations' obligations under equality, diversity and human rights legislation are complied with.

Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of Internal Audit's work. The overall level of the Head of Internal Audit Opinion is one of significant assurance. Significant assurance can be given that there was a generally sound system of internal control designed to meet the organisation's objectives and that controls were generally being applied consistently. However some weaknesses in the design or inconsistent application of controls put the achievement of particular objectives at risk. Executive managers within the organisation who had responsibility for the development and maintenance of the system of internal control provided me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that managed the risks to the organisation achieving its principal objectives have been reviewed.

My review is also informed by:

- Attendance and debate at the Corporate Management Team Meetings, Primary Care Trust Board, and reports from the Audit Committee.
- The achievement of financial duties and the financial position of the Primary Care Trust.

Assessments from Mersey Internal Audit which report:

- Classified the Assurance Framework at the highest level 'A': 'An Assurance Framework has been established which is designed and operating to meet the requirements of the Annual Governance Statement and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation'.
- Responses to staff and patient surveys and other external reviews.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control.

In addition I am aware of the importance of the roles of the following:

- The Board, The Board's role is to provide active leadership of the Trust within a framework of prudent and effective controls that enable risk to be assessed and managed
- The Audit Committee, as part of an integrated committee structure, is pivotal in advising the Board on the effectiveness of the system of internal control. Any significant internal control issues would be reported to the Board via the Audit Committee. An Audit Committee report has been produced outlining how the Committee complied with its duties delegated to it by the Primary Care Trust Board in its Terms of Reference.
- Executive Directors' roles and responsibilities in ensuring systems of internal control are in place and implemented effectively.
- Internal Audit provides reports to each meeting of the Audit Committee and full reports to the Director of Finance and key officers. The Audit Committee also receives details of any actions that remain outstanding from the follow up of previous audit work. The Director of Finance also meets regularly with the Audit Manager.
- External Audit – provides external audit annual management letter and progress reports to the Audit Committee.

Significant Issues

Financial Position at Year End for NHS Cheshire, Warrington and Wirral

The Cluster Plans were for an overall budget of £3.3 billion, which includes £1.1 billion in respect of the North West wide Specialist Commissioning function. The total surplus planned and delivered for the year is £10.3 million, excluding impairments. In addition, it is worth noting the challenging Quality, Innovation, Productivity and Prevention savings of £107.4 million, of which £55.7 million was cash releasing.

NHS 111 Programme

The 111 Programme had an established governance process for mobilisation actions which were required along with an established, and now on-going clinical governance assurance process since the "go live" of the service at the end of March. The Cluster role was to ensure that the mobilisation requirements were fulfilled and any outstanding actions were managed by way of a risk register as part of the joint mobilisation arrangements with Merseyside. This was due to the contract for the 111 programme being provided on a joint Cheshire and Mersey footprint.

The Cluster also ensured that the clinical governance arrangements were implemented and a structure of local clinical advisory groups (LCAG) established. Each LCAG (based around Out of Hours Services) will be led by a Clinical Commissioning Group, who will be responsible for co-ordinating and establishing the LCAGs, who will report through the 'county' specific clinical governance groups and ultimately via a clinical lead to the North West Clinical advisory group.

Financial Position

The surplus for 2012/13 is £3.132 million and is in line with the planned surplus for 2012/13 of £3.088m. It reflects an underlying recurrent surplus of £15.483 million offset by non recurrent commitments of £12.351 million, primarily on initiatives to deliver longer term QIPP savings, redundancy costs and pump priming the new health system. Planned QIPP savings are reported by ten key themes, delivering planned savings of £6.414 million.

Performance Issues

Wirral University Teaching Hospital NHS Foundation Trust struggled to deliver the accident and emergency 4 hour standard in both Quarter 3 and Quarter 4 of 2012/13 and as a result of this failed to deliver the required overall year to date standard. The Trust is working closely with commissioners to identify reasons for this and to put in place robust action plans to ensure performance against this standard for 2013/14 is delivered. Pressure remains for the Trust in delivering both the elective 18 week pathway and the diagnostic tests standard however the Trust is working with the commissioner to ensure any issues are highlighted and mitigating actions put in place.

Conclusion

To the best of my knowledge, the governance arrangements in place are effective with the exception of the significant issues reported above.

Accountable Officer: Moira Dumma

Organisation: Wirral Primary Care Trust

Signature: Moira Dumma

Date: 3.6.2013