Department of Health

NHS

Bradford and Airedale Teaching Primary Care Trust

2012-13 Annual Report and Accounts

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Bradford and Airedale Primary Care Trust

2012-13 Annual Report

NHS
Bradford and Airedale

Annual Report 2012-13

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Foreword

While this has been a year of transition for NHS Bradford and Airedale, bringing its own challenges, we are proud of our continuing achievements to treat people quicker and with greater dignity and respect, respond to emergency and urgent needs more consistently and develop continuing healthcare services. We have continued to listen to the concerns of patients and have not hesitated to act when shortcomings in service delivery have been identified.

As a result of the health care reforms and the introduction of the Health and Social Care Act 2012, NHS Bradford and Airedale ceased to exist on 31 March 2013 and our responsibilities for commissioning health and care services transferred to the new clinical commissioning groups on 1st April 2013. The responsibility for public health has transferred to Bradford Council and Public Health England, and NHS England will maintain responsibility for specialist health service commissioning, and primary care services.

We are confident that there has been a smooth handover of our commissioning and public health responsibilities to the CCGs, local authority and NHS England.

We have ensured that the new organisations have solid foundations on which to build their health commissioning priorities thanks to the efforts of our staff, and our partner NHS trusts. In particular, we have ensured a firm financial base for the new CCGs, including cash reserves and non-recurrent financial headroom.

NHS Bradford and Airedale has enjoyed six successful years commissioning and delivering improved health and care services for the people of the district. I feel it is fitting in our final year of operation that I acknowledge the commitment and dedication of our staff in ensuring that the quality of our performance has continually improved during this time.

Finally, I would like to pay tribute to our former chair, Linda Pollard OBE, JP,DL for her commitment to ensuring the people of Bradford and Airedale have access to a quality range of health and care services.

Brian Marsden

Chair

NHS Airedale, Bradford and Leeds

Andy Buck

Director (West Yorkshire)

NHS England

The changing face of the NHS

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

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

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

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

Primary care trusts (PCTs), including NHS Bradford and Airedale, were abolished at the end of March 2013 and the majority of the PCT's public health responsibilities were transferred to Bradford Council.

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

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

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

About NHS Bradford and Airedale

NHS Bradford and Airedale has been responsible for commissioning healthcare services for people living in the district since its inception in October 2006.

As the local leader of the NHS, our aim has been to make sure that the best healthcare services have been available for everyone who has needed them. This year, we received £951,099,000 to give our estimated 522,452 residents the healthcare they needed. To do this, we have worked with local partners and stakeholders, such as primary and secondary care providers, social services and voluntary and community sector (VCS) organisations.

Primary care services are provided by local doctors, pharmacists, optometrists and dentists. In Bradford and Airedale, there are 80 general practices in the area, 67 dental practices, 139 pharmacies (including four internet only pharmacies) and 58 opticians.

We have commissioned the majority of our secondary care (acute hospital services) from Bradford Teaching Hospitals NHS Foundation Trust (Bradford Royal Infirmary and St Luke's Hospital) and Airedale NHS Foundation Trust (Airedale General Hospital). Community health, mental health and learning disability services have been commissioned from Bradford District Care Trust and we have worked with our local statutory partner – the City of Bradford Metropolitan District Council – to develop a consistent and co-ordinated approach across a wide range of health and social care services.

We have engaged with our patients and the public to get their input on our services to ensure they reflect the changing needs of local people. We have also undertaken a broad range of public health initiatives to improve local people's health and quality of life.

As part of the transformation of the NHS set out in the Health and Social Care Act 2012, PCTs ceased to exist on 31 March 2013. Commissioning responsibilities for healthcare transferred to clinical commissioning groups (CCGs) and other organisations from 1 April 2013. Run by GPs, doctors and nurses, each new CCG has the power and freedom to make decisions about the care and services they provide for their local communities.

NHS Bradford and Airedale has worked closely with: the three incoming CCGs for the district (for more information about CCGs, see page 27); the West and South Yorkshire and Bassetlaw Commissioning Support Unit, NHS Property Services, NHS England, the City of Bradford Metropolitan District Council and Public Health England to arrange the smooth transition of staff and functions to these organisations.

Having formed a cluster with NHS Leeds in October 2011 as part of the transition process, NHS Airedale, Bradford and Leeds has been operating with a single board and executive team since that date. Clusters are not organisations in their own right and

each PCT remained as a statutory organisation. This annual report, therefore, focuses solely on the achievements of NHS Bradford and Airedale.

The board

Throughout 201213 the board of NHS Airedale, Bradford and Leeds has met in public regularly. Through those meetings, the board has been responsible for taking key strategic decisions about the organisation – how it uses resources, agreeing key priorities and overseeing the delegated functions and budgets to clinical commissioning groups.

Board members of NHS Airedale, Bradford and Leeds are a mixture of executive directors who are full-time officers, and non-executive directors who are local people interested in the work of the NHS and appointed by the national NHS Appointments Commission (now abolished).

In July 2012 the chief executive of NHS Airedale, Bradford and Leeds advised that he would be absent from his role as accountable officer for the foreseeable future due to ill health. The director of finance was appointed as acting chief executive. In January 2013 it became clear that the chief executive would take up a position with NHS England, and the acting chief executive was given accountable officer status.

On 14 September 2012, chief clinical officers (designate) and chief officers (designate) of the six clinical commissioning groups covering the Airedale, Bradford and Leeds geography were invited to the join the NHS Airedale, Bradford and Leeds cluster board in a non-voting capacity.

On 31 January 2013, the chair of NHS Airedale, Bradford and Leeds resigned her position to take up a post at Leeds Teaching Hospitals NHS Trust. Two further non-executive directors also resigned on 31 January 2013 in order to focus on the lay member roles they had been appointed to with CCGs. A chair and an audit committee chair for NHS Airedale, Bradford and Leeds were appointed from the existing complement of non-executive directors.

All directors have stated that he or she is aware that there is no relevant audit information of which the NHS body's auditors are unaware and that he or she has taken all the steps that he or she ought to have taken as a director in order to make him or herself aware of any relevant information, and to establish that the NHS body's auditors are aware of that information.

During the financial year April 2012 to March 2013, seven public meetings of the NHS Airedale, Bradford and Leeds cluster board took place. All meetings were recorded as fully quorate, with each meeting attended by at least one third of the board, including one non-executive director, one executive director, the chair and the chief executive.

Members of the board are listed below:

Executive directors
John Lawlor, chief executive (April-July 2012)
Kevin Howells, director of finance, and acting chief executive (July 2012-March 2013)
Dr Ian Cameron, director of public health, Leeds
Dr Anita Parkin, director of public health, Bradford
Philomena Corrigan, executive director of strategy and commissioning
Dr Damian Riley, executive director of primary care/medical director
Jo Coombs, executive director of nursing and quality (April-October 2012)
Matt Neligan, executive director of commissioning development (April-October 2012)
Dr Simon Stockill, clinical commissioning executive chair
June Goodson-Moore, director of workforce and corporate development

Non-executive directors
Linda Pollard OBE, JP, DL – chair (April 2012-January 2013)
Neil Franklin, deputy chair (April-June 2012)
Brian Marsden, non-executive director, and chair (February-March 2013)
David Munt, audit committee chair (April 2012-January 2013)
Barry Fulton, non-executive director, audit committee chair (February-March 2013)
Peter Myers, non-executive director (April 2012-January 2013)
Shafiq Ahmed, non-executive director
Cathy Clelland, non-executive director

Other committees and sub-committees of the board

Details of other committees and sub-committees of the board and their membership are listed below.

Remuneration committee
The remuneration committee is a formally appointed committee of the board of directors and its terms of reference comply with the Secretary of State's code of conduct and accountability for NHS boards.

The role of the remuneration committee is to advise and make recommendations to the board about appropriate remuneration and terms of service for the chief executive, executive directors and other very senior managers covered by the pay framework for very senior managers (VSMs) in strategic health authorities, primary care trusts and ambulance trusts – gateway reference 6931. The committee also approves any residual local pay arrangements and ratifies the application of the national terms for staff.

The committee is made up of the board chair and two non-executive board members, with a quorum being at least two members – the chair and one other non-executive board member. During the financial year April 2012 to March 2013, 10 meetings of the remuneration committee were held. All meetings were recorded as fully quorate.

List of remuneration committee members:

April to June 2012
Linda Pollard, chair
Neil Franklin, non-executive director
Peter Myers, non-executive director

June 2012 to January 2013
Linda Pollard, chair
Peter Myers, non-executive director
Shafiq Ahmed, non-executive director

February to March 2013
Brian Marsden, chair
Shafiq Ahmed, non-executive director
Cathy Clelland, non-executive director

Audit committee
The audit committee was established to provide the board with an independent and objective review of its financial systems, financial information and compliance with laws, guidance and regulations governing the NHS.

The committee was appointed by the board from the trust's non-executive directors and consisted of not less than three members, with a quorum being two members. During the financial year April 2012 to March 2013, five audit committee meetings were held. All meetings were recorded as fully quorate.

As the constituent PCTs of the NHS Airedale, Bradford and Leeds Cluster (from 3/10/11) remained as separate statutory bodies, it was necessary for each PCT to continue to have their own audit committee. Membership of the audit committees for NHS Leeds and NHS Bradford and Airedale was the same, however, and two separate meetings are held, with different internal auditors, external auditors and local counter fraud representatives attending each to ensure that the board was giving sufficient focus to the audit matters of each constituent PCT. On 1 November 2012 the external auditors for Bradford and Airedale PCT transferred from the audit commission to KPMG.

List of audit committee members:

April 2012 to January 2013
David Munt, chair, non-executive director
Brian Marsden, non-executive director
Peter Myers, non-executive director

February to March 2013
Barry Fulton, chair, non-executive director
Cathy Clelland, non-executive director
Shafiq Ahmed, non-executive director

Both internal and external auditors also attend the audit committee.

Governance and risk committee

The governance and risk committee has the task of working closely with the audit committee and executive directors to provide assurance to the board that the trust has effective systems of internal control in relation to risk management and governance.

This committee has delegated responsibility for developing key assurance and risk systems and processes in order that the trust will be compliant with its statutory requirements and be able to ensure sound internal control arrangements. During the financial year April 2012 to March 2013, five governance and risk committee meetings were held. All meetings were recorded as fully quorate.

List of governance and risk committee members:

April to December 2012
Linda Pollard, chair
Brian Marsden, non-executive director
Cathy Clelland, non-executive director
John Lawlor, chief executive
Kevin Howells, director of finance
June Goodson-Moore, director of workforce and corporate development
Dr Ian Cameron, director of public health (Leeds)
Dr Anita Parkin, director of public health (Bradford and Airedale)
Dr Damian Riley, director of primary care/medical director
Philomena Corrigan, director of strategy and commissioning/nurse director
Jo Coombs, director of quality and nursing
Matt Neligan, director of commissioning development

December 2012-January 2013
Linda Pollard, chair
Brian Marsden, non-executive director
Cath Clelland, non-executive director
John Lawlor, chief executive
Kevin Howells, director of finance
June Goodson-Moore, director of workforce and corporate development
Dr Ian Cameron, director of public health (Leeds)
Dr Anita Parkin, director of public health (Bradford and Airedale)
Dr Damian Riley, director of primary care/medical director
Philomena Corrigan, director of strategy and commissioning/nurse director

February-March 2013
Brian Marsden, chair, non-executive director
Cathy Clelland, non-executive director
Shafiq Ahmed, non-executive director
Kevin Howells, director of finance
June Goodson-Moore, director of workforce and corporate development
Dr Ian Cameron, director of public health (Leeds)
Dr Anita Parkin, director of public health (Bradford and Airedale)

Dr Damian Riley, director of primary care/medical director
Philomena Corrigan, director of strategy and commissioning/nurse director

Internal auditors also attend the governance and risk committee.

Our responsibilities

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

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

All NHS organisations and those they contract to provide services must complete an annual assessment using the information governance toolkit (IGT). This performance tool produced by the Department of Health (DH) has helped us measure and assess our compliance and continually strive to promote best practice in secure information handling.

The IGT covers six areas:

- information governance management
- confidentiality/data protection
- information security
- clinical information
- secondary use information
- corporate information.

Using the IGT, we carried out a joint cluster assessment on behalf of NHS Airedale, Bradford and Leeds for NHS Connecting for Health. We achieved an excellent score of 79% which the toolkit classed as satisfactory. Following the assessment, an internal audit provided our board with full assurance.

During 2012/13, we have provided unique support and guidance to all our primary care services who were required to complete the IGT this year. Specialist IG training to staff working in GP surgeries was also provided, along with ongoing advice and guidance to pharmacies, dentists and commercial third party organisations.

Staff have been continually reminded to make sure any personal information they have dealt with has been kept secure at all times, in particular, data held electronically which must be encrypted. This includes USB sticks and laptops. Any incidents involving the loss of unencrypted personal data, such as the theft of an unencrypted laptop, may incur a

fine but we can report there were no serious incidents involving data loss during 2012-13.

Summary of serious untoward incidents involving personal data as reported to the Information Commissioner's office in 2012-13

Date of incident	Nature of Incident	Nature of data involved	Number of people potentially affected	Notification steps
None	None	None	None	None

Summary of personal data related incidents in 2012-13

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	0
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	0
V	Other	0

Freedom of Information Act 2000 (FOI)

This year, 370 Freedom of Information (FOI) requests were sent to the PCT from different sectors, including members of the public, private companies, the media, MPs and researchers. A large number of requests for information have been around the emerging new CCGs in the Bradford and Airedale area and how they will operate in the future.

FOI gives individuals or organisations the right to request information held by public authorities and the PCT has dealt with many subjects, from the emerging CCGs to how much has been spent on stationery and pot plants. Freedom of Information legislation has been embraced by the PCT as an opportunity to demonstrate openness and accountability throughout the organisation. All staff have been regularly reminded of their responsibility to provide information in response to a request within the 20 working day deadline. The NHS Bradford and Airedale IG team is proud to report that 100% of our FOI responses were provided within the 20 working day timescale. No matter how trivial the request may have seemed, they were all answered with the same deference and professionalism.

Health, safety and security

We have always attached great importance to the health, safety, security and welfare of our staff, patients, contractors, visitors and occupiers of our premises. We have always been committed to developing and promoting a positive health and safety (H&S) culture in our organisation, as this has contributed to the overall quality of the services we have provided and the premises we have maintained.

We have measured our performance against agreed standards to help identify where improvements have been needed.

During the last year we have:

- carried out H&S inspections at all of our premises (owned or leased)
- provided H&S training as part of the mandatory training programme to all staff; provided other tailored training for display screen assessment assessors, staff who manage our buildings and those with control of substances hazardous to health (COSHH) responsibilities, as well as some conflict resolution training
- reviewed our suite of H&S risk and regulation policies to ensure they are compliant and up to date
- offered health, safety and security advice to all staff on a proactive and reactive basis involving union representatives as part of our H&S groups and committees and in other decisions
- monitored our performance in two key areas: mandatory occupational H&S standards produced by NHS Employers (http://www.nhsemployers.org/Pages/home.aspx) and a risk policy audit tool to monitor manager compliance.

Our annual health and safety work plan was approved and implemented over the last 12 months. The plan focuses on five key objectives in relation to policy, organising the safety management system (SMS), planning and implementation, measuring performance, audit and review. It also includes the seven areas of work covered by NHS Protect, the national organisation responsible for tackling fraud and managing security. For more information about NHS Protect follow this link: http://www.nhsbsa.nhs.uk/Protect.aspx

Safeguarding adults and children

The health and wellbeing of children and adults has remained one of our priorities and has been integral to the services we have commissioned.

Our safeguarding adults and children policies and procedures were reviewed and amended in recognition of the transfer to clinical commissioning groups.

We have continued to demonstrate strong local safeguarding leadership across the health economy and have played a lead role in both safeguarding children and adults boards.

We have made a significant contribution to multi-agency training and safeguarding case conferences, as well as chairing and membership of regional safeguarding networks and

local safeguarding board sub-groups. In addition, we have continued contributing to the violence against women and girls strategy steering group and represented the PCT on the panel of two domestic homicide reviews within the district.

Training and safeguarding support to our primary care providers including GPs, dentists, opticians and pharmacists has been another important aspect to our work.

Over 90% of GP practices in Bradford and Airedale have an identified lead GP for safeguarding children, and a programme of training (including level 3) and support for these doctors continues. Sixty-one percent of practices now have an identified lead professional for safeguarding adults, who have received, and will continue to receive, appropriate training. The remaining practices are being invited to identify a lead professional for safeguarding adults and will be offered appropriate training.

We have worked closely with safeguarding leads in our local NHS trusts and independent contractors to support the ongoing development of safeguarding practice and strengthen the quality monitoring and performance management of our contracts. This includes overseeing action plans from serious case reviews to ensure that learning from these cases is incorporated into practice. We have continued to offer clinical supervision to the named nurses for safeguarding children in our local trusts.

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

Emergency planning and preparedness

Emergency planning has remained a key priority for NHS Bradford and Airedale, particularly during a period of transition and change. All primary care trusts (PCTs) are categorised by the Civil Contingencies Act (2004) as category one responders. This means there are certain statutory obligations to which we must respond and adhere to, with regards to emergency preparedness. These are:

- to assess risk of emergencies and use this to inform planning
- to put in place and regularly test emergency plans including training for key staff
- to put in place business continuity arrangements
- to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- to share information and cooperate with other local responders to enhance co-ordination and efficiency.

NHS Bradford and Airedale has been an active member of the West Yorkshire Resilience Forum health sub group which is a multi agency group and has a regional remit for emergency preparedness under the Civil Contingencies Act (2004). Other stakeholders include the Yorkshire Ambulance Service, police, local authority and Health Protection Agency. Close links have also been maintained with the West Yorkshire emergency preparedness and resilience manager, based at NHS Calderdale, Kirklees and Wakefield. This has been to ensure that the NHS in West Yorkshire has a coordinated approach to emergency planning and response across the region.

Moving towards the transition of the NHS into the new arrangements under the Health and Social Care Act, emergency planning teams across West Yorkshire have worked together to maximise opportunities for efficient and effective ways of working.

Responding to queries, concerns and complaints

People's views have been gathered through our patient advice and liaison service (PALS). Aiming to answer patients' queries, resolve any concerns people may have or signpost people to appropriate services, PALS officers have provided 'on the spot' help to patients. They have recorded compliments, comments and concerns in relation to patients' experience of local healthcare services and these are used to improve local services.

During the year, the service received 1,545 enquiries: 49 comments, two compliments, 963 concerns and 531 requests for information. The main issues discussed were access to services, care or treatment received, attitude of staff and funding.

This year, our complaints team received 172 'formal' complaints, which were dealt with in accordance with the NHS complaints procedure. A number of these complaints have involved more than one NHS organisation and in such cases our complaints manager has coordinated the investigations and responses to complainants.

Twenty seven of the complaints related to commissioning or funding decisions and other organisational issues and 73 cases raised issues about services we commission, such as those provided in a hospital or community setting.

We also received 123 complaints about our primary care services with the majority of these relating to GP practices (85 cases). Thirty cases involved dentists and eight were about pharmacists.

As well as resolving complaints, we have aimed to learn from any issues raised and take action where necessary – for example, by improving communication, reviewing care plans, appointments, policies and procedures; and providing training for staff.

If a complainant remains dissatisfied with the outcome of their complaint they can contact the Parliamentary and Health Service Ombudsman (PHSO). The ombudsman contacted us about eight cases during 2012/13. All of these cases involved services that we commission. No further action was necessary in two cases and one case is ongoing at the time of writing this report. In the other five cases, the PHSO made recommendations for actions to be taken for service improvements, and in addition recommended that the complainants be compensated by the trusts concerned, by way of financial redress for the distress, anxiety, hardship or injustice suffered.

Our chief executive and chair also responded to 44 letters from MPs and local authority councillors. These were either about commissioning, policy and strategy or concerns about individual patient healthcare issues.

Performance

Like other NHS trusts, we have been responsible for making sure we have provided efficient, effective services to meet the needs of people living in Bradford and Airedale. Our performance across directorates and services has been regularly monitored and reviewed, and improvements have been made to ensure patients have received high quality healthcare services in a timely manner.

Performance against key targets, such as waiting times and public health targets, are shown in the integrated performance reports presented to the cluster board. The 2012/13 reports can be viewed here: http://www.leeds.nhs.uk/ablcluster/board/march-2013.htm.

A number of national targets are set out in the annual NHS Operating Framework and we have held our healthcare providers accountable for the delivery of these requirements. In addition, we have monitored performance against a range of indicators which have reflected the local priorities of the PCT.

Highlights for this year include:

- The ongoing delivery of the four hour A&E standard and of the national cancer waiting times targets.
- Higher than national and regional utilisation of the Choose and Book system, ensuring patients have access to a choice of providers when referred for a hospital consultation, and improving the flow and quality of referral information between primary and secondary care.
- Ensuring that incidences of CDiff across both community and secondary care was below the maximum thresholds set by the Department of Health (DH).
- Reducing the number of emergency admissions to hospital for ambulatory care sensitive conditions i.e. those conditions which should be managed within primary care.
- Keeping the number of hospital discharges which are delayed for non clinical reasons to a minimum.
- Improving access to full health checks for pregnant women at 12 weeks into their pregnancy.
- Continued achievement of the national ambulance response times targets by Yorkshire Ambulance Service NHS Trust (YAS).
- Continuing to offer our local residents, aged 40 to 74 years, a free NHS health check to assess their health and identify any health risks.
- Further increases in the delivery of mental health services for patients needing early intervention or crisis resolution.
- A continued reduction in the number of pregnancies among teenagers, with 2011 performance remaining below the national and regional averages.

Some performance challenges still exist and will remain key priorities for CCGs in 2013/14. These include:

- Working with Bradford Teaching Hospitals Trust to fully implement their 18 week turnaround plan to ensure that national 18 week targets are once again achieved from July onwards.
- Further reducing the number of incidences of CDiff in line with even more challenging national targets being issued by the DH for 2013/14.
- Ensuring a zero tolerance on MRSA incidents.
- Improving breastfeeding rates, particularly beyond the 6-8 week period after birth, and reducing smoking in pregnancy, both of which contribute towards the goal to improve infant mortality rates across the district.
- Ensuring that access to a specialist stoke unit continues to improve stoke patients' recovery and rehabilitation.
- Further improving access to psychological therapy to meet the needs of the population of Bradford & Airedale.

Our staff

This year has been a very demanding one for our staff as the NHS reforms gathered pace leading up to the closure of the Trust and transfer of staff to a wide variety of new NHS organisations and bodies on 1st April 2013.

We have followed the national HR Transition Policy and Guidelines and have been fully committed to supporting and engaging with our staff. A Staff Engagement Forum was introduced to promote open, two-way communication across the organisation and this has helped facilitate staff involvement with regard to transition and wider business planning, harnessing views, ideas and contributions from the whole workforce.

We have held staff road shows and formal consultation meetings to provide an opportunity for staff to hear from the chief executive and other members of the executive team on key developments, including transition plans. In addition to this, we have also used various internal communication briefings mechanisms to ensure all staff have been informed. This has allowed us to foster an open and honest culture where staff opinions are valued and respected.

During this period of change we have strived to maintain our statutory and mandatory training compliance, achieving a 90% success rate. It was important to ensure staff moved forward to their new receiving organisations maintaining their compliance requirements.

Furthermore, it was necessary to support managers and staff to move forward through this changing and challenging time, and a number of programmes were delivered to support individuals and teams. Programmes included resilience training; staff support programmes for CV writing; presenting a positive image; assertive behaviour and individual coaching as well as core skill development, including IT skills. A large majority of the organisation was supported to access training and development.

A considerable amount of organisation development expertise and resources were dedicated to supporting Clinical Commissioning Group (CCSG) developments as these teams came together to form their new organisations. Specific team and leadership development programmes relevant for the new receiving organisations we delivered throughout the year.

This broad range of training/development interventions has seen approximately 60% of the workforce having accessed programmes specifically designed for change.

Sickness absence levels

In the calendar year 2012-13 we lost a total of 3,202 days to sickness absence. With total staff years of 412, this gives the average number of working days lost as 7.77 per employee.

Equality and diversity

Equality and diversity have remained very important to us. During 2012-13 the NHS Bradford and Airedale Equality Group has continued to work with us on assessing and improving our progress in meeting the public sector equality duties outlined in the Equality Act 2010. The group has members from voluntary and community service (VCS) and local hospital providers.

We have been using the national equality delivery system (EDS): a system designed to support our organisation in our commissioning role, as well as our providers of services, in order to deliver better outcomes for the local population and better working environments for staff, which are personal, fair and diverse.

Through this work, we have developed, with our local hospital and community provider trusts, a set of priority equality objectives. We have continued to work with Sheffield Hallam University, the University of Leeds, and NHS Sheffield to take forward the collaborative research project *Evidence and Ethnicity in Commissioning*. This project is looking at how current and future commissioners make good use of evidence to buy and provide services for our diverse communities.

Here are some examples of specific equality and diversity work we have carried out this year:

- we have been working with other agencies across West Yorkshire, including local authorities, the police and universities, to ensure that our services better meet the needs of transgender patients
- we have held focus groups with local people who have recently used maternity services so that we can use their feedback to make improvements
- we have remained committed to recruiting a diverse workforce and have commissioned Enable2, a local social enterprise, to invite unsuccessful disabled and black and minority ethnic (BME) job applicants to a one-day positive action programme to help them develop their job seeking skills
- we have been carrying out a survey among local lesbian and bisexual women to measure the effectiveness of our earlier campaign to encourage greater uptake of cervical screening tests by lesbian and bisexual women.

Our year at a glance

Throughout the year, we have continued to strive to develop and improve the services we have provided. We have involved users of our services, as well as staff and members of the public to make sure the best and most appropriate healthcare services have been available for everyone who has needed them: services that are safe, high quality, effective and accessible. Here are some of the highlights from 2012-13.

April 2012

Thousands of new patients seen on dental access days
Over 4,000 people, many of whom had not been to the dentist in the last two years, received NHS dental care during a recent series of open access days.

Almost half of all NHS practices across the district opened their doors to new patients on three dates. A total of 4,396 appointments were made over the three days, meaning many more people were able to access an NHS dentist and receive care and advice to look after their oral health.

Patients with C. diff urged to carry the card
A new NHS campaign in Bradford and Airedale aimed to help prevent people who have had C.diff infection getting ill from it again in the future.

Clostridium difficile (C.diff) is a healthcare associated infection that affects mainly elderly people, although people of all ages can get it. Across the district, about 250 people a year are infected with C.diff and up to 30% of people who have had it get it again.

The local NHS, including the hospital trusts, Bradford District Care Trust and in partnership with Bradford Council, launched a pilot project to improve the care of people who have had the infection.

May 2012

Local NHS organisations support Dying Matters Awareness Week
Health and support organisations in Bradford and Airedale joined other members of the Dying Matters Coalition for a week of action to encourage people to talk to friends, family and loved ones about their wishes for the end of their lives, including where they want to die and their funeral plans.

As part of the awareness week, called ‘Small actions, big difference’, there was a chance for people to visit information stalls and talk to staff from the NHS end of life care team at shopping centres in Bradford and Keighley.

The Dying Matters Coalition has been set up by the National Council for Palliative Care to raise awareness of death, dying and bereavement and provide the support and information needed to have these conversations with loved ones.

New project helps identify patients with early signs of chronic kidney disease
Hundreds of previously undiagnosed people across Bradford and Airedale were helped to manage the early stages of chronic kidney disease (CKD) thanks to an innovative improvement project.

The patients' conditions were identified by comparing blood test results over a period of time to identify how well their kidneys were working. Over half of the district's practices volunteered to take part in the project managed by the clinical effectiveness team at NHS Airedale, Bradford and Leeds – and so far an additional 1,700 adult patients have been diagnosed with early stage CKD.

With advice from the project team, which includes facilitators and clinical specialists, practices have used new data searches to identify where further blood tests need to be done to find patients whose kidneys are not working as well as they should be.

June 2012

Major new technology development set to improve patient care
Patients and health professionals in Bradford and Airedale are benefiting from a major investment in innovative new IT which will mean quicker, easier access to patient records and other healthcare information.

The project – the first of its scale in the NHS in England – is a £4.2 million local investment in new computer technology for all the GP practices and health centres in the district.

It will replace outdated PCs with new virtual desktop technology that will allow quicker log-in speeds and give health professionals the flexibility to log-in and access patient records from whichever NHS base they are working from that day.

Get to know about diabetes in Bradford
A week of special diabetes events were held across the district to help encourage more people to be aware of diabetes and know the risks related to the condition.

The community engagement team organised a range of community events including a mix of health checks, information giving and awareness raising around symptoms, risk factors and self-management of the condition.

The events were in areas of Bradford where prevalence of type 2 diabetes is high; to increase early detection, uptake of services and improve self-management.

July 2012

Top up on the sunshine vitamin this summer
A new public health campaign was launched to encourage more people in Bradford and Airedale to top up on vitamin D during the summer to avoid the risk of deficiency.

Many people are unaware that they or their children could be at risk of vitamin D deficiency by not getting outdoors enough each day.

To help tackle the issue of vitamin D deficiency, the local NHS and partners launched a new publicity campaign to raise awareness about ways to get enough vitamin D.

Local mosques support stop smoking and health advice during Ramadan
The local NHS stop smoking service once again teamed up with mosques during Ramadan to give congregations easy access to help and advice with quitting, as well as offering a one-stop-shop for other health advice.

Visits to mosques have been part of the Ramadan campaign for the past 10 years, but last year the local NHS started offering health checks as well as stop smoking advice. The visits have proved a great success and increased referrals to the stop smoking service.

August 2012

New NHS landscape discussed in live online chat
Local plans to put patients at the heart of the NHS were discussed during a live webchat with a GP involved in one of Bradford's new clinical commissioning groups (CCGs).

Dr Yasmin Khan, an elected member of Bradford Districts CCG, went online to answer questions about how the CCG will work and how patients can get more involved in helping to shape local health services.

Make a Change 4 Life with adult weight loss programmes
The local NHS obesity team launched a new series of adult weight management programmes in Bradford and Airedale.

Across the district, around half of all adults are putting their health at risk by carrying excess weight. The obesity team provides a variety of weight management services at different venues in Bradford and Airedale. The team offers weight management programmes for adults and separate ones for children and families.

September 2012

Health campaign warns of the danger of smoking shisha
An advertising campaign was unveiled by the NHS in Bradford to highlight the health risks of smoking shisha.

Shisha smoking is becoming increasingly popular in the area with many new shisha bars opening up, but health experts are warning that despite the misconceptions, it is not a safe alternative to smoking cigarettes.

Shisha smoke contains the same combination of nicotine, tar, carbon monoxide and heavy metals that cigarette smoke contains. Smoking shisha also harms others by producing second hand smoke.

October 2012

Bradford and Airedale mums urged to protect their babies against whooping cough
Health professionals in Bradford and Airedale urged mums to protect their newborn babies against the whooping cough as cases continued to rise nationally.

The local NHS launched a local vaccination campaign offering all pregnant women who have reached at least 28 weeks of pregnancy, and mums of newborn babies who have never previously been immunised with a whooping cough vaccination, the chance to protect their children against the highly contagious infection.

Local mums were encouraged to speak to their GPs or their midwife to find out more and take up the offer of being vaccinated.

Local NHS CCGs launch new websites
The three new CCGs in Bradford, Airedale, Wharfedale and Craven went live with their own websites to tell people about their plans for improving healthcare for all, and how patients and the public can get involved.

A priority for all three local CCGs is to have patients and the public central to decision making, to hear what people think and to use this information as they make decisions about services and to tell people how they have used their views. The websites tell people how they can get involved through an online feedback form, by phone, Twitter or Facebook.

November 2012

Local project to raise awareness of diabetes scoops national award
The work of a local NHS team to help encourage more people to be aware of diabetes and know the risks related to the condition received national recognition.

The community engagement team won a prestigious Quality in Care Diabetes 2012 award in the 'best initiative addressing unacceptable variation' category for their work with communities in Bradford.

Over the last three years the community engagement team has worked in community settings in areas of Bradford, where prevalence of type 2 diabetes is high, to raise awareness of the risk factors and symptoms of diabetes and give people information on self-management of the condition.

Patients in Bradford and Airedale urged to Choose well in winter
Doctors urged patients in Bradford and Airedale to Choose well and get the right NHS treatment over winter.

Thousands of Choose well leaflets were sent to GPs, pharmacists and local hospitals across the district to help people make the right choice about which health service to use over the winter months, and help reduce demand on emergency services.

December 2012

Tackling alcohol harm is top priority for new CCGs
Bradford and Airedale's new NHS CCGs invested over £1 million in a pilot specialist health support scheme to tackle alcohol-related harm.

In Bradford and Airedale 92,000 people drink at hazardous levels and 17,000 of these at harmful levels, and this data shows that alcohol misuse continues to cause a range of problems, especially health problems, locally.

There is an increasing range of practical support and advice on offer across the district to help people with alcohol problems, and new funding from the three CCGs – Bradford City; Bradford Districts; and Airedale, Wharfedale and Craven – will expand the range of alcohol misuse services on offer.

Local artwork supported World AIDS Day
World Aids Day took place worldwide on 1 December. As part of this, a local event featuring live music, fun activities and artwork was held to raise awareness of HIV and AIDS.

World AIDS Day is about reminding everyone that HIV has not gone away and there is still a need to increase awareness, fight prejudice, and improve education. Around 97,000 people are living with HIV in the UK (with around a quarter not knowing they have the virus), and globally an estimated 34 million people have HIV.

January 2013

Green light for new health organisations
The three organisations which will buy and design healthcare services for local people were given the green light to become fully established.

Bradford City CCG, and Bradford Districts CCG were authorised by the NHS Commissioning Board without any conditions. Airedale, Wharfedale and Craven CCG was authorised with only one condition around its capacity to manage arrangements for commissioning support – which was being resolved through ongoing recruitment.

This followed an intensive assessment period to ensure the CCGs can commission hospital, community health and mental health services on behalf of local people. The assessment included reviewing policies, carrying out site visits, interviewing leaders and assessing work with stakeholders, patients and the public.

New project helps heart attack and stroke patients
Patients in Bradford and Airedale who have suffered a heart attack or stroke are being helped to learn more about their condition and how to keep themselves well for the long-term.

A new project developed by the local NHS clinical effectiveness team aims to encourage GPs and other health professionals to improve the treatment and management of

patients who have suffered a heart attack or stroke – to reduce the chances of their illness recurring.

Launched at a conference in Bradford, the innovative project is supported by the three local CCGs.

February 2013

Healthcare survey for lesbian and bisexual women
The local NHS encouraged lesbian and bisexual women in Bradford and Airedale to take part in a survey to find out about their recent experience of using healthcare services.

This followed up on successful work that has been done over the last few years to increase the take-up of cervical screening in this group of women.

A myth-busting campaign was developed by the NHS and Bradford's Equity Partnership to encourage more lesbian and bisexual women in Bradford and Airedale to get screened for cervical cancer.

Mental health on the agenda for local health commissioners
Mental health was on the agenda as Bradford Districts CCG's governing body met in public.

A mental health advocacy worker talked about her experiences of using local services and how they can be taken into account as the group further develops its strategy.

March 2013

Local health commissioners tune into young people's views
Young people in Bradford were invited to play a key role in helping local health commissioners shape services around their unique needs.

Bradford City CCG invited a group of young people to its governing body meeting to share their experiences, and discuss how CCGs can work with and involve young people – in particular around mental health services – and talk about what's important to them.

The young people have already taken part in partnership groups which aim to improve involvement in decision making, enable young people to make a difference, tackle stigma around mental health and improve how services view their users.

Investing in services

Urgent care services
We want to make sure the most appropriate urgent care services are available to all our residents if they have an urgent healthcare need. Throughout the year new developments have taken place to improve access to services across the district.

NHS 111
The government has decided to introduce a new national 111 service for patients who need urgent healthcare services. To implement this in Yorkshire and the Humber we have worked with our colleagues to design, develop and commission the service which will be available 24 hours a day, 365 days a year from March 2013.

In July 2012 NHS Commissioners in Yorkshire and the Humber announced the partnership of Yorkshire Ambulance Service NHS Trust and Local Care Direct as the preferred provider to deliver the new NHS 111 service for the region.

The NHS 111 service will make it easier for the public to access healthcare services when they need medical help fast, but it's not a life-threatening situation. The contract will also include out-of-hours urgent treatment services for residents of West Yorkshire and Craven.

The free to call service, being rolled out across England, is part of wider revisions to the urgent care system.

On dialling 111 callers will be put through to a team of fully trained advisers and experienced nurses, receive a clinical assessment and be directed to the local service that can help them best at that time. This could be providing details of the nearest pharmacy, booking an appointment at an outpatient's clinic or even calling 999 if the adviser feels necessary.

The service will increase the efficiency of the NHS while reducing the number of non-emergency calls received by 999 and avoidable ambulance journeys.

There are now only three numbers people need to know; 999 for life-threatening emergencies, their GP surgery and 111. For any more information on NHS 111 visit www.nhs.uk/111

Out-of-hours
Last year we looked at the out-of-hours services provided across Bradford and Airedale to help shape the future of urgent care

As part of a 12-week engagement process, we asked people to have their say on where urgent GP out-of-hours healthcare is provided in the district.

'Urgent care' describes the NHS services people use when they need advice or treatment immediately, but which is not an emergency or life-threatening. This can be used any time of day or night and any day of the week, including bank holidays.

The review focused on where patients should be able to see a GP if they have an urgent health need in the out of hours period – these are known as primary care centres.

The PCT board agreed to support the recommendations to keep the current locations for services at, or close to, the A&E departments at BRI and Airedale Hospital, and further improve these services by providing more doctors to increase the number of appointments available. It also agreed to continue to provide the same limited GP out-of-hours service in the community, based at Eccleshill Community Hospital.

Unscheduled dental care
Over the past year work has started to re-commission the district's unscheduled dental care service, which provides people with access to urgent dental appointments.

An engagement process has been running to hear people's views on the NHS unplanned or urgent dental service provided in West Yorkshire for:

- people without a regular dentist who need treatment
- people who need treatment urgently but cannot access their regular dentist.

There are currently five different services across West Yorkshire and the contracts for these come to an end in March 2014.

Integrated care
The PCT has worked with local providers of health and social care, including Bradford Teaching Hospitals, Voluntary Services, Bradford Council and Bradford District Care Trust to develop the Integrated Care for Adults programme.

The aims of Integrated Care include fostering co-working and communication between the different organisations that provide support to Bradford and Airedale residents in order to offer a joined-up, holistic approach to care within communities and prevent avoidable stays in hospital. It involves identifying people with complex and multiple needs and helping them to remedy issues before they lead to unplanned hospital or care home admissions. Working in this way enables people to continue living at home, with all the things that are important to them within easy reach, keeping hospital beds free for emergencies and planned admissions. Integrated care has a strong focus on helping people to have clear plans to help themselves, as for every hour a person might spend with a health or social care professional, they will spend many more with their own families or by themselves.

The programme has funded a number of new initiatives in the district such as delivering education around self care and healthy lifestyles to young people, thus helping to prevent the onset of health limiting conditions like diabetes and obesity. Integrated Care teams, which are linked to GP practices, are currently in place in several test sites and will soon be rolled out to all areas.

The future

During 2012-13, three shadow clinical commissioning groups (CCGs) were established in Bradford and Airedale. These were: Bradford City CCG, Bradford Districts CCG and Airedale, Wharfedale and Craven CCG. Becoming fully established on 1 April 2013, the CCGs took over some of the PCT's responsibilities.

Each CCG's role includes commissioning services for its local population. It also has other duties including working in partnership with other CCGs and the local authority. CCGs are very different from PCTs and any of their predecessors. They are made up of member GP practices which, through their constitution, establish a governing body to oversee the way they carry out their responsibilities. As a minimum, the governing body includes GPs, a hospital specialist, a nurse, two lay members, a chief financial officer and the accountable officer.

Each CCG went through a strict process to become authorised as a statutory NHS body. This provides assurance that they have the right skills and abilities to take on responsibility for commissioning NHS services for their populations. Services CCGs are responsible for buying include:

- community health services
- maternity services
- planned hospital care (operations, scans etc)
- rehabilitation services
- urgent and emergency care, including A&E, ambulances and out-of-hours services
- continuing healthcare (a package of care provided outside hospital, arranged and funded by the NHS, for people with ongoing healthcare needs).

NHS England, another new NHS organisation, is responsible for commissioning some specialist services:

- primary care services, including community pharmacy and NHS sight tests
- all dental services
- specialised services
- high security psychiatric services
- health services for prisoners
- some services for members of the armed forced and their families
- some public health services.

Public health services are provided by Bradford Council, including responsibility for health improvement services such as:

- most sexual health services
- the Healthy Child programme for school age children – including school nurses

- local programmes to promote physical activity, healthy eating and weight management
- drug and alcohol misuse services
- stop smoking services
- local projects to prevent accidental injury, such as stopping people falling
- local projects to reduce deaths related to the seasons, for example, cold-related deaths in winter
- emergency planning.

Bradford Council is also responsible for the joint strategic needs assessment (JSNA). This includes identifying the health needs of the district through an assessment of health and wellbeing so that the right services can be put in place now and in the future. Public Health England is responsible for protecting and improving the health and wellbeing of the population and in reducing inequalities in health and wellbeing.

Bradford City CCG
Bradford City CCG has 28 member practices serving over 118,000 people. Its leaders are Dr Akram Khan, clinical chair, and Helen Hirst, chief officer. The CCG's mission is to be an outstanding NHS organisation that tackles health inequalities and improves health outcomes for its population. Its key priorities are:

- improving people's health and wellbeing and increasing life expectancy
- to develop better, locally integrated long-term conditions management
- to improve patients' experience through meaningful engagement with the community, primary care and partners
- developing a viable, sustainable, effective organisation
- commissioning and ensuring delivery of safe, high quality, effective services

Bradford City CCG can be contacted at:

Douglas Mill
Bowling Old Lane
Bradford
BD5 7JR

Tel: 0845 1115000 (switchboard)
Fax: 01274 237453

Bradford Districts CCG
Bradford Districts CCG has 41 member practices serving 330,115 people, covering areas including Bingley, Shipley, Saltaire, Heaton and Tong. Its leaders are Dr Andy Withers, clinical chair, and Helen Hirst, chief officer. The CCG's mission is to transform services and achieve integration through clinical drive, strong leadership and working in partnership with its members, population and stakeholders. Its key priorities are:

- tackling health inequalities through prevention, integration and partnerships
- improving patient safety and the patient experience

- transforming urgent care
- improving outcomes of people with long-term conditions
- transforming mental health and community services
- improving primary care quality and ensuring genuine engagement.

Bradford Districts CCG can be contacted at:

Douglas Mill
Bowling Old Lane
Bradford
BD5 7JR

Tel: 0845 1115000 (switchboard)
Fax: 01274 237453

Airedale, Wharfedale and Craven CCG
Airedale, Wharfedale and Craven CCG has 17 member practices serving 156,000 people. Its leaders are Dr Colin Renwick, chair, and Dr Phil Pue, chief clinical officer. The CCG's mission is to provide clinically led, innovative commissioning of efficient and effective healthcare, informed by patients, carers and clinicians. Its key priorities are:

- transforming planned care and long-term conditions
- transformation and integration of health and social care for adult and children's services
- reducing health inequalities and increasing health promotion
- transforming mental health and urgent care services
- maintaining safe, high quality and effective care.

Airedale, Wharfedale and Craven CCG can be contacted at:

Millennium Business Park
Station Road
Steeton
Keighley
BD20 6QW

Tel: 0845 111 5000 (switchboard)

Financial information

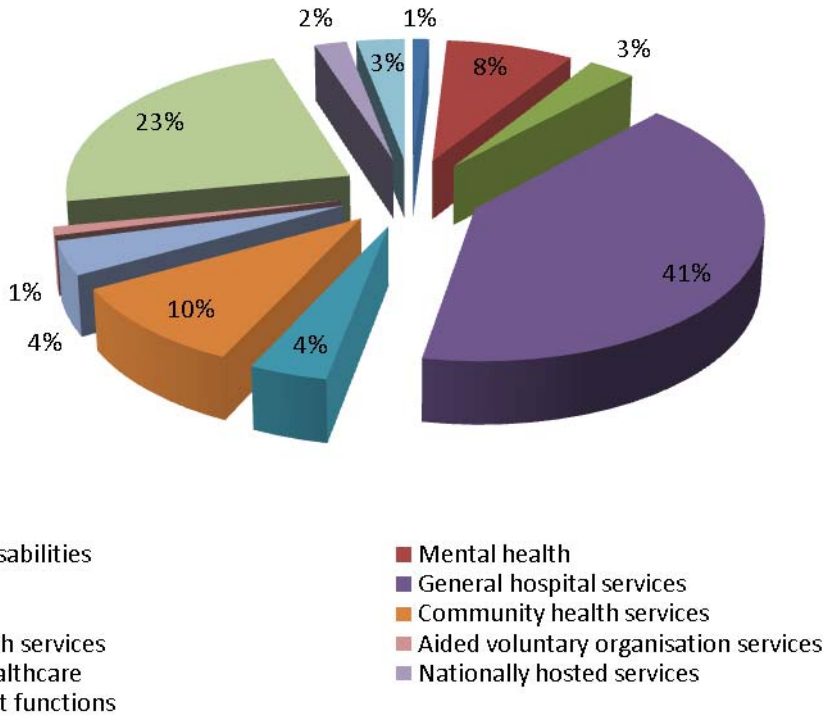
The PCT met all its financial targets and reported a surplus of £7.5m (0.79% of resources) which will be carried forward to invest in future years.

Target performance	Actual performance	Target Achieved
Keep Net Operating Costs within the Revenue Resource Limit of £951,099,000	Net Operating Costs of £943,599,000	Yes
Revenue Surplus of £7,500,000	Revenue Surplus of £7,500,000	Yes
Keep Capital Expenditure within the Capital Resource Limit of £700,000	Capital Expenditure of £496,000	Yes
Operate within the Cash Limit of £940,690,000 set by the Department of Health	Net Cash Payments of £939,390,000 made in the year	Yes

The PCT's 2012-13 Revenue Resource Limit is shown after a reduction of £2m in respect of a transfer to the Strategic Investment Fund held by the Yorkshire and The Humber Strategic Health Authority. These funds will be made available by NHS England to the three CCGs covering the Bradford district to fund future commitments from 2013-14 onwards.

Spending in 2012-13

Net operating costs for the year amounted to £943.6m and were spent in the following way:



Better Payment Practice Code - 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	16,397	113,395	17,330	107,583
Total non-NHS trade invoices paid within target	15,631	104,880	16,587	102,113
Percentage of NHS trade invoices paid within target	**95.33%**	**92.49%**	**95.71%**	**94.92%**
NHS payables				
Total NHS trade invoices paid in the year	5,023	603,388	4,882	588,845
Total NHS trade invoices paid within target	4,701	598,605	4,351	579,888
Percentage of NHS trade invoices paid within target	**93.59%**	**99.21%**	**89.12%**	**98.48%**

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

Asset values

In accordance with the requirements of International Financial Reporting Standards, the PCT must review its property asset values on a regular basis. The district valuer has re-valued the PCT's property as at 31 March 2013 resulting in an increase in value of £409k compared to the stated value at the end of March 2012. The value of PCT land and building assets (excluding dwellings) now stands at £48.8m.

Audit fees

Audit fees paid to the PCT's external auditors (KPMG LLP) for the audit of annual accounts and statutory grant work totalled £135,679. Further assurance services provided by KPMG LLP had a value of £48,196, which related to the audit of clinical coding as part of Payments by Results work (£25,200), data extraction for national fraud initiative work (£1,000), the audit of the PCT's Charitable Funds (£2,376) and the PCT share of the Cluster cost of work on PCT Transition and Governance Arrangements (£19,620). See page 8 for the membership and operation of the audit committee.

Remuneration Report

This report provides details of the policy regarding the remuneration of senior managers employed by the PCT during 2012/13 and details of the remuneration paid to them. The report reflects the Airedale, Bradford and Leeds Cluster Board arrangements for managing the PCT. Senior managers for the purpose of this report are defined as the directors and non-executive directors of the PCT.

Remuneration policy

Senior manager remuneration levels are set by the remuneration committee (see page 7 for more details) in line with the Pay Framework for Very Senior Managers as issued by the Department of Health. Under this framework, an annual uplift (consolidated into annual salary) and a performance bonus (not consolidated into annual salary) can be

awarded depending on the performance of each senior manager. The uplift and performance bonus are determined annually based on recommendations made by the Remuneration Committee.

Senior manager remuneration

Table 1 provides details of the PCTs share (pro-rata to population) of the remuneration paid to each senior manager employed by either NHS Bradford and Airedale PCT or NHS Leeds PCT in 2012/13 together with comparative figures for 2011/12. This includes benefits in kind which relates to the provision of leased cars.

The banded annualised remuneration of the highest paid director in the PCT in the 2012/13 financial year was £100,000 to £105,000. This was three times the median remuneration of the workforce which was £34,189. In 2012/13, 24 employees received annualised remuneration in excess of the highest paid director.

Total remuneration includes salary, non-consolidated performance related pay, benefits-in-kind and severance payments. In 2012/13, remuneration ranged from £2,172 to £180,299, with the higher value including a lump sum redundancy payment.

Table 2 provides details of the accrued benefits under the NHS Pension Scheme for each senior manager employed by either PCT in 2012/13 as for Table 1, but the values shown are total accrued benefits rather than a population based share. Comparative figures for the cash equivalent transfer value are also shown for 2011/12.

The increases in pension and cash equivalent transfer values are measured against the 2011/12 value inflated by 5.2% (in line with Cabinet Office inflation calculations) to give a real terms change in value. For the cash equivalent transfer value, the employer funds 70% of the change in value and it is this figure that is disclosed.

The content of and notes to Tables 1 and 2 have been subject to audit as the Tables and notes include figures that have not already been disclosed within the PCT's Annual Accounts.

Table 3 provides a summary of staff departures that had a related exit package analysed by type of departure and cost band.

Review of tax arrangements of public sector appointees

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

Table 1: Senior Manager disclosures – salaries and allowances

Name	Position	2012/13				2011/12			
		Salary £000	Other remuneration £000	Bonus payments £000	Benefits in kind £000	Salary £000	Other remuneration £000	Bonus payments £000	Benefits in kind £000
John Chuter	Chairman to 2.10.11					15-20			
David Munt	Non-executive director to 31.1.13***	0-5	0-5			5-10			
Shafiq Ahmed	Non-executive director***	0-5				0-5			
Dr Mohammed Ali	Non-executive director to 2.10.11					0-5			
Alison Richards	Non-executive director to 2.10.11					0-5			
Pam Essler	Non-executive director to 2.10.11					0-5			
Alyson McGregor	Non-executive director to 2.10.11					0-5			
Cathy Clelland	Non-executive director***	0-5				0-5			
Simon Morritt	Chief executive to 12.6.11					25-30			1
Matt Neligan	Director of Commissioning					15-20			
	Interim chief executive from 13.6.11 to 2.10.11					40-45			
	Director of commissioning development from 3.10.11 – 26.10.12***	20-25				15-20			

Anne Flanagan	Interim director of commissioning from 13.6.11 – 2.10.11					25-30			
Jo Coombs	Director of nursing to 2.10.11					45-50			
	Director of quality & nursing from 3.10.11 – 31.10.12***	20-25				15-20			
Steve Ingleson	Director of performance & IT to 2.10.11					45-50			
Dr Andy McElligott	Medical director to 2.10.11					50-55			
Dr Anita Parkin	Director of public health***	95-100			8	95-100			14
Jane Hazelgrave	Director of finance to 2.10.11					50-55			5
Linda Pollard	Chairman from 3.10.11 – 31.1.13***	10-15				5-10			
Barry Fulton	Non-executive director from 3.10.11***	0-5				0-5			
Brian Marsden	Non-executive director from 3.10.11 – 31.1.13***	0-5				0-5			
	Chairman from 1.2.13***	0-5							
Neil Franklin	Non-executive director from 3.10.11 – 30.6.12***	0-5				0-5			
Peter Myers	Non-executive director from 3.10.11 – 31.1.13***	0-5	0-5			0-5			
John Lawlor	Chief executive from 3.10.11 – 9.1.13***	50-55				30-35			
June Goodson-Moore	Director of corporate development from 3.10.11***	45-50				20-25			

Philomena Corrigan	Director of delivery & service transformation from 3.10.11***	50-55				20-25			
Dr Damian Riley	Medical director from 3.10.11***	55-60				20-25			
Kevin Howells	Director of finance from 3.10.11***	40-45				25-30			
	Acting chief executive from 23.7.12***	15-20							

*** Bradford and Airedale PCT share of Cluster Board costs from 3 October 2011

Airedale, Bradford and Leeds cluster

From 3 October 2011, Leeds PCT and Bradford and Airedale PCT, in accordance with Department of Health requirements, worked together under cluster arrangements – the NHS Airedale, Bradford and Leeds cluster. From that date there was a single cluster Board, comprising executive and non-executive members who were responsible for the management of both statutory PCT organisations. The costs of these members have been allocated 60% to Leeds PCT and 40% to Bradford and Airedale PCT (with the exception of the Director of Public Health (Bradford) and the remuneration details shown above only include the Bradford and Airedale PCT share as required by the Department of Health.

Total salary costs for the Cluster Board for 2012/13 were:

Name	Position in Airedale, Bradford and Leeds Cluster	Salary	Other remuneration
David Munt	Non Executive Director to 31.1.13	10-15	0-5
Shafiq Ahmed	Non Executive Director	5-10	
Cathy Clelland	Non Executive Director	5-10	
Matt Neligan	Director of Commissioning Development to 26.10.12	60-65	
Jo Coombs	Director of Quality & Nursing to 31.10.12	55-60	
Dr Anita Parkin	Director of Public Health	95-100	
Linda Pollard	Chairman to 31.1.13	35-40	
Barry Fulton	Non Executive Director	5-10	
Brian Marsden	Non Executive Director to 31.1.13	5-10	
	Chairman from 1.2.13	5-10	
Neil Franklin	Non Executive Director to 30.6.12	0-5	
Peter Myers	Non Executive Director to 31.1.13	5-10	5-10
John Lawlor	Chief Executive to 9.1.13	125-130	
June Goodson-Moore	Director of Corporate Development	120-125	
Philomena Corrigan	Director of Delivery & Service Transformation	130-135	
Dr Damian Riley	Medical Director	140-145	
Kevin Howells	Director of Finance	100-105	
	Acting Chief Executive from 23.7.12	45-50	

Table 2: Senior manager pensions

	Real increase in pension at age 60	Lump sum at age 60 related to real increase in pension	Total accrued pension at age 60 at 31 March 2013	Lump sum at age 60 related to accrued pension at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2012	Real increase in Cash Equivalent Transfer Value	Employer's contribution to stakeholder pension
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Matthew Neligan Director of commissioning development to 26.10.12	-2.5-0	-2.5-0	20-25	60-65	273	261	3	0
Linda Joanne Coombs Director of quality and nursing to 31.10.12	0-2.5	0-2.5	35-40	115-120	679	635	15	4
Anita Parkin Director of public health	0-2.5	0-2.5	25-30	80-85	458	422	25	10
John Lawlor Chief executive to 9.1.13	-2.5-0	-2.5-0	55-60	165-170	1025	961	11	8
Kevin Howells Director of finance	-2.5-0	-2.5-0	45-50	140-145	951	894	11	7
Acting chief executive from 23.7.12								
Philomena Corrigan Director of delivery and service transformation	-2.5-0	-2.5-0	35-40	105-110	621	579	12	8

	Real increase in pension at age 60	Lump sum at age 60 related to real increase in pension	Total accrued pension at age 60 at 31 March 2013	Lump sum at age 60 related to accrued pension at	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2012	Real increase in Cash Equivalent Transfer Value	Employer's contribution to stakeholder pension
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Damian Riley Medical director	2.5-5	5-10	40-45	130-135	804	691	78	54
June Goodson-Moore Director of corporate development	0-2.5	5-10	45-50	135-140	1045	920	77	54

Table 3: Exit packages 2012-13

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
Lees than £10,000	6	3	9
£10,001-£25,000	9	2	11
£25,001-£50,000	5	3	8
£50,001-£100,000	6	1	7
£100,001 - £150,000	1	1	2
£150,001 - £200,000	2	0	2
>£200,000	1	0	1
Total number of exit packages by type	**30**	**10**	**40**
Total cost of Exit Packages (£'000)	**£1,438**	**£326**	**£1,764**

Disclosure of information for audit purposes

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

Annual accounts – report of the financial director

The PCT's financial statements have been prepared in accordance with the Resource Accounting Manual (RAM) issued by HM Treasury. The full details of the accounting policies adopted by the Primary Care Trust can be obtained from our audited accounts (see appendix 1).

NHS Airedale, Bradford and Leeds PCT cluster board members register of interests 2012/13

Name and position	Name of company, partnership, local authority of other organisation	Nature of interest	Type of interest	Date of appointment/ resignation
Linda Pollard Chairman OBE, JPDL (to 31 January 2013)	Yorkshire Forward	Deputy chair	Direct pecuniary	Resigned: June 2012
	University of Leeds	Chair and pro-chancellor	Direct non pecuniary	Appointed: January 2007
	Coutts plc	Regional chair	Direct pecuniary	Appointed: April 2007
	2% Club	Chair	Direct non pecuniary	Appointed: April 2009
	An Inspirational Journey	Chair	Direct non pecuniary	Appointed: March 2011
	Universities and Colleges Employers Association	Board member	Direct non pecuniary	Resigned: February 2012
	Committee of University Chairs	Committee member	Direct non pecuniary	Joined: January 2007
Shafiq Ahmed Non-executive director	Bradford Teaching Hospitals NHS Foundation Trust	Partner governor	Direct non pecuniary	Appointed: August 2007
	Farnham Road Children's Centre	Centre manager	Direct pecuniary	Appointed: December 2007
	Bradford Children's Trust board	Member	Direct non pecuniary	Appointed: June 2008
Cathy Clelland Non-executive director	Canny Consultants Ltd	50% owner & employee	Direct pecuniary	Appointed: October 1996
	City Kippig Ltd	90% owner/ director	Direct non pecuniary	Appointed: May 1999, dormant since 2000
	West North West Homes Ltd (Arms length management organisation)	Non-executive director	Direct pecuniary	Appointed: MApril 2006
	The Regional Food Group for Yorkshire and Humber Ltd	Non-executive director/chair	Direct pecuniary	Appointed: September 2010

Name and position	Name of company, partnership, local authority of other organisation	Nature of interest	Type of interest	Date of appointment/ resignation
Cathy Clelland Non-executive director (cont)	The Agriculture and Horticulture Development Board HGCA Ltd	Non-executive director	Direct pecuniary	Appointed: April 2011
	Harrogate and District NHS Foundation Trust	Stakeholder governor	Direct non pecuniary	Appointed: 1 May 2012
Brian Marsden Non-executive director	Harrogate and District NHS Foundation Trust	Stakeholder governor	Direct non pecuniary	Resigned: 1 May 2012
	Joint committee of the WYCSS	Non-executive member	Indirect	Appointed: 24 May 2012
Peter Myers Non-executive director	Finance Yorkshire Ltd	Non-executive director	Direct pecuniary	Appointed: 1 September 2009
	Royal Air Force Volunteer Reserve (training)	Officer	Direct pecuniary	Appointed: 28 April 2009
	Beverley Building Society	Chief executive	Direct pecuniary	Appointed: 1 September2011
David Munt Non-executive director	University of Chester (As part of its courses the university trains nurses and midwives)	External advisor to the audit and risk committee	Direct non pecuniary	Appointed: 26 May 2006
		Member of University Council	Indirect non pecuniary	Appointed: 1 June 2012 (Council approved 28 June 2012)
John Lawlor Chief executive	Bradford Teaching Hospitals NHS Foundation Trust	Wife is an employee	Indirect non pecuniary	Appointed: October 2009
	NHS Commissioning Board Authority	Part-time secondment	Direct non pecuniary	Appointed: 1 March 2012
Ian Cameron Joint director of public health (Leeds)	Leeds City Council	Joint director of public health	Direct non pecuniary	Appointed: 1 October 2010

Name and position	Name of company, partnership, local authority of other organisation	Nature of interest	Type of interest	Date of appointment/ resignation
Jo Coombs Director of quality and nursing	Hammond and Coombs Dental Practice, Meanwood, Leeds	Husband is partner/owner	Indirect pecuniary	Appointed: Owner for past 20 years
Philomena Corrigan Director of delivery and service transformation	Leeds West Clinical Commissioning Group	Shadow accountable officer	Direct pecuniary	Appointed: 1 May 2012
Kevin Howells Director of finance (and July 2013 onwards, acting chief executive)	Community Ventures	Public sector director	Direct non pecuniary	Appointed: 1 September2009
June Goodson-Moore Director of corporate development	Employment tribunals panels	Employment judge/lay member	Direct non pecuniary	Appointed: 1990
	Leeds Partnership Foundation Trust	Partner governor	Direct non pecuniary	Appointed: November 2009 Resigned: 31 March 2012
Matt Neligan Director of commissioning development	Oasis School of Human Relations	Mother is non-executive director	Indirect non pecuniary	
Anita Parkin Joint director of public health (Bradford and Airedale)	Cit of Bradford Metropolitan District Council	Joint director of public health	Direct non pecuniary	Appointed: 16 April 2007
Damian Riley Medical director	National Clinical Assessment Service	Trainer and clinical assessor	Direct non pecuniary	Appointed: 1 April 2002
	Woodhouse Surgery, Leeds	General Practitioner	Direct non pecuniary	Appointed: 1 November 2007

Name and position	Name of company, partnership, local authority of other organisation	Nature of interest	Type of interest	Date of appointment/ resignation
Damian Riley Medical director (cont)	Leylands Medical Practice, Bradford	Wife is salaried employee	Indirect pecuniary	Appointed: 2004
Simon Stockill Clinical chair (Leeds)	Leeds Clinical Commissioning Groups	Interim director of transformation	Direct pecuniary* (paid as clinical chair)	Appointed: 1 June 2012
	Kirkstall Lane Medical Centre	Partner	Direct pecuniary	Appointed: 15 November 2006
	H3+ Commissioning Group	Member	Direct pecuniary	Appointed: 2008
	Assura Leeds LLP	Shareholder	Direct pecuniary	Appointed: 2008 Resigned: 3 September 2012
	National Youth Theatre of Great Britain	Board member/ trustee	Direct non pecuniary	Appointed: 2001
	The Labour Party	Member	Direct non pecuniary	Joined: 1996

Department of Health

NHS

Bradford and Airedale Teaching Primary Care Trust

2012-13 Accounts

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Bradford and Airedale Primary Care Trust

2012-13 Accounts

Data entered below will be used throughout the workbook:

Entity name:	Bradford And Airedale Teaching PCT Q32 5NY
This year	2012-13
Last year	2011-12
This year ended	31 March 2013
Last year ended	31 March 2012
This year commencing:	1 April 2012
Last year commencing:	1 April 2011

Accounts Foreword

The Primary Care Trust has prepared these Accounts in compliance with the determination and directions given by the Secretary of State for Health under the powers conferred on him under section 232 (Schedule 15,3(1)) of the National Health Services Act 2006.

Bradford and Airedale Teaching PCT was dissolved on 1st April 2013 and the PCT's functions, assets and liabilities were transferred to other public sector entities. When a reconfiguration of this nature occurs, in line with Government accounting requirements, the activities of the PCT are considered to be continuing operations and therefore these Accounts have been prepared on a "going concern" basis.

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 in England, an officer of the Department of Health, to discharge the following responsibilities for the Department, to ensure that for the year ended 31 March 2013:

- there were effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

- value for money was achieved from the resources available to the primary care trust;

- the expenditure and income of the primary care trust had been applied to the purposes intended by Parliament and conform to the authorities which govern them;

- effective and sound financial management systems were in place; and

- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the net operating cost, recognised gains and losses and cash flows for the year.

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

nb: sign and date in any colour ink except black

Signed .....Designated Signing Officer

Name Andrew Buck

Date 4/6/13

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 cashflows 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 prepaing the accounts.

By order of the Permanent Secretary.

nb: sign and date in any colour ink except black

4.6.13 .....Date ....Signing Officer

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

Bradford and Airedale PCT Annual Governance Statement

Between 1 April 2012 and 31 March 2013 NHS Bradford and Airedale has controlled a range of strategic risks in relation to the priorities set out in the NHS Operating Framework 2012/13 and managing the transition to the changing architecture of the NHS and the establishment and authorisation of Clinical Commissioning Groups, brought about by new primary legislation. The Board Assurance Framework (BAF) for 2012/13 captured the risks in relation to the transition moving forward.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively.

The Governance Framework of the Organisation

NHS Bradford and Airedale has a governance framework within which risk is managed. The governance framework maintains internal control to support the organisation to achieve its policies, aims and objectives and safeguard public funds and assets. NHS Bradford and Airedale deliberately sets out to manage risks to a reasonable level through a robust process of risk assessment, prioritisation and management through a series of governance activities.

NHS Bradford and Airedale's Board has an established governance structure and embedded risk management processes to maintain control and proactively manage the achievement of its objectives.

The Board has overall responsibility for risk management and has several formal sub committees that have delegated responsibilities. These are attached at appendix 1. Collectively these committees provide assurance to the Board that they receive assurance in accordance with their terms of reference. Committees are well attended and routinely considered for quoracy.

The Assurance Framework is the key source of evidence that links strategic

objectives to risks and provides the Board with a simple but comprehensive method for the effective and focused management of the risks that arise in meeting strategic objectives. It also provides a structure for the evidence to support the Annual Governance Statement. This simplifies Board reporting and prioritisation, which in turn allows more effective performance management. The Assurance Framework also facilitates reporting key information to the Board, and is maintained as a dynamic document. The Board has undertaken a review of the assurance framework during the reporting period. In addition CCG's are maintaining their own Governing Body Assurance frameworks which are kept up to date and routinely reported to their Governing Bodies.

By working closely together, the Directors and I lead the risk management process, to ensure an integrated and holistic approach to NHS Bradford and Airedale's risk management activities. Throughout the reporting period there have been a number of Board workshops that reviewed the effectiveness and development of a range of governance requirements.

The Board is of the opinion that it has discharged its duties in accordance with its legal and statutory requirements and the main principles and provisions of The UK Corporate Governance Code June 2010.

There have been four Audit Committee meetings during the reporting period and each meeting has been quorate.

The arrangements for Closure & Handover were managed across the cluster to cover NHS Leeds and NHS Bradford & Airedale PCTs. In order to manage the transfer of the responsibilities to the successor organisations a Programme Board called the Closure and Handover Programme Board was established in July 2012, operating as a sub-committee of the Executive Management Team with the following delegated aims.

a) Ensure that all statutory accountabilities are safely and effectively

transferred to successor organisations

b) Ensure a safe, effective, meaningful and accessible handover of relevant

information to successors

c) Arrange for the archiving of all other relevant information in line with

legislation, guidance and best practice

d) Ensure that all PCT assets are transferred or disposed of

e) Ensure that all liabilities are effectively dealt with prior to closure

f) Arrange for the legal transfer of all licences, Service level Agreements,

contracts and leases

g) Ensure that the system for safe and effective governance of the PCT

continues up to 31 March 2013

h) Ensure that the employed workforce of the trusts are transferred to

successor organisations or that employment ceases in line with legal and

contractual requirements

i) Ensure the delivery of an audited set of final accounts for each PCT

Since establishment, the Closure & Handover Programme Board have met on nine occasions. At each meeting detailed Delivery & Risk Reports for the 11 workstream elements which form the Closure & Handover Programme have been discussed and challenged.

Each workstream element has developed a project plan detailing key milestones and dates for delivery. These are maintained through the Closure & Handover Programme Board and linkages across and between elements and workstreams are identified to ensure a cohesive programme was achieved.

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

- Two Receiver events were held across West Yorkshire, to engage Receivers in the transition process, supported by DAC Beachcroft our legal advisors
- Face to face meetings to produce the due diligence information in preparation of Transfer Scheme documentation, with sign off of the relevant Annex 2 documentation prior to each DH submission.
- Attendance at the Public Health Transition Steering Group meetings
- Attendance at the CCG senior management team meetings.
- Engagement with West Yorkshire Commissioning Support Unit (WYCSU) transition team
- Clarification of sign off process for transition for NHS Commissioning Board
- 'Page turn' process for the quality handover document with providers

- Programme highlight report produced for Cluster Governance & Risk Committee and Programme Boards.
- Work has recently taken place by West Yorkshire Audit Consortium (NHS Bradford Internal Auditors) to provide assurance on the delivery of the Closure & Handover Programme. A high level review

was completed of the arrangements which the PCT Cluster has put in place to manage the process of closing down the PCTs and handing over responsibilities to the receiving organisations. The review involved examining the structures and processes which have been established to manage and oversee the transition.

- Work was undertaken by KMPG in December and early January 2013 to provide assurance over the appropriateness and adequacy of the delivery of the Closure & Handover Programme and the associated controls.
- All ongoing risks have a future risk destination identified within the risk register which is attached as an appendix to this report.

- Quality Assembly held on 19 March 2013 for the formal handover of the quality documentation to Receivers
- Board scrutiny of transfer documentation on 21 March 2013.

In preparation for closure of the PCT the Cluster Board Assurance Framework 2012/13 was reviewed at the Cluster Governance and Risk Committee on the

21 February 2013. Recommendations were made on where BAF risks may need to be forwarded as they may still be relevant to Receiving Organisations or cease on 31 March 2013.

As a result of the Committee decisions the Director of Workforce and Corporate Development formally wrote to the relevant Receiver Organisations on 6 March 2013 for them to give due consideration and relevant assessment of the risks. This assures the Board that all BAF risks have been appropriately managed for closure of the PCT on 31 March 2013.

At the point of closure there are four corporate risks that are being managed corporately. Each of these four risks have also been supplied, at the same time as the BAF risks, with information on existing control and assurance mechanisms to the relevant Receiver Organisations in order for closure of the PCT on 31 March 2013.

Under a separate risk management process, the relevant Receiver Organisations have been notified of the current active operational risks for their due consideration and relevant assessment.

In line with Department of Health guidance a sub-committee of the Department of Health Audit and Risk Committee has been established for the Airedale, Bradford and Leeds PCT cluster. The sub committee met in late May to review the annual report, financial statements and governance statements of the two PCTs prior to sign off by the West Yorkshire Area Team Director and Director of Finance. The annual report, financial

statements and annual governance statement have been prepared by experienced members of staff, some of whom are part of an established legacy close down team, with appropriate senior officer review.

NHS Bradford and Airedale is compliant with the Secretary of State's Directions for counter fraud and the requirement for the provision for a Local Counter Fraud Specialist (LCFS). The activities undertaken by the LCFS during the year have been delivered to ensure that they are risk-based and in-line with the latest thought-leadership and emerging methodologies, including the Government's National Fraud Strategy and Chartered Institute of Public Finance and Accountancy (CIPFA) 'Managing the Risk of Fraud' document which are considered best practice when countering fraud.

Risk Assessment

The risk management strategy sets the clear intention for NHS Bradford and Airedale to maintain a robust system of internal control processes, critically examine and effectively manage all risks that could affect the ability of the organisation to carry out its normal activities and achieve its strategic objectives. It also sets out comprehensive arrangements for all levels of the organisation to undertake risk assessments appropriate to their areas of responsibility. The strategy of this organisation is to manage and assess risks through an organisationally layered approach. Internal Audit assesses the effectiveness of the risk management systems and processes to assure and assist compliance and continuous improvement.

The Board Assurance Framework for 2012/13 was developed through the workshops with the board and working with the PCT senor leadership team and approved by the Board. The Board has continued to develop the Assurance Framework during this period.

The Governance and Risk Committee uses established and embedded risk management processes and these operate throughout the organisation in the vast array of activities and functions. These are routinely audited to ensure they are operating effectively. NHS Bradford and Airedale has a framework for the assessment and scoring of risks to enable ongoing analysis of all risks. The resulting rating of each risk's consequence and likelihood, and description of the risk treatment plans are entered in the organisation's risk registers. The risks and controls on

registers are routinely reviewed and when indicated are escalated. The Board and the Governance and Risk Committee routinely review the corporate risks in order to provide Board assurance and dialogue about controls.

A sequence of systematic processes ensures that NHS Bradford and Airedale manages risk and that managers escalate appropriately risks that exceed specified levels. The

Board receives a risk profile at every meeting that sets out those risks in need of consideration. The Governance and Risk Committee review the assurance framework and risks register at every meeting and as required recommend those risks in need of Board review. There is integration of the risk assessment process within the performance reporting arrangements to ensure that the Board are able to see at a glance those risks that require their attention.

The PCT has continued to equip its staff to manage and improve the management of risk through a range of learning and development activities, including local and individual briefings and training in respect of a range of requirements. These include health and safety assessments; risk register management; and incident reporting, investigation and analysis. The PCT has continued emergency planning and business continuity training for staff. The PCT provided project and programme management training according to identified need. In house training modules are in operation providing a comprehensive set of resources available to all staff including risk management and assessment. The PCT has continued to review, develop and update its Health and Safety Policy and guidance.

The PCT has reviewed and updated its Risk Management Strategy and policy and produced a Governance Handbook which summarises how the PCT discharges its governance arrangements. A web-based risk management system was implemented last year as good practice to enable more responsive and timely incident and complaint reporting and learning. PCT staff actively network with others in the risk and governance field in order to share good practice.

In the financial year 2012/13 there have been no serious incidents relating to data loss

The Risk and Control Framework

NHS Bradford and Airedale Directors, Managers and staff work together to provide an integrated approach to the management of risk and work towards developing a culture that encourages or ensures:

- staff work together effectively, to recognise and manage the risks inherent in healthcare services that are commissioned and directly provided;
- increasing and effective incident reporting and complaints, claims & incident investigation and management;
- the undertaking and updating of risk assessments, and the development of control and treatment plans;
- improved systems of monitoring, performance management and learning from the risks we manage;

- achievement of, and compliance with, standards regarding the management of risks as specified by the organisations providing assurance to the PCT;
- the establishment of a framework of regular internal assessment and review of the risks we manage;
- better and safer buildings, estates, equipment and environments for both patients and staff;
- the delivery of safe systems of clinical practice;
- the provision of training and education for staff, to better equip them to manage the risks within their work environment; and
- NHS Bradford and Airedale remains compliant with current and future legislation.

NHS Bradford and Airedale's Board has approved and reviewed the Assurance Framework, which provides evidence of the effectiveness of controls in place to manage major risks to the organisation achieving its principal objectives and has governance processes in place to ensure that these are regularly reviewed. The Board has corporate objectives that reflect the requirements of the Care Quality Commission's essential standards of quality and safety. The Assurance Framework has provided the Board and I with evidence of the controls and independent assurances that exist, to support delivery of all the organisation's objectives and actions. The Assurance Framework and the performance management system has highlighted that NHS Bradford and Airedale has good evidence of controls and assurances on key objective areas.

The components of the Assurance Framework are in keeping with historical Strategic Health Authorities (SHA) requirements and include strategic objectives, risks, controls, positive assurance, gaps in assurance and control and any remedial action. The content of the Assurance Framework and corporate risk register have been discussed at the Board and the Governance and Risk Committee, and the Assurance Framework and corporate risk registers have been reviewed to ensure that they reflect the discussions in order to assure the Board that risks are controlled. The Chairs of these meetings are assured of the accuracy of the documentation associated with the above issues.

At the current time arrangements are in place to manage those risks identified on the Assurance Framework. Risks relating to data security are managed and controlled by ensuring that NHS Bradford and Airedale assess its policies, procedures and practices against the criteria detailed within the NHS Information Governance Toolkit and addresses any shortcomings by in-year actions plans. The Internal Audit Team assists in ensuring that any self-assessment is robust

Risk management is embedded within the organisation and standard practices are in operation and integrated within key activities such as policy development, risk

assessment and equality impact assessments. All Directorates use agreed risk assessment processes and guidance and operate with agreed Health and Safety requirements.

In addition, the PCT has agreed a robust and ambitious approach to the Quality, Innovation, Productivity and Prevention (QIPP) challenges faced by the NHS to maximise value for money across all services. A Bradford and Airedale-wide Health and Social Care Transformation Board has been established to secure the delivery of these QIPP plans in partnership with local providers and Bradford Metropolitan District Council. In addition an internal multi- disciplinary QIPP group meet on a fortnightly basis underpinned by a programme management office (PMO) to ensure risks are effectively managed and appropriate remedial action taken.

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 of the effectiveness of the system of internal control is informed in a number of ways, by the work of the internal auditors and the executive managers and clinical leads within the trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of a number of reports and performance information available to me. My review is also informed by comments made by the external auditors in their management letter. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, the Governance and Risk Committee and plans to address weaknesses and ensure continuous improvement of the system are in place.

Executive Directors within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the

effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by the NHS Bradford and Airedale performance management system, internal and external auditor reviews and specific SHA related reviews.

- 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. Based on

the work undertaken in 2012/13 significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk. There was one report with limited assurance. This was in relation to access to the network and ensuring leaving members of staff are not given access to the system post leaving. The recommendations from the report have been implemented. No weaknesses have been detected to core financial systems and assurance mechanisms.

Assurance Mechanisms:

NHS Bradford and Airedales external auditors, KPMG, have undertaken a range of work against their 2012/13 plan.

NHS Bradford and Airedale internal auditors have completed the programme of a risk-based plan of work, agreed with management and approved by the Audit Committee, which was designed to provide a reasonable level of assurance, for 2012/13, including a range of financial systems based audits. NHS Bradford and Airedale has agreed action plans with auditors to improve our control environment, but no significant control weaknesses have been found during the audits.

NHS Bradford and Airedale maintains NHS Litigation Authority (NHSLA) compliance against the NHSLA PCT Risk Management Standards at Level 1.

NHS Bradford and Airedale' Audit Committee, with the advice of the Executive Director of Finance and other Executive Directors, take the lead role, on behalf of me

and the Board, in maintaining and reviewing the effectiveness of the system of internal control. The Audit Committee advise and assure the Board upon the adequacy and effective operation of the organisations overall internal control system focussing upon the framework of risks, controls and assurances that underpin the delivery of the organisations objectives and to review the disclosure statements that flow from those assurance processes. There have been four Audit Committee meetings during the reporting period and each meeting has been quorate.

NHS Bradford and Airedale is compliant with the Secretary of State's Directions for counter fraud and the requirement for the provision for a Local Counter Fraud Specialist (LCFS). The activities undertaken by the LCFS during the year have been delivered to ensure that they are risk-based and in-line with the latest thought-leadership and emerging methodologies, including the Government's National Fraud Strategy and CIPFA's 'Managing the Risk of Fraud' document which are considered best practice when countering fraud.

The Governance and Risk Committee monitors and reviews NHS Bradford and Airedale' risk management arrangements and oversees key assurance and risk systems and processes, in order that the PCT is compliant with its statutory requirements and is able to ensure sound internal control arrangements. The Governance and Risk Committee reviews the effectiveness of the risk management activities and, in this, is helped by the Head of Internal Audit's work, report and opinion on the effectiveness of the PCT's system of internal control.

The Quality Committee (previously know as the Clinical Governance Committee) oversees the commissioning responsibility for clinical quality and effectiveness. It provides a strategic lead for the functioning of clinical governance within the PCT through the development and implementation of a patient focused, organisation wide, annual clinical governance development plan to improve standards, processes and systems for clinical excellence. It provides the Board with assurance that clinical governance systems, processes and mechanisms for quality improvement are in place and operating effectively within and across all providers from whom we commission care.

The Information Governance Committee oversees the approach to and implementation of a robust Information Governance framework for the management of information. It provides me and the Board with assurance that all information processing is undertaken in accordance with relevant legislation and best practice, minimises and manages key risks arising from information handling processes and maintains standards to required levels.

legislation and best practice, minimises and manages key risks arising from information handling processes and maintains standards to required levels.

Significant issues

The Head of internal audit reports that, based on the work they have undertaken in this reporting period on the Trust's system on internal control, they do not consider that within the audited areas there are any issues that need to be flagged as significant internal control issues within the AGS.

The system of internal control has been in place in NHS Bradford and Airedale for the year ended 31 March 2013.. My view is that NHS Bradford and Airedale has no significant control issues that need to be raised in the AGS, after taking into consideration our systems of internal control and the assurance work conducted by internal audit. There are sound system of internal control that supports the achievement of its policies, aims and objectives.

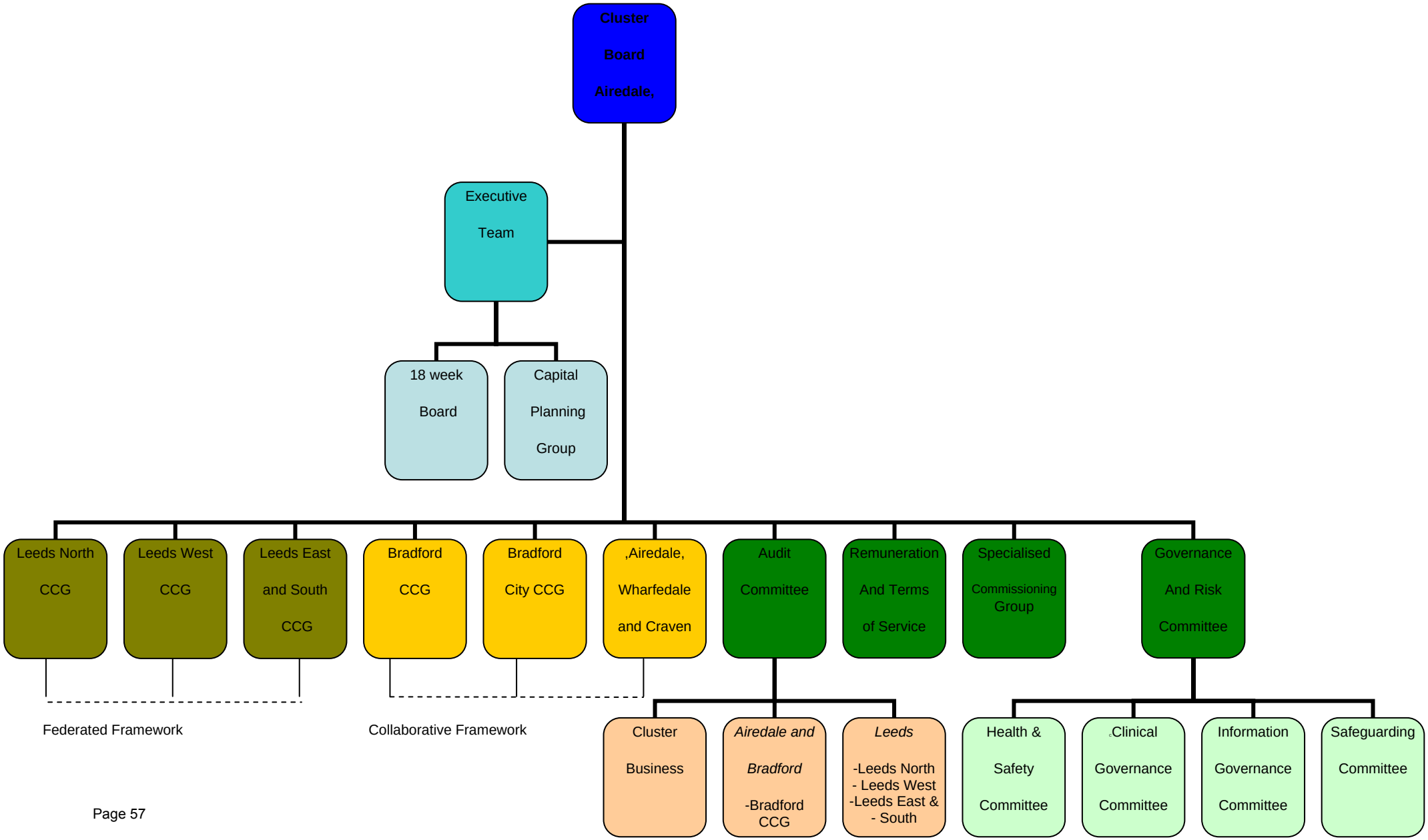
Accountable Officer: Name: Andy Buck

Organisation: NHS England

SIGNATURE  **DIRECTOR (WEST YORKSHIRE)**

Date 4.6.13

From 1 April 2012



INDEPENDENT AUDITOR'S REPORT TO THE SIGNING OFFICERS OF BRADFORD AND AIREDALE TEACHING PCT

We have audited the financial statements of Bradford and Airedale Teaching PCT for the year ended 31 March 2013 on pages I to IV and 1 to 52. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England. We have also audited the information in the Remuneration Report that is subject to audit.

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

Respective responsibilities of Signing Officer and auditor

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

Scope of the audit of the financial statements

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

Opinion on financial statements

In our opinion the financial statements:

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

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

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

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

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

In our opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and

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

Matters on which we are required to report by exception

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

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

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

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

We have undertaken our audit in accordance with the Code of Audit Practice 2010 for local NHS bodies, having regard to the guidance issued by the Audit Commission in November 2012. We have considered the results of the following:

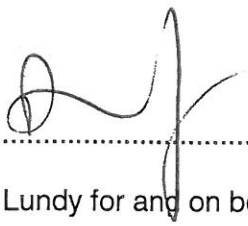
- our review of the Governance Statement; and

- the work of other relevant regulatory bodies or inspectorates, to the extent that the results of this work impact on our responsibilities at the PCT.

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

Certificate

We certify that we have completed the audit of the accounts of Bradford and Airedale Teaching PCT in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission.



..... 4 June 2013

Paul Lundy for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
1 The Embankment
Neville Street
Leeds
LS1 4DW

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	**22,419**	25,358
Other costs	5.1	**945,320**	921,163
Income	4	**(26,988)**	(26,956)
Net operating costs before interest		**940,751**	919,565
Investment income	9	**(128)**	(121)
Other (Gains)/Losses	10	**0**	(5)
Finance costs	11	**2,976**	2,879
Net operating costs for the financial year		**943,599**	922,318
Transfers by absorption -(gains)		**0**	
Transfers by absorption - losses		**0**	
Net (gain)/loss on transfers by absorption		**0**	
Net Operating Costs for the Financial Year including absorption transfers		**943,599**	**922,318**
Of which:			
Administration Costs			
Gross employee benefits	7.1	**19,113**	19,542
Other costs	5.1	**17,058**	13,303
Income	4	**(3,487)**	(3,682)
Net administration costs before interest		**32,684**	**29,163**
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**0**	0
Net administration costs for the financial year		**32,684**	**29,163**
Programme Expenditure			
Gross employee benefits	7.1	**3,306**	5,816
Other costs	5.1	**928,262**	907,860
Income	4	**(23,501)**	(23,274)
Net programme expenditure before interest		**908,067**	**890,402**
Investment income	9	**(128)**	(121)
Other (Gains)/Losses	10	**0**	(5)
Finance costs	11	**2,976**	2,879
Net programme expenditure for the financial year		**910,915**	**893,155**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**(124)**	(234)
Net (gain) on revaluation of property, plant & equipment	**(160)**	(258)
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**	
Release of Reserves to Statement of Comprehensive Net Expenditure	**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*	**943,315**	**921,826**

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

The notes on pages 5 to 52 form part of this account.

Statement of Financial Position at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	12.1	**52,018**	55,197
Intangible assets	13.1	**1**	21
Investment property	15	**0**	0
Other financial assets	21	**848**	848
Trade and other receivables	19	**0**	0
Total non-current assets		**52,867**	56,066
Current assets:			
Inventories	18	**0**	0
Trade and other receivables	19.1	**4,246**	5,499
Other financial assets	21	**0**	0
Other current assets	22	**0**	0
Cash and cash equivalents	23	**123**	81
Total current assets		**4,369**	5,580
Non-current assets held for sale	24	**600**	600
Total current assets		**4,969**	6,180
Total assets		**57,836**	62,246
Current liabilities			
Trade and other payables	25	**(37,515)**	(45,473)
Other liabilities	26	**0**	0
Provisions	32	**(9,022)**	(2,418)
Borrowings	27	**(551)**	(488)
Other financial liabilities	28	**0**	0
Total current liabilities		**(47,088)**	(48,379)
Non-current assets plus/less net current assets/liabilities		**10,748**	13,867
Non-current liabilities			
Trade and other payables	25	**0**	0
Other Liabilities	26	**0**	0
Provisions	32	**(3,625)**	(2,264)
Borrowings	27	**(33,243)**	(33,798)
Other financial liabilities	28	**0**	0
Total non-current liabilities		**(36,868)**	(36,062)
Total Assets Employed:		**(26,120)**	(22,195)
Financed by taxpayers' equity:			
General fund		**(35,060)**	(31,005)
Revaluation reserve		**8,940**	8,810
Other reserves		**0**	0
Total taxpayers' equity:		**(26,120)**	(22,195)

The financial statements on pages 5 to 52 were approved by the Board on .....
and signed on its behalf by

Signing Officer: Date: 4/6/13

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

	General fund	Revaluation reserve	Other reserves	Total reserves
	£000	£000	£000	£000
Balance at 1 April 2012	**(31,005)**	**8,810**	**0**	**(22,195)**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(943,599)			**(943,599)**
Net gain on revaluation of property, plant, equipment		160		**160**
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		124		**124**
Movements in other reserves			0	**0**
Transfers between reserves*	154	(154)		**0**
Release of Reserves to SOCNE		0		**0**
Reclassification Adjustments				
Transfers between Revaluation Reserve & General Fund in respect of assets transferred under absorption	0	0		**0**
Net actuarial gain/(loss) on pensions	0		0	**0**
Total recognised income and expense for 2012-13	**(943,445)**	**130**	**0**	**(943,315)**
Net Parliamentary funding	939,390			**939,390**
Balance at 31 March 2013	**(35,060)**	**8,940**	**0**	**(26,120)**
* including transfers from the revaluation reserve to the general fund in respect of impairments as follows:	0	0	0	**0**

Balance at 1 April 2011	**(36,459)**	**10,551**	**0**	**(25,908)**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(922,318)			(922,318)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment		258		258
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		234		234
Movements in other reserves			0	0
Transfers between reserves*	2,233	(2,233)		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	0
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	(920,085)	(1,741)	0	(921,826)
Net Parliamentary funding	925,539			925,539
Balance at 31 March 2012	**(31,005)**	**8,810**	**0**	**(22,195)**
* including transfers from the revaluation reserve to the general fund in respect of impairments as follows:	0	0	0	**0**

Statement of cash flows for the year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities			
Net Operating Cost Before Interest		**(940,751)**	(919,565)
Depreciation and Amortisation	5.1	**3,130**	2,356
Impairments and Reversals	14	**849**	(1,156)
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	11	**(2,971)**	(2,873)
Release of PFI/deferred credit		**0**	0
(Increase)/Decrease in Inventories		**0**	0
(Increase)/Decrease in Trade and Other Receivables		**1,253**	(174)
(Increase)/Decrease in Other Current Assets		**0**	0
Increase/(Decrease) in Trade and Other Payables		**(6,329)**	(611)
(Increase)/Decrease in Other Current Liabilities		**0**	0
Provisions Utilised		**(2,832)**	(2,087)
Increase/(Decrease) in Provisions		**10,792**	942
Net Cash Inflow/(Outflow) from Operating Activities		**(936,859)**	**(923,168)**
Cash flows from investing activities			
Interest Received	9	**128**	121
(Payments) for Property, Plant and Equipment		**(2,125)**	(2,727)
(Payments) for Intangible Assets		**0**	0
(Payments) for Other Financial Assets		**0**	0
(Payments) for Financial Assets (LIFT)		**0**	0
Proceeds of disposal of assets held for sale (PPE)		**0**	520
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		**(1,997)**	**(2,086)**
Net cash inflow/(outflow) before financing		**(938,856)**	**(925,254)**
Cash flows from financing activities			
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**(492)**	(455)
Net Parliamentary Funding		**939,390**	925,539
Capital Receipts Surrendered		**0**	0
Capital grants and other capital receipts		**0**	0
Cash Transferred (to)/from Other NHS Bodies (free text note required)		**0**	0
Net Cash Inflow/(Outflow) from Financing Activities		**938,898**	**925,084**
Net increase/(decrease) in cash and cash equivalents		**42**	**(170)**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**81**	**251**
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		**123**	**81**

1. Accounting policies

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

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

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

Under the provisions of The Health and Social Care Act 2012 (Commencement No. 4. Transitional, Savings and Transitory Provisions) Order 2013, Bradford and Airedale Teaching PCT was dissolved on 1st April 2013. The PCT's functions, assets and liabilities transferred to other public sector entities as outlined in note 42 Events After The Reporting Period. Where reconfigurations of this nature take place within the public sector, Government accounting requires that the activities concerned are to be considered as continuing operations, and so the closing entity prepares accounts on a "going concern" basis.

The Statement of Financial Position 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 so no disclosures have been made under IFRS 5 Non-Current Assets Held for Sale and Discontinued Operations. Any revaluations and impairments recognised in the period are considered routine within the annual cycle of activity.

1.1 Accounting Conventions

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

Transforming Community Services (TCS) transactions

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

Acquisitions and Discontinued Operations

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

Critical accounting judgements and key sources of estimation uncertainty

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

Critical judgements in applying accounting policies

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

In determining the value at which LIFT scheme assets have been recognised in the Accounts, the PCT considers that the assets will continue to be used by the Community Health Partnerships (a limited company wholly owned by the Department of Health and to which the LIFT assets will transfer on 1 April 2013), beyond the initial contract term. This results in a higher asset value being recognised at the start of the contract term, with the assets being depreciated over their estimated useful lives as opposed to the shorter contract term. The value of LIFT assets as at 31 March 2013 is £26.722m.

1. Accounting policies (continued)

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

All PCT owned land and buildings have been revalued as at 31 March 2013 on a "Modern Equivalent Asset" basis using District Valuer estimates of changes in the value of land and buildings since 31 March 2012. Further information regarding the basis of the valuation is provided in note 1.6 with details of the financial impact of the revaluation being provided in note 12.3.

In preparing the financial statements it has been necessary to estimate the financial value of some services received in year,most significantly primary care prescribing and secondary care healthcare contract activity, For primary care prescribing and those secondary healthcare contracts whose costs vary directly with patient activity, it has been necessary to estimate the value of services received in March 2013. These estimates are based on actual activity levels for 11 months of the year and whilst actual full year costs will differ from these estimates, no material differences are expected.

As a result of the introduction of deadlines for the assessment of a patient's eligibility for continuing healthcare funding, a significant number of retrospective claims for continuing healthcare funding up to 31 March 2012 have been received by the PCT. A provision has been made for the expected cost of these claims, but actual costs will only be confirmed on completion of in-depth case reviews which will be completed in the following financial year. Actual claim values will differ from the estimates made, but the overall difference is not expected to be material.

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 can enter into a pooled budget arrangement under s75 of the NHS Act 2006. Where the PCT is the host body for apooled budget arrangement it prepares a memorandum account relating to the activities of the pool.

The PCT accounts for its share of the assets, liabilities, income and expenditure of the pool as determined by the pooled budget arrangement. Where the assets and liabilities of the pool are material they will be included in the PCT's Statement of Financial Position.

Details of the PCT's pooled budget arrangements are included in note 40.

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
HM Treasury has set performance targets in respect of administration expenditure which is defined as any cost incurred that is not a direct payment for the provision of healthcare or healthcare related service. For PCTs, this definition of administration expenditure is used as the basis for the calculation of PCT running costs.

Costs which do not fall within the definition of administration costs are classified as programme costs.

However, costs incurred under NHS transition redundancy programmes are classed as "programme" under HM Treasury budgetary control arrangements and are 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

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

1.10 Non-current assets held for sale

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

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

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

1.11 Inventories

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

1.12 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.

1.13 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).

1.14 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)

1.15 Employee benefits

Short-term employee benefits

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

Retirement benefit costs

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

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

1.16 Research and Development

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

1.17 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.

1.18 Grant making

Under s256 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.

1.19 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. Accounting policies (continued)

1.20 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.

1.21 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.

1.22 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. For general provisions there are three rates; short term (0 to 5 years) -1.8%, medium term (6 to 10 years) -1.0% and long term (exceeding 10 years) 2.2%. The appropriate rate will be applied to the relevant cashflow in each year.
A real terms rate of 2.35% is applied in respect of early staff departures.

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 arising 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)

1.23 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 de-recognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

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

Financial assets at fair value through profit and loss

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

Held to maturity investments

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

Available for sale financial assets

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

Loans and receivables

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

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

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

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

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

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

1. Accounting policies (continued)

1.23 Financial Instruments (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 de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Financial liabilities are initially recognised at fair value.

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

Financial liabilities at fair value through profit and loss

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

Other financial liabilities

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

1.24 Private Finance Initiative (PFI) and NHS LIFT transactions

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

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

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

a) Services received

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

b) LIFT assets, liabilities, and finance costs

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

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

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

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

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

1. Accounting policies (continued)

1.24 Private Finance Initiative (PFI) and NHS LIFT transactions (continued)

c) Lifecycle replacement

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

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

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

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

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

Other assets contributed by the PCT to the operator

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

1.24 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
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IPSAS 32 - Service Concession Arrangement - subject to consultation

2 Operating segments

The operating segments reflect the separate responsibilities of the organisation in each year. Financial performance is reviewed and reported to the Cluster Board and responsible officers for each relevant segment.

The Hosted Services segment is reported separately as it includes national and local commissioning services that have "ring-fenced" resource allocations that are administered by the PCT. The segment includes the National Diabetes and Kidney Care Collaborative, the West Yorkshire Cardiac Network and the National Drugs Agency.

	PCT Commissioning		Hosted Projects		Total	
	2012-13	2011-12	**2012-13**	2011-12	**2012-13**	2011-12
	£000	£000	**£000**	£000	**£000**	£000
Income	**(26,636)**	(26,607)	**(352)**	(349)	**(26,988)**	(26,956)
Expenditure	**951,548**	931,434	**16,191**	15,087	**967,739**	946,521
Common costs	**0**	0	**0**	0	**0**	0
Net Operating Cost before interest	**924,912**	904,827	**15,839**	14,738	**940,751**	919,565
Under/(Over) spend against Revenue Resource Limit	**7,116**	8,165	**384**	0	**7,500**	8,165
Segment net assets	**(25,263)**	(20,952)	**(857)**	(1,243)	**(26,120)**	(22,195)

There are no inter-segment transactions between the Commissioning and Hosted Projects segments.

In 2012/13 expenditure with the following suppliers exceeded 10% of total PCT expenditure:

Bradford Teaching Hospitals NHS Foundation Trust	£259,255,000
Bradford District Care Trust	£116,103,000

3. Financial Performance Targets

3.1 Revenue Resource Limit

The PCTs' performance for the year ended 31 March 2013 is as follows:

	2012-13 £000	2011-12 £000
Total Net Operating Cost for the Financial Year	**943,599**	922,318
Net operating cost plus (gain)/loss on transfers by absorption	**0**	
Adjusted for prior period adjustments in respect of errors	**0**	0
Revenue Resource Limit	**951,099**	930,483
Under/(Over)spend Against Revenue Resource Limit (RRL)	**7,500**	8,165

The PCT's 2012-13 Revenue Resource Limit is shown after a reduction of £2m in respect of a transfer to the Strategic Investment Fund held by theYorkshire and The Humber Strategic Health Authority. These funds will be made available by the NHS Commissioning Board to the three Clinical Commissioning Groups covering the Bradford District to fund future commitments from 2013-14 onwards.

3.2 Capital Resource Limit

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

	2012-13 £000	2011-12 £000
Capital Resource Limit	**700**	4,400
Charge to Capital Resource Limit	**496**	3,785
Under/(Over)spend Against Capital Resource Limit (CRL)	**204**	**615**

3.3 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**939,390**	925,539
Cash Limit	**940,690**	925,539
Under/(Over)spend Against Cash Limit	**1,300**	**0**

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

	2012-13 £000
Total cash received from DH (Gross)	816,638
Less: Trade Income from DH (reported on AoB form 98)	(581)
Less/(Plus): movement in DH working balances (reported on AoB form 98)	0
Sub total: net advances	**816,057**
(Less)/plus: transfers (to)/from other resource account bodies (free text note required)	0
Plus: cost of Dentistry Schemes (central charge to cash limits)	21,543
Plus: drugs reimbursement (central charge to cash limits)	101,790
Parliamentary funding credited to General Fund	**939,390**

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	**4,718**		4,718	4,929
Dental Charge income from Trust-Led GDS & PDS	**0**		0	0
Prescription Charge income	**5,149**		5,149	4,899
Strategic Health Authorities	**1,040**	24	1,016	1,017
NHS Trusts	**5,885**	1,343	4,542	6,077
NHS Foundation Trusts	**3,370**	416	2,954	3,394
Primary Care Trusts Contributions to DATs	**0**		0	0
Primary Care Trusts - Other	**687**	380	307	625
Primary Care Trusts - Lead Commissioning	**0**	0	0	0
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	**581**	0	581	277
Recoveries in respect of employee benefits	**834**	834	0	743
Local Authorities	**1,651**	50	1,601	2,217
Patient Transport Services	**0**		0	0
Education, Training and Research	**0**	0	0	0
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	0
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 revemue from finance leases	**0**	0	0	0
Rental reenue from operating leases	**0**	0	0	0
Other revenue *	**3,073**	440	2,633	2,778
Total miscellaneous revenue	**26,988**	**3,487**	**23,501**	**26,956**

* Other income includes charges to GP practices for use of PCT buildings and services and the receipt of project and grant income.

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	**71,605**		71,605	63,377
Non-Healthcare	**1,906**	1,906	0	1,736
Total	**73,511**	**1,906**	**71,605**	**65,113**
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	**158,955**	1,629	157,326	163,627
Goods and services (other, excl Trusts, FT and PCT))	**250**	231	19	798
Total	**159,205**	**1,860**	**157,345**	**164,425**
Goods and Services from Foundation Trusts	**355,493**	1,605	353,888	348,189
Purchase of Healthcare from Non-NHS bodies	**80,040**		80,040	71,233
Social Care from Independent Providers	**0**		0	0
Expenditure on Drugs Action Teams	**5,701**		5,701	6,278
Non-GMS Services from GPs	**7,337**	873	6,464	6,635
Contractor Led GDS & PDS (excluding employee benefits)	**27,683**		27,683	27,148
Salaried Trust-Led PDS & PCT DS (excluding employee benefits)	**4,876**		4,876	4,576
Chair, Non-executive Directors & PEC remuneration	**39**	39	0	80
Executive committee members costs	**1,002**	1,002	0	612
Consultancy Services	**495**	269	226	668
Prescribing Costs	**84,097**		84,097	85,478
G/PMS, APMS and PCTMS (excluding employee benefits)	**84,704**	157	84,547	84,526
Pharmaceutical Services	**0**		0	0
Local Pharmaceutical Services Pilots	**0**		0	0
New Pharmacy Contract	**24,316**		24,316	24,645
General Ophthalmic Services	**6,813**		6,813	6,877
Supplies and Services - Clinical	**777**	0	777	1,047
Supplies and Services - General	**593**	80	513	478
Establishment	**4,793**	3,315	1,478	3,771
Transport	**720**	37	683	714
Premises	**9,351**	3,751	5,600	8,812
Impairments & Reversals of Property, plant and equipment	**849**	0	849	(1,156)
Impairments and Reversals of non-current assets held for sale	**0**	0	0	0
Depreciation	**3,110**	430	2,680	2,331
Amortisation	**20**	0	20	25
Impairment & Reversals Intangible non-current assets	**0**	0	0	0
Impairment and Reversals of Financial Assets	**0**	0	0	0
Impairment of Receivables	**81**	81	0	(27)
Inventory write offs	**0**	0	0	0
Research and Development Expenditure	**0**	0	0	0
Audit Fees	**136**	136	0	224
Other Auditors Remuneration	**48**	48	0	36
Clinical Negligence Costs	**200**	85	115	265
Education and Training	**720**	485	235	555
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 *	**8,610**	899	7,711	7,605
Total Operating costs charged to Statement of Comprehensive Net	**945,320**	**17,058**	**928,262**	**921,163**
Employee Benefits (excluding capitalised costs)				
Employee Benefits associated with PCTMS	**250**	0	250	1,081
Trust led PDS and PCT DS	**0**	0	0	0
PCT Officer Board Members	**517**	517	0	818
Other Employee Benefits	**21,652**	18,596	3,056	23,459
Total Employee Benefits charged to SOCNE	**22,419**	**19,113**	**3,306**	**25,358**
Total Operating Costs	**967,739**	**36,171**	**931,568**	**946,521**

* Other expenditure includes grants and project expenditure and also payments to voluntary sector organisations.

5. Operating Costs

5.1 Analysis of operating costs (continued)

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
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)	**32,684**	30,366	2,318
Weighted population (number in units)*	**534,170**	534,170	534,170
Running costs per head of population (£ per head)	**61**	**57**	**4**
PCT Running Costs 2011-12			
Running costs (£000s)	**29,163**	26,504	2,659
Weighted population (number in units)	**534,170**	534,170	534,170
Running costs per head of population (£ per head)	**55**	**50**	**5**

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

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

The calculation of Running Costs requires the inclusion of costs relating to national hosted projects, e.g. National Diabetes and Kidney Care Collaborative and the West Yorkshire Cardiac Network, the Running Costs of which are £10,058k. Excluding this, the core Running Costs for the PCT (including Public Health) are £22,626k which represents £42.37 per head of population (2011-12: £20,669m, £38.69 per head).

The increase from 2011-12 reflects the additional dual running costs of shadow CCGs and transition support and set up costs.

5.2 Analysis of operating expenditure by expenditure classification

	2012-13 £000	2011-12 £000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	84,954	85,607
Prescribing costs	84,097	85,478
Contractor led GDS & PDS	27,683	27,148
Trust led GDS & PDS	4,876	4,576
General Ophthalmic Services	6,813	6,877
Department of Health Initiative Funding	0	0
Pharmaceutical services	0	0
Local Pharmaceutical Services Pilots	0	0
New Pharmacy Contract	24,316	24,645
Non-GMS Services from GPs	873	741
Other	0	0
Total Primary Healthcare purchased	**233,612**	235,072
Purchase of Secondary Healthcare		
Learning Difficulties	13,540	12,715
Mental Illness	77,610	80,960
Maternity	25,998	28,512
General and Acute	384,939	384,384
Accident and emergency	35,940	33,172
Community Health Services	97,858	94,739
Other Contractual	33,542	22,296
Total Secondary Healthcare Purchased	**669,427**	656,778
Grant Funding		
Grants for capital purposes	0	0
Grants for revenue purposes	0	0
Total Healthcare Purchased by PCT	**903,039**	**891,850**
PCT self-provided secondary healthcare included above	0	0
Social Care from Independent Providers	0	0
Healthcare from NHS FTs included above	353,888	347,077

6. Operating Leases

The PCT has entered in to lease arranagements for the following:

- Premises (including land but excluding primary care contractor arrangements)
- Cars
- Photocopier machines

These arrangements meet the criteria for operating leases under IAS 17 as the leases are short term compared to the useful economic life of the equipment or assets being leased. All lease payments are recognised as an expense in the Statement of Comprehensive Net Expenditure.

The total of future minimum lease payments are analysed over the periods that payment fall due.

In addition, the PCT has entered into financial arrangements relating to the use of GP premises. The financial value included in the Statement of Comprehensive Net Expenditure for 2012-13 is £5,311,762 (2011-12: £5,091,580) and is included within "Other" Payments recognised as an expense.

Under IFRIC4, these arrangements have been assessed as containing a lease, which under IAS17 are operating leases.

Under normal circumstances, the future operating cost commitments of these leases would be included in the disclosures in note 6.1. However, as the financial arrangements have no defined lease term, it is not possible to analyse future operating lease commitments for these leases.

6.1 PCT as lessee

	Land £000	Buildings £000	Other £000	2012-13 Total £000	2011-12 £000
Payments recognised as an expense					
Minimum lease payments	**53**	**3,122**	**5,407**	**8,582**	8,109
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total	**53**	**3,122**	**5,407**	**8,582**	**8,109**
Payable:					
No later than one year	**53**	**2,567**	**61**	**2,681**	3,094
Between one and five years	**213**	**4,826**	**5**	**5,044**	7,082
After five years	**4,481**	**8,278**	**0**	**12,759**	13,238
Total	**4,747**	**15,671**	**66**	**20,484**	**23,414**
Total future sublease payments expected to be received				**0**	0

6.2 PCT as lessor

	2012-13 £000	2011-12 £000
Recognised as income		
Rental Revenue	**0**	0
Contingent rents	**0**	0
Total	**0**	0
Receivable:		
No later than one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Total	**0**	0

7. Employee benefits and staff numbers

7.1 Employee benefits

Employee Benefits 2012-13

				Permanently employed			Other		
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Employee Benefits - Gross Expenditure									
Salaries and wages	**18,611**	16,419	2,192	**15,607**	13,579	2,028	**3,004**	2,840	164
Social security costs	**1,269**	1,061	208	**1,269**	1,061	208	**0**	0	0
Employer Contributions to NHS BSA - Pensions Division	**1,953**	1,633	320	**1,953**	1,633	320	**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	**586**	0	586	**586**	0	586	**0**	0	0
Total employee benefits	**22,419**	**19,113**	**3,306**	**19,415**	**16,273**	**3,142**	**3,004**	**2,840**	**164**
Less recoveries in respect of employee benefits (table below)	**(834)**	(834)	0	**(830)**	**(830)**	**0**	**(4)**	**(4)**	**0**
Total - Net Employee Benefits including capitalised costs	**21,585**	**18,279**	**3,306**	**18,585**	**15,443**	**3,142**	**3,000**	**2,836**	**164**
Employee costs capitalised	**0**	0	0	**0**	0	0	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**22,419**	**19,113**	**3,306**	**19,415**	**16,273**	**3,142**	**3,004**	**2,840**	**164**
Recognised as:									
Commissioning employee benefits	**22,419**			**19,415**			**3,004**		
Provider employee benefits	**0**			**0**			**0**		
Gross Employee Benefits excluding capitalised costs	**22,419**			**19,415**			**3,004**		

				Permanently employed			Other		
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Employee Benefits - Revenue									
Salaries and wages	**834**	834	0	**830**	830	0	**4**	4	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	**834**	**834**	**0**	**830**	**830**	**0**	**4**	**4**	**0**

Employee Benefits - revenue relate to the recharge income received for staff employed by the PCT but seconded to other organisations within the financial year.

7. Employee benefits and staff numbers (continued)

7.1 Employee benefits (continued)

Employee Benefits - Prior year 2011-12

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure			
Salaries and wages	**19,866**	16,981	2,885
Social security costs	**1,351**	1,351	0
Employer Contributions to NHS BSA - Pensions Division	**2,203**	2,203	0
Other pension costs	**0**	0	0
Other post-employment benefits	**0**	0	0
Other employment benefits	**0**	0	0
Termination benefits	**1,938**	1,938	0
Total gross employee benefits	**25,358**	**22,473**	**2,885**
Less recoveries in respect of employee benefits	**(743)**	(743)	0
Total - Net Employee Benefits including capitalised costs	**24,615**	**21,730**	**2,885**
Employee costs capitalised	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**25,358**	**22,473**	**2,885**
Recognised as:			
Commissioning employee benefits	**25,358**		
Provider employee benefits	**0**		
Gross Employee Benefits excluding capitalised costs	**25,358**		

7.2 Staff Numbers

	2012-13 Total Number	2012-13 Permanently employed Number	2012-13 Other Number	2011-12 Total Number	2011-12 Permanently employed Number	2011-12 Other Number
Average Staff Numbers						
Medical and dental	**7**	7	0	**13**	9	4
Ambulance staff	**0**	0	0	**0**	0	0
Administration and estates	**380**	355	25	**426**	409	17
Healthcare assistants and other support staff	**0**	0	0	**2**	2	0
Nursing, midwifery and health visiting staff	**30**	30	0	**30**	30	0
Nursing, midwifery and health visiting learners	**0**	0	0	**0**	0	0
Scientific, therapeutic and technical staff	**24**	9	15	**27**	12	15
Social Care Staff	**0**	0	0	**0**	0	0
Other	**6**	6	0	**5**	5	0
TOTAL	**447**	**407**	**40**	**503**	**467**	**36**
Of the above - staff engaged on capital projects	**0**	0	0	**0**	0	0

7. Employee benefits and staff numbers (continued)

7.3 Staff Sickness absence and ill health retirements

	2012-13 Number	2011-12 Number
Total Days Lost	**3,202**	4,370
Total Staff Years	**412**	495
Average working Days Lost	**7.77**	8.83

The staff sickness absence information is collated centrally by the Department of Health and relates to the reporting period January to December 2012.

	2012-13 Number	2011-12 Number
Number of persons retired early on ill health grounds	**2**	2
	£000s	£000s
Total additional pensions liabilities accrued in the year	**86**	111

Ill health retirement information has been provided by the Department of Health.

7.4 Exit Packages agreed during 2012-13

Exit package cost band (including any special payment element)	2012-13 Number of compulsory redundancies	2012-13 Number of other departures agreed	2012-13 Total number of exit packages by cost band	2011-12 Number of compulsory redundancies	2011-12 Number of other departures agreed	2011-12 Total number of exit packages by cost band
	Number	Number	Number	Number	Number	Number
Lees than £10,000	**6**	**3**	**9**	4	5	**9**
£10,001-£25,000	**9**	**2**	**11**	1	7	**8**
£25,001-£50,000	**5**	**3**	**8**	1	17	**18**
£50,001-£100,000	**6**	**1**	**7**	3	12	**15**
£100,001 - £150,000	**1**	**1**	**2**	0	5	**5**
£150,001 - £200,000	**2**	**0**	**2**	1	0	**1**
>£200,000	**1**	**0**	**1**	0	0	**0**
Total number of exit packages by type (total cost	**30**	**10**	**40**	**10**	**46**	**56**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Total resource cost	1,438	326	**1,764**	530	2,162	**2,692**

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

7. Employee benefits and staff numbers (continued)

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 at 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) Resource Account, 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 as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:
The Scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.
With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as “pension commutation”.
Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer price Index (CPI) will be used to replace the Retail Price Index (RPI).

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

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

8. Better Payment Practice Code

8.1 Measure of compliance

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**16,397**	**113,395**	17,330	107,583
Total Non-NHS Trade Invoices Paid Within Target	**15,631**	**104,880**	16,587	102,113
Percentage of NHS Trade Invoices Paid Within Target	**95.33%**	**92.49%**	95.71%	94.92%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**5,023**	**603,388**	4,882	588,845
Total NHS Trade Invoices Paid Within Target	**4,701**	**598,605**	4,351	579,888
Percentage of NHS Trade Invoices Paid Within Target	**93.59%**	**99.21%**	89.12%	98.48%

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

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

	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

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Rental Income				
PFI finance lease revenue (planned)	**0**	**0**	**0**	0
PFI finance lease revenue (contingent)	**0**	**0**	**0**	0
Other finance lease revenue	**0**	**0**	**0**	0
Subtotal	**0**	**0**	**0**	0
Interest Income				
LIFT: equity dividends receivable	**0**	**0**	**0**	0
LIFT: loan interest receivable	**128**	**0**	**128**	121
Bank interest	**0**	**0**	**0**	0
Other loans and receivables	**0**	**0**	**0**	0
Impaired financial assets	**0**	**0**	**0**	0
Other financial assets	**0**	**0**	**0**	0
Subtotal	**128**	**0**	**128**	121
Total investment income	**128**	**0**	**128**	121

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)	**0**	**0**	**0**	5
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	**0**	**0**	**0**	5

11. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest				
Interest on obligations under finance leases	**0**	**0**	**0**	0
Interest on obligations under PFI contracts:				
- main finance cost	**0**	**0**	**0**	0
- contingent finance cost	**0**	**0**	**0**	0
Interest on obligations under LIFT contracts:				
- main finance cost	**2,317**	**0**	**2,317**	2,345
- contingent finance cost	**654**	**0**	**654**	528
Interest on late payment of commercial debt	**0**	**0**	**0**	0
Other interest expense	**0**	**0**	**0**	0
Total interest expense	**2,971**	**0**	**2,971**	**2,873**
Other finance costs	**0**	**0**	**0**	0
Provisions - unwinding of discount	**5**		**5**	6
Total	**2,976**	**0**	**2,976**	**2,879**

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	**7,214**	**43,265**	**0**	**0**	**2,082**	**0**	**10,935**	**772**	**64,268**
Additions of Assets Under Construction				0					**0**
Additions Purchased	0	197	0		0	0	299	0	**496**
Additions Donated	0	0	0	0	0	0	0	0	**0**
Additions Government Granted	0	0	0	0	0	0	0	0	**0**
Additions Leased	0	0	0		0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassifications as Held for Sale	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	0	0	0	0	**0**
Upward revaluation/positive indexation	0	160	0	0	0	0	0	0	**160**
Impairments/negative indexation	(110)	(48)	0	0	0	0	0	0	**(158)**
Reversal of Impairments	0	282	0	0	0	0	0	0	**282**
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	**0**
At 31 March 2013	**7,104**	**43,856**	**0**	**0**	**2,082**	**0**	**11,234**	**772**	**65,048**
Depreciation									
At 1 April 2012	**68**	**146**	**0**	**0**	**2,014**	**0**	**6,174**	**669**	**9,071**
Reclassifications		0	0		0	0	0	0	**0**
Reclassifications as Held for Sale	0	0	0		0	0	0	0	**0**
Disposals other than for sale	0	0	0		0	0	0	0	**0**
Upward revaluation/positive indexation	0	0	0		0	0	0	0	**0**
Impairments	66	859	0	0	39	0	180	16	**1,160**
Reversal of Impairments	0	(311)	0	0	0	0	0	0	**(311)**
Charged During the Year	0	1,350	0		29	0	1,691	40	**3,110**
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	**0**
At 31 March 2013	**134**	**2,044**	**0**	**0**	**2,082**	**0**	**8,045**	**725**	**13,030**
Net Book Value at 31 March 2013	**6,970**	**41,812**	**0**	**0**	**0**	**0**	**3,189**	**47**	**52,018**
Purchased	6,970	41,812	0	0	0	0	3,189	47	**52,018**
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	**6,970**	**41,812**	**0**	**0**	**0**	**0**	**3,189**	**47**	**52,018**
Asset financing:									
Owned	3,777	18,283	0	0	0	0	3,189	47	**25,296**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	3,193	23,529	0	0	0	0	0	0	**26,722**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2013	**6,970**	**41,812**	**0**	**0**	**0**	**0**	**3,189**	**47**	**52,018**

12.1 Property, plant and equipment (continued)

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	**1,816**	**6,939**	**0**	**0**	**38**	**0**	**0**	**17**	**8,810**
Movements (specify)	(140)	308	0	0	(38)	0	0	0	**130**
At 31 March 2013	**1,676**	**7,247**	**0**	**0**	**0**	**0**	**0**	**17**	**8,940**

Additions to Assets Under Construction in 2012-13

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

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	**8,929**	**53,988**	**0**	**0**	**2,082**	**0**	**6,862**	**772**	**72,633**
Additions - purchased	0	227	0	0	0	0	4,073	0	**4,300**
Additions - donated	0	0	0	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassified as held for sale	(600)	0	0	0	0	0	0	0	**(600)**
Disposals other than by sale	0	0	0	0	0	0	0	0	**0**
Revaluation & indexation gains	0	258	0	0	0	0	0	0	**258**
Impairments	(110)	(35)	0	0	0	0	0	0	**(145)**
Reversals of impairments	0	379	0	0	0	0	0	0	**379**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluatior	(1,005)	(11,552)	0	0	0	0	0	0	**(12,557)**
At 31 March 2012	**7,214**	**43,265**	**0**	**0**	**2,082**	**0**	**10,935**	**772**	**64,268**
Depreciation									
At 1 April 2011	**1,005**	**11,552**	**0**		**1,985**	**0**	**5,302**	**609**	**20,453**
Reclassifications		0	0		0	0	0	0	**0**
Reclassifications as Held for Sale	0	0	0		0	0	0	0	**0**
Disposals other than for sale	0	0	0		0	0	0	0	**0**
Upward revaluation/positive indexation	0	0	0		0	0	0	0	**0**
Impairments	68	0	0	0	0	0	0	0	**68**
Reversal of Impairments	0	(1,224)	0	0	0	0	0	0	**(1,224)**
Charged During the Year	0	1,370	0		29	0	872	60	**2,331**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluatior	(1,005)	(11,552)	0	0	0	0	0	0	**(12,557)**
At 31 March 2012	**68**	**146**	**0**	**0**	**2,014**	**0**	**6,174**	**669**	**9,071**
Net Book Value at 31 March 2012	**7,146**	**43,119**	**0**	**0**	**68**	**0**	**4,761**	**103**	**55,197**
Purchased	7,146	43,119	0	0	68	0	4,761	103	**55,197**
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	**7,146**	**43,119**	**0**	**0**	**68**	**0**	**4,761**	**103**	**55,197**
Asset financing:									
Owned	3,899	19,562	0	0	68	0	4,761	103	**28,393**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	3,247	23,557	0	0	0	0	0	0	**26,804**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**7,146**	**43,119**	**0**	**0**	**68**	**0**	**4,761**	**103**	**55,197**

12.3 Property, plant and equipment

The net book value of land and buildings at 31 March comprise:

	2012-13	2011-12
	£000	£000
Freehold	21,395	22,786
Leasehold	665	675
Short leasehold	26,722	26,804
	48,782	50,265

Property assets have been revalued as at 31 March 2013 by the District Valuation Service which is the commercial arm of the Valuation Office Agency, which is itself an executive agancy of HM Revenue and Customs.

The revaluation represents a further update of the last full revaluation that was carried out on 1 April 2009 by the District Valuation Service and the same valuation methodology has been used, but applied by a desk-top review rather than a full property inspection. This ensures that these assets continue to be stated at fair value in accordance with HM Treasury and IAS 16 requirements.

Due to the specialised nature of the PCT's property assets, fair value is based on depreciated replacement cost assuming continued use of the assets and the assets have been valued on a modern equivalent asset basis.

The change in asset values as a result of the revaluation was:

	Gain	Impairment	Net	Taken to SoCNE	Taken to Revaluation Reserve
	£000	£000	£000	£000	£000
Land		(122)	(122)	12	110
Leased land		(53)	(53)	53	0
Buildings	327	(170)	157	40	(197)
Leased buildings	427		427	(229)	(198)
	754	(345)	409	(124)	(285)

Economic Lives of Non-Current Assets

	Min Life Years	Max Life Years
Property, Plant and Equipment		
Buildings excl Dwellings	5	56
Dwellings		
Plant and Machinery	2	5
Transport Equipment		
Information Technology	1	8
Furniture and Fittings	1	5

13.1 Intangible non-current assets

2012-13	Software internally generated £000	Software purchased £000	Licences & trademarks £000	Patents £000	Development expenditure £000	Total £000
At 1 April 2012	**0**	**185**	**0**	**0**	**0**	**185**
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**	**185**	**0**	**0**	**0**	**185**
Amortisation						
At 1 April 2012	**0**	**164**	**0**	**0**	**0**	**164**
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	20	0	0	0	**20**
In-year transfers to NHS bodies	0	0	0	0	0	**0**
At 31 March 2013	**0**	**184**	**0**	**0**	**0**	**184**
Net Book Value at 31 March 2013	**0**	**1**	**0**	**0**	**0**	**1**
Net Book Value at 31 March 2013 comprises						
Purchased	0	1	0	0	0	**1**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	**0**
Total at 31 March 2013	**0**	**1**	**0**	**0**	**0**	**1**

Revaluation reserve balance for intangible non-current assets

	Software internally generated £000's	Software purchased £000's	Licences & trademarks £000's	Patents £000's	Development expenditure £000's	Total £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	Software purchased	Licences & trademarks	Patents	Development expenditure	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2011	**0**	**185**	**0**	**0**	**0**	**185**
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**
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**	**185**	**0**	**0**	**0**	**185**
Amortisation						
At 1 April 2011	**0**	**139**	**0**	**0**	**0**	**139**
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	25	0	0	0	**25**
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**	**164**	**0**	**0**	**0**	**164**
Net Book Value at 31 March 2012	**0**	**21**	**0**	**0**	**0**	**21**
Net Book Value at 31 March 2012 comprises						
Purchased	0	21	0	0	0	**21**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	**0**
Total at 31 March 2012	**0**	**21**	**0**	**0**	**0**	**21**

13.3 Intangible non-current assets

Economic Lives of Non-Current Assets

	Min Life Years	Max Life Years
Intangible Assets		
Software licences	1	1
Licences and trademarks		
Patents		
Development expenditure		

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

	Total £000	Admin £000	Programme £000
Property, Plant and Equipment impairments and reversals taken to SoCNE			
Loss or damage resulting from normal operations	973	0	973
Over-specification of assets	0	0	0
Abandonment of assets in the course of construction	0	0	0
Total charged to Departmental Expenditure Limit	**973**	**0**	**973**
Unforeseen obsolescence	0		0
Loss as a result of catastrophe	0		0
Other	0		0
Changes in market price	(124)		(124)
Total charged to Annually Managed Expenditure	**(124)**		**(124)**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Loss or damage resulting from normal operations	0		
Over Specification of Assets	0		
Abandonment of assets in the course of construction	0		
Unforeseen obsolescence	0		
Loss as a result of catastrophe	0		
Other	0		
Changes in market price	(124)		(124)
Total impairments for PPE charged to reserves	**(124)**	**0**	**(124)**
Total Impairments of Property, Plant and Equipment	**725**	**0**	**725**
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
Loss as a result of catastrophe	0		0
Other	0		0
Changes in market price	0		0
Total charged to Annually Managed Expenditure	**0**		**0**
Intangible Assets impairments and reversals charged to the Revaluation Reserve			
Loss or damage resulting from normal operations	0		
Over-specification of assets	0		
Abandonment of assets in the course of construction	0		
Unforeseen obsolescence	0		
Loss as a result of catastrophe	0		
Other	0		
Changes in market price	0		
Total impairments for Intangible Assets charged to Reserves	**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
Other	0		0
Total charged to Annually Managed Expenditure	**0**		**0**
Financial Assets impairments and reversals charged to the Revaluation Reserve			
Loss or damage resulting from normal operations	0		
Loss as a result of catastrophe	0		
Other	0		
TOTAL impairments for Financial Assets charged to reserves	**0**		
Total Impairments of Financial Assets	**0**	**0**	**0**

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

	Total £000	Admin £000	Programme £000
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
Loss as a result of catastrophe	0		0
Other	0		0
Changes in market price	0		0
Total charged to Annually Managed Expenditure	**0**		**0**
Total impairments of non-current assets held for sale	**0**	**0**	**0**
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
Loss as a Result of a Catastrophe	0		0
Other (Free text note required)*	0		0
Changes in Market Price	0		0
Total charged to Annually Managed Expenditure	**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
Loss as a Result of a Catastrophe	0		0
Other (Free text note required)*	0		0
Changes in Market Price	0		0
Total charged to Annually Managed Expenditure	**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		
Over Specification of Assets	0		
Abandonment of Assets in the Course of Construction	0		
Unforeseen Obsolescence	0		
Loss as a Result of a Catastrophe	0		
Other (Free text note required)*	0		
Changes in Market Price	0		
TOTAL impairments for Investment Property charged to Reserves	**0**		
Total Investment Property Impairments	**0**	**0**	**0**
Total Impairments charged to Revaluation Reserve	(124)	0	(124)
Total Impairments charged to SoCNE - DEL	973	0	973
Total Impairments charged to SoCNE - AME	(124)		(124)
Overall Total Impairments	**725**	**0**	**725**
Of which:			
Impairment on revaluation to "modern equivalent asset" basis	**0**	0	0

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

Impairments on property, plant and equipment in 2012-13 are as follows:

	Taken to SoCNE £000	Taken to Revaluation Reserve £000	Total £000
Changes in fair value of property assets	187	158	345
Reversal of previous impairments	(311)	(282)	(593)
Write off of Fixed assets (see below)	973		973
	849	**(124)**	**725**

The fall in fair value of property assets results from the annual updating of property values by District Valuation Services. The charge to SoCNE arises as there is either no remaining balance on the Revaluation Reserve or a previous impairment has reversed and the SoCNE is credited with expenditure to the extent of the decrease previously charged there.

A number of of assets have been written down to their recoverable amount resulting in a write down of asset values of £972,469. This mainly relates to capitalised fit out costs for leased buildings which will no longer be under the control of the PCT from 1 April 2013.

15 Investment property

	31 March 2013 £000	31 March 2012 £000
At fair value		
Balance at 1 April 2012	**0**	0
Additions Through Subsequent Expenditure	**0**	0
Other Acquisitions	**0**	0
Disposals	**0**	0
Property Reclassified as Held for Sale	**0**	0
Loss from Fair Value Adjustments - Impairments	**0**	0
Gain from Fair Value Adjustments - Reversal of Impairments	**0**	
Gain from Fair Value Adjustments	**0**	0
Transfers (to)/from Other Public Sector Bodies	**0**	
Other Changes	**0**	0
Balance at 31 March 2013	**0**	0
Investment property capital transactions in 2012-13		
Capital expenditure	**0**	0
Capital income	**0**	0
	0	0

16 Commitments

16.1 Capital commitments

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

	31 March 2013 £000	31 March 2012 £000
Property, plant and equipment	**0**	236
Intangible assets	**0**	0
Total	**0**	236

16.2 Other financial commitments

The trust has entered into non-cancellable contracts (which are not leases or PFI contracts or other

	31 March 2013 £000	31 March 2012 £000
Not later than one year	**0**	0
Later than one year and not later than five year	**0**	0
Later than five years	**0**	0
Total	**0**	0

17 Intra-Government and other balances

	Current receivables	Non-current receivables	Current payables	Non-current payables
	£000	£000	£000	£000
Balances with other Central Government Bodies	1,851	0	2,080	0
Balances with Local Authorities	135	0	833	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	97	0	5,758	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	2,163	0	28,844	0
At 31 March 2013	**4,246**	**0**	**37,515**	**0**
prior period:				
Balances with other Central Government Bodies	335	0	1,806	0
Balances with Local Authorities	544	0	3,699	0
Balances with NHS Trusts and Foundation Trusts	1,726	0	6,150	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	2,894	0	33,818	0
At 31 March 2012	**5,499**	**0**	**45,473**	**0**

18 Inventories

The PCT does not hold any material amounts of inventory.

19.1 Trade and other receivables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
NHS receivables - revenue	**397**	1,977	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**1,340**	7	**0**	0
Non-NHS receivables - revenue	**515**	850	**0**	0
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**1,902**	2,632	**0**	0
Provision for the impairment of receivables	**(119)**	(44)	**0**	0
VAT	**211**	77	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	**0**	0	**0**	0
Interest receivables	**0**	0	**0**	0
Finance lease receivables	**0**	0	**0**	0
Operating lease receivables	**0**	0	**0**	0
Other receivables	**0**	0	**0**	0
Total	**4,246**	5,499	**0**	0
Total current and non current	**4,246**	5,499		
Included above:				
Prepaid pensions contributions	**0**	0		

19.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	**494**	1,990
By three to six months	**4**	100
By more than six months	**42**	34
Total	**540**	2,124

19.3 Provision for impairment of receivables

	2012-13 £000	**2011-12 £000**
Balance at 1 April 2012	**(44)**	(78)
Amount written off during the year	**6**	7
Amount recovered during the year	**12**	43
(Increase)/decrease in receivables impaired	**(93)**	(16)
Balance at 31 March 2013	**(119)**	(44)

20 NHS LIFT investments

	Loan	Share capital	Total
	£000	£000	£000
Balance at 1 April 2012	**845**	**3**	**848**
Additions	**0**	**0**	**0**
Disposals	**0**	**0**	**0**
Loan repayments	**0**	**0**	**0**
Revaluations	**0**	**0**	**0**
Loans repayable within 12 months	**0**	**0**	**0**
Balance at 31 March 2013	**845**	**3**	**848**
Balance at 1 April 2011	845	3	848
Additions	0	0	0
Disposals	0	0	0
Loan repayments	0	0	0
Revaluations	0	0	0
Loans repayable within 12 months	0	0	0
Balance at 31 March 2012	**845**	**3**	**848**

21 Other Financial Assets

21.1 Other financial assets - Current

	31 March 2013	31 March 2012
	£000	£000
Opening balance 1 April	0	0
Transfers (to)/from Other Public Sector Bodies in year	0	0
Other Movements	0	0
Closing balance 31 March	**0**	0

21.2 Other Financial Assets - Non Current

	31 March 2013	31 March 2012
	£000	£000
Opening balance 1 April	**848**	848
Additions	0	0
Revaluation	0	0
Impairments	0	0
Impairment Reversals	0	0
Transferred to current financial assets	0	0
Disposals	0	0
Transfers (to)/from Other Public Sector Bodies in year	0	0
Total Other Financial Assets - Non Current	**848**	848

21.3 Other Financial Assets - Capital Analysis

	31 March 2013	31 March 2012
	£000	£000
Capital Expenditure	**0**	0
Capital Income	**0**	0

22 Other Current Assets

	31 March 2013	31 March 2012
	£000	£000
EU Emissions Trading Scheme Allowance	**0**	0
Other Assets	**0**	0
Total	**0**	0

23 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**81**	251
Net change in year	**42**	(170)
Closing balance	**123**	81
Made up of		
Cash with Government Banking Service	**123**	77
Commercial banks	**0**	4
Cash in hand	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**123**	81
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**123**	81
Patients' money held by the PCT, not included above	**0**	0

24 Non-current assets held for sale

	Land	Buildings, excl. dwellings	Dwellings	Asset Under Construction and Payments on Account	Plant and Machinery	Transport and Equipment	Information Technology	Furniture and Fittings	Intangible Assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Balance at 1 April 2012	600	0	0	0	0	0	0	0	0	**600**
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from other public sector bodies	0	0	0	0	0	0	0	0	0	**0**
Revaluation	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2013	**600**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**600**
Liabilities associated with assets held for sale at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
										0
Balance at 1 April 2011	395	120	0	0	0	0	0	0	0	**515**
Plus assets classified as held for sale in the year	600	0	0	0	0	0	0	0	0	**600**
Less assets sold in the year	(395)	(120)	0	0	0	0	0	0	0	**(515)**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2012	**600**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**600**
Liabilities associated with assets held for sale at 31 March 2012	0	0	0	0	0	0	0	0	0	**0**

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

At 31 March 2012	0
At 31 March 2013	0

The PCT expected to complete the sale of a former hospital site in 2012-13. Due to delays in the process the sale in now expected to complete in 2013-14. The asset therefore continues to be classified as "Held For Sale".

25 Trade and other payables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Interest payable	**0**	0		
NHS payables - revenue	**998**	1,735	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**6,076**	5,456	**0**	0
Family Health Services (FHS) payables	**13,352**	14,471		
Non-NHS payables - revenue	**1,279**	3,236	**0**	0
Non-NHS payables - capital	**0**	1,629	**0**	0
Non_NHS accruals and deferred income	**13,952**	17,490	**0**	0
Social security costs	**198**	205		
VAT	**0**	0	**0**	0
Tax	**307**	295		
Payments received on account	**0**	0	**0**	0
Other	**1,353**	956	**0**	0
Total	**37,515**	45,473	**0**	0
Total payables (current and non-current)	**37,515**	**45,473**		

Other payables includes £259,075 (2011-12 £265,397) in respect of outstanding pensions contributions at 31 March 2013.

26 Other liabilities

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
PFI/LIFT deferred credit	**0**	0	**0**	**0**
Lease incentives	**0**	0	**0**	**0**
Other	**0**	0	**0**	**0**
Total	**0**	0	**0**	0
Total other liabilities (current and non-current)	**0**	**0**		

27 Borrowings

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Bank overdraft - Government Banking Service	**0**	0		
Bank overdraft - commercial banks	**0**	0		
PFI liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
LIFT liabilities:				
Main liability	**551**	488	**33,243**	33,798
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**0**	0	**0**	0
Other (describe)	**0**	0	**0**	0
Total	**551**	**488**	**33,243**	**33,798**
Total other liabilities (current and non-current)	**33,794**	**34,286**		

Borrowings/Loans - Payment of Principal Falling Due in:

	DH £000s	**Other £000s**	**Total £000s**
0 - 1 Years	0	551	**551**
1 - 2 Years	0	542	**542**
2 - 5 Years	0	1,294	**1,294**
Over 5 Years	0	31,407	**31,407**
TOTAL	**0**	**33,794**	**33,794**

28 Other financial liabilities

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

29 Deferred income

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Opening balance at1 April 2012	**1,875**	3,106	**0**	0
Deferred income addition	**1,697**	1,875	**0**	0
Transfer of deferred income	**(1,875)**	(3,106)	**0**	0
Current deferred Income at 31 March 2013	**1,697**	1,875	**0**	0
Total other liabilities (current and non-current)	**1,697**	**1,875**		

30 Finance lease obligations

The PCT has no Finance leases.

31 Finance lease receivables as lessor

The PCT has no Finance leases.

32 Provisions

		Comprising:								
	Total £000	**Pensions to Former Directors £000**	**Pensions Relating to Other Staff £000**	**Legal Claims £000**	**Restructuring £000**	**Continuing Care £000**	**Equal Pay £000**	**Agenda for Change £000**	**Other £000**	**Redundancy £000**
Balance at 1 April 2012	**4,682**	0	803	1,888	0	835	0	0	0	1,156
Arising During the Year	**11,493**	0	194	478	0	10,590	0	0	231	0
Utilised During the Year	**(2,832)**	0	(997)	(977)	0	(336)	0	0	0	(522)
Reversed Unused	**(701)**	0	0	(67)	0	0	0	0	0	(634)
Unwinding of Discount	**5**	0	0	5	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	**12,647**	**0**	**0**	**1,327**	**0**	**11,089**	**0**	**0**	**231**	**0**
Expected Timing of Cash Flows:										
No Later than One Year	**9,022**	**0**	**0**	**705**	**0**	**8,317**	**0**	**0**	**0**	**0**
Later than One Year and not later than Five Years	**2,942**	**0**	**0**	**170**	**0**	**2,772**	**0**	**0**	**0**	**0**
Later than Five Years	**683**	**0**	**0**	**452**	**0**	**0**	**0**	**0**	**231**	**0**

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at 31 March 2013	622
As at 31 March 2012	153

The Legal claims provision relates to:
a) Injury benefit claims settled against the PCT which result in an annual allowance for the life of the individual claimant. The value of the provision for these claims is £655,848 and relates to 4 claimants.

b) The PCT's excess on claims made under the Liability to Third Parties Scheme administered by the NHS Litigation Authority. The provision has a value of £13,000 and is based on the probability of success for the claimant of 50% or greater. The balance of the claims excess not provided for is shown as a contingent liability. The outcome of the claims will determine the PCT's actual liability.

c) The PCT has made a provision of £235,000 in relation to an asbestosis claim. The value is an estimate of the potential liability.

d) Other contractual claims (£355,000) are under negotiation with the relevant non-NHS organisation.

e) The PCT has provided for the potential costs associated with the restructure of support functions supplied by other organisations.

Continuing Care:
This represents the estimated cost of the reimbursement of healthcare costs for individuals claiming eligibility for continuing healthcare funding from the PCT under the National Framework for Continuing Healthcare. As a result of the introduction of deadlines for the assessment of eligibility for continuing healthcare funding, a significant number of retrospective claims for periods of care up to 31 March 2012 have been received. An assessment has been made of the likelihood that these applications will qualify for health funding, together with an estimate of the cost of settling these claims. The value of the provision for these costs is £11,089,000 and actual costs will be confirmed following in-depth case reviews. Due to the large number of claimants, the review process is expected to continue into 2014/15.

Other provisions relate to the expected building lifecycle costs of the Eccleshill ISTC.

33 Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities		
Equal Pay	**0**	0
Other	**(8)**	(927)
Amounts Recoverable Against Contingent Liabilities	**(5,482)**	0
Net Value of Contingent Liabilities	**(5,490)**	(927)
Contingent Assets		
Contingent Assets	**0**	0
Net Value of Contingent Assets	**0**	0

The contingent liability relates to:
a) The PCT's estimated liability in respect of Employer Liability claims handled by the NHS Litigation Authority (£8,000).

b) Where it has been possible to make an estimate of the cost of claims for continuing healthcare funding, the value of the estimate not provided for (based on the probability of a claims success) has been include as a contingent liability and has a value of £5,481,605. The results of the claims review process will determine the extent to which any of this contingency is realised.

Claims for continuing healthcare funding for the period 1 April 2012 to 31 March 2013 must be received by 31 March 2014 in order to be assessed. No claims have been received to date for this period and therefore it is not possible to quantify the value of any potential contingent liability.

34 PFI and LIFT

34.1 PFI Contracts

The PCT has no PFI schemes.

34 PFI and LIFT (continued)

34.2 LIFT Contracts

Provision of GP medical centres in the Bradford district (including one facility that has 18 medical beds) by Bradford and Airedale Community Solutions Limited (B&ACS), in which the PCT has a 20% shareholding. B&ACS are responsible for the design, construction and operation of these facilities for the 25 year duration of the contract.

Annual Payments under the contract increase in line with the annual movement in RPI in the preceding 12 months (based on the February RPI value) on 1 April each year.

At the end of the contract term the PCT has an option to purchase the site and the facility at a price linked to its fair value and calculated in line with the contract terms. Alternatively, the PCT can either enter in to a new contract for the use of the building, or stop using the site altogether. These contractual rights will transfer to Community Health Partnerships (a limited company wholly owned by the Department of Health) on 1 April 2013.

The facilities provided under LIFT contracts are:

	Contract start date
Haworth Medical Centre	21/11/2005
Low Moor Medical Centre	20/12/2005
Westbourne Green Community Centre	06/03/2006
Hillside Bridge Community Centre	28/01/2008
Thornbury Medical Centre	08/10/2007
Undercliffe Medical Centre	21/01/2008
Canalside Medical Centre	01/02/2010

All contracts are for 25 years.

Under IFRIC 12 (Service concessions), the sites and facilities are treated as assets of the PCT as the substance of the contracts is that the PCT has a financelease for these assets. Payments under the contracts comprise two elements; service charges and imputed finance lease charges (details provided in the tables below).

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

	31 March 2013 £000	31 March 2012 £000
Total Charge to Operating Expenses in year - OFF SOFP LIFT	**0**	0
Service element of on SOFP LIFT charged to operating expenses in year	**766**	746
Total	**766**	746

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

	31 March 2013 £000	31 March 2012 £000
LIFT Scheme Expiry Date:		
No Later than One Year	**672**	757
Later than One Year, No Later than Five Years	**2,860**	2,757
Later than Five Years	**12,834**	13,417
Total	**16,366**	16,931

The estimated annual payments in future years are not expected to be materially different from those that are committed to be made during the next year by Community Health Partnerships Ltd (the company to which PCT LIFT schemes will transfer on 1 April 2013).

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

	31 March 2013 £000	31 March 2012 £000
No Later than One Year	**2,837**	2,805
Later than One Year, No Later than Five Years	**10,653**	10,920
Later than Five Years	**58,881**	61,455
Subtotal	**72,371**	75,180
Less: Interest Element	**(38,577)**	(40,894)
Total	**33,794**	34,286

35 Impact of IFRS treatment

	Total £000	Admin £000	Programme £000
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g LIFT/PFI)			
Depreciation charges	**456**	0	456
Interest Expense	**2,970**	0	2,970
Impairment charge - AME	**(176)**		(176)
Impairment charge - DEL	**0**	0	0
Other Expenditure	**766**	0	766
Revenue Receivable from subleasing	**0**	0	0
Total IFRS Expenditure (IFRIC12)	**4,016**	**0**	**4,016**
Revenue consequences of LIFT/PFI schemes under UK GAAP / ESA95 (net of any sublease income)	**(4,225)**	0	(4,225)
Net IFRS change (IFRIC12)	**(209)**	**0**	**(209)**

Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12	
Capital expenditure 2012-13	0
UK GAAP capital expenditure 2012-13 (Reversionary Interest	0

36 Financial Instruments

Financial risk management

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

Currency risk

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

Interest rate risk

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

Credit Risk

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

Liquidity Risk

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

36 Financial Instruments (continued)

36.1 Financial Assets

	At 'fair value through profit and loss'	Loans and receivables	Available for sale	Total
	£000	£000	£000	£000
Embedded derivatives	0			**0**
Receivables - NHS		397		**397**
Receivables - non-NHS		515		**515**
Cash at bank and in hand		123		**123**
Other financial assets	848	0	0	**848**
Total at 31 March 2013	**848**	**1,035**	**0**	**1,883**
Embedded derivatives	0			0
Receivables - NHS		1,977		1,977
Receivables - non-NHS		850		850
Cash at bank and in hand		81		81
Other financial assets	848	0	0	848
Total at 31 March 2012	848	2,908	0	3,756

36.2 Financial Liabilities

	At 'fair value through profit and loss'	Other	Total
	£000	£000	£000
Embedded derivatives	0		**0**
NHS payables		998	**998**
Non-NHS payables		14,861	**14,861**
Other borrowings		33,794	**33,794**
PFI & finance lease obligations		0	**0**
Other financial liabilities	0	0	**0**
Total at 31 March 2013	**0**	**49,653**	**49,653**
Embedded derivatives	0		0
NHS payables		1,735	1,735
Non-NHS payables		19,439	19,439
Other borrowings		34,286	34,286
PFI & finance lease obligations		0	0
Other financial liabilities	0	0	0
Total at 31 March 2012	**0**	55,460	55,460

37 Related party transactions

During the year the following Board members or members of the key management team, or parties related to them, have undertaken material transactions with the PCT to the value set out below.

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	£000	£000	£000
Senior Employee				
Linda Pollard (1/4/12 - 31/1/13) - University of Leeds	908		76	
Dr Damien Riley - Leylands Medical Practice (Indirect)	1,626	26	153	
Dr Anita Parkin - Bradford Metropolitan District Council	41,902	1,517	833	135
Member				
Dr Phil Pue - Farfield Group Practice	1,789		137	
Pam Essler - Keighley Healthy Living	102			
Pam Essler - Bradford & Airedale Citizens Advice Bureau	25			
Pam Essler - Airedale & Bradford Crossroads	45			
Pam Essler - Enable2 CIC	800	29	26	1
Dr Graeme Summers - Ilkley Moor Medical Practice	2,413		101	1
Dr Brendan Kennedy - Kilmeny Group Practice	1,993		137	
Dr Paul Bolton - Holycroft Surgery	1,238	38	106	
Dr Andy Withers - The Grange Medical Practice	1,237		71	
Mr Ali Jan Haider - Attock Community Association	19		6	
Dr Puish Patel - Shipley Medical Practice (1/2/13 - 31/3/13)	1,754		52	
Dr Chris Harris - The Ridge Medical Practice	4,929	32	144	10
Dr Chris Harris - The Ridge Medical Ltd	155			
Dr Matt Fay - Westcliffe Medical Practice	2,555		193	2
Dr Matt Fay - Westcliffe Care UK	1,090		22	
Dr Matt Fay - Bradford Dermatology Group Ltd	255		6	
Dr Matt Fay - The Willows Medical Practice (Indirect 1/4/12 - 31/1/13)	1,160	2	48	
Dr Yasmin Khan - The Willows Medical Practice (1/4/12 - 31/1/13)	1,160	2	48	
Dr Yasmin Khan - Westcliffe Medical Practice (Indirect 1/4/12 -31/3/13)	2,555		193	2
Dr Yasmin Khan - Westcliffe Care UK (Indirect 1/4/12 -31/3/13)	1,090		22	
Dr Yasmin Khan - Bradford Dermatology Group Ltd (Indirect 1/4/12 -31/3/13)	255		6	
Dr Bridget Pitcairn - Bingley Medical Practice (1/3/13 - 31/3/13)	1,482	72	100	
Dr Richard Falls - The Bradford Moor Surgery	504	12	14	4
Dr Richard Falls - The Bradford Community Epilepsy Service (The Ridge MP)	224			
Dr Akram Khan - Avicenna Medical Practice	1,179		24	1
Mrs Pat Drake - Yorkshire Ambulance Service NHS Trust	21,141		356	
Dr Aamer Khan - The City Medical Practice	225	10	20	45
Dr Aamer Khan - The Lister Surgery	359	5	21	4
Dr Adeel Iqbal - Kensington Medical Practice	516	15	30	4
Dr Ish Gilkar - Dr Gilkar & Partners	931	1	40	11
Dr Raf Rashid - Picton Medical Centre	728	23	29	
Dr Waheed Hussain - Clarendon Medical Centre	595		35	3

Related parties are declared wherever individuals have a decalred emplyment or trustee relationship - these may be paid or unpaid.
The amounts disclosed represent all transactions made by the PCT with the Related Party.

The PCT considers that all amounts due from Related Parties are fully recoverable within one year.

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 North of Engand
- Bradford Teaching Hospitals NHS Foundation Trust
- Airedale NHS Foundation Trust
- Bradford District Care Trust
- Leeds Teaching Hospitals Trust
- Barnsley Primary Care Trust (lead commissioner SCG)
- Calderdale Primary Care Trust (lead commissioner Urgent Care)
- Calderdale & Huddersfield NHS Foundation Trust
- Yorkshire Ambulance Service NHS Trust
- NHS Litigation Authority
- NHS Business Services Authority
- Prescription pricing Authority
- West Yorkshire Central Services Agency (hosted by Leeds PCT)

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 Bradford Metropolitan District Council in respect of joint working.

The PCT has also received revenue and capital payments from a number of charitable funds, certain of the trustees for which are also members of the PCT board. The funds have been have been fully utilised in 2012-13 and there is no balance remaining at 31 March 2013.

37 Related party transactions (continued)

Prior Year Comparators

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£'000	£'000	£'000	£'000
Senior Employee				
Pam Essler - Enable 2	732			
Pam Essler - Airedale and Bradford Crossroads	45			
Dr Damien Riley (3/10/11 - 31/3/12) - Leylands Medical Practice (indirect)	1,697	24	119	
Dr A McElligot (1/4/11 - 30/6/11) - Sunnybank Medical Practice	1,759			
Dr A Parkin - Bradford Metropolitan District Council	44,152	2,254	3,699	544
Jane Hazelgrave (1/4/11 - 2/11/11) - Bradford & Airedale Community Solutions Ltd	4,289			
Member				
Dr Chris Harris - Ridge Medical Practice	4,540	33	236	33
Dr Phil Pue - Farfield Medical Practice	1,729		50	
Dr Jude Danby (1/4/11 - 2/11/11) - Ashwell Medical Practice	1,078	16	53	
Dr Akram Khan - Avicenna Medical Practice	1,039	26	49	
Dr Richard Haddad (1/4/11 - 2/11/11) - Rockwell and Wrose Medical Practice	1,253	20		
Dr Andy Withers - The Grange Medical Practice	1,167		40	
Dr Brendan Kennedy - Kilmeny Medical Centre	1,879			
Dr Matt Fay - Westcliffe Medical Practice	2,485	6	233	36
Dr Matt Fay - The Willows Medical Practice (indirect)	1,096		25	
Dr Graeme Summers (3/11/11 - 31/3/12) - Ilkley Moor Medical Practice	2,351	111	72	
Dr Richard Falls (3/11/11 - 31/3/12) - Bradford Moor Medical Practice	491	12	7	
Dr Yasmin Khan (3/11/11 - 31/3/12) - The Willows Medical Pratice	1,096		25	
Dr Yasmin Khan (3/11/11 - 31/3/12) - Westcliffe Medical Practice (indirect)	2,485	6	233	36
Dr I Gilkar (3/11/11 - 31/3/12) - Dr I Gilkar	944	13	41	39
Dr M Iqbal (3/11/11 - 31/3/12) - Kensington Street Medical Centre	454	11	39	11
Dr Aaemer Khan (3/11/11 - 31/3/12) - Dr Masood	280		17	21
Dr Aaemer Khan (3/11/11 - 31/3/12) - The Lister Surgery	354	6	3	8
Dr R Rashid (3/11/11 - 31/3/12) - Picton Surgery	705		14	

38 Losses and special payments

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

	Total Value of Cases £s	Total Number of Cases
Losses - PCT management costs	6,802	13
Special payments - PCT management costs *	74,700	4
Losses in respect of the provision of family practitioner services	0	0
Special payments in respect of the provision of family practitioner services	0	0
Total losses	6,802	13
Total special payments	74,700	4
Total losses and special payments	81,502	17

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

	Total Value of Cases £s	Total Number of Cases
Losses - PCT management costs	47,805	25
Special payments - PCT management costs*	106,991	2
Losses in respect of the provision of family practitioner services	0	0
Special payments in respect of he provision of family practitioner services	0	0
Total losses	47,805	25
Total special payments	106,991	2
Total losses and special payments	154,796	27

Details of cases individually over £250,000
There are no cases which are individually over £250,000.

* Special Payments - PCT management costs includes compromise agreements (2012-13 £58,700, 2012-12 £7,260) and excess payments for settled cases (2012-13 £16,000, 2011-12 £99,730).

39 Third party assets

The PCT holds no cash or cash equivalent items on behalf of patients.

40 Pooled budgets

Integrated Community Equipment Service

The PCT has entered into a pooled budget arrangement with Bradford Metropolitan District Council. Under the arrangement funds are pooled under s75 of the NHS Act 2006 for the provision of an integrated Community Equipment Service.

The pooled budget is hosted by Bradford Metropolitan District Council who produces a Memorandum Account relating to the activities of the arrangement each year.

As a commissioner of healthcare services the PCT makes contributions to the pool which are then used to provide equipment to support healthcare needs for people at home. The value of the PCT's contributions in 2012-13 was £1,146,700 (2011-12 £1,291,819).

The assets and liabilities of the pool have not been included in the PCT's Statement of Financila Position as they are not considered to be material. The estimated value of the PCTs share of the closing stock held by the Integrated Community Equipment Service at 31 March 2013 is £200,000.

41 Cashflows relating to exceptional items

There are no exceptional cashflow items.

42 Events after the end of the reporting period

Under the provisions of The Health and Social Care Act 2012 (Commencement No. 4. Transitional, Savings and Transitory Provisions) Order 2013, Bradford and Airedale Teaching PCT was dissolved on 1st April 2013.

The main functions carried out by Bradford and Airedale Teaching PCT in 2012-13 are to be carried out by other public sector bodies from 1 April 2013.

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