Department of Health

NHS

Sheffield Primary Care Trust

2012-13 Annual Report and Accounts

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Sheffield Primary Care Trust

2012-13 Annual Report

Contents

NHS Sheffield Annual Report 2012/13

Foreword

Welcome to the Annual Report for NHS Sheffield for the period 1 April 2012 to 31 March 2013; the last for Sheffield Primary Care Trust (PCT). This year has been a transitional year as we work to ensure that the local NHS is ready for the new arrangements from April 2013 as a result of the Health and Social Care Act 2012. We have worked closely with local clinicians to develop a Sheffield Clinical Commissioning Group. This has operated in shadow form during the year to ensure it is able to take over the commissioning of health services for the city from April 2013.

With the Health and Social Care Bill becoming an Act of Parliament in March 2012, this year has been one of the most challenging years yet for the NHS. In this context, it is extremely pleasing that we can announce we have met our statutory financial obligations. This would not have been possible without the outstanding commitment and hard work of our staff and health providers, especially when set against the challenging economic climate we currently face.

In a challenging period of change we have also met key performance targets and remained committed to delivering our local and national priorities with our Sheffield Clinical Commissioning Group (SCCG) colleagues to improve local services and reduce health inequalities across the city.

We would like to thank all those staff and board members of the PCT over the years who have helped to ensure that patients of Sheffield received high quality, safe and effective health services and care within ever increasingly tight budgets

Ms Eleri De Gilbert
Designated Signing Officer, NHS South Yorkshire and Bassetlaw

Mr Ian Atkinson
Accountable Officer, NHS Sheffield Clinical Commissioning Group

1. Who We Are

About NHS Sheffield

NHS Sheffield was formed in October 2006; the result of the merger of four primary care trusts in the city. We serve a population of approximately 557,000 and cover the same area as Sheffield City Council. Sheffield is a unique city, with a diverse population and wide range of cultures and it's our role to make sure we meet everyone's needs. In 2012/13 we had a budget of around £1 billion to spend on services for local people and are responsible for ensuring they reflect needs, offer value for money and help to improve health and health services.

We commission services from GP practices, dental practices, opticians, pharmacists, hospital trusts, mental health care providers, independent providers and voluntary providers. While we don't run these services, we are responsible for how well they perform. We also provide a range of community services to the people of Sheffield. It's our job to get the very best performance across all NHS services in the city. A further part of our work is to improve the health of Sheffield people with advice and programmes to help them lead healthier lifestyles and manage their own health better. Following the publication of the Government white paper "Equity and Excellence: Liberating the NHS" NHS Sheffield worked closely with the four GP Locality Groups to help them develop their commissioning capability, in preparation for the end of PCTs.

About the NHS Sheffield Clinical Commissioning Group (SCCG)

NHS Sheffield Clinical Commissioning Group (SCCG) comprises of 88 GP practices and is fully authorised as the statutory organisation from 1st April 2013 with responsibility for commissioning many of the healthcare services for our local population of approximately 560,000 people. In advance of April 2013, it has been operating in shadow form, to ensure that it is fully prepared to take on its new responsibilities.

SCCG aims to involve other clinicians, healthcare professionals, patients and the public, to deliver high quality, efficient and cost effective healthcare services for people across the whole of Sheffield. It has set out four priority aims:

- To improve patient experience and access to care;
- To improve the quality and equality of healthcare in Sheffield;
- To work with Sheffield City Council to continue to reduce health inequalities in Sheffield;
- To ensure there is a sustainable, affordable healthcare system in Sheffield.

The Group will promote good governance and proper stewardship of public resources in pursuance of its goals and in meeting its statutory duties.

About NHS South Yorkshire and Bassetlaw

NHS South Yorkshire and Bassetlaw Cluster is made up of NHS Sheffield, NHS Rotherham, NHS Barnsley, NHS Doncaster and NHS Bassetlaw. The South Yorkshire and Bassetlaw Board has continued to ensure that the five primary care trusts continued to meet their legal, financial and performance responsibilities and obligations throughout 2012/13, until Clinical Commissioning Groups assume full responsibility for budgets in April 2013.

Whilst each PCT remained the statutory organisation, the five PCTs shared a Chief Executive and a number of director posts. During this year we continued to operate as a single trust board. NHS South Yorkshire and Bassetlaw Cluster Board members are from each of the constituent PCTs and the meetings were held monthly, in public, throughout the year.
As well as ensuring the continuation of statutory responsibilities by each of the constituent PCTs, the cluster has supported the transition to the new commissioning and public health arrangements set out in the Health and Social Care Act 2012.

All five Clinical Commissioning Groups (CCGs) in South Yorkshire and Bassetlaw have been established in shadow form as committees of the Cluster Board during the year. Under a scheme of delegation, the CCGs have managed delegated budgets and functions.

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 Commissioning Board (known as NHS England) and Public Health England. In addition Health and Wellbeing Boards have been established as part of the transfer of a range of public health responsibilities to local authorities.

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

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 Sheffield were abolished at the end of March 2013.

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

Commissioning support units (CSUs): These new NHS organisations provide 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 CCG 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 to support the 15 CCGs in the region.

Local authorities will take on a bigger role, assuming responsibility for budgets for public health. In Sheffield, the majority of the PCT's public health responsibilities will be transferred to Sheffield City Council.

Local Involvement Networks (LINks) will transform 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 will 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.
Formerly established as the NHS Commissioning Board in October 2012, **NHS England** is an independent body, at arm's length to the government. Its main role is to improve health outcomes for people in England. It will:

- provide national leadership for improving outcomes and driving up the quality of care
- oversee the operation of clinical commissioning groups
- allocate resources to clinical commissioning groups
- commission primary care and specialist services

2. Our strategy

Following appointment of the members of the shadow Sheffield Clinical Commissioning Group in October 2011 it was decided to publish a clear statement of goals for the health of the people of Sheffield. The shadow Sheffield Clinical Commissioning Group Prospectus was published in January 2012 which sets out the visions and objectives of the committee.

Practices, partner organisations, members of the public and staff currently working for NHS Sheffield were all consulted as we developed this statement. The resulting short document has been sent to all the practices that make up the CCG, to partner organisations, and published on the NHS Sheffield internet site for access by members of the public and our staff.

Within the Prospectus, the CCG set out four priority aims:

1. To improve patient experience and access to care
2. To improve the quality and equality of healthcare in Sheffield
3. To work with Sheffield City Council to continue to reduce health inequalities in Sheffield
4. To ensure there is a sustainable, affordable healthcare system in Sheffield

The Clinical Commissioning Group in Sheffield will lead on five strategic programmes: elective care, urgent care and long term conditions, mental health and learning disabilities, continuing healthcare and medicines management.

Quality Innovation Productivity and Prevention (QIPP)

Every commissioning organisation is required to deliver a QIPP programme each year. QIPP is a national initiative which stands for "Quality, Innovation, Productivity and Prevention". The aim is to free up savings by delivering care in more efficient ways, at the same time as improving quality and patient experience. Our savings this year have also partly been delivered by reducing our own management costs.

Sheffield has a good record of delivering savings *and* improved patient care through service redesign. This year the PCT invested £3.4m in a range of new initiatives, including:

- increased "step down" care, and enhanced support for people with dementia, to address excessively long hospital inpatient stays for older people;
- new facilities for children with complex disabilities, who were previously cared for out of city; enabling them to be cared for in Sheffield;
- improved discharge processes to help people get home from hospital faster;
- a practice based information system which helps GPs and community nurses to identify vulnerable patients who at risk of an unplanned admission to hospital;

- new “pathways” of care designed by local doctors, based on national evidence, for example alternatives to surgery for people with hand and wrist conditions;
- supporting GPs to follow up patients after a hospital procedure or course of treatment, thus freeing up hospital outpatient appointments.

NHS Sheffield was able to free up savings in 2012/13 £12.2m, which were higher than the original £10 million we were aiming for.

Right First Time

The Right First Time Programme (RFT) formally started in 2012/13 and has made positive progress during the last 12 months. The programme is jointly sponsored by Sheffield City Council, Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield Health and Social Care Foundation Trust, Sheffield Children’s Hospital NHS Foundation Trust and NHS Sheffield. The programme has focussed in the first 12 months on improving the unscheduled care for older people in the city. The main aim has been to increase the capacity within the community to reduce the risk of admission to hospital. The programme is also using the additional community capacity to ensure that when older people are in hospital they go home with the right level of support when they are ready.

The main achievements for the programme in 2012/13 have been:

- Getting 95 per cent of the population of Sheffield risk assessed so that we know what the factors are that may result in hospital admission
- Aligning health and social care services in the community so that it is easier for them to integrate the services offered
- Supporting the development of the Frailty Unit within Sheffield Teaching Hospitals Foundation Trust. The new unit has been successful at ensuring swift and comprehensive assessment of care needs are undertaken and with better alignment with community services has resulted in many more patients returning home within 24-48 hours. We can demonstrate that this has reduced readmission rates
- Standardising the discharge process for patients with more complex needs and again aligning community resources to begin reducing the delays that can occur with such discharges

The programme team and the chief executives for each of the partners in the programme are currently working up plans for a more ambitious second year of the programme in 2013/14.

3. Ensuring High Quality Care

We strive to ensure that health services provided in Sheffield are amongst the very best and continue to work in partnership with organisations responsible for providing and commissioning patient care. We seek to ensure that services are safe, effective and provide a good patient experience as well as being good value for money.

Our work in the last year has meant further progression in key areas, all achieved through close partnership working with our health service providers and Sheffield City Council, building on the strong foundations already in place.

We agreed new national contracts with all our providers, including a number of quality requirements and measures of quality. This helped us to set robust frameworks and monitoring processes.
Quality is monitored by regular quality review meetings with commissioned services, using a quality framework. This is agreed and negotiated with each provider and assurance is gained on the quality of care and services, with remedial action being taken where necessary.

We closely monitor our performance against the range of indicators highlighted in the Operating Framework 2012/13, including existing commitments and national priority areas as well as a selection of local and other indicators. We do this in order to both ensure we are on track to meet our targets as well as establish an understanding of how well we are progressing against our strategy. Our robust approach to targets has allowed us to improve or maintain as a minimum our performance on most areas when compared to the previous year, as outlined below.

Eliminating Mixed Sex Accommodation
2011/12 has seen our acute providers able to declare continued compliance with the guidance surrounding Mixed Sex accommodation. The requirement: to comply with the national definition "to eliminate mixed sex accommodation except where it is in the overall best interest of the patient, or reflects patient choice".

Friends and Family Test
May 2012 saw the announcement of the introduction of the 'Friends and Family Test'. The aim of this is to improve patient care and identify the best performing hospitals in England.

From April 2013 all in patients and attendees of A&E services within adult acute hospitals will be asked:

'How likely are you to recommend our ward to friends and family if they needed similar care or treatment?'
or
'How likely are you to recommend our A&E department to friends and family if they needed similar care or treatment?

The test will help organisations identify wards where there are potential concerns and help commissioners understand the levels of patient experience within the services that they commission. This can be used by commissioners to drive improvements. Within Sheffield there are three organisations that are required to undertake the Friends and Family Test. They have all developed plans to implement the test by April 2013 with results being available from May 2013.

Reducing Health Care Associated Infection (infection control)
Significant reductions have been made in respect of MRSA and Clostridium difficile infections this year, compared to last year, both in the hospital and community settings. More work needs to be undertaken, however; to further reduce community C.difficile cases and meet national targets next year. Specifically hospitals in Sheffield have reported lower rates of MRSA, compared with others in England.

Serious Incidents
We have a duty to performance manage serious incidents occurring in Sheffield of both NHS and private providers. This ensures that improvements in practice have taken place, and lessons are learnt and shared. We encourage all of our providers to use the National Patient Safety Agency guidance on investigating and reporting and on 'Being Open' principals, which encourages involvement of those involved in incidents and / or their families where appropriate.

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)
During the past 12 months, NHS Sheffield has been assisting Sheffield City Council's (SCC) DoLS and Safeguarding Team in preparing for taking on full responsibility for DoLS as stipulated in the Health and Social Care Act. During this transitions phase, NHS Sheffield and SCC have continued to work together by way of a 'section 75' agreement that has supported our continued partnership working for MCA/DoLS. However, a memorandum of understanding has been drawn up for PCT authorisations that will extend beyond 31 March 13 to enable SCC to continue to manage these cases to their expiry date. Monthly joint governance meetings have also been held in order to support the transition phase.

We have continued to ensure that the managing authorities from which NHS Sheffield commissions care are fully aware of their responsibilities under the DoLS and consider whether they have been proactive enough in promoting and supporting understanding of the Safeguards.

In 2012/13 we undertook 50 DoLS assessments in hospitals with 23 being granted and 27 declined. Progress continues to be made in ensuring that the hospitals in Sheffield are active in the safeguards process. To this end, a further audit of supervisory body systems and processes is being undertaken which will provide recommendations for any improvements. These recommendations will continue to be reviewed on an annual basis by SCC. Training also continues to be provided across health & social care organisations.

Further Best Interests Assessors and Mental Health Assessors have also been recruited to the service in the past 12 months.

The MCA/DoLS lead for the CCG will continue to maintain links with colleagues across the Yorkshire and Humber region through the Yorkshire and Humber MCA Regional Network. This remains essential in maintaining contact with others who have responsibility for ensuring MCA compliance and is beneficial to further developing our safeguarding service. The MCA Lead will also continue to attend updates and training events commissioned by the Yorkshire and Humber BIA/MHA Training Forum Group.

4. Workforce

We recognise our staff as our biggest asset and work in partnership with them and their representatives from recognised trade unions and staff organisations to continuously develop and improve communication and consultation arrangements.

We have carried forward into NHS Sheffield, as a commissioner only organisation, well established partnership working practices, including the Joint Staff Consultative and Negotiation Committee (JSCNC), which provides a forum for detailed discussion and debate on organisational strategy, performance, operational issues and policy, procedural development and, increasingly, transfer and transition issues. Unison has recruited additional representatives to work within NHS Sheffield.

NHS Sheffield has monthly 'all staff' meetings which all staff, managers, senior managers and directors attend to discuss issues and receive feedback particularly about transition arrangements.
We recognise that the importance of effective staff communication and involvement is especially critical during organisational change. The arrangements described above help to keep staff informed about developments in the changes to the structure of the NHS as outlined in the Health and Social Care Act, particularly the arrangements for the transition to Clinical Commissioning Groups, the NHS Commissioning Board, local authority, Public Health England and others and the planned abolition of primary care trusts in 2013. Both the Head of Human Resources and the staff representatives are members of the South Yorkshire and Bassetlaw Social Partnership Forum which includes all the HR leads from the constituent PCTs in the NHS South Yorkshire and Bassetlaw cluster along with local representatives and full time officers of trade unions. The Forum maintains resilience in partnership working arrangements and develops a consistent approach to transition issues affecting all staff across the cluster, including standard policies and procedures.

Equal opportunities

We are committed to ensuring equal opportunities in employment and have appropriate policies in place to provide guidance, including in specific areas such as Maternity Leave and Retirement, and via our Equality Strategy and Single Equality Scheme which covers six equality strands.

Positive about disabled people

All job applicants who meet the minimum criteria for a post are shortlisted for interview in accordance with our commitment to the disability symbol.

Equality and Diversity

Equality and Diversity (E&D) is central to the work of NHS Sheffield to ensure there is equality of access and treatment within the services that we commission. The promotion of equality, diversity and human rights is central to the NHS Constitution, Achieving Balanced

Health 3 (ABH3) and other national drivers to reduce health inequalities and increase the health and well-being of all our population.

NHS Sheffield is committed to embedding equality and diversity values into policies, procedures, employment and the commissioning process that secure health and social care for the people of Sheffield.

We have ensured that commissioning managers are embedding equality and diversity across policies and through aligning contracts for the commissioning intentions for 2012/13. We also monitor the performance of all providers in Sheffield.
We have developed our CCG Equality Objectives that have been developed and supported by underpinning actions that are linked to the four Equality Delivery System (EDS) goals which are:

- Better health outcomes for all
- Improved patient access and experience
- Empowered, engaged and included staff
- Inclusive leadership

The outline plan includes actions to:

- Ensuring equality is core commissioning business
- Improve the range of activity information we have about patients in protected groups and how this is being used
- Improve our understanding of patient experience of services, re E&D, and act upon instances of potential discrimination
- Developing strong and consistent leadership on equality issues
- Improving access to services i.e. contracting

The progress of the actions is reported to the Governing Body of the CCG on a six monthly basis.
Sheffield CCG continues to facilitate partnership working between the NHS Foundation Trust in Sheffield, Sheffield City Council and HealthWatch to share equalities objectives and identified collaborative approach to reduce health inequalities in Sheffield.

Sickness absence data

Information relating to staff sickness is shown in the table below:

	2012-13 Number	2011-12 Number
Total Days Lost	2,086	15,370
Total Staff Years	339	1,685
Average working Days Lost	**6.15**	**9.12**

5. Involving People

How we engage - Duty to Involve

All primary care trusts have had a duty to produce an annual report on consultations about commissioning and other relevant decisions, as set out in section 242A (1) of the NHS Act 2006. This is where consultations have informed the commissioning of or changes to services. These are **'commissioning decisions', and includes decisions about primary care, secondary care and** community health services. As well as information collected by the PCT, the reports can include information collected by partners or providers, or other trusts from which we have commissioned services.

Consulting in the sense of the report is the act of asking a person for their views on a proposal or issue, before a decision is taken. Consultations must have the following four elements:-

1. It must take place when a proposal is at a formative stage;
2. The proposer must give sufficient reasons for any proposal to permit intelligent consideration and response;
3. Adequate time must be given for consideration and response; *This may vary, and does not necessarily mean 12 weeks*
4. The outcomes of consultation must be conscientiously taken into account in finalising any statutory proposals.

However, NHS Sheffield has interpreted this wording in the context of the Department of Health Statutory Guidance, Real Involvement, (2008 p16), which widens this to cover a wider spectrum of activity, information giving, engagement, participation and other involvement activity.

The reporting period is the financial year 1 April 2012 to 31 March 2013. This is the last year of a legal duty placed on Primary Care Trusts (PCTs) to report annually on consultations with patients and the public that have an impact on commissioning decisions. PCTs will be abolished in April 2013, and local health service commissioning will become the responsibility of Clinical Commissioning Groups (CCG), which will have statutory duties to involve local people in the commissioning process.

In the examples quoted, the NHS Sheffield would like to acknowledge the active involvement of local people as individual patients and through groups for their generosity in sharing their views and experiences of local health services.

Completed Consultations/Engagement activity

Decisions by the following service areas have been informed by patients and the public:

- **Autism Spectrum Condition Service** - Engagement with Sheffield people with this condition, and with family representatives to develop a service model for Sheffield. The

resulting new service for adults will be in place during the last quarter of 2013. This took place throughout 2012

- **Annual Self-Assessment Framework** - April- June 2012 - Series of events to seek the views of people with learning disability, their paid and unpaid carers around progress of Sheffield in delivering improvements to key health services and against national priorities.

- **Community IV Antibiotic Service** - Patient feedback questionnaire informed the decision making process and this service has now been commissioned. This was managed in conjunction with North Locality Business Team.

- **Tier 2 weight management Service –** Patient feedback has informed the service specification for the business case with the aim of commissioning this service in the future. This was managed in conjunction with North Locality Business Team.

- **Children with complex health needs –** April 2012 in conjunction with Sheffield Future Shape Children's Health Programme engagement concentrated on access to health services. This lead to the development of several work streams and commissioning intentions being developed.

- **Maternity Care** – June 2012 the Maternity Services Liaison Committee held a consultation exercise to inform the work plan for future services. This lead to a greater focus on antenatal care, bereavement support for families who had experienced miscarriage or still birth and a reduction in interventions with no clinical need.

- **Decommissioning of male circumcision service –** Engagement activity was undertaken, particularly with faith sector groups, around the decommissioning of circumcision which has no clinical need.

- **Right First Time –** Engagement activity was undertaken with Sheffield LINKs and the wider public in conjunction with NHS partners, Sheffield City Council and Voluntary Action Sheffield. This programme aims to transform health and social care services over the next 5-10 years.

- **Birch Avenue and Woodland View Care Homes Closure** – Engagement with families and staff continued with the main engagement activity being undertaken in the 2011/12 year.

The Duty requires the PCT to be responsible for reporting on consultations undertaken by **NHS trusts** or **NHS foundation trusts** that are independent of the PCT, but the outcome will influence the commissioning decisions of the PCT.

- **Sheffield Teaching Hospitals NHS Foundation Trust** has led on arrange of Consultation and Engagement activity including:
    - Services for people with dementia

- Older people strategy

- Report on consultations undertaken by the **Yorkshire and Humber Specialist Commissioning Group**, which will have an impact on the commissioning decisions of the PCT.
  - No reports have been received

- Report on **national consultations**
  - Locally, people were invited to contribute to the national consultation on developing local Healthwatch

- The Duty requires the PCT to be responsible for reporting on consultations undertaken **jointly with another organisation through an integrated management arrangement**, such as with a local authority, on commissioning decisions by the PCT - No additional reports have been received in time for publication.

Compliments and complaints

Sheffield Primary Care Trust encourages people to complain if they are not satisfied with any aspect of their treatment. We strive to improve our services and we ensure that through a rigorous review process, improvements are made to NHS services as a direct result of complaints. This section covers compliments and complaints received in relation to Sheffield Primary Care Trust as a commissioner of services and in relation to independent providers and primary care providers (this includes GPs, dentists, pharmacists, opticians and some nursing homes). A total of 10 compliments were received in 2012/13.

Sheffield Primary Care Trust received 280 complaints during 2012/13. Of these, 56 were redirected, with the complainant's consent, to the independent provider or primary care provider as the appropriate body to handle the complaint. The remaining 224 complaints were handled by Sheffield Primary Care Trust. 87 of these complaints were dealt with informally. 137 were formal complaints, of which 34 were upheld or partially upheld.

Complaints that involve more than one NHS or Local Authority body are handled jointly with one organisation taking responsibility for leading the investigation and response. Sheffield Primary Care Trust contributed to the response of an additional 24 complaints for which another organisation was the complaint lead.

During 2012/13, four complaints were referred to the Ombudsman. In three cases the Ombudsman either rejected the complaint or declined to investigate it. The fourth complaint is under review.

The majority of complaints that Sheffield Primary Care Trust handled were about clinical treatment and commissioning decisions. Here are some examples of actions taken as a result of complaints:

- **Prescription Prepayment Certificate.** A patient was unaware of the Prescription Prepayment Certificate. We made the patient's pharmacy and GP practice aware and they have agreed to advertise the Certificate.

- **Orthodontic waiting times.** A patient was unaware that orthodontic practices have differing waiting times. We wrote to all dental practices in Sheffield and asked them to ensure that patients and parents are told about the different waiting times so that this can be taken into account when deciding which practice to refer to.

- **Urgent dental care.** After a patient experienced difficulty accessing urgent dental care on a domiciliary basis we wrote to all care homes in Sheffield explaining how to access urgent dental care. As a result of a complaint about a patient not being given an emergency dental appointment, the nurse who had assessed the patient over the phone was given extra training in relation to the criteria for emergency dental treatment.

- **Removing patients from GP lists.** We sent information to GP practices to ensure that they are aware of the correct processes for removing patients from their list (for example if the patient has moved away), and emphasised the importance of following correct processes to ensure patients are not removed incorrectly.

- **Funding for tonsillectomy.** Approval of funding for a tonsillectomy was delayed because the GP practice that submitted the request for funding had not included all the required information. The practice is now aware of the correct process and will submit all the necessary information with future funding requests

6. Ensuring Continuity

Looking after personal information

We have a clear Information Governance Strategy and Policy, and this is supported by a Cluster Information Governance Strategy. We have a Senior Information Risk Owner and Caldicott Guardian both locally and at Board level.

We have undertaken various initiatives to ensure good information governance within the organisation and in our work without partners, including:

- A full review and update of the information asset register and patient identifiable dataflows in and out of the organisation.
- Reviewing incidents that relate to information governance issues and ensuring that where applicable remedial action is completed.
- Undertaking IG risk assessments on NHS Sheffield premises to ensure compliance with the Data Protection Act and Confidentiality Code of Conduct.
- Ensuring safe records management arrangements continue to be in place.
- Providing support for staff in their completion of annual Information Governance training.

NHS Sheffield reported no Serious Incidents (SIs) relating to Information Governance in 2012/13.

The Information Governance Toolkit is a compulsory web-based self-assessment tool for NHS Trusts which is governed by Connecting for Health. The toolkit covers:

- Information Governance Management
- Confidentiality and Data Protection Assurance
- Information Security Assurance
- Clinical Information Assurance
- Secondary Use Assurance
- Corporate Information Assurance

In 2012/13 the Information Governance Toolkit submission was a Cluster submission covering all five constituent PCTs and based on the lowest score across the Cluster.

NHS Sheffield has complied with Treasury Guidance on setting charges for processing of information.

Sustainability Report

Our facilities management team lead have this year led on energy efficiency within the trust, taking over this role from the public health directorate. We have a Vital Sign to reduce our carbon footprint with our baseline for energy usage reported through our annual ERIC (Estates Return Information Collection) Return, which is available on request. We are always

looking for ways to reduce the use of natural resources. Where water meters are fitted, we have systems in place to monitor the use of water and reduce its usage.

Throughout the year we have continued to work with the local voluntary sector and Sheffield City Council to promote Fuel Poverty, Health and Wellbeing promotions and the expert patient programme to encourage self-care in the community.

Being prepared for an emergency

We have a Major Incident Plan that is fully compliant with the requirements of the NHS Emergency Planning Guidance 2005 and all associated guidance. During the year, our emergency planning staff attended major incident training exercises.

Better Payments Practice Code

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. The table below shows the PCTs compliance with the 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	26,699	170,271	33,321	190,015
Total Non-NHS Trade Invoices Paid Within Target	25,111	164,706	32,125	185,435
Percentage of NHS Trade Invoices Paid Within Target	**94.05%**	**96.73%**	96.41%	97.59%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	4,311	665,863	5,249	690,448
Total NHS Trade Invoices Paid Within Target	4,076	664,189	4,934	688,893
Percentage of NHS Trade Invoices Paid Within Target	**94.55%**	**99.75%**	94.00%	99.77%

7. Who's Who

The board

Throughout 2012/13 the board of NHS South Yorkshire and Bassetlaw 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 and agreeing key priorities and overseeing the delegated functions and budgets to clinical commissioning groups.

Board members of NHS South Yorkshire and Bassetlaw 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). During the financial year April 2012 to March 2013, 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.

NHS South Yorkshire and Bassetlaw Cluster Board and Senior Officers

Andy Buck – Chief Executive

As Chief Executive of NHS South Yorkshire and Bassetlaw, Mr Buck is responsible for ensuring that all five PCTs, and hence the cluster as whole, successfully fulfil all our responsibilities by commissioning services that are accessible, safe, high quality and affordable, and provide value for money. He is also responsible for ensuring that the transition to the new commissioning and public health arrangements proposed by the Government is effectively managed.

Steve Hackett – Director of Finance

Steve Hackett is a qualified accountant with 20 years NHS experience. His career profile has spanned Health Authorities, Primary Care Trusts and Secondary Care so has a wide range of commissioning and provision experience. Since joining NHS Barnsley in 2006 Mr Hackett's primary role is strategic financial advice to the Board and Directors. Over this time, in addition, he has also taken lead roles in Information Technology and Health Intelligence. His current portfolio includes strategic financial advice to Specialised Commissioning Group and the Commissioning lead on Estates management. He is also the public sector Director representative on the NHS Barnsley, Doncaster and Sheffield LIFT development. Mr Hackett is, at present, the Director of Finance for the NHS South Yorkshire and Bassetlaw 'cluster' of primary care trusts.

Debbie Hilditch – Director of HR and Governance

Debbie Hilditch has responsibility for providing strategic HR advice and governance support to the Trust board, chief operating officers and clinical commissioning groups, in addition to supporting emerging clinical commissioning groups to identify organisational development requirements and is lead director for communications and engagement.

Margaret Kitching – Nurse Director

Margaret Kitching is primarily responsible for the quality and patient safety processes across South Yorkshire and Bassetlaw. She has a number of cluster wide accountable roles

including infection control, safeguarding children and adults, accountable officer for controlled drugs and the Caldicott guardian. As lead nurse she is responsible for nursing practice and clinical governance arrangements across the cluster. A key area of work is around supporting and advising the cluster board and the CCG's in all areas of clinical practice through this transitional period.

Dr Phillip Foster – Medical Director

Phillip Foster is responsible for monitoring the performance of independent contractors including GPs, dentists, pharmacists and optometrists. He oversees the procedures for dealing with poor performance under the regulations relating to maintaining high professional performance. As the Responsible Officer for the cluster he oversees the appraisal and the introduction of revalidation for GPs. The medical director role is integral to the working of the clinical networks across South Yorkshire and Bassetlaw including the role out of 111.

Alan Tolhurst OBE – Chairman

Alan Tolhurst retired from the Royal Air Force in 1988 after 31 years' service where he commanded a Hercules transport aircraft squadron as well as the largest RAF flying training station. He was also Personal Staff Officer to a NATO commander, a senior member of the RAF Policy Department and Air Advisor to the British High Commissioner in Canada.

Since 1988 Alan's appointments have included General Manager of Universiade GB Ltd where he had overall responsibility for organising, funding and running the World Student Games which took place in Sheffield in 1991. In 1991 he set up his own career development consultancy alongside being Chairman of North Nottinghamshire Health Authority. In 1992 he was appointed as Deputy Lieutenant for South Yorkshire. He was appointed as Career Development Coach under the NHS 'Executive Choice' scheme in 1997 and in 1999 he was appointed as a mentor with the NHS Leadership Development Programme for Chief Executives. Alan has also chaired the North Nottinghamshire Partnership, where he helped to attract an extra £28 million of Government funding to supports development projects.

Very active in the voluntary sector, Alan is Chairman of a County Branch of SSAFA Forces Help, Governor of Portland College, Chairman of Portshel Industries (Sheltered Workshop), Trustee of Carmichael-Walker Trust (Welfare), Trustee of South Yorkshire/North Nottinghamshire Aircraft Museum, Treasurer of Firbeck Parochial Church Council and a Welfare Case Worker for the RAF Benevolent Fund and a Lecturer on Project management on the Executive MBA Course at Sheffield University. He has also previously been a Director for the Advisory Board of the Centre for Health Services Management at the University of Nottingham and County Organiser and campaigner for the National Playing Fields Association.

Alan was appointed as Chairman of Rotherham Primary Care Trust when it was established on 1st April 2002. In 2009 Alan was awarded an OBE for his voluntary services to the community.

David Liggins – Non Executive Director and Vice Chair
David Liggins is NHS Bassetlaw locality chair and chair of quality and patient safety committee at SY+B PCT cluster. He takes a particular interest in mental health and learning disabilities and is an ambassador for LD at Nottinghamshire Healthcare Trust, where he is a governor. He also chairs Doncaster and Barnsley LIFT companies, both of which are public-private partnerships responsible for designing, building and funding 10 primary care centres. David is a voluntary tutor on the Staying Well (long-term conditions) programme run by Bassetlaw Action Centre, where he is also a non-executive director.

Roger Greenwood LLB – Non Executive Director and Vice Chair
Roger Greenwood was Chairman of Doncaster East PCT from 2001 – 2006, and subsequently Chairman of NHS Doncaster 2006- September 2011 before from October 2011 to date becoming Vice Chairman for NHS South Yorkshire and Bassetlaw and Locality Chairman NHS Doncaster. His previous roles have included senior police officer and operations manager for an international security company.

Tom Sheard – Non Executive Director and Vice Chair
Tom Sheard lives in Barnsley he has extensive experience of the NHS, having been a member of the Barnsley District Health Authority and Chairman of the Community and Priority Services NHS Trust (1984-2002). He was Chair of NHS Barnsley from (2002-2011). He is a Fellow of the Institute of Directors and became a Chartered Director in 2007.

Melvyn Lunn – Non Executive Director and Audit Committee Chair
Melvyn Lunn is a Chartered Accountant and has worked in both the public and private sector, latterly as a Finance Director in the clothing industry for over 17 years, and now runs his own accountancy practice. He is a co-opted member of Barnsley MBC Audit Committee, Non-Executive Director and Audit Committee Chair of Berneslai Homes Limited, Director/Trustee of Barnsley Community Build, Director/Trustee of Priory Campus, Director/Trustee of Voice UK and Management Board member of Sheffield Mutual Friendly Society.

Robert Bailey – Non Executive Director and Audit Committee Vice Chair
Robert Bailey is a retired corporate banker with 30 years experience in the Corporate and International sectors of HSBC. He has been involved with South Yorkshire Police Authority as an appointed member. He was Chairman of North Sheffield PCT from February 2001 until 30 September 2006. He is presently Chairman of the Advisory Committee for Clinical Excellence Awards for Yorkshire and Humber and also reviews National Excellence Awards. He is a partner in Muir Wood Properties LLP.

Pat Wade – Non Executive Director
Patricia Wade is the Non Executive Director representing the Rotherham locality. She is married with 3 Grown-up Children and 4 Grandchildren and is now retired, having previously worked in Education and Training. Pat is a Parish Councillor for Aston-cum-Aughton Parish Council, a Magistrate, Rotherham Supplemental List and Member of the Labour Party.

Melvyn Morris – Associate Non Executive Director
Mel Morris is a Chartered Engineer and graduate of Leeds Metropolitan University and Sheffield Hallam University Business School. He has 37 years of NHS experience, 25 at board level. The most recent was with University Hospital Birmingham where he was the Director for the development of the recently opened Queen Elizabeth Hospital. He currently chairs the Pharmacy committee and is a member of both the Audit committee and Capital investment group. His main interest lies in achieving a high level of GP, Patient and Public engagement in the development of the future NHS.

Dr Leslie Ranson – Associate Non Executive Director
Dr Les Ranson studied at London University's Imperial College and is a retired former director of the London & Scandinavian Metallurgical Company. Prior to that he worked in the chemical and water industries. He is the Chair of governors of Wadworth Primary School, Doncaster. Dr Ranson served on the Doncaster PCT board from 2006 until 2011 when he joined the NHS South Yorkshire and Bassetlaw Single Trust Board.

Dr Jeremy Wight - Sheffield's Director of Public Health (shared post with Sheffield City Council):
Jeremy Wight qualified in medicine from Cambridge University and St Thomas' Hospital in 1982 and moved to Sheffield three years later on a General Medical Registrar rotation. After completing a research degree in 1989, he spent three years working as a registrar on the renal unit at the Northern General Hospital in Sheffield before training in public health medicine. Dr Wight was consultant in public health medicine at Wakefield Health Authority from 1996-2002 and then director of public health at the North Sheffield PCT. He was appointed director for public health at Sheffield PCT in November 2006. This is a joint appointment with the Sheffield City Council

Dr Tony Baxter - Doncaster's Director of Public Health (shared post with Doncaster Council):
Tony graduated from Aberdeen University Medical School in 1982. He worked as a GP in Doncaster before training in public health medicine. Tony was a consultant in Public Health in Barnsley from 1995 -2002, then Director of Public Health at Doncaster East PCT and was appointed Joint Director of Public Health for Doncaster in 2006.

Dr John Radford - Rotherham's Director of Public Health (shared post with Rotherham Council):
Dr Radford was a GP in Sheffield before undertaking Public Health training. He was previously Director of Public Health in Doncaster and has been Director of Public Health and Medical Director including prescribing lead in Rotherham from 2002 to 2011. Following the devolution of Primary Care Trust provider arms and the development of GP commissioning he now works as the joint DPH for Rotherham MBC and the PCT. He is a member of one of the National NICE Appraisal Committees. Dr Radford continues to work in General Practice. He chairs the Child death overview Panel and is a member of Rotherham Safeguarding Children Board. John is a member of the Directors of Public Health Advisory Forum for the White Paper 2011/12 and also of the National Obesity Review Group.

Dr Elizabeth Shassere - Barnsley's Director of Public Health (shared post with Barnsley Metropolitan Borough Council)

Dr Chris Kenny - Bassetlaw Director of Public Health (joint post with Bassetlaw District Council):
Dr Chris Kenny is currently working as the Director of Public Health (DPH) for NHS Nottinghamshire County and NHS Bassetlaw, which is a joint appointment with Nottinghamshire County Council (started 1 October 2006). Before that he was the DPH for Ashfield and Mansfield District Primary Care Trusts (April 2004-Sept 2006) and prior to that he was the DPH for Mansfield District PCT (2002-04).

After graduating from Nottingham University Medical School in 1983, he undertook house jobs in York and Luton before training as a GP in Leeds and Sheffield (1984-87). He then joined the Trent rotational training scheme for public health medicine, working in Derby and Nottingham (1987-91). He was appointed as a Consultant in Public Health Medicine to Southern Derbyshire Health Authority in August 1991, and then later moved on to join the Public Health Team at the Trent Regional Office of the NHS Executive (1998-2002).

As well as leading the public health function across the county of Nottinghamshire, Chris is involved in training public health staff and is a tutor at Nottingham University. He was the Deputy Advisor for the Faculty of Public Health in the East Midlands from 2004-07, and is currently an East Midlands member of the Executive Committee of the Association of Directors of Public Health.

Details of company directorships or other significant interests held by directors are attached in Appendix A, Register of Interests.

Shadow Sheffield Clinical Commissioning Group

Chair, Dr Tim Moorhead
Since becoming a Principal in General Practice, Tim has always had an interest in NHS administration. He has been an active member of the Local Medical Committee and is currently Vice Chair. He was on the board of Sheffield West PCG. He is clinical lead of Sheffield West LLP which has been delivering Practice Based Commissioning on behalf of West GPs for the past 3 years. He is also a director in Rivelin Healthcare, a privately owned company owned by most GPs in Sheffield West which is providing clinical services to patients. Some of this broad range of interests may now raise questions of conflict of interest and will be realigned at an early stage of his role as Chair of Sheffield CCG to mitigate this perception.

Accountable Officer, Ian Atkinson
Ian Atkinson was appointed as Interim Chief Executive from January 2011 to 31 March 2011 and from April 2011 became Chief Operating Officer for NHS Sheffield under the new PCT cluster governance arrangements. He was appointed as NHS Sheffield's Director of Performance in April 2007. Prior to that he was Director of Information Services at Barnsley Hospital NHS Foundation Trust. He has previously held senior management posts in

Wakefield as well as within the private sector, where he worked for a large IT company which specialised in healthcare systems. Ian has a clinical background, having started his NHS career in Sheffield within mental health services.

Chief Finance Officer, Julia Newton

Julia Newton was appointed as director of finance in July 2007, having undertaken the role on an interim basis since the creation of Sheffield PCT in October 2006, and became Chief Finance Officer for NHS Sheffield from May 2011 under the new cluster governance arrangements. A chartered accountant, Ms Newton was previously acting director of finance at South Yorkshire Strategic Health Authority and has held a number of senior finance posts since joining the NHS in 1992 from KPMG.

Chief Operating Officer, Idris Griffiths

Idris was appointed as the Chief Operating Officer for NHS Sheffield CCG in September 2012. Prior to working in commissioning Idris held a number of senior roles in community services and acute hospitals, including the roles of Deputy Director of Operations and Assistant Director of Strategy and Turnaround for a Trust covering three hospital sites. Prior to this, Idris worked in retail management before moving into human resource management in the NHS over 20 years ago. Idris holds an MBA and is a qualified personnel and development manager.

Chief of Business Planning and Partnerships, Tim Furness

Tim joined the NHS in 1990 and previously worked in the Unemployment Benefit Service. He has worked in primary care commissioning and development since 1993, including working as a practice fundholding manager for five years. He was appointed to the Chief of Business Planning and Partnerships post in September 2012, having previously been Deputy Director of Strategy for Sheffield PCT and before that, Director of Planning and Commissioning for Sheffield West PCT.

Chief Nurse, Kevin Clifford

Kevin joined NHS Sheffield in March 2010 as Chief Operating Officer for Provider Services and since September 2011 has fulfilled his role as Nurse member of the emerging CCG. Kevin, a registered nurse since 1983, previously worked at Sheffield Teaching Hospitals NHS Foundation Trust where he was Nurse Director for Emergency Care and Director of Clinical Operations.

Joint Clinical Directors, Dr Richard Oliver and Dr Zak McMurray

Dr Richard Oliver. Richard has been a GP partner at Ecclesfield since 1989. Actively engaged in prescribing activity he was an early member of the Sheffield Prescribing Group and helped to establish the Sheffield Formulary. In 2004 he became the Chair of the North Sheffield PCT Professional Executive Committee (PEC) and following the unification of the four PCTs, was a Joint Chair of the Interim PEC. Throughout this time he has been a member of the Sheffield Local Medical Committee.

Dr Zak McMurray. After qualifying in 1988 Zak joined the Sheffield Vocational Training Scheme before joining his practice in Woodhouse. He joined the South East Sheffield Primary Care Group (PCG) in 1999 as a Board member and acted as mental health and

commissioning lead before taking over as PEC Chair. He acted as Joint Interim PEC Chair during the PCT merger process and was previously appointed Joint PEC Chair with Richard Oliver in August 2007.

Elected Member, Dr Ted Turner
Ted graduated in 1988 and has been practicing as a GP at Shiregreen Medical Centre in Sheffield since 1995. Ted's interests include dermatology and skin surgery, cardiovascular medicine and care of the elderly.

Elected Member, Dr Marion Sloan
Marion has practiced as a GP for 33 years and is currently a partner at the Sloan Medical Centre in Sheffield. Recent projects she has been involved in include sexual health, chlamydia screening and bowel cancer awareness.

Elected Member, Dr Margaret Ainger
Margaret has been a partner at Page Hall Medical Centre in Sheffield for over 20 years. She is the North lead for the elderly and is the GP lead for the Children's Partnership Board.

Elected Member, Dr Anil Gill
Anil graduated in 1995 at Sheffield Medical School having entered as a mature student. Anil spent six years as a GP in Rotherham and Chesterfield. This was followed by a year as a locum before going back to general practice at Selborne Road, Sheffield.

Appointed Representative, Dr Amir Afzal
Amir qualified from Nottingham Medical School in 1986 and is a practicing GP at Duke Medical Centre in Sheffield. This is in the Central Locality.

Appointed Representative, Dr Andrew McGinty
Andrew has been a full time partner at the Woodhouse medical practice for the last 11years. This is in the Hallam and South (HASC) Locality.

Appointed Representative, Dr Leigh Sorsbie
Leigh graduated from Sheffield Medical School in 1990 and has been a partner at Firth Park Surgery since 1997. This is in the North Locality. Her interests include Mental Health, Elderly Medicine, Minor Surgery and Diabetes.

Secondary Care Doctor, Dr Richard Davidson
Richard has been a Consultant in Intensive Care Medicine and Anaesthesia at Bradford Teaching Hospitals NHS Foundation Trust since January 2000. An educational enthusiast he has contributed at Trust level as Foundation Training Programme Director and at regional level as Deputy Regional Advisor in Intensive Care Medicine.
More recently he has taken up management roles, initially as Intensive Care Unit (ICU) Director and subsequently as Clinical Director for Anaesthesia, Intensive Care, Pain Management and Sleep Medicine and has deputised for the Divisional Director (Surgery and Anaesthesia). He is currently Associate Medical Director with a portfolio of RTT (18 week

referral to treatment target) and has contributed to the NHS Sheffield CCG since November 2012.

Lay Member, John Boyington CBE
John is about to finish 42 years working in health services both in the NHS and Civil Service. He originally trained as a nurse and has held chief executive posts in NHS Trusts and in a PCT. He received the CBE in 2007 for leading national prisoner health care reforms and was for 5 years Director of the World Health Organization (WHO) Collaborating Centre for prisons and public health. Although he has worked in London, Leicester and latterly Manchester he has remained a resident of Sheffield and a keen supporter of Sheffield United Football Club.
John is Vice Chairman of the CCG Governing Body and has lead responsibility for governance.

Lay Member, Amanda Forrest
Amanda Forrest has worked in the voluntary and public service for over 30 years- predominantly working on issues around patient and public engagement, working in partnership, and service innovation. Currently works as Director of the Sheffield Wellbeing Consortium - an organization which enables voluntary sector organisations to work collaboratively.
Her particular interest in the CCG is to support meaningful and effective engagement with the public and patients through well thought through approaches at all levels.

Audit Committee

As a committee of the NHS South Yorkshire and Bassetlaw Board the committee is responsible for:

- Reviewing the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the organisation's activities that supports the achievement of the organisation's objectives.

- Monitoring the implementation of agreed control improvements, largely through the work of external and internal audit, both of which are represented at committee meetings.

- Ensuring there is an effective internal and external audit function.

- Reviewing the accounting policies and the draft annual financial statements prior to submission to the Board. Monitoring compliance with Standing Orders and Standing Financial Instructions.

Our audit committee members are:

Mr M Lunn Audit Committee Chairman
Dr L Ranson Associate Non-Executive Director
Mr M Morris Associate Non-Executive Director
Mrs P Wade Non-Executive Director
Mr R Bailey Audit Committee Vice Chairman

Remuneration and Terms of Service Committee

As a committee of the NHS South Yorkshire and Bassetlaw Board the committee is responsible for advising about the appropriate remuneration and terms of service for the Chief Executive, executive directors and other senior managers, as well as monitoring and evaluating their performance.

For the purpose of this report senior managers are defined as:
'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Trust. This means those who influence the decisions of the organisation as a whole rather than the decisions of individual directorates or departments.'

The salaries and relevant pension details of the most senior managers, and the Non-Executive members of the Board, who had control over the major activities of the Primary Care Trust in 20012/13 can be found in the Summary Financial Statement. There were no early termination issues for senior officers to report in the year.

The committee members consist of:

Mr Alan Tolhurst *Chairman*
Mr Andy Buck *Chief Executive*
Mr Roger Greenwood *Non-Executive Director, Vice Chair & Locality Chair*
Mr Steve Hackett *Director of Finance*
Mrs Debbie Hilditch *Director of Human Resources & Governance*
Mr David Liggins *Non-Executive Director, Vice Chair & Locality Chair*
Mr Tom Sheard *Non-Executive Director, Vice Chair & Locality Chair*

Financial and Risk Management

Maintaining sound financial health

The dual objectives were to ensure that the PCT ended the year in good financial health, given that this is the final year of the PCT and secondly to take forward investments in support of our strategic objectives set out in the Shadow CCG perspective, in particular to begin to reduce our historic over reliance on hospital services and invest in care closer to home.

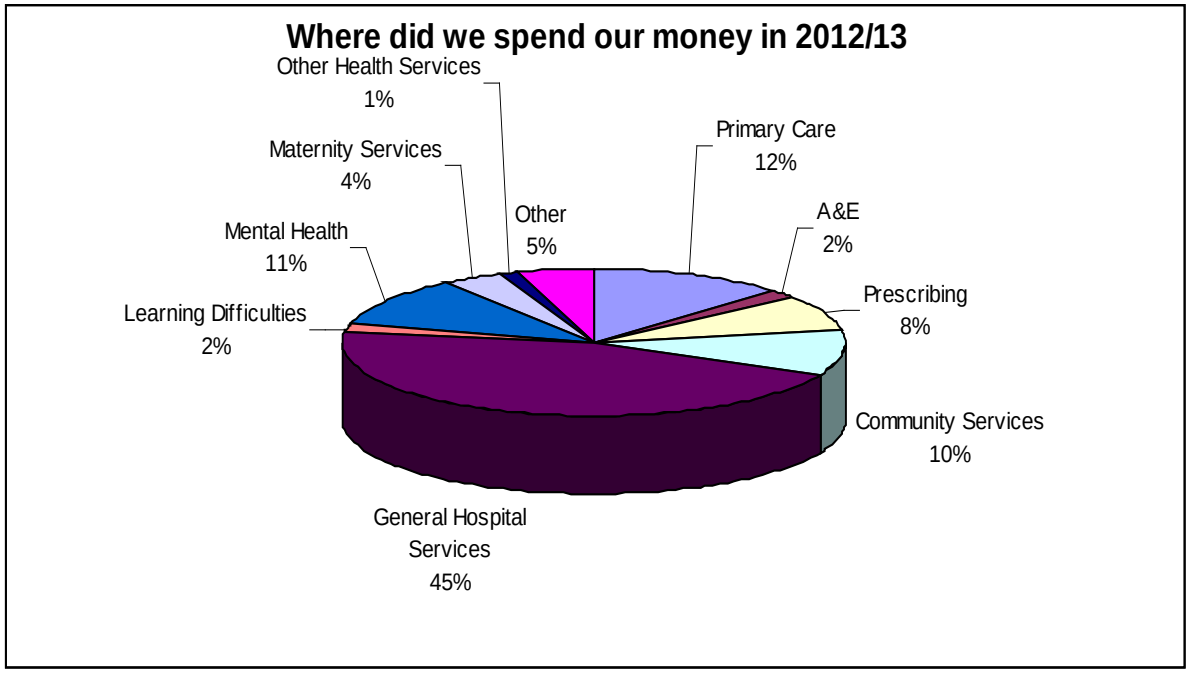
We are able to report compliance with our statutory duty of delivering financial balance against our resources allocated by the Department of Health. Our revenue expenditure for the year was within the Revenue Resource Limit set, and we generated a small surplus of £478k (0.05%). Our capital expenditure for the year was within the Capital Resource Limit, and we had a small underspend of £256k (1.3%). We utilised our full cash limit, and had a small bank balance of £18k at 31st March 2013. Full sets of detailed annual accounts are available, free of charge, from Linda Tully, NHS Sheffield, 722 Prince of Wales Road, Sheffield, S9 4EU. Email: sheccg.foi@nhs.net

Overall we spent an average of £1,897 per person on health care for the people of Sheffield. (2011/12 £1,849).

The table below provides an analysis of how we invested our resources in 2012/13 compared to the previous financial year. The analysis includes spend against external income as well our revenue resources received from the Department of Health.

	2012/13	2011/12
	£m	£m
Primary Health Care		
Medical/Dental/Ophthalmic & Pharmacy services	148	146
Prescribing costs	83	87
Secondary Healthcare		
Learning Difficulties *(note 2)*	21	19
Mental Illness	118	119
Maternity	39	38
General and Acute	459	449
Accident And Emergency	22	19
Community Health Services	106	98
Other Contractual	13	9
Commissioning Running Costs in 12/13 (Management costs in prior years) *note 3*	15	15
Other	34	31
Total	**1,058**	**1,030**

The chart below presents similar information but shows expenditure net of external income, as a percentage of the total.



Pension Liabilities

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.

Remuneration Report

Directors Remuneration and Terms of Service

The Executive Directors remuneration for 2012/13 was determined by the Remuneration and Terms of Service Committee. As a committee of the NHS South Yorkshire and Bassetlaw Board the committee is responsible for advising about the appropriate remuneration and terms of service for the Chief Executive, executive directors and other senior managers, as well as monitoring and evaluating their performance.

For the purpose of this report senior managers are defined as:
'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Trust. This means those who influence the decisions of the organisation as a whole rather than the decisions of individual directorates or departments.'

The salaries and relevant pension details of the most senior managers, and the Non-Executive members of the Board, who had control over the major activities of the Primary Care Trust in 20012/13 can be found in Appendix B attached. There were no early termination issues for senior officers to report in the year.

In line with the Very Senior Manager's pay scale set by the Department of Health Executive Directors are on permanent contracts and six months' notice is required by either party to terminate the contract. The only contractual liability on the PCT's termination of an Executive's contract is six months' notice.

Non-Executive Directors (NED) remuneration is set by the Department of Health via a standard circular which mandates the annual allowances for the Chairs of PCTs and other NED members. NEDs have a 4 year term of office. There is no contractual liability on termination of office for a NED.

Exit Packages

During the year there were 17 staff left the organisation under the voluntary redundancy scheme. None of these staff were members of the Cluster Board.

Pay Multiples

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

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

The mid-point of banded remuneration of the highest paid director in Sheffield Primary Care Trust in the financial year 2012-13 was £147,500 (2011/12 £147,500). This was 4.3 times (2011/12 5.4 times) the median remuneration of the workforce which was £34,540 (2011/12 £27,350)

The pay multiple reduced slightly between 2011/12 and 2012/13 even though there was no inflation uplift to pay for any employees of the PCT including Directors. This decrease is due to a number of lower banded staff leaving the organisation and a number of new starters above the median salary. This resulted in a small increase in the median level of pay for all employees whilst the pay of the highest employee remained unchanged.

Remuneration for PCT employees ranged from £7,880 to £147,500 (2011/12 £13,650 to £147,500)

Salary and Pensions Entitlement of Senior Managers Report

Each PCT remains a statutory organisation in its own right with its own senior manager structure. The Cluster Board is a joint sub-committee of each PCT and operates with one Board each sharing the same Board members.

The table at Appendix B detail the remuneration of the senior managers of the Cluster Board during 2012-13 as described above, together with the prior year comparators. The full value of the salaries of the Cluster Board members are shown alongside the organisation share of the full values which have been apportioned equally between the five PCT Cluster members i.e. each PCT shows 20% of the full value of the salary with the exception of the Director of Public Health for which each PCT has its own Director on the Cluster Board and therefore 100% of the salary costs are included.

As a meaningful comparison the comparators are shown for the Cluster Board rather than for the PCT Board which operated April to September 2011.

Reporting related to the Review of Tax Arrangements of Public Sector Appointees

In line with the requirement for NHS bodies to disclose any 'off payroll' engagements, Sheffield PCT can confirm that it had no such arrangements in place in 2012/13.

External auditor details

NHS Sheffield's external auditor for 2012/13 was the Audit Commission to end of September 2012 and from October 2012, KPMG. The total cost for their services for the year was £148,000 (inclusive of VAT). This was split £146,000 for the audit of the statutory financial statements and £2,000 as Sheffield PCT's share of an additional audit fee to provide independent assurance to the South Yorkshire and Bassetlaw NHS Cluster on readiness for the new CCG Finance System.

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

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

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

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

Signed.....Designated Signing Officer

Name:……..

Date.....

Annual Governance Statement

NHS Sheffield has developed strategic objectives and identified the principal risks in achieving these. These risks, controls and sources of assurance along with any gaps in controls are identified in our Assurance Framework, which, together with detailed action plans, are recorded in the risk register. The Assurance Framework and risk register are continuously monitored and provide assurance to the shadow Clinical Commissioning Group as well as providing documentary evidence to support the Annual Governance Statement.

The information governance framework ensures appropriate structures, policies and procedures are in place to ensure information is managed in a secure and confidential manner to quality and ethical standards. Since October 2011, South Yorkshire and Bassetlaw Cluster have had responsibility for information governance but its management has been devolved locally to an area Senior Information Risk Owner, Caldicott Guardian and Information Governance Lead. Local information governance structures are in place which includes key individuals in areas such as information, records and risk management, performance and IT. Completion of the Information Governance Toolkit (IGT) was undertaken locally which fed into the Cluster IGT return. We achieved a minimum of the required level 2 in all 31 relevant standards. We record and investigate all incidents involving information. Incidents which reach a threshold level are deemed serious untoward incidents and are reported to the Strategic Health Authority and the Information Commissioner. There were no serious untoward incidents recorded in 2011/12.

NHS Sheffield has adopted a proactive and systematic process of risk identification, analysis, treatment and evaluation of potential and actual risks. The primary purpose is to enable the organisation to deal competently with all key risks which might compromise our strategic objectives.

The Annual Governance Statement records the stewardship of the organisation, providing an overview of how successfully we have coped with the challenges we have faced. The statement draws together position statements and evidence on governance, risk management and control, providing a coherent and consistent reporting mechanism..

A copy of the Annual Governance Statement is available free of charge from: Freedom of Information, 722 Prince of Wales Road, Sheffield, S9 4EU. Email: shef-pct.foi@nhs.net

Appendix A
Register of Interests

Names	Title	Declaration
Alan Tolhurst	Chairman	• Director of ACT Consultancy • Chairman of Robin Hood Airport Consultative Committee • Chairman St Leger Homes, Doncaster • Member Rotherham Health and Wellbeing Board • Member of Sheffield Teaching Hospitals FT, Rotherham FT and Nottinghamshire Healthcare FT • Deputy Lieutenant of South Yorkshire
Andy Buck	Chief Executive	• None
David Liggins	Vice Chair and Locality Chair	• Director and 50 per cent shareholder of S and L Properties, 30-34 Watson Road, Worksop – main tenant is Nottinghamshire Police who sublet to NHS Drugs and Alcohol Team (DAT) • Member of the Steering Group of Rural Bassetlaw Befriending • Chair of Barnsley & Doncaster Community Solutions Ltd (Doncaster LiftCo) • Member of Doncaster Strategic Partnering Board • Volunteer Tutor, Expert Patient Programme, Retford Action Centre • Partner Governor, Nottinghamshire Healthcare Trust
Tom Sheard	Vice Chair and Locality Chair	• Company Secretary, Barnsley TUC Training Ltd • Non Executive Director of Barnsley Premier Leisure • Chairman, Unite Barnsley No 1 Branch • Elected Member of Barnsley Chamber of Commerce • Elected Member of Barnsley MBC Kingstone Ward (Labour Party) • Trustee Shawlands Charitable Trust, Barnsley

Roger Greenwood	Vice Chair and Locality Chair	• Chairman Braithwell with Micklebring Parish Council
Pat Wade	Non- Executive Director	• Parish Councillor of Aston-cum-Aughton • Member of the Labour Party • Justice of the Peace, supplemental list at Rotherham Magistrates Court
Les Ranson	Associate Non-Executive Director	• Chairman of Governors at Wadworth Primary School
Mel Morris	Associate Non-Executive Director	• Senior Partner of MAA Associates
Melvyn Lunn	Audit Committee Chair	• Non-Executive Director of Berneslai Homes Ltd and Chair of Audit Committee; • Non-Executive Director/Trustee, Barnsley Community Build; • Director/Trustee of Priory Campus.
Robert Bailey	Audit Committee Vice Chair	• Financial Director Emmaus Sheffield Ltd • Director of Muir Wood Properties • Chairman of ACCEA Advisory Committee for Clinical Excellence Awards for Y&H • Panel Member for ACCEA National Review Panel for Platinum Awards
Steve Hackett	Executive Director of Finance	• Public Sector Director Barnsley Community Service Ltd (Barnsley LIFTco) • Public Sector Director Doncaster Community Solutions Ltd (Doncaster LiFTco) • Public Sector Director Community First Sheffield Ltd
Dr Phil Foster	Medical Director (until December 2012)	• Shareholder, Retford Health • Medical Director Bassetlaw Hospice • Medical Director, NHS Bassetlaw • Parish Councillor, Babworth Parish Council
Dr David Black	Medical Director (From December 2012)	• None

Margaret Kitching	Executive Nurse Director	• None
Debbie Hilditch	Executive Director of HR and Governance	• None
Tony Baxter	Director of Public Health, NHS Doncaster	• Parent Governor and Vice Chair of Board of Governors at Doncaster School for the Deaf
Jeremy Wight	Director of Public Health, NHS Sheffield	• Trustee for Talbot Trust
John Radford	Director of Public Health, NHS Rotherham	• None
Elizabeth Shassere	Director of Public Health, NHS Barnsley (until November 2012)	• None
Chris Kenny	Director of Public Health, NHS Bassetlaw	• Chair of Trustees Nottinghamshire Hospice
Sharon Stoltz	Acting Director of Public Health, NHS Barnsley (from August 2012)	• None

Appendix B

Salary and Pension Entitlements of Senior Managers

	2012-13				2011-12			
	Total Salary	**Organisation share (bands of £5k)**	**Other remuneration**	**Benefits in kind**	Total Salary	Organisation share	Other remuneration	Benefits in kind
	(bands of £5k)		**(bands of £5k)**	**(bands of £100**	(bands of £5k)	(bands of £5k)	(bands of £5k)	(bands of £100)
	£000	**£000**	**£000**	**£00**	£000	£001	£000	£00
Directors Remunerations for South Yorkshire and Bassetlaw Cluster								
Name and title								
A Buck Chief Executive South Yorkshire and Bassetlaw Cluster	**145 - 150**	**25 - 30**	**0**	**22 - 23**	145 - 150	25 - 30	0	21 - 22
D Black (Commenced Nov 12) Medical Director South Yorkshire and Bassetlaw Cluster	**50 - 55**	**10 - 15**	**0**	**0**	N/A	N/A	N/A	N/A
P. Foster (to Jan' 13) Medical Director South Yorkshire and Bassetlaw Cluster	**75 - 80**	**15 -20**	**0**	**0**	20 - 25	0 - 5	0	0
S.Hackett Director of Finance South Yorkshire and Bassetlaw Cluster	**110 - 115**	**20 - 25**	**0**	**0**	100 - 105	20 - 25	0	0
D Hilditch Director of Human Resources and Governance South Yorkshire and Bassetlaw Cluster	**85 - 90**	**15-20**	**0**	**0**	40 - 45	5-10	0	0

M.Kitching								
Nurse Director South Yorkshire and Bassetlaw Cluster	**95 - 100**	**15 -20**	**0**	**0**	45 - 50	5 - 10	0	0
Jeremy Wight Director of Public Health (Sheffield Primary Care Trust) South Yorkshire and Bassetlaw Cluster	**125 -130**	**125 -130**	**15 -20**	**0**	145 - 150	145 - 150	0	0
A Tolhurst Chairman for South Yorkshire and Bassetlaw Cluster	**40 - 45**	**5 - 10**	**0**	**0**	10 - 15	0 - 5	0	0
R.Bailey Non Executive for South Yorkshire and Bassetlaw Cluster	**10 - 15**	**0 - 5**	**0**	**0**	5 - 10	0 - 5	0	0
R. Greenwood Non Executive & Vice Chair for South Yorkshire and Bassetlaw Cluster	**40 - 45**	**5 - 10**	**0**	**0**	5 - 10	0 - 5	0	0
D Liggins Non Executive & Vice Chair for South Yorkshire and Bassetlaw Cluster	**30 - 35**	**5 - 10**	**0**	**0**	15 - 20	0 - 5	0	0
M.Lunn Non Executive for South Yorkshire and Bassetlaw Cluster	**10 - 15**	**0 - 5**	**0**	**0**	5 - 10	0 - 5	0	0
M Morris Associate Non Executive for South Yorkshire and Bassetlaw Cluster	**5 - 10**	**0 - 5**	**0**	**0**	0 - 5	0 - 5	0	0
Dr. L Ranson Associate Non Executive for South Yorkshire and Bassetlaw Cluster	**5 - 10**	**0 - 5**	**0**	**0**	0 - 5	0 - 5	0	0

T.Sheard Non Executive & Vice Chair for South Yorkshire and Bassetlaw Cluster	**30 - 35**	**5 - 10**	**0**	**0**	15 - 20	0 - 5	0	0
P. Wade Non Executive for South Yorkshire and Bassetlaw Cluster	**5 - 10**	**0 - 5**	**0**	**0**	0 - 5	0 - 5	0	0
Prior Year Comparators for Cluster staff with a split role								
A Tolhurst Non Executive Director (Oct 11 – Dec 11)					5 - 10	0 - 5	0	0
R Bailey Non Executive Director (April 11 – Sept 11)					5 – 10	0	0	0

Pension entitlements Name and title	Real Increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at aged 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2013 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2013 £000	Cash Equivalent Transfer Value at 31 March 2012 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension (rounded to nearest £'00 £'00
A Buck Chief Executive South Yorkshire and Bassetlaw Cluster	0 - 2.5	0 - 2.5	50 - 55	155 - 160	1,051	969	32	0
D Black (Commenced Nov' 12) Medical Director South Yorkshire and Bassetlaw Cluster	0 – 2.5	0 - 2.5	40 – 45	120 – 125	694	641	8	0
P. Foster (to Jan' 13) Medical Director South Yorkshire and Bassetlaw Cluster	0	0	0	0	0	0	0	0
S Hackett Director of Finance South Yorkshire and Bassetlaw Cluster	5 - 7.5	17.5 - 20	30 - 35	95 - 100	448	415	90	0
D Hilditch Director of Human Resources & Governance South Yorkshire and Bassetlaw Cluster	0 - 2.5	5 - 7.5	30 - 35	100 - 105	612	560	52	0
M.Kitching Nurse Director South Yorkshire and Bassetlaw Cluster	12.5 - 15	42.5 - 45	35 - 40	105 - 110	751	645	226	0
Jeremy Wight Director of Public Health (Sheffield PCT) South Yorkshire and Bassetlaw Cluster	(0 - 2.5)	(2.5 - 5.0)	50 - 55	160 - 165	1,115	1,051	9	0

As Non-Executive members do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive members.

Cash Equivalent Transfer Values

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

The CETV figure, and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

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

Ms Eleri De Gilbert
Designated Signing Officer, NHS South Yorkshire and Bassetlaw

Glossary of terms

ABH - Achieving Balanced Health. This is our strategy. It sets out how we intend to achieve our objectives of reducing health inequalities and improving health in Sheffield, and ensuring health services in the city remain affordable so that everyone gets the highest quality and most personalised service possible.

BME - Black and Minority Ethnic

BO4P - Better Outcomes for Patients was a two year programme where patients, carers and healthcare professionals looked at ten health conditions to come up with 50 ideas that would make a difference

CBRN - Chemical, Biological, Radioactive or Nuclear substance. As part of our role around emergency preparedness we take part in training exercises, which test our response to issues like this.

CCG - Clinical Commissioning Group

COPD - Chronic Obstructive Pulmonary Disease. A term used for a number of conditions; including chronic bronchitis and emphysema.

CQC - Care Quality Commission. The Care Quality Commission is the independent regulator of health and social care in England.

DESMOND - Diabetes Education and Self-Management for On-going and Newly Diagnosed

EDS – Equality Delivery System

EPHP - Enhanced Public Health Programme. They cover a third of Sheffield and are designed to improve health and reduce mortality in the areas with the worst health and deprivation levels

GUM - Genito Urinary Medicine. The core work of genito-urinary medicine relates to sexually transmitted infections

H1N1 - Swine flu

HIV - Human immunodeficiency virus

HPV – Human Papilloma Virus

HPU - Health Protection Unit

JSCC - Joint Staff Consultative Committee

KPI - Key Performance Indicator. A range of indicators exist to help measure our performance in key areas

LIFT - Local Improvement Finance Initiative. Our LIFT partner is Community First. They own and maintain the LIFT buildings and lease the premises to us.

LARC - Long Acting Reversible Contraceptive

LDC - Local Dental Committee. The LDC represents the interests of dentists. We consult with theLDC on matters of local dental interest, local commissioning and developments in the provision of NHS dental services.

LMC - Local Medical Committee. The LMC represents the interests of GPs. We consult with the LMC on matters of local medical interest, local commissioning and developments in the provision of NHS GP services

LOC - Local Optometric Committee. The LOC represents the interests of optometrists. We consult with the LOC on matters of local optometric interest, local commissioning and developments in the provision of NHS optometric services

LPC - Local Pharmaceutical Committee. The LPC represents the interests of pharmacists. We consult with the LPC on matters of pharmaceutical interest, local commissioning and developments in the provision of NHS pharmaceutical services

LSE - London School of Economics

MCA – Mental Capacity Act

MBE - Merit of the British Empire. One of the types of British honours awarded

NES - Neurological Enablement Service. A service which supports the needs of people living with long term neurological conditions

NGH Northern General Hospital. One of the main hospital sites at Sheffield Teaching Hospitals NHS Foundation Trust

NHSCB – National Health Service Commissioning Board

NHSS – NHS Sheffield

NICE – National Institute for Health and Clinical Excellence

PEC - Professional Executive Committee. The PEC is a small group of experienced Sheffield doctors, a nurse, and a pharmacist, who help to lead improvements in health services in the city.

PCT - Primary Care Trust

PBC - Practice Based Commissioning

QIPP - Quality, Innovation, Productivity and Prevention

RIS - Referral Information Service. A service which receives, collates and analyses all GP and primary care referrals from GP practices and optometrists

SASP – Sheffield Adult Safeguarding Partnership

SCC – Sheffield City Council

SCG - Specialised Commissioning Group. Made up of PCTs, this group ensures Sheffield people have access to specialised services

SCH/SCHFT – Sheffield Children's Hospital Foundation Trust

SCRs – Serious Case Review

SHSC/SHSCFT – Sheffield Health and Social Care Foundation Trust

SIs – Serious Incidents

SLC4L - Sheffield Let's Change4Life. A programme aimed at preventing obesity in children, young people and families.

SPA - Single Point of Access. A service which manages referrals to all community health services provided by Sheffield Primary Care Trust (Provider Services)

SSCB – Sheffield Safeguarding Children Board

STH/STHFT – Sheffield Teaching Hospitals Foundation Trust

STI - Sexually Transmitted Infections

WTE – Whole Time Equivalent, in reference to working hours.

Department of Health

NHS

Sheffield Primary Care Trust

2012-13 Accounts

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www.gov.uk/dh

Sheffield Primary Care Trust

2012-13 Accounts

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

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

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

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

Signed.....Designated Signing Officer

Name: Clare Gilbert

Date.....6.6.13

2012-13 Annual Accounts of Sheffield Primary Care Trust

STATEMENT OF RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

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

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

- make judgements and estimates which are reasonable and prudent;

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

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

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

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

By order of the Permanent Secretary.

6.6.13 Date ..... Signing Officer

6.6.13 Date ..... Finance Signing Officer

NHS SHEFFIELD

Organisation Code: 5N4

Annual Governance Statement for 2012/13

1. Scope of responsibility

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

As Accountable Officer I have responsibility for strategic leadership, including ensuring that the Risk Management and Assurance Frameworks are implemented in full. This involves identifying the most significant risks to achieving the organisation's strategic objectives and ensuring that mitigating actions are taken where possible and that these risks are kept under regular review. This was achieved as part of the quarterly reports to the PCT Board on the Assurance Framework (AF) and Risk Register.

2. The governance framework of the organisation

Overview

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- Identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives;
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

2012/13 has seen a continuation of the transition towards the new NHS commissioning architecture set out in the Health and Social Care Act which received Royal Assent on 27th March 2012. This Annual Governance Statement therefore reflects the changing assurance processes during the year.

NHS Sheffield (legally known as Sheffield Primary Care Trust) has remained as the statutory body throughout the period 1 April 2012 to 31 March 2013 and will remain so until its planned dissolution on 1 April 2013.

Throughout 2012/13 the NHS South Yorkshire and Bassetlaw cluster of PCTs consisting of the five constituent PCTs: NHS Barnsley, NHS Bassetlaw, NHS Doncaster, NHS Rotherham and NHS Sheffield remained in place to provide leadership and ensure governance across all 5 areas. In these arrangements all five PCTs shared a single Accountable Officer (Chief Executive), a single Director of Finance and a team of Executive Directors and Non-executive Directors. Each PCT retained individual Directors of Public Health.

Also throughout 2012/13 Clinical Commissioning Groups have been Sub Committees of the Trust Board under a scheme of delegation and managerial letter of delegation to Chief Operating Officers dating from 1 October 2011. Formal delegation of responsibilities to the Sheffield Clinical Commissioning Group (Sheffield CCG) related to the future work of

Sheffield CCG such as Acute, Mental Health and Community healthcare commissioning (whilst accountability was retained by the Trust Board). NHS Sheffield continued to have responsibility for the governance of non-CCG responsibilities such as primary care (whilst accountability was retained by the Trust Board).

In January 2013 Sheffield CCG was authorised without any conditions as part of the second wave of authorisation, to take on the full range statutory responsibilities from 1 April 2013.

Sheffield CCG has operated during 2012-13 with an Accountable Officer (designate), a Chief Finance Officer (designate) and an underpinning management, governance and Committee structure.

The system of internal control has been in place through the above mechanisms throughout the financial year to 31 March 2013.

Robust processes were also in place for working closely with the Yorkshire and Humber Strategic Health Authority (SHA) and partner organisations. Review meetings were held with the SHA to discuss performance. I and colleagues have attended regular meetings with Chief Executives and Chairs across NHS organisations in Sheffield and the wider Yorkshire and Humber areas. Meetings with local MPs have also been held to discuss general and specific health matters.

Sheffield CCG was an active member of the Sheffield First family of partnerships. We attended the Sheffield Executive Board which included senior membership from the City Council, the voluntary sector, statutory authorities and local businesses. The Accountable Officer (designate) attended the Health and Wellbeing Partnership Board, which ensured delivery against the Local Area Agreement targets and which is supported by public health and performance colleagues.

In order to address health related issues within our local community, Public Health Consultants were each linked with the city's Community Assemblies. There has been executive level membership on the Children's and Adults Safeguarding Boards, and officer level representation at the Operational Executive Committees. The Accountable Officer (designate) sat on the Children's Trust Executive Board with other Sheffield Chief Executive Officers and Directors. The Local Authority's Health and Community Care Scrutiny and Policy Development Boards also reviewed matters relating to the planning, provision and operation of health services in Sheffield. To underpin this, meetings were held with the Chief Executive of the Local Authority and members of his senior team on a regular basis.

Sheffield CCG Sub Committee had a programme of meetings with boards of Foundation Trusts in Sheffield and the Local Authority Cabinet, in place of the previous PCT Board meetings with these key partner organisations. In addition, the Accountable Officer (designate) also chaired the Commissioning Executive Team which, with GP and management leads from each of the four localities set Sheffield's Clinical Commissioning Strategy, decided on priorities and the Quality, Innovation, Prevention and Productivity (QIPP) projects and our strategy.

NHS Sheffield has complied at all times with the UK Corporate Governance Code in respect of:

- ***Leadership:*** Headed by an effective cluster board comprised of Executive and Non Executive Directors with a clear division of responsibilities, a clear process for decision-making and a Chair responsible for leadership of the Board.

2012 and by the Cluster Audit Committee as a closing position in March 2013. The Risk Register was received by the Board in January 2012 and updated outside of the Board thereafter. The Information Governance Strategy was last received in February 2012. Monthly reports were received on Finance, Quality and Performance.

Sheffield Clinical Commissioning Group (as a Committee of the PCT Cluster Board)

The establishment of the Sheffield CCG sub Committee, together with its terms of reference, was formally approved by the Trust Board in October 2011 and was in place throughout the period 1 April 2012 to 31 March 2013. The sub Committee was quorate at each of its meetings.

The Sheffield CCG sub Committee had approved in autumn 2011 the governance sub structure comprising Commissioning Executive Team (CET), Clinical Reference Group (CRG), Planning and Delivery Group, Audit & Integrated Governance Group (AIGG), Assurance Group and the Governance Group and approved the Terms of Reference for each of the Groups. Each of these Groups continued to operate throughout 2012-13.

In addition the formal delegation arrangements of 1 October 2011 from the Cluster PCT Accountable Officer to NHS Sheffield's Chief Operating Officer (also known as the CCG's Accountable Officer (designate)) and Chief Finance Officer have remained in place.

Handover and Closedown

The NHS South Yorkshire & Bassetlaw Board and the Sheffield CCG Committee have prepared for transition to the new NHS architecture in line with Department of Health guidelines for closedown of PCTs. A Transfer Scheme was developed for both Assets and Liabilities and for Staffing, and this was in place by 31st March 2013. when the formal transfer took place. A Handover Assembly was held on 8th March 2013 between the PCT as sender and all local receiving organisations including the Clinical Commissioning Group to ensure an effective legacy handover to receiving organisations.

Annual Accounts
In terms of annual accounts, a clear process has been identified which mirrors arrangements in 2011/12 and which will ensure that PCT accounts are effectively closed down and accounts produced. Accounts scrutiny and sign-off is planned via the Cluster Audit Committee (which will remain for a short period to June 2013).

3 Risk assessment

NHS South Yorkshire & Bassetlaw
To support the work of the Board and its Committees and to provide assurance that the risks across the Cluster were known and understood, a single Assurance Framework covering all constituent PCT areas was developed and has been in use throughout 2012/13. The Assurance Framework took into account the accountabilities and responsibilities referenced in the following:

- Objectives from the *Cluster Implementation Guidance* (January 2011) and the *Shared Operating Model for PCT Clusters* (July 2011);
- NHS Commissioning Board duties (e.g. offender healthcare military healthcare, primary care contracting, emergency planning);
- Escalating Clinical Commissioning Group issues based on *Functions of GP Commissioning Consortia: A Working Document* (March 2011).

- ***Effectiveness:*** Comprised of individuals with a range of skills, experience and knowledge provided with a range of strategic information covering quality, finance, performance, strategy, policy and risk. Subject to annual evaluation via the Annual Governance Statement.

- ***Accountability:*** Effective management of conflicts of interest and a robust process for risk management and internal control assured through regular reporting and opinion from Internal and External Audit.

- ***Remuneration:*** Set by the Cluster Remuneration and Terms of Service Committee.

- ***Relations with Stakeholders:*** Effective partnership arrangements and sharing of information via an Annual Report and Annual General Meeting.

South Yorkshire and Bassetlaw Cluster Arrangements during 2012/13

NHS South Yorkshire & Bassetlaw had a single Trust Board in place throughout the financial year to 31 March 2013 covering all 5 PCTs in the cluster. The Board considered a range of governance documents, strategies and quality / financial / performance assurance reports. The Board also received both the public and private minutes of the Sheffield CCG to which responsibility for commissioning the majority of local healthcare was delegated (whilst accountability was retained by the Board).

The Trust Board was supported in its assurance responsibilities by a formal sub-structure of of Committees which applied to all 5 PCTs, including the following key governance committees: Audit Committee, Quality & Patient Safety Committee, Remuneration Committee and Reference Committee.

Effectiveness

The effectiveness of the Board was last reviewed at a Timeout session on 22nd February 2012 which concluded that the Board was functioning effectively and focusing on the right issues. Due to the abolition of the Board from 31st March 2013, its effectiveness has not been reviewed during 2012/13. A Governance paper was received and approved by the first Trust Board meeting in October 2011 in which:

- The Board was advised on the governance structure to support the Single Trust Board of NHS Barnsley, NHS Bassetlaw, NHS Doncaster, NHS Rotherham and NHS Sheffield.
- Approval was given for the terms of reference for the committees of the Trust Board which covered Audit, Quality and Patient Safety, Remuneration, Maintaining High Professional Standards, Pharmacy applications and Clinical Commissioning Groups. These reflected the movement to a single Trust Board.
- Revised Standing Orders / Standing Financial Instructions and Scheme of Delegation were agreed.
- It was identified where the Chief Executive and Director of Finance sought to delegate further functions to the Chief Officer and Chief Finance Officer. These were then covered in Letters of Delegation to each CCG.
- The Board membership (including Directors) and the accountability arrangements at Board level were noted.

Risk Management

A single cluster wide Board Assurance Framework (AF) and Risk Register have been maintained throughout the 2012/13 financial year, co-ordinated by the governance leads of the constituent PCTs. The Assurance Framework was received by the Board in January

In developing the NHS South Yorkshire & Bassetlaw Assurance Framework all existing PCT Assurance Framework risks and any new/emerging risks in light of the changing NHS architecture were captured. The Assurance Framework was developed in accordance with guidelines provided by the Department of Health, Internal Audit and the Strategic Health Authority and comprised risks which affected the achievement of Cluster objectives.

A standard 5x5 risk matrix was used to assess risk which incorporates both consequence and likelihood as detailed below.

Risk Matrix		Likelihood				
		(1) Rare	(2) Unlikely	(3) Possible	(4) Likely	(5) Almost certain
Consequence	(1) Negligible	1	2	3	4	5
	(2) Minor	2	4	6	8	10
	(3) Moderate	3	6	9	12	15
	(4) Major	4	8	12	16	20
	(5) Extreme	5	10	15	20	25

1-5	Low
6-11	Medium
12-15	High
16-20	Very High
25	Extreme

The Board agreed a risk tolerance (appetite under which risks can be tolerated) as a score of 11 or below where the assessment has been undertaken following the implementation of controls and assurances. This is the same for both the Cluster Assurance Framework and the Clinical Commissioning Groups' Assurance Frameworks.

Local Clinical Commissioning Group Assurance Framework risks which are scored at or in excess of a score of 16 were escalated to the Cluster Assurance Framework and all new risks scoring 16-20 were notified to the Board as part of the integrated performance report. Whilst 30 new risks were reported to the Sheffield Governance Group over the year none had a risk score in excess of 12 and hence none needed to be reported to the cluster Board.

The objectives for PCT Clusters as detailed in the Department of Health *Shared Operating Model for PCT Clusters* (July 2011) were taken as those against which the Cluster Assurance Framework risks were mapped:

- Integrated Finance, Operations and Delivery
- Commissioning Development
- Ensuring Quality (Effectiveness, Experience & Safety)
- Emergency Planning & Resilience
- Commissioning Elements of Provider Development
- Communication and Engagement

There has been full alignment of the 5 PCT's principal risks with the Cluster principal risks. All PCT Assurance Framework risks which were not expected to carry forward to the Clinical Commissioning Group Assurance Frameworks were captured on the Cluster Assurance

Internal Audit and now clearly identifies controls and assurances against each risk. Target dates for review of both gaps in control and gaps in assurance continue to be proactively managed and leads pursued for information on progress against targets. This additional rigour has provided further assurance to the Sheffield CCG sub Committee on meeting key objectives.

All gaps in control are given robust time limited action plans.

5 Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of Internal Audit's work. The overall level of the Head of Internal Audit Opinion is significant assurance.

Directors and managers 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.

At 31 March 2013 the AF identified the following outstanding gaps in control within the CCG Assurance Framework:

- CHC improvement plan not fully completed
- Uncertainty in Public Health programmes arising from move to City Council
- DPH report publication date not yet agreed
- Full ownership of targets by important providers not guaranteed yet. Turbulence in Providers with new areas of responsibility an issue. Incentive schemes paying primary care not aligned adequately with VS targets,
- Transition to LA may alter access to necessary NHS data/intelligence resources.

All of the above gaps in control have robust time limited action plans and have been built into the 2013/14 Frameworks. There were no significant gaps in control identified.

My review is also informed by:

- External Auditors providing progress reports to Audit Committee
- Internal Audit reviews of systems of internal control and progress reports to Audit Committee, together with the Head of Internal Audit opinion statement
- Action plans to address recommendations made by both internal and external audit
- Information Governance Toolkit Assessment
- Monthly Delivery and Quality Performance reports
- Regular reviews of corporate risk registers by directorates
- Reviews of potential risks affecting the delivery of strategic objectives
- Annual Business Plan
- Single Integrated Plan
- Regular reports to Board from each of the formal Committees to the Board. The Audit Committee provides an independent overview of the arrangements for risk management and undertakes its own annual self assessment of its effectiveness. The Quality and Patient Safety Committee has an over-arching responsibility for clinical risk management.
- CCG Authorisation Assessment giving unconditional authorisation

I have also been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Sheffield CCG sub Committee, the Sheffield CCG Audit and Integrated Governance Group and managers within NHS Sheffield. Action plans to address any significant identified weaknesses and ensure continues improvement of the system is in place via the AF action plan and also via action plans embedded within risk registers.

Significant Issues

There are no significant issues to report

Accountable Officer:

My review confirms that NHS Sheffield / NHS Sheffield Clinical Commissioning Group has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

Accountable Officer: **Eleri De Gilbert**

Organisation: **NHS South Yorkshire & Bassetlaw**

Relating to responsibilities of: **NHS Sheffield**
NHS Sheffield Clinical Commissioning Group

Signature: Eleri de.

Date: 6.6.13

INDEPENDENT AUDITORS' REPORT TO THE SIGNING OFFICERS OF SHEFFIELD PRIMARY CARE TRUST

We have audited the financial statements of Sheffield Primary Care Trust for the year ended 31 March 2013 on pages 1 to 50. 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 Sheffield Primary Care Trust 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 auditors' report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the signing 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 responsibilities of the signing officer of the Primary Care Trust, 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 Sheffield Primary Care Trust 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 signing officer's report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

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

- in our opinion, the Annual 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 Annual Governance Statement;

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

- our locally determined risk-based work on a more detailed risk assessment of the demise of 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 Sheffield Primary Care Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission.

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

Chartered Accountants
1 The Embankment
Neville Street
Leeds
LS1 4DW

6 June 2013

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	**17,427**	16,664
Other costs	5.1	**1,040,196**	1,013,228
Income	4	**(32,070)**	(30,857)
Net operating costs before interest		**1,025,553**	999,035
Investment income	9	**(117)**	(28)
Other (Gains)/Losses	10	**(50)**	0
Finance costs	11	**1,079**	470
Net operating costs for the financial year		**1,026,465**	999,477
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		**1,026,465**	**999,477**
Of which:			
Administration Costs			
Gross employee benefits	7.1	**12,121**	9,482
Other costs	5.1	**9,205**	8,304
Income	4	**(2,892)**	(2,252)
Net administration costs before interest		**18,434**	**15,534**
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**0**	0
Net administration costs for the financial year		**18,434**	**15,534**
Programme Expenditure			
Gross employee benefits	7.1	**5,306**	7,182
Other costs	5.1	**1,030,991**	1,004,924
Income	4	**(29,178)**	(28,605)
Net programme expenditure before interest		**1,007,119**	**983,501**
Investment income	9	**(117)**	(28)
Other (Gains)/Losses	10	**(50)**	0
Finance costs	11	**1,079**	470
Net programme expenditure for the financial year		**1,008,031**	**983,943**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**616**	169
Net (gain) on revaluation of property, plant & equipment	**(931)**	(101)
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
The notes on pages 5 to 48 form part of this account.	**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*	**1,026,150**	**999,545**

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

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	**39,071**	24,911
Intangible assets	13	**84**	90
investment property	15	**0**	0
Other financial assets	21	**719**	726
Trade and other receivables	19	**0**	0
Total non-current assets		**39,874**	25,727
Current assets:			
Inventories	18	**0**	2
Trade and other receivables	19	**8,552**	8,992
Other financial assets	36	**7**	3
Other current assets	22	**0**	0
Cash and cash equivalents	23	**18**	8
Total current assets		**8,577**	9,005
Non-current assets held for sale	24	**0**	0
Total current assets		**8,577**	9,005
Total assets		**48,451**	34,732
Current liabilities			
Trade and other payables	25	**(45,962)**	(49,047)
Other liabilities	26,28	**0**	0
Provisions	32	**(2,981)**	(830)
Borrowings	27	**(349)**	(266)
Other financial liabilities	36.2	**0**	0
Total current liabilities		**(49,292)**	(50,143)
Non-current assets plus/less net current assets/liabilities		**(841)**	(15,411)
Non-current liabilities			
Trade and other payables	25	0	0
Other Liabilities	28	0	0
Provisions	32	(5,071)	(2,409)
Borrowings	27	(24,872)	(7,927)
Other financial liabilities	36.2	0	0
Total non-current liabilities		**(29,943)**	(10,336)
Total Assets Employed:		**(30,784)**	(25,747)
Financed by taxpayers' equity:			
General fund		(33,688)	(28,336)
Revaluation reserve		2,904	2,589
Other reserves		0	0
Total taxpayers' equity:		**(30,784)**	(25,747)

The notes on pages 5 to 50 form part of this account.

The financial statements on pages *1 to 4* were approved by the Designated Signing Officer on 6th June

Designated Signing Officer: Date: 6.6.13.

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

	General fund	Revaluation reserve	Other reserves	Total reserves
	£000	£000	£000	£000
Balance at 1 April 2012	**(28,336)**	**2,589**	**0**	**(25,747)**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(1,026,465)			**(1,026,465)**
Net gain on revaluation of property, plant, equipment		931		**931**
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		(616)		**(616)**
Movements in other reserves			0	**0**
Transfers between reserves	0	0		**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	**(1,026,465)**	**315**	**0**	**(1,026,150)**
Net Parliamentary funding	1,021,113			**1,021,113**
Balance at 31 March 2013	**(33,688)**	**2,904**	**0**	**(30,784)**

Balance at 1 April 2011	**(24,044)**	**2696**	**0**	**(21,348)**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(999,477)			(999,477)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment		101		101
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		(169)		(169)
Movements in other reserves			0	0
Transfers between reserves	39	(39)		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	(999,438)	(107)	0	(999,545)
Net Parliamentary funding	995,146			995,146
Balance at 31 March 2012	**(28,336)**	**2,589**	**0**	**(25,747)**

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		(1,025,553)	(999,035)
Depreciation and Amortisation		2,804	2,561
Impairments and Reversals		2,477	437
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		(1,022)	(385)
Release of PFI/deferred credit		0	0
(Increase)/Decrease in Inventories		2	233
(Increase)/Decrease in Trade and Other Receivables		440	(1,667)
(Increase)/Decrease in Other Current Assets		0	0
Increase/(Decrease) in Trade and Other Payables		(2,958)	7,490
(Increase)/Decrease in Other Current Liabilities		0	0
Provisions Utilised		(3,673)	(841)
Increase/(Decrease) in Provisions		8,429	202
Net Cash Inflow/(Outflow) from Operating Activities		(1,019,054)	(991,005)
Cash flows from investing activities			
Interest Received		117	28
(Payments) for Property, Plant and Equipment		(2,099)	(3,545)
(Payments) for Intangible Assets		(58)	(26)
(Payments) for Other Financial Assets		0	0
(Payments) for Financial Assets (LIFT)		0	(496)
Proceeds of disposal of assets held for sale (PPE)		300	125
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		4	3
Rental Revenue		0	0
Net Cash Inflow/(Outflow) from Investing Activities		(1,736)	(3,911)
Net cash inflow/(outflow) before financing		(1,020,790)	(994,916)
Cash flows from financing activities			
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		(313)	(255)
Net Parliamentary Funding		1,021,113	995,146
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		1,020,800	994,891
Net increase/(decrease) in cash and cash equivalents		10	(25)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		8	33
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		18	8

1. Accounting policies

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

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

The PCT does not consolidate any NHS charitable funds as it is not a corporate trustee.

1.1 Accounting Conventions

Going concern

Under the provisions of *The Health and Social Care Act 2012 (Commencement No.4. Transitional, Savings and Transitory Provisions) Order 2013,* Sheffield 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 SOFP has therefore been drawn up at 31 March 2013 on the same basis as in previous years, reporting balances on the same basis as would a continuing entity. In particular, there has been no general revaluation of assets or liabilities, and no disclosures have been made under IFRS 5 *Non-current Assets Held for Sale and Discontinued Operation.*

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.

Operating lease commitments - Sheffield Primary Care Trust has entered into property leases over a number of sites. As it had been determined that Sheffield Primary Care Trust has not obtained substantially all the risks and rewards of ownership of these properties, the leases have been classified as operating leases and accounted for accordingly.

Key sources of estimation uncertainty

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

The Department of Health no longer publishes annual indices for NHS organisations in determining a fair value for non-current assets. In accordance with IFRS and IAS 16 land and buildings (excluding LIFT developments) have been re-valued by the District Valuer on Modern Equivalent Asset basis at fair value. Plant and equipment (other than IT equipment) is no longer subject to indexation and is carried at historical cost less accumulated depreciation as allowed under IAS 16. IT equipment and purchased software continue to be reported at historical cost less accumulated depreciation.

3 LIFT developments came onto the Statement of Financial Position on 1 April 2009 at values based on construction and development costs. A revaluation has not taken place since that date but new residual values provided by the District Valuer in March 2013 produced a potential increase in value totalling £1,162k. This resulted in previous impairments of £413k on these assets being reversed and credited to the SCONE in 2012-13.
3 LIFT developments came onto the Statement of Financial Position on 31 December 2012 at values based on construction and development costs. A revaluation was carried out by the District Valuer in March 2013 which resulted in reduction in value totalling £1,721k. This downward movement has been reported as an impairment in these accounts.
1 LIFT development came onto the Statement of Financial Position on 31 March 2013 at a value based on construction and development costs. A revaluation was carried out by the District Valuer in March 2013 which resulted in reduction in value totalling £553k. This downward movement has been reported as an impairment in these accounts.

Asset lives are reviewed annually to reflect changes in technology, lease terms and component reporting requirements for property. The individual distinct elements of each property are valued by the District Valuer separately and allocated different assets lives. The usual categories relate to building structure, building services and external works.

1. Accounting policies (continued)

Provisions - Sheffield Primary Care Trust has long term provisions. The carrying amount of these provisions is estimated based on assumptions. A change in estimates could have a material impact on the carrying amount of these provisions.

Basis of estimation of key accruals - The PCT has included certain accruals within the financial statements which are estimates. The basis of the estimation of key accruals were approved by the Chief Finance Officer and reported to Audit & Integrated Governance Group . The key areas requiring estimation were Fixed Asset values, Provisions, Healthcare contracts and Primary Care contracts.

The main provision relates to Continuing Healthcare retrospective claims and appeals. It arises due to the introduction of national deadlines in 2012/13 for the assessment of a patient's eligibility for continuing healthcare funding for any periods up to 31 March 2012. The large volume of claims received, together with the detailed and complex processes required to make individual assessments means that the process will continue for many months and there is incomplete information on some claimants. As a result, at the balance sheet date, a provision has been made for the expected costs using judgments on a range of factors including average length of and average costs of packages of care, existing success rates of appeals and eligibility rates for new claimants . The degree of estimation means that there is level of uncertainty associated with the value included in the financial statements. Actual claims approved at the end of the process 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 has entered into a pooled budget with Sheffield City Council. Under the arrangement funds are pooled under S75 of the NHS Act 2006 for Intermediate Care activities and a memorandum note to the accounts provides details of the joint income and expenditure.

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

The PCT has entered into a pooled budget with Sheffield City Council. Under the arrangement funds are pooled under S75 of the NHS Act 2006 for Community Equipment Services and a memorandum note to the accounts provides details of the joint income and expenditure.

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

Sheffield Primary Care Trust is also a partner in a Learning Disabilities pooled budget hosted by Sheffield City Council.

1.4 Taxation

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

1.5 Administration and Programme Costs

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

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

1. Accounting policies (continued)

1.6 Property, Plant & Equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation

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

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

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost
- LIFT Assets - present value of minimum lease payments

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 was ceased. The carrying value of existing assets at that date has been written off over their remaining useful lives. 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 amortised 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.

From 2011/12 impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). 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 Government grants

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

1.11 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.

1.12 Inventories

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

1.13 Cash and cash equivalents

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

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

1.14 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings including losses which would have been made good through insurance cover had PCTs not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.15 Clinical Negligence Costs

From 1 April 2000, the NHS Litigation Authority (NHSLA) took over the full financial responsibility for all Existing Liabilities Scheme (ELS) cases unsettled at that date and from 1 April 2002 all Clinical Negligence Scheme for Trusts (CNST) cases. Provisions for these are included in the accounts of the NHSLA. Although the NHSLA is administratively responsible for all cases from 1 April 2000, the legal liability remains with the PCTs.

The NHSLA operates a risk pooling scheme under which the PCT pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure in the year that it is due. The total value of clinical negligence provisions carried by the NHSLA on behalf of the PCT is disclosed at Note 32.

1. Accounting policies (continued)

1.16 Employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, 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.

1.17 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.

1.18 Other expenses

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

1.19 Grant making

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

1.20 EU Emissions Trading Scheme

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

1. Accounting policies (continued)

1.21 Contingencies

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

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

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

1.22 Leases

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

The PCT as lessee

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

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

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

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

The PCT as lessor

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

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

1.23 Foreign exchange

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

1.24 Provisions

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

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

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

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

1. Accounting policies (continued)

1.25 Financial Instruments

Financial assets

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

Financial assets are initially recognised at fair value.

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

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. There is no market in which the sub-ordinated debt can be traded and henced valued. Consequently the asset is shown at purchase price, less capital repaid.

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 are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

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

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

1. Accounting policies (continued)

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

Financial liabilities are initially recognised at fair value.

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

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

1.26 Private Finance Initiative (PFI) and NHS LIFT transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes (including NHS LIFT) where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The PCT therefore recognises the 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 LIFT asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

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

b) LIFT assets, liabilities, and finance costs

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

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

1. Accounting policies (continued)

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

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

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

c) Lifecycle replacement

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

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. 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. Accounting policies (continued)

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

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

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

2 Operating segments

In 2012-13 there are no separate operating divisions and Segmental reporting is therefore not required.

During the year Sheffield Primary Care Trust paid £399,084K (approx. 38% of total expenditure) to Sheffield Teaching Hospitals NHS Foundation Trust for the purchase of healthcare and other services provided (2011-12 £388,304K approx 38%).

3. Financial Performance Targets

3.1 Revenue Resource Limit

	2012-13 £000	2011-12 £000
The PCTs' performance for the year ended 2012-13 is as follows:		
Total Net Operating Cost for the Financial Year		999,477
Net operating cost plus (gain)/loss on transfers by absorption	1,026,465	
Adjusted for prior period adjustments in respect of errors	0	0
Revenue Resource Limit	1,026,943	999,966
Under/(Over)spend Against Revenue Resource Limit (RRL)	478	489

3.2 Capital Resource Limit

	2012-13 £000	2011-12 £000
The PCT is required to keep within its Capital Resource Limit.		
Capital Resource Limit	19,376	4,549
Charge to Capital Resource Limit	19,120	4,002
(Over)/Underspend Against CRL	256	547

3.3 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	1,021,112	995,146
Cash Limit	1,021,112	998,746
Under/(Over)spend Against Cash Limit	0	3,600

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

	2012-13 £000
Total cash received from DH (Gross)	890,472
Less: Trade Income from DH	(26)
Less/(Plus): movement in DH working balances	(66)
Sub total: net advances	890,380
(Less)/plus: transfers (to)/from other resource account bodies (free text note required)	0
Plus: cost of Dentistry Schemes (central charge to cash limits)	27,254
Plus: drugs reimbursement (central charge to cash limits)	103,479
Parliamentary funding credited to General Fund	1,021,113

4 Miscellaneous Revenue

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Fees and Charges	**11**	4	7	23
Dental Charge income from Contractor-Led GDS & PDS	**7,944**		7,944	7,813
Dental Charge income from Trust-Led GDS & PDS	**0**		0	0
Prescription Charge income	**5,786**		5,786	5,623
Strategic Health Authorities	**1,713**	36	1,677	1,629
NHS Trusts	**0**	0	0	5
NHS Foundation Trusts	**2,602**	1,139	1,463	3,987
Primary Care Trusts Contributions to DATs	**0**		0	0
Primary Care Trusts - Other	**1,070**	63	1,007	1,101
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	**27**	1	26	72
Recoveries in respect of employee benefits	**663**	565	98	522
Local Authorities	**3,538**	637	2,901	2,539
Patient Transport Services	**0**		0	0
Education, Training and Research	**3,836**	0	3,836	3,699
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 revenue from finance leases	**0**	0	0	0
Rental revenue from operating leases	**3,398**	0	3,398	2,283
Other revenue	**1,482**	447	1,035	1,561
Total miscellaneous revenue	**32,070**	**2,892**	**29,178**	**30,857**

5. Operating Costs

5.1 Analysis ofoperating costs:

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
Goods and Services from Other PCTs				
Healthcare	114,637		114,637	102,624
Non-Healthcare	1,726	1,719	7	1,311
Total	116,363	1,719	114,644	103,935
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	23,058	0	23,058	23,646
Goods and services (other, excl Trusts, FT and PCT))	193	188	5	535
Total	23,251	188	23,063	24,181
Goods and Services from Foundation Trusts	544,865	1,867	542,998	528,473
Purchase of Healthcare from Non-NHS bodies	96,554		96,554	98,020
Social Care from Independent Providers	0		0	0
Expenditure on Drugs Action Teams	9,391		9,391	9,560
Non-GMS Services from GPs	5,015	1,119	3,896	0
Contractor Led GDS & PDS (excluding employee benefits)	35,346		35,346	34,954
Salaried Trust-Led PDS & PCT DS (excluding employee benefits)	0		0	0
Chair, Non-executive Directors & PEC remuneration	14	14	0	65
Executive committee members costs	0	0	0	47
Consultancy Services	390	390	0	388
Prescribing Costs	82,549		82,549	86,612
G/PMS, APMS and PCTMS (excluding employee benefits)	75,470	0	75,470	78,517
Pharmaceutical Services	1,495		1,495	1,887
Local Pharmaceutical Services Pilots	0		0	0
New Pharmacy Contract	25,621		25,621	25,649
General Ophthalmic Services	5,308		5,308	5,371
Supplies and Services - Clinical	16	0	16	20
Supplies and Services - General	32	11	21	11
Establishment	609	331	278	773
Transport	15	9	6	28
Premises	3,843	1,575	2,268	2,464
Impairments & Reversals of Property, plant and equipment	2,377	0	2,377	380
Impairments and Reversals of non-current assets held for sale	100	0	100	57
Depreciation	2,745	514	2,231	2,492
Amortisation	59	24	35	69
Impairment & Reversals Intangible non-current assets	0	0	0	0
Impairment and Reversals of Financial Assets	0	0	0	0
Impairment of Receivables	(5)	0	(5)	267
Inventory write offs	0	0	0	77
Research and Development Expenditure	0	0	0	0
Audit Fees	146	146	0	261
Other Auditors Remuneration	2	2	0	0
Clinical Negligence Costs	0	0	0	0
Education and Training	3,928	45	3,883	3,746
Grants for capital purposes	1,450	0	1,450	760
Grants for revenue purposes	0	0	0	0
Impairments and reversals for investment properties	0	0	0	0
Other	3,247	1,251	1,996	4,164
Total Operating costs charged to Statement of Comprehensive Net Expenditure	1,040,196	9,205	1,030,991	1,013,228
Employee Benefits (excluding capitalised costs)				
Employee Benefits associated with PCTMS	0	0	0	0
Trust led PDS and PCT DS	0	0	0	0
PCT Officer Board Members	322	140	182	663
Other Employee Benefits	17,105	8,714	8,391	16,001
Total Employee Benefits charged to SOCNE	17,427	8,854	8,573	16,664
Total Operating Costs	1,057,623	18,059	1,039,564	1,029,892
Analysis of grants reported in total operating costs				
For capital purposes				
Grants to fund Capital Projects - GMS	492	0	492	297
Grants to Local Authorities to Fund Capital Projects	0	0	0	0
Grants to Private Sector to Fund Capital Projects	650	0	650	258
Grants to Fund Capital Projects - Dental	136	0	136	205
Grants to Fund Capital Projects - Other	172	0	172	0
Total Capital Grants	1,450	0	1,450	760
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	1,450	0	1,450	760

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	15,167	14,076	1,091
Weighted population (number in units)*	569,707	569,707	569,707
Running costs per head of population (£ per head)	27	25	2
PCT Running Costs 2011-12			
Running costs (£000s)	15,534	14,631	903
Weighted population (number in units)	569,707	569,707	569,707
Running costs per head of population (£ per head)	27	26	2

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

5.2 Analysis of operating expenditure by expenditure classification	2012-13 £000	2011-12 £000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	75,470	78,517
Prescribing costs	82,549	86,612
Contractor led GDS & PDS	35,346	34,954
Trust led GDS & PDS	0	0
General Ophthalmic Services	5,308	5,371
Department of Health Initiative Funding	0	0
Pharmaceutical services	1,495	1,887
Local Pharmaceutical Services Pilots	0	0
New Pharmacy Contract	25,621	25,649
Non-GMS Services from GPs*	5,015	0
Other	0	0
Total Primary Healthcare purchased	**230,804**	232,990
Purchase of Secondary Healthcare		
Learning Difficulties	21,249	19,715
Mental Illness	117,667	119,339
Maternity	38,623	38,045
General and Acute	459,235	449,157
Accident and emergency	21,641	19,237
Community Health Services	105,575	97,526
Other Contractual	13,278	8,825
Total Secondary Healthcare Purchased	**777,268**	751,844
Grant Funding		
Grants for capital purposes	1,450	760
Grants for revenue purposes	0	0
Total Healthcare Purchased by PCT	**1,009,522**	**985,594**
PCT self-provided secondary healthcare included above	0	0
Social Care from Independent Providers	0	0
Healthcare from NHS FTs included above	543,001	527,031

* In 2012-13 under "Non GMS Services from GPs" the PCT has separately disclosed payments made to GP practices such as those for local enhanced services which are in addition to national contractual arrangements. Such payments were included under "GMS/PMS/APMS/PCTMS" in 2011/12 when spend on a comparable basis was £4,706k

6. Operating Leases

6.1 PCT as lessee

	Land £000	Buildings £000	Other £000	2012-13 Total £000	2011-12 £000
Payments recognised as an expense					
Minimum lease payments				6,814	1,052
Contingent rents				0	0
Sub-lease payments				616	615
Total				7,430	1,667
Payable:					
No later than one year	90	1,943	12	2,045	1,353
Between one and five years	342	6,471	13	6,826	5,049
After five years	1,719	19,075	0	20,794	11,794
Total	2,151	27,489	25	29,665	18,196
Total future sublease payments expected to be received				0	0

Sheffield PCT has entered into certain financial arrangements involving the use of GP Premises. Under: IAS 17 Leases, SIC 27 'Evaluating the substance of transactions involving the legal form of a lease' and IFRIC 4 'Determining whether an arrangement contains a lease', the PCT has determined that those operating leases must be recognised, but, as there is no defined term in the arrangements entered into, it is not possible to analyse the arrangements over financial years. The financial value included in the Statement of Comprehensive Net Expenditure for 2012/13 is £5,470k. In 2011/12 the reported figure was £0k but should have been £5,381k.

6.2 PCT as lessor

	2012-13 £000	2011-12 £000
Recognised as income		
Rental Revenue	3,398	2,283
Contingent rents	0	0
Total	3398	2,283
Receivable:		
No later than one year	0	2,331
Between one and five years	0	0
After five years	0	0
Total	0	2,331

Properties occupied by services which transferred to Foundation Trusts as part of Transforming Community Services on 1 April 2011 have continued to be retained by the PCT throughout 2012/13 and rented to the Foundation Trusts operating the services. The value of rents receivable and included in the Statement of Comprehensive Net Expenditure for 2012-13 is £3,292k. All properties are transferring to the relevant Foundation Trust or NHS Property Services on 1 April 2013 and hence rental income receivable for future years is shown as £nil.

7. Employee benefits and staff numbers

7.1 Employee benefits

2012-13				Permanently employed			Other		
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Employee Benefits - Gross Expenditure									
Salaries and wages	14,632	10,072	4,560	14,277	9,811	4,466	355	261	94
Social security costs	918	631	287	918	631	287	0	0	0
Employer Contributions to NHS BSA - Pensions Division	1,401	962	439	1,401	962	439	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	476	456	20	476	456	20	0	0	0
Total employee benefits	17,427	12,121	5,306	17,072	11,860	5,212	355	261	94
Less recoveries in respect of employee benefits (table below)	(663)	(565)	(98)	(663)	(565)	(98)	0	0	0
Total - Net Employee Benefits including capitalised costs	16,764	11,556	5,208	16,409	11,295	5,114	355	261	94
Employee costs capitalised	0	0	0	0	0	0	0	0	0
Gross Employee Benefits excluding capitalised costs	17,427	12,121	5,306	17,072	11,860	5,212	355	261	94
Recognised as:									
Commissioning employee benefits	17,427			17,072			355		
Provider employee benefits	0			0			0		
Gross Employee Benefits excluding capitalised costs	17,427			17,072			355		

2012-13				Permanently employed			Other		
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Employee Benefits - Revenue									
Salaries and wages	663	565	98	663	565	98	0	0	0
Social Security costs	0	0	0	0	0	0	0	0	0
Employer Contributions to NHS BSA - Pensions Division	0	0	0	0	0	0	0	0	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other Post Employment Benefits	0	0	0	0	0	0	0	0	0
Other Employment Benefits	0	0	0	0	0	0	0	0	0
Termination Benefits	0	0	0	0	0	0	0	0	0
TOTAL excluding capitalised costs	663	565	98	663	565	98	0	0	0

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	12,297	12,123	174
Social security costs	857	857	0
Employer Contributions to NHS BSA - Pensions Division	1,330	1,330	0
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	2,180	2,180	0
Total gross employee benefits	16,664	16,490	174
Less recoveries in respect of employee benefits	(522)	(522)	0
Total - Net Employee Benefits including capitalised costs	16,142	15,968	174
Employee costs capitalised	0	0	0
Gross Employee Benefits excluding capitalised costs	16,664	16,490	174
Recognised as:			
Commissioning employee benefits	16,664		
Provider employee benefits	0		
Gross Employee Benefits excluding capitalised costs	16,664		

7.2 Staff Numbers

	2012-13			2011-12		
	Total Number	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number
Average Staff Numbers						
Medical and dental	5	4	1	6	4	2
Ambulance staff	0	0	0	0	0	0
Administration and estates	226	220	6	261	252	9
Healthcare assistants and other support staff	0	0	0	0	0	0
Nursing, midwifery and health visiting staff	40	38	1	38	31	7
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	22	21	1	24	23	1
Social Care Staff	0	0	0	0	0	0
Other	0	0	0	0	0	0
TOTAL	293	284	9	329	310	19
Of the above - staff engaged on capital projects	0	0	0	0	0	0

7.3 Staff Sickness absence and ill health retirements

	2012-13 Number	2011-12 Number
Total Days Lost	2,086	15,370
Total Staff Years	339	1,685
Average working Days Lost	6.15	9.12

The figures included for Staff Sickness Absence are for the calendar year 2012 as provided by the Department of Health. The figure for 2011-12 includes staff who transferred to Sheffield Teaching Hospitals, Sheffield Children's and Sheffield Health and Social Care NHS Foundation Trusts as part of the Transfer of Community Services. For 2012/13 the figure includes PCT Commissioning Staff only.

7.4 Exit Packages agreed during 2012-13

	2012-13			2011-12		
Exit package cost band (including any special payment element)	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**
	Number	**Number**	**Number**	**Number**	**Number**	**Number**
Less than £10,000	**0**	**0**	**0**	0	1	**1**
£10,001-£25,000	**3**	**1**	**4**	0	5	**5**
£25,001-£50,000	**0**	**3**	**3**	0	13	**13**
£50,001-£100,000	**2**	**4**	**6**	0	9	**9**
£100,001 - £150,000	**0**	**4**	**4**	0	3	**3**
£150,001 - £200,000	**0**	**0**	**0**	0	1	**1**
>£200,000	**0**	**0**	**0**	0	1	**1**
Total number of exit packages by type (total cost	**5**	**12**	**17**	**0**	**33**	**33**
	£	**£**	**£**	**£**	**£**	**£**
Total resource cost	179,995	941,029	**1,121,024**	0	1,958,000	**1,958,000**

* 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 South Yorkshire & Bassetlaw Cluster Wide Voluntary Redundancy Scheme and the NHS South Yorkshire & Bassetlaw Cluster Wide Compulsory Redundancy 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.

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

7.5 Pension costs

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

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

a) Accounting valuation

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

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

b) Full actuarial (funding) valuation

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

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

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

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

c) Scheme provisions

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

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

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

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

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

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

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

8. Better Payment Practice Code

8.1 Measure of compliance

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**26,699**	**170,271**	33,321	190,015
Total Non-NHS Trade Invoices Paid Within Target	**25,111**	**164,706**	32,125	185,435
Percentage of NHS Trade Invoices Paid Within Target	94.05%	96.73%	96.41%	97.59%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**4,311**	**665,863**	5,249	690,448
Total NHS Trade Invoices Paid Within Target	**4,076**	**664,189**	4,934	688,893
Percentage of NHS Trade Invoices Paid Within Target	94.55%	99.75%	94.00%	99.77%

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

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

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

9. Investment Income

	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	117	0	117	28
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	117	0	117	28
Total investment income	117	0	117	28

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	0
Gain/(Loss) on disposal of assets other than by sale (intangibles)	0	0	0	0
Gain/(Loss) on disposal of Financial Assets - other than held for sale	0	0	0	0
Gain (Loss) on disposal of assets held for sale	50	0	50	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	50	0	50	0

11. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest				
Interest on obligations under finance leases	0	0	0	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	949	0	949	347
- contingent finance cost	73	0	73	57
Interest on late payment of commercial debt	0	0	0	0
Other interest expense	0	0	0	0
Total interest expense	1,022	0	1,022	404
Other finance costs	0	0	0	0
Provisions - unwinding of discount	57		57	66
Total	1,079	0	1,079	470

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	1,259	21,056	0	2,930	2,176	140	3,832	974	32,367
Additions of Assets Under Construction				0					0
Additions Purchased	0	588	0		151	0	998	240	1,977
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	17,341	0		0	0	0	0	17,341
Reclassifications	0	2,929	0	(2,929)	0	0	0	0	0
Reclassifications as Held for Sale	(120)	(231)	0	0	0	0	0	0	(351)
Disposals other than for sale	0	(98)	0	0	0	0	(1,390)	0	(1,488)
Upward revaluation/positive indexation	0	931	0	0	0	0	0	0	931
Impairments/negative indexation	(136)	(480)	0	0	0	0	0	0	(616)
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	0
At 31 March 2013	1,003	42,036	0	1	2,327	140	3,440	1,214	50,161
Depreciation									
At 1 April 2012	0	3,425	0	1	913	99	2,627	391	7,456
Reclassifications	0	0	0		0	0	0	0	0
Reclassifications as Held for Sale	0	0	0		0	0	0	0	0
Disposals other than for sale	0	(98)	0		0	0	(1,390)	0	(1,488)
Upward revaluation/positive indexation	0	0	0		0	0	0	0	0
Impairments	33	2,954	0	0	0	0	0	0	2,987
Reversal of Impairments	0	(610)	0	0	0	0	0	0	(610)
Charged During the Year	0	1,664	0		192	14	790	85	2,745
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	0
At 31 March 2013	33	7,335	0	1	1,105	113	2,027	476	11,090
Net Book Value at 31 March 2013	970	34,701	0	0	1,222	27	1,413	738	39,071
Purchased	970	33,720	0	0	1,222	27	1,413	738	38,090
Donated	0	0	0	0	0	0	0	0	0
Government Granted	0	981	0	0	0	0	0	0	981
Total at 31 March 2013	970	34,701	0	0	1,222	27	1,413	738	39,071
Asset financing:									
Owned	970	11,890	0	0	1,222	27	1,413	738	16,260
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP PFI contracts	0	22,811	0	0	0	0	0	0	22,811
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	970	34,701	0	0	1,222	27	1,413	738	39,071

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	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2012	1,486	924	0	0	134	0	0	45	2,589
Movements (specify)	(136)	451	0	0	0	0	0	0	315
At 31 March 2013	1,350	1,375	0	0	134	0	0	45	2,904

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	**1,310**	**18,455**	**0**	**2,658**	**2,064**	**140**	**3,280**	**935**	**28,842**
Additions - purchased	0	2,593	0	299	112	0	552	39	**3,595**
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	27	0	(27)	0	0	0	0	**0**
Reclassified as held for sale	0	(2)	0	0	0	0	0	0	**(2)**
Disposals other than by sale	0	0	0	0	0	0	0	0	**0**
Revaluation & indexation gains	0	101	0	0	0	0	0	0	**101**
Impairments	(51)	(118)	0	0	0	0	0	0	**(169)**
Reversals of impairments	0	0	0	0	0	0	0	0	**0**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluatio	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**1,259**	**21,056**	**0**	**2,930**	**2,176**	**140**	**3,832**	**974**	**32,367**
Depreciation									
At 1 April 2011	**0**	**1,660**	**0**		**732**	**85**	**1,797**	**310**	**4,584**
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	0	451	0	1	0	0	0	0	**452**
Reversal of Impairments	0	(72)	0	0	0	0	0	0	**(72)**
Charged During the Year	0	1,386	0		181	14	830	81	**2,492**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluatio	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**0**	**3,425**	**0**	**1**	**913**	**99**	**2,627**	**391**	**7,456**
Net Book Value at 31 March 2012	**1,259**	**17,631**	**0**	**2,929**	**1,263**	**41**	**1,205**	**583**	**24,911**
Purchased	1,259	15,843	0	2,929	1,263	41	1,205	583	**23,123**
Donated	0	0	0	0	0	0	0	0	**0**
Government Granted	0	1,788	0	0	0	0	0	0	**1,788**
At 31 March 2012	**1,259**	**17,631**	**0**	**2,929**	**1,263**	**41**	**1,205**	**583**	**24,911**
Asset financing:									
Owned	1,259	10,573	0	2,929	1,263	41	1,205	583	**17,853**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	7,058	0	0	0	0	0	0	**7,058**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**1,259**	**17,631**	**0**	**2,929**	**1,263**	**41**	**1,205**	**583**	**24,911**

12.3 Property, plant and equipment

Nature of Valuation of Property, Plant and Equipment assets

Valuations of non LIFT land and buildings were carried out by the District Valuer, having regard to International Financial Reporting Standards as applied to the UK public sector and in accordance with HM Treasury guidance, International Valuation Standards and the requirements of the Royal Institution of Chartered Surveyors (RICS) Valuation Standards 6th edition. These terms are consistent with the requirements of HM Treasury, the National Health Service and the Department of Health.

Land and building valuations were undertaken in February 2013 as at the prospective valuation date of 31 March 2013 and were applied on that date.

Valuations have been carried out primarily on the basis of Market Value on the assumption (as required by the Department of Health for operational assets) that the property is sold as part of the continuing enterprise in occupation. For non-specialised operational assets this equates in practice to Existing Use Value.

For specialised operational assets, in the absence of any market-based evidence, fair value is estimated using depreciated replacement cost assuming continuing use. In definition this is the current cost of replacing an asset with its modern equivalent asset less deductions for physical deterioration and all forms of obsolescence and optimisation.

Non-operational assets, including surplus land, are valued on the basis of Market Value, making the assumption the property is no longer required for existing operations.

Plant and equipment, including IT assets, are carried at historical cost less cumulative depreciation and without subsequent annual indexation or revaluation.

Existing Use Value of Property

There are no material differences between the existing use value (EUV) of assets and the Open Market Value of these assets.

Effect of impairments on recoverable amounts

LIFT developments initially recognised on the Statement of Financial Position (SoFP) in 2009/10 have been valued in 2012/13 based on fair and residual values provided by the District Valuer.

These values indicated impairments on the 4 new LIFT buildings and upward movements in values to the 3 LIFT properties brought onto the SoFP in 2009/10. The total impairment of £2,274K on new LIFT was reduced by a reversal of £413k impairments previously charged to the SoCNE relating to the 3 older properties. A net impairment of £1,861k has been recognised in the SoCNE for LIFT buildings in 2012/13.

Impairments totalling £1,132k for non LIFT assets (excluding assets held for sale) were recognised as a result of the revaluation exercise, of which £516k was a charge to operating costs (net of £197k reversal of previous impairments).

Donated Assets

There were no donations of assets made in year.

Gross carrying amounts of fully depreciated assets still in use are detailed below:-

	£'000
Land	0
Buildings	0
IT equipment (of which £13k relates to Government Granted assets)	1390
Vehicles	0
Plant & machinery	293
Fixtures & fittings	29
Total	**1,712**

Asset lives for each Class of Asset

	Min Life Years	Max Life Years
Property, Plant and Equipment		
Buildings exc Dwellings	0	105
Dwellings	0	0
Plant & Machinery	0	10
Transport Equipment	2	2
Information Technology	0	5
Furniture and Fittings	0	17

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**	**338**	**0**	**0**	**0**	**338**
Additions - purchased	0	53	0	0	0	**53**
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**	**391**	**0**	**0**	**0**	**391**
Amortisation						
At 1 April 2012	**0**	**248**	**0**	**0**	**0**	**248**
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	59	0	0	0	**59**
In-year transfers to NHS bodies	0	0	0	0	0	**0**
At 31 March 2013	**0**	**307**	**0**	**0**	**0**	**307**
Net Book Value at 31 March 2013	**0**	**84**	**0**	**0**	**0**	**84**
Net Book Value at 31 March 2013 comprises						
Purchased	0	84	0	0	0	**84**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	**0**
Total at 31 March 2013	**0**	**84**	**0**	**0**	**0**	**84**

Revaluation reserve balance for intangible non-current assets

	Software internally generated £000	Software purchased £000	Licences & trademarks £000	Patents £000	Development expenditure £000	Total £000
At 1 April 2012	**0**	**0**	**0**	**0**	**0**	**0**
Movements	0	0	0	0	0	**0**
At 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**

13.2 Intangible non-current assets

2011-12	Software internally generated £000	Software purchased £000	Licences & trademarks £000	Patents £000	Development expenditure £000	Total £000
At 1 April 2011	0	307	0	0	0	307
Additions - purchased	0	31	0	0	0	31
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	338	0	0	0	338
Amortisation						
At 1 April 2011	0	179	0	0	0	179
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	69	0	0	0	69
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	248	0	0	0	248
Net Book Value at 31 March 2012	0	90	0	0	0	90
Net Book Value at 31 March 2012 comprises						
Purchased	0	90	0	0	0	90
Donated	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0
Total at 31 March 2012	0	90	0	0	0	90

13.3 Intangible non-current assets

New intangible assets (purchased software) are given finite economic lives of three years and amortised on a straight line basis.

Following initial recognition intangible assets are carried at historical cost less amortisation and without subsequent indexation or revaluation.

Fully amortised intangible assets still in use (including assets acquired by government grant) to the value of £223K relate to Headquarters, Continuing Care, Drugs Intervention Programme and GPSoC.

There are no internally generated intangible assets.

Intangible assets acquired by government grant:

	£000
Fair value initially recognised (historic cost)	21
Carrying amount	0

Economic Lives of Non-Current Assets

	Min Life Years	Max Life Years
Intangible Assets		
Software Licences	0	3
Licences and Trademarks	0	0
Patents	0	0
Development Expenditure	0	0

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

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000
Property, Plant and Equipment impairments and reversals taken to SoCNE			
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	2,377		2,377
Total charged to Annually Managed Expenditure	**2,377**		**2,377**
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	616		
Total impairments for PPE charged to reserves	**616**		
Total Impairments of Property, Plant and Equipment	**2,993**	**0**	**2,377**
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**

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

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000
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**
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	100		100
Total charged to Annually Managed Expenditure	**100**		**100**
Total impairments of non-current assets held for sale	**100**	**0**	**100**
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	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 Catastrophe	0		0
Other	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	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	616		
Total Impairments charged to SoCNE - DEL	0	0	0
Total Impairments charged to SoCNE - AME	2,477		2,477
Overall Total Impairments	**3,093**	**0**	**2,477**
Of which:			
Impairment on revaluation to "modern equivalent asset" basis	**2,382**	0	2,382

Note 14 ctd

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

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000
Donated and Gov Granted Assets, included above -			
PPE - Donated and Government Granted Asset Impairments: amount charged to SoCNE -DEL*	0	0	0
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SoCNE -AME*	0	0	0

Total impairments of £3,093k were recognised in year. These resulted from valuations of non LIFT properties including those held for sale and the fair and residual values of LIFT premises. All valuations were carried out by the District Valuer.

Revaluations of non LIFT properties were based on fair value in accordance with IAS 16. The market value was determined by the District Valuer on the assumption that the property is sold as part of the continuing enterprise in operation.

LIFT properties were based on fair and residual values provided by the District Valuer, used to revise the LIFT models, resulting in new carrying values.

The recoverable amount of held for sale assets was based on fair value less costs to sell.

The highest impairment was £602k on the Sharrow Lane SureStart building

All impairments relate to 'buildings excluding dwellings' apart from £100k for 'assets for sale' and £169k for 'land'.

Impairments	**£'000**
- LIFT	1,861
- Non LIFT	1,132
- Assets Held For Sale	100
	3,093

Impairments are reported net of reversals of previous impairments charged to the SoCNE, to the value of £610k. This is the result of upward movements in buildings values, which would normally be reflected in the Revaluation Reserve.

* AME is Annually Managed Expenditure and DEL is Departmental Expenditure Limit

15 Investment property

Sheffield PCT did not hold any investment property during the financial year.

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	0
Intangible assets	0	0
Total	0	0

16.2 Other financial commitments

The trust has not entered into any non-cancellable contracts (other than LIFT contracts).

	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 £000	Non-current receivables £000	Current payables £000	Non-current payables £000
Balances with other Central Government Bodies	1,058	0	849	0
Balances with Local Authorities	3,174	0	3,536	0
Balances with NHS bodies outside the Departmental Group	0	0	1	0
Balances with NHS Trusts and Foundation Trusts	3,509	0	6,788	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	811	0	34,788	0
At 31 March 2013	8,552	0	45,962	0
prior period:				
Balances with other Central Government Bodies	1,532	0	824	0
Balances with Local Authorities	227	0	636	0
Balances with NHS Trusts and Foundation Trusts	3,421	0	8,765	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	3,812	0	38,822	0
At 31 March 2012	8,992	0	49,047	0

18 Inventories

	Drugs £000	Consumables £000	Energy £000	Work in progress £000	Loan Equipment £000	Other £000	Total £000	Of Which held at NRV £000
Balance at 1 April 2012	0	0	0	0	0	2	2	0
Additions	0	0	0	0	0	0	0	0
Inventories recognised as an expense in the period	0	0	0	0	0	(2)	(2)	0
Write-down of inventories (including losses)	0	0	0	0	0	0	0	0
Reversal of write-down previously taken to SoCNE	0	0	0	0	0	0	0	0
Transfers (to)/from other public sector bodies	0	0	0	0	0	0	0	0
Balance at 31 March 2013	0	0	0	0	0	0	0	0

The inventories held at 31 March 2013 were negligible.

19.1 Trade and other receivables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
NHS receivables - revenue	4,410	4,872	0	0
NHS receivables - capital	0	0	0	0
NHS prepayments and accrued income	0	57	0	0
Non-NHS receivables - revenue	4,213	3,919	0	0
Non-NHS receivables - capital	0	0	0	0
Non-NHS prepayments and accrued income	284	673	0	0
Provision for the impairment of receivables	(503)	(553)	0	0
VAT	148	24	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	8,552	8,992	0	0
Total current and non current	8,552	8,992		
Included above:				
Prepaid pensions contributions	0	0		

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

19.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	79	328
By three to six months	4	192
By more than six months	69	795
Total	152	1,315

19.3 Provision for impairment of receivables

	2012-13 £000	2011-12 £000
Balance at 1 April 2012	(553)	(664)
Amount written off during the year	45	378
Amount recovered during the year	506	0
(Increase)/decrease in receivables impaired	(501)	(267)
Balance at 31 March 2013	(503)	(553)

Receivables impaired include the following items:
Income invoiced to Sheffield City Council in respect of Continuing Healthcare packages where eligibility has moved to the Local Authority totalling £1,523,000 has been impaired by £500,000 (33%).

Debts overdue by 91+ days raised by prior to 31 March 2013, totalling £2,504

20 NHS LIFT investments

	Loan £000	Share capital £000	Total £000
Balance at 1 April 2012	**726**	**0**	**726**
Additions	**0**	**0**	**0**
Disposals	**0**	**0**	**0**
Loan repayments	**0**	**0**	**0**
Revaluations	**0**	**0**	**0**
Loans repayable within 12 months	**(7)**	**0**	**(7)**
Balance at 31 March 2013	**719**	**0**	**719**
Balance at 1 April 2011	233	0	233
Additions	496	0	496
Disposals	0	0	0
Loan repayments	(3)	0	(3)
Revaluations	0	0	0
Loans repayable within 12 months	0	0	0
Balance at 31 March 2012	**726**	**0**	**726**

21.1 Other financial assets - Current

	31 March 2013 £000	31 March 2012 £000
Opening balance 1 April	3	3
Transfers (to)/from Other Public Sector Bodies in year	0	0
Other Movements	4	0
Closing balance 31 March	**7**	3

21.2 Other Financial Assets - Non Current

	31 March 2013 £000	31 March 2012 £000
Opening balance 1 April	**726**	233
Additions	0	496
Revaluation	0	0
Impairments	0	0
Impairment Reversals	0	0
Transferred to current financial assets	(7)	(3)
Disposals	0	0
Transfers (to)/from Other Public Sector Bodies in year	0	0
Total Other Financial Assets - Non Current	**719**	726

21.3 Other Financial Assets - Capital Analysis

	31 March 2013 £000	31 March 2012 £000
Capital Expenditure	**0**	0
Capital Income	**(3)**	(3)

22 Other current assets

	31 March 2013 £000	31 March 2012 £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	**8**	33
Net change in year	**10**	(25)
Closing balance	**18**	8
Made up of		
Cash with Government Banking Service	**18**	6
Commercial banks	**0**	2
Cash in hand	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**18**	8
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**18**	8
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	0	0	0	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	120	231	0	0	0	0	0	0	0	**351**
Less assets sold in the year	(80)	(171)	0	0	0	0	0	0	0	**(251)**
Less impairment of assets held for sale	(40)	(60)	0	0	0	0	0	0	0	**(100)**
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	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
										0
Balance at 1 April 2011	175	0	0	0	0	0	0	0	0	**175**
Plus assets classified as held for sale in the year	2	0	0	0	0	0	0	0	0	**2**
Less assets sold in the year	(120)	0	0	0	0	0	0	0	0	**(120)**
Less impairment of assets held for sale	(57)	0	0	0	0	0	0	0	0	**(57)**
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	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2012	0	0	0	0	0	0	0	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 health centres at Darnall and Norfolk Park and the Westfield portacabin were identified in year as available for sale.

This was as a result of new LIFT premises at Darnall and Norfolk Park being brought into operational use this year. The Westfield portacabin was no longer required as temporary accommodation.

Darnall was impaired by £63k prior to being held for sale and was not subsequently impaired. A profit of £50k was made on the sale proceeds of £200k.

Norfolk Park was impaired initially by £98k and by a further £100k on recognition as held for sale. No gain or loss was made on the sale proceeds of £100k.

Both properties were recognised as "non current assets held for sale" in year and were sold prior to the year end.

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	6,816	9,095	0	0
NHS payables - capital	23	0	0	0
NHS accruals and deferred income	0	0	0	0
Family Health Services (FHS) payables	19,399	22,217		
Non-NHS payables - revenue	4,658	2,382	0	0
Non-NHS payables - capital	414	564	0	0
Non_NHS accruals and deferred income	14,016	14,265	0	0
Social security costs	146	140		
VAT	0	7	0	0
Tax	250	160		
Payments received on account	0	4	0	0
Other	240	213	0	0
Total	45,962	49,047	0	0
Total payables (current and non-current)	45,962	49,047		

Other payables £240k (2011-12: £213k) includes £236k in respect of outstanding pensions contributions at 31 March 2013 (31 March 2012: £187k).

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	349	266	24,872	7,927
Lifecycle replacement received in advance	0	0	0	0
Finance lease liabilities	0	0	0	0
Other	0	0	0	0
Total	349	266	24,872	7,927
Total other liabilities (current and non-current)	25,221	8,193		

Borrowings/Loans - Payment of Principal Falling Due in:

	DH £000s	Other £000s	Total £000s
0 - 1 Years	0	349	349
1 - 2 Years	0	393	393
2 - 5 Years	0	1,756	1,756
Over 5 Years	0	22,723	22,723
TOTAL	0	25,221	25,221

28 Other financial liabilities

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

29 Deferred income

	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Opening balance at1 April 2012	**4**	36	**0**	0
Deferred income addition	**0**	4	**0**	0
Transfer of deferred income	**(4)**	(36)	**0**	0
Current deferred Income at 31 March 2013	**0**	4	**0**	0
Total other liabilities (current and non-current)	**0**	4		

30 Finance lease obligations

Amounts payable under finance leases (Buildings)

	Minimum lease payments		**Present value of minimum lease payments**	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Within one year	**0**	0	**0**	0
Between one and five years	**0**	0	**0**	0
After five years	**0**	0	**0**	0
Less future finance charges	**0**	0		
Present value of minimum lease payments	**0**	0	**0**	0
Included in:				
Current borrowings			**0**	0
Non-current borrowings			**0**	0
			0	0

Amounts payable under finance leases (Land)

	Minimum lease payments		**Present value of minimum lease**	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Within one year	**0**	0	**0**	0
Between one and five years	**0**	0	**0**	0
After five years	**0**	0	**0**	0
Less future finance charges	**0**	0		
Present value of minimum lease payments	**0**	0	**0**	0
Included in:				
Current borrowings			**0**	0
Non-current borrowings			**0**	0
			0	0

Amounts payable under finance leases (Other)

	Minimum lease payments		**Present value of minimum lease**	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Within one year	**0**	0	**0**	0
Between one and five years	**0**	0	**0**	0
After five years	**0**	0	**0**	0
Less future finance charges	**0**	0		
Present value of minimum lease payments	**0**	0	**0**	0
Included in:				
Current borrowings			**0**	0
Non-current borrowings			**0**	0
			0	0

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

31 Finance lease receivables as lessor

Amounts receivable under finance leases (buildings)	Gross investments in leases		Present value of minimum lease	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
Within one year	0	0	0	0
Between one and five years	0	0	0	0
After five years	0	0	0	0
Less future finance charges	0	0	-	-
Present value of minimum lease payments	0	0	0	0
Less allowance for uncollectible lease payments:	0	0	0	0
Total finance lease receivable recognised in the statement of financial position	0	0	0	0
Included in:				
Current finance lease receivables			0	0
Non-current finance lease receivables			0	0
			0	0

Amounts receivable under finance leases (land)	Gross investments in leases		Present value of minimum lease	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
Within one year	0	0	0	0
Between one and five years	0	0	0	0
After five years	0	0	0	0
Less future finance charges	0	0	-	-
Present value of minimum lease payments	0	0	0	0
Less allowance for uncollectible lease payments:	0	0	0	0
Total finance lease receivable recognised in the statement of financial position	0	0	0	0
Included in:				
Current finance lease receivables			0	0
Non-current finance lease receivables			0	0
			0	0

Amounts receivable under finance leases (other)	Gross investments in leases		Present value of minimum lease	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
Within one year	0	0	0	0
Between one and five years	0	0	0	0
After five years	0	0	0	0
Less future finance charges	0	0	-	-
Present value of minimum lease payments	0	0	0	0
Less allowance for uncollectible lease payments:	0	0	0	0
Total finance lease receivable recognised in the statement of financial position	0	0	0	0
Included in:				
Current finance lease receivables			0	0
Non-current finance lease receivables			0	0
			0	0

Finance Leases (as a Lessor)	31 March 2013 £000	31 March 2012 £000
The unguaranteed residual value accruing to the PCT is	0	0
Accumulated allowance for uncollectible minium lease payments receivable	0	0

Rental Income	31 March 2013 £000	31 March 2012 £000
Contingent rent	0	0
Other	0	0
Total rental income	0	0

Finance Lease Commitments	31 March 2013 £000	31 March 2012 £000
Lease	0	0

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	**3,239**	0	2,043	799	0	0	0	0	176	221
Arising During the Year	**8,496**	0	0	588	0	7,606	0	0	302	0
Utilised During the Year	**(3,673)**	0	(2,100)	(1,176)	0	0	0	0	(176)	(221)
Reversed Unused	**(67)**	0	0	(67)	0	0	0	0	0	0
Unwinding of Discount	**57**	0	57	0	0	0	0	0	0	0
Change in Discount Rate	**0**	0	0	0	0	0	0	0	0	0
Transferred (to)/from otherPublic Sector bodies	**0**	0	0	0	0	0	0	0	0	0
Balance at 31 March 2013	**8,052**	**0**	**0**	**144**	**0**	**7,606**	**0**	**0**	**302**	**0**
Expected Timing of Cash Flows:										
No Later than One Year	**2,981**	**0**	**0**	**144**	**0**	**2,535**	**0**	**0**	**302**	**0**
Later than One Year and not later than Five Years	**5,071**	**0**	**0**	**0**	**0**	**5,071**	**0**	**0**	**0**	**0**
Later than Five Years	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at 31 March 2013	562
As at 31 March 2012	710

Pre-1995 Early Retirements Provision

The provision for pensions relating to other staff (£2,043k at 1 April 2012) was in respect of early retirement settlements for staff who took early retirement prior to 1 April 1995. Historically payments were made quarterly to the NHS Pension authority to discharge this liability. In January 2013 the PCT settled the outstanding sum in full so that the provision at 31 March 2013 is £nil

Legal Claims – Back to Back Provisions with NHS Foundation Trusts

The legal claims provision at 1 April 2012 included an amount of £745k for legal claims at Foundation Trusts in Sheffield which were covered by the PCT as part of healthcare contract arrangements. The full value was settled in 2012-13 leaving a £nil value for back to back provisions at 31 March 2013.

Continuing Care

In March 2012 the Department of Health announced that it was introducing a deadline for individuals (or their representatives) to submit retrospective claims for assessment for Continuing Health Care (CHC) eligibility. The deadline for periods prior to 31 March 2011was 30 September 2012 and for periods up to 31 March 2012 the deadline was 31 March 2013.The introduction of these deadlines was accompanied by a nationally co-ordinated publicity campaign to inform the public of their right to apply for CHC eligibility and the timescales.

Sheffield PCT received around 500 claims before the deadlines and a detailed assessment process on potential eligibility for CHC funding is underway. A methodology has been developed for estimating the level of financial liability arising from the claims submitted. This provides the basis of the provision included in these accounts of £7.6m

The value above also includes an element for the estimated liability of £344k arising from the requirement of the PCT to cover the clinical and administration time related to the process of assessing all the claims received in respect of CHC eligibility.

Other

The other provisions are in respect of potential PAYE liability related to the treatment of GPs working in the GP collaborative out of hours service run by the PCT from 1 Oct 2006 to 31 March 2011. The employment status of these staff is being considered by HMRC as part of a PAYE review and the estimate of the potential liability to the PCT at the balance sheet date is £288k

£562k is included in the provisions of the NHS Litigation Authority at 31/3/2013 in respect of clinical negligence liabilities of the PCT (31/03/2012: £710k).

33 Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities		
Equal Pay	**0**	0
Other	**(29,241)**	(1,314)
Amounts Recoverable Against Contingent Liabilities	**0**	0
Net Value of Contingent Liabilities	**(29,241)**	(1,314)
Contingent Assets		
Contingent Assets	**0**	0
Net Value of Contingent Assets	**0**	0

Legal Claims - NHS LA

The PCT received notification of 4 potential claims currently under review by the NHS Litigation Authority (NHSLA) where there may be a potential liability for the PCT. The NHSLA have indicated that two have a 75% probability of being settled and two a 50% probability of being settled as a result £30,000 is included as a provision (see Note 21) hence £10,000 recognised above as a contingent liability.

Legal Claims - Other

A Schedule is maintained of notified legal claims against the PCT which remain unsettled. Legal advice is received on the position of each case, either from our own advisors or from the Strategic Health Authority. This advice is periodically updated and reported to the appropriate PCT committee. The advice includes an estimate of cost of settlement of the claim.

In 2012-13 an assessment, based on the information provided, was made of the probability of each case resulting in expense to the PCT. Where the probability of expense exceeds 50%, a provision for the estimated expense has been made in the Operating Costs for 2012-13. Where the probability is assessed as below 50% the estimated expense is disclosed above as a contingent liability. The value of these in 2012-13 is £31,000

CHC retrospective eligibility claims

In March 2012 the Department of Health announced that it was introducing a deadline for individuals (or their representatives) to submit retrospective claims for assessment for Continuing Health Care (CHC) eligibility. The deadline for periods prior to 31 March 2011 was 30 September 2012 and for periods up to 31 March 2012 the deadline was 31 March 2013.The introduction of these deadlines was accompanied by a nationally co-ordinated publicity campaign to inform the public of their right to apply for CHC eligibility and the timescales

Sheffield PCT received nearly 500 claims before the deadlines of which 444 remained within the process at 31 March 2013 as a few claims had already been resolved and 30 claims had been withdrawn by 31 March 2013. A detailed assessment process on potential eligibility for CHC funding is underway. A methodology has been developed for estimating the level of financial liability arising from the claims submitted. This provides the basis of the provision included in these accounts of £7.3m.

The estimated total value of the remaining claims at 31 March 2013, plus interest, is £36.5m. The difference between the liability should all these be successful and the sum provided in note 32, is £29.2m which is disclosed above. 18 of the claims evaluated since 31 March 2013 have not passed the initial sifting exercise and therefore are unlikely to be paid.

34 PFI and LIFT - additional information

	31 March 2013 £000	31 March 2012 £000
34.1 Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI		
Total charge to operating expenses in year - OFF SOFP PFI	0	0
Service element of on SOFP PFI charged to operating expenses in year	0	0
Total	0	0
Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI		
No Later than One Year	0	0
Later than One Year, No Later than Five Years	0	0
Later than Five Years	0	0
Total	0	0

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

	31 March 2013 £000	31 March 2012 £000
Estimated Capital Value of Project - off SOFP PFI	0	0
Value of Deferred Assets - off SOFP PFI	0	0
Value of Reversionary Interest - off SOFP PFI	0	0
34.2 Imputed "finance lease" obligations for on SOFP PFI contracts due		
Analysed by when PFI payments are due		
No Later than One Year	0	0
Later than One Year, No Later than Five Years	0	0
Later than Five Years	0	0
Subtotal	0	0
Less: Interest Element	0	0
Total	0	0

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	691	504
Total	691	504

	31 March 2013 £000	31 March 2012 £000
Payments committed to in respect of off SOFP LIFT and the service element of on SOFP LIFT.		
LIFT Scheme Expiry Date:		
No Later than One Year	976	504
Later than One Year, No Later than Five Years	3,905	2,018
Later than Five Years	16,368	7,686
Total	21,249	10,208

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

	31 March 2013 £000	31 March 2012 £000
Estimated capital value of project - off SOFP LIFT	0	0
Value of Deferred Assets - off SOFP LIFT	0	0
Value of Residual Interest - off SOFP LIFT	0	0

Imputed "finance lease" obligations for on SOFP LIFT Contracts due	31 March 2013 £000	31 March 2012 £000
No Later than One Year	2,236	602
Later than One Year, No Later than Five Years	9,441	2,409
Later than Five Years	43,655	9,168
Subtotal	55,332	12,179
Less: Interest Element	(30,111)	(3,986)
Total	25,221	8,193

35 Impact of IFRS treatment - 2012-13

	Total £000	Admin £000	Programme £000
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g LIFT/PFI)			
Depreciation charges	477	0	477
Interest Expense	1,022	0	1,022
Impairment charge - AME	1,861		1,861
Impairment charge - DEL	0	0	0
Other Expenditure	691	0	691
Revenue Receivable from subleasing	0	0	0
Total IFRS Expenditure (IFRIC12)	4,051	0	4,051
Revenue consequences of LIFT/PFI schemes under UK GAAP / ESA95 (net of any sublease income)	(2,026)	0	(2,026)
Net IFRS change (IFRIC12)	2,025	0	2,025

Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12	
Capital expenditure 2012-13	17,341
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 risk.

Currency risk

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

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

Credit Risk

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

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

36.1 Financial Assets	At 'fair value through profit and loss' £000	Loans and receivables £000	Available for sale £000	Total £000
Embedded derivatives	0			**0**
Receivables - NHS		4,410		**4,410**
Receivables - non-NHS		4,213		**4,213**
Cash at bank and in hand		18		**18**
Other financial assets	0	0	726	**726**
Total at 31 March 2013	**0**	**8,641**	**726**	**9,367**
Embedded derivatives	0			0
Receivables - NHS		4,872		4,872
Receivables - non-NHS		3,366		3,366
Cash at bank and in hand		8		8
Other financial assets	0	0	729	729
Total at 31 March 2012	0	8,246	729	8,975

36.2 Financial Liabilities	At 'fair value through profit and loss' £000	Other £000	Total £000
Embedded derivatives	0		**0**
NHS payables		6,839	**6,839**
Non-NHS payables		38,364	**38,364**
Other borrowings		0	**0**
PFI & finance lease obligations		25,221	**25,221**
Other financial liabilities	0	0	**0**
Total at 31 March 2013	**0**	**70,424**	**70,424**
Embedded derivatives	0		0
NHS payables		9,095	9,095
Non-NHS payables		39,454	39,454
Other borrowings		0	0
PFI & finance lease obligations		8,193	8,193
Other financial liabilities	0	0	0
Total at 31 March 2012	**0**	56,742	56,742

37 Related party transactions

Details of related party transactions with individuals who have declared an interest are as follows:

South Yorkshire and Bassetlaw PCT Cluster (April 2012 to March 2013)	Related Party	Payments to Related Party(ies)	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
		£	£	£	£
Steve Hackett - Director of Finance	Community First Sheffield Ltd	2,960,688	1,295	118,531	9,812
R Bailey Non Executive	Emmaus Sheffield Ltd	3,045	0	0	0

The values recorded above are the transactions with the organisations where senior managers have an interest.

Amounts owed to related parties are unsecured, interest-free and have no fixed terms of repayment. The balances will be settled in cash. No guarantees have been given or received. No provisions for doubtful debts have been raised against amounts outstanding and no expense has been recognised during the period in respect of bad or doubtful debts due from related parties.

At the balance sheet date there were no amounts owed to related parties or amounts due from related parties.

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. For example :

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

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 Sheffield City Council. Sheffield Primary Care Trust also had a number of transactions with Sheffield Hospitals Charitable Trust.

Prior year comparators

Details of related party transactions with individuals who have declared an interest are as follows:

	Related Party	Payments to Related Party(ies)	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
		£	£	£	£
South Yorkshire and Bassetlaw PCT Cluster (April 2011 to March 2012)					
Tony Pedder - Chairman (October to December only)	Sheffield University	25,585	108	0	0
Tom Sheard - Non Executive Director	Barnsley MBC	0	190	0	0
Sheffield PCT - (for the period April 2011 to September 2011)					
Tony Pedder - Chairman	Sheffield University	50,603	22,005	0	0
Ian Atkinson - Chief Operating Officer	South Yorkshire Housing Association	1,155,818	4,480	0	0
Simon Kirk - Director of Strategy and Transition	Community 1st Sheffield Ltd	1,181,196	0	0	0
Mohammed Ismail - Non Executive Director	South Yorkshire Police Authority	68,623	13	0	0
Mark Lovell - Non Executive Director (April to July only)	A4E Ltd	3,801	1,505	0	0
Malcolm Whitfield - Non Executive Director	Sheffield Hallam University	7,267	5,729	0	0
Malcolm Lindley - Non Executive Director	Community 1st Sheffield Ltd, Upperthorpe Healthy Living Centre	1,230,953	0	0	0
Zak McMurray - Joint Professional Executive Committee Chair and Board Member	Woodhouse Health Care, Woodhouse Health Care Services Ltd	843,820	0	0	0
Richard Oliver - Joint Professional Executive Committee Chair and Board Member	Ecclesfield Group Practice, Sheffield Local Medical Committee	590,735	0	0	0

The values recorded above are the transactions with the organisations where senior managers have an interest.

From April 2011 NHS Sheffield, NHS Rotherham, NHS Barnsley, NHS Doncaster and NHS Bassetlaw formed the NHS South Yorkshire and Bassetlaw Cluster of PCTs.
Each PCT remains a statutory organisation in its own right with it's own senior manager structure for the first half of the financial year. From April to September the Cluster Board was a joint sub-committee of each PCT, and from October 2011 each PCT in the cluster began to operate as if they were one Board each sharing the same officers.
This note details the related party transactions for the senior officer's of the PCT as described above.

Amounts owed to related parties are unsecured, interest-free and have no fixed terms of repayment. The balances will be settled in cash. No guarantees have been given or received. No provisions for doubtful debts have been raised against amounts outstanding and no expense has been recognised during the period in respect of bad or doubtful debts due from related parties.

At the balance sheet date there were no amounts owed to related parties or amounts due from related parties as there was only one PCT board member in post at that date who had declared interests and there were no amounts owed or due from the related party.

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. For example :

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

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 Sheffield City Council. Sheffield Primary Care Trust also had a number of transactions with Sheffield Hospitals Charitable Trust.

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 £	Total Number of Cases
Losses - PCT management costs	0	0
Special payments - PCT management costs	0	0
Losses in respect of the provision of family practitioner services	0	0
Special payments in respect of the provision of family practitioner services	23,140	1
Total losses	0	0
Total special payments	23,140	1
Total losses and special payments	23,140	1

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

	Total Value of Cases £	Total Number of Cases
Losses - PCT management costs	79,622	2
Special payments - PCT management costs	6,523	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	79,622	2
Total special payments	6,523	4
Total losses and special payments	86,145	6

39 Third party assets

Sheffield PCT does not hold any third party assets at 31 March 2013.

40 Pooled budget

Sheffield Primary Care Trust is a partner with Sheffield City Council in the following pooled budget arrangements:

Sheffield PCT has a pooled budget arrangement with Sheffield City Council for Learning Disabilities Services. Sheffield City Council is the host. The memorandum account for the pooled budget is:

Financial contribution of each of the partners

	2012/13	2011/12
	£000	£000
Sheffield Primary Care Trust	2,676.8	2,158.8
Sheffield City Council	21,160.7	21,398.4
	23,837.5	**23,557.2**

Allocation of Expenditure

	2012/13	2011/12
	£000	£000
City Council Accommodation Schemes	1,995.7	2,057.4
Housing Association Accommodation Schemes	16,451.1	18,279.1
Respite Services	2,171.3	1,594.5
Individual Funding Arrangements	60.3	60.4
Support Staff	151.0	96.5
Accommodation Development Team	558.6	455.5
Service Reconfiguration	2,449.5	1,013.8
	23,837.5	**23,557.2**

Sheffield PCT has a pooled budget arrangement with Sheffield City Council for Intermediate Care Services. Sheffield PCT is the host. The memorandum account for the pooled budget is:

Financial contribution of each of the partners.

	2012/13	2011/12
	£000	£000
Sheffield Primary Care Trust	293.8	299.2
Sheffield City Council	108.4	108.4
	402.2	**407.6**

Allocation to each scheme	2012/13	2011/12
	£000	£000
Rapid Assessment Clinics	133.4	135.1
Rehabilitation and Resource Centres	268.8	272.4
	402.2	**407.5**

Sheffield PCT has a pooled budget arrangement with Sheffield City Council for Community Equipment Loan Scheme. Sheffield PCT is the host. The memorandum account for the pooled budget is:

Financial contribution of each of the partners:

	2012/13	2011/12
	£000	£000
Sheffield Primary Care Trust	1,715.3	1,607.2
Sheffield City Council	849.8	894.4
	2,565.1	**2,501.6**

Allocation of Expenditure

	2012/13	2011/12
	£000	£000
Staffing Costs	885.3	869.5
Medical & Surgical Equipment	993.2	944.4
Running Costs	686.6	687.8
	2,565.1	**2,501.7**

Certificate of Director of Finance

I certify that the above pooled fund memorandum accounts accurately discloses the income received and expenditure incurred in accordance with the partnership agreement, as amended by any subsequent agreed variations, entered into under section 75 of the Health Act 2006 (formerly section 31 of the Health Act 1999).

Signed ..... Date .....

Director of Finance

41 Cashflows relating to exceptional items

The PCT has no cashflows relating to exceptional items

42 Events after the end of the reporting period

1 Transfer of functions as result of PCT disestablishment

The main functions carried out by Sheffield PCT in 2012-13 are to be carried out in 2013-14 by the public sector bodies set out below. The revenue values shown for the functions transferred are the actual spend contained in the 2012-13 Financial Statements. These are not the same as the allocation transferred to the receiving bodies in 2013-14 due for example to national changes to the definition of specialised services for 2013-14.

NHS Sheffield Clinical Commissioning Group
Commissioning of acute and community healthcare services. Revenue value in 2012-13 of £650,808k
GP Prescribing. Revenue value in 2012-13 of £82,768k

NHS England
Commissioning of specialised and secondary dental healthcare services. Revenue value in 2012-13 of £106,797k
Commissioning of core contract healthcare services from Primary Care Contractors. Revenue value in 2012-13 of £123,027k
Commissioning of certain Public Health services. Revenue value in 2012-13 of £12,085k

Public Health England
Commissioning of certain Public Health services. Revenue value in 2012-13 of £237k

Sheffield City Council
Certain Public Health functions. Revenue value in 2012-13 of £28,357k

NHS Property Services
Provision of Estate management services on properties owned by Sheffield PCT up to 31 March 2013. Gross expenditure in 2012-13 of £4,555k, with gross income of £2,769k. Net Revenue £1,768k

Ownership of 5 freehold properties with NBV at 31 March of £2,489k
Management of 7 LIFT properties leases (transferred to CHP Ltd) with a NBV at 31 March of £21,644k
Management of 7 short term leasehold properties

2 Transfer of assets as a result of PCT disestablishment
Certain assets have transferred to NHS Property Services, to Sheffield Teaching Hospitals NHS Foundation Trust and to Sheffield Health and Social Care NHS Foundation Trust on 1st April 2013. These were considered operational at the year end, and so have not been impaired in the PCT's books. It is for the successor body to consider whether, in 2013-14, it is necessary to review these for impairment.

INDEPENDENT AUDITORS' REPORT TO THE SIGNING OFFICERS OF SHEFFIELD PRIMARY CARE TRUST

We have audited the financial statements of Sheffield Primary Care Trust for the year ended 31 March 2013 on pages 1 to 50. 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 Sheffield Primary Care Trust 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 auditors' report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the signing 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 responsibilities of the signing officer of the Primary Care Trust, 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 Sheffield Primary Care Trust 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 signing officer's report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

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

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

- our locally determined risk-based work on a more detailed risk assessment of the demise of 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 Sheffield Primary Care Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission.

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

Chartered Accountants
1 The Embankment
Neville Street
Leeds
LS1 4DW

6 June 2013