Department of Health

NHS

Leicester City Primary Care Trust

2012-13 Annual Report and Accounts

Published to gov.uk, in PDF format only.

www.gov.uk/dh

Leicester City Primary Care Trust

2012-13 Annual Report

NHS
Leicester City

Annual Report
and
Summary Financial Statements

2012-2013

Annual Report 2012-13

CONTENTS

Contact information and enquiries

NHS Leicester City and NHS Leicestershire County and Rutland have ceased operating, in line with the Health and Social Care Act 2012. Enquiries about this report should be sent to:-

The Local Area Director NHS England, Fosse House, 6 Smith Way, Enderby, Leicester LE19 1SX.

Single hard copies of this annual report are available on request. In line with Department of Health policy, we do not make a charge for this service.

Who are were and what do we did?

This annual report is essentially about two NHS organisations, both primary care trusts, which have ceased operating as part of the NHS reforms brought about by the Health and Social Care Act 2012. The report describes their functions and status while they were functioning NHS organisations up to 31 March 2013.

NHS Leicester City (NHS LC) was responsible for commissioning health services to meet the needs of 365,000 people who live in the city. NHS Leicestershire County and Rutland (NHS LCR) was responsible for 'commissioning' health services to meet the needs of 674,000 people who live in the two counties. Other organisations provided the actual, frontline healthcare, which we commissioned. Our organisations were formed in October 2006 along with 150 other primary care trusts in England around the same time.

In October 2010 NHS Leicestershire County and Rutland joined forces with NHS Leicester City (NHS LC) to form a cluster, in line with the requirements of the Department of Health. However, although we worked in very close co-operation, we have not legally merged, and we still retained our separate statutory duties for our own specific areas.

In terms of assessment, our two primary care trusts reported to the East Midlands Strategic Health Authority, which monitored regional activity. It too operated in a cluster arrangement with the West Midlands SHA and the East of England SHA and was known as the Midlands and East SHA. We were also accountable to the people of Leicester, Leicestershire and Rutland through a number of formal representative bodies, including the Overview and Scrutiny Committees for Health, and our Local Involvement Networks (LINks).

With a joint annual budget of just over £1.5 billion – two thirds of which was the counties' and the rest was the city's – we commissioned a wide range of services including emergency and other hospital care, community-based services, rehabilitation and therapies, mental-health care, GPs, ophthalmology, pharmacy, and dentistry. These healthcare services were provided by a range of NHS organisations, including the University Hospitals of Leicester, Leicestershire Partnership Trust, which is the area's main provider of mental healthcare, and by various NHS and non-NHS contractors and private-sector health providers, as well as the voluntary sector. Our main priorities were to address health inequalities across Leicester, Leicestershire and Rutland – that is, the differences between the healthier and less healthy parts of our area – and to improve life expectancy, health and wellbeing – by investing in services to meet local needs.

We worked in partnership with other organisations such as Leicester City Council, Leicestershire County Council, Rutland County Council and seven district councils, with the joint objective of improving the overall quality of life. To this end we also worked closely with other agencies to address health, economic, social and environmental factors.

What's the state of our areas' health?

Leicester at a glance:

The health of people in Leicester is generally worse than the England average. Deprivation is higher than average and about 22,400 children live in poverty. Life expectancy for both men and women is lower than the England average.

Life expectancy is 9.4 years lower for men and 5.0 years lower for women in the most deprived areas of Leicester than in the least deprived areas. Over the last ten years, all-cause mortality rates have fallen. The early death rate from heart disease and stroke has fallen but is worse than the England average.

About 20.6% of Year 6 children are classified as obese, higher than the average for England. Levels of teenage pregnancy and GCSE attainment are worse than the England average.

Estimated levels of adult 'healthy eating', smoking and physical activity are worse than the England average.

Rates of hip fractures, smoking related deaths and hospital stays for alcohol related harm are worse than the England average. Rates of road injuries and deaths are better than the England average. The rates of statutory homelessness and incidence of malignant melanoma are lower than average.

Priorities in Leicester include improving lifestyle risk factors related to heart disease, respiratory disease and cancer; improving preventative primary care; and addressing the wider determinants of health.

Leicestershire at a glance:

The health of people in Leicestershire is generally better than the England average. Deprivation is lower than average, however about 14,300 children live in poverty. Life expectancy for both men and women is higher than the England average.

Life expectancy is 6.2 years lower for men and 5.7 years lower for women in the most deprived areas of Leicestershire than in the least deprived areas. Over the last 10 years, all-cause mortality rates have fallen. The early death rate from heart disease and stroke has fallen and is better than the England average.

About 15.0% of Year 6 children are classified as obese, lower than the average for England. Levels of GCSE attainment and breast feeding initiation are worse than the England average. Levels of teenage pregnancy, alcohol-specific hospital stays among those under 18 and smoking in pregnancy are better than the England average.

The estimated level of adult smoking is better than the England average.

Rates of hip fractures, sexually transmitted infections, road injuries and deaths, smoking related deaths and hospital stays for alcohol related harm are better than the England average.

Priorities include giving children the best start in life, managing the shift to early intervention and prevention, and supporting the aging population. For more information, see the Joint Strategic Needs Assessment on www.lsr-online.org

Rutland at a glance:

The health of people in Rutland is generally better than the England average. Deprivation is lower than average, however about 500 children live in poverty. Life expectancy for men is higher than the England average.

Life expectancy is not significantly different for men and women in the most deprived areas of Rutland compared to the least deprived areas.

Over the last ten years, all-cause mortality rates show no clear trend. Early death rates from cancer and from heart disease and stroke show no clear trend.

About 16.8% of Year 6 children are classified as obese. Levels of teenage pregnancy and alcohol-specific hospital stays among those under 18 are better than the England average.

Estimated levels of adult smoking and physical activity are better than the England average. The rate of road injuries and deaths is worse than the England average.

Rates of sexually transmitted infections, smoking related deaths and hospital stays for alcohol related harm are better than the England average.

Priorities in Rutland include promoting healthy lifestyles, improving outcomes for frail older people and early intervention for children, young people and families. For more information, see the Shadow Health and Wellbeing Board pages on www.rutland.gov.uk

Foreword by the Cluster Board Chair

NHS Leicester City and NHS Leicestershire County and Rutland were created in October 2006 as two of 152 primary care trusts across England. Over those six years PCTs like ours have done a great deal to improve healthcare commissioning. We have become better informed about the many causes, social, lifestyle, environmental and economic – as well as health issues - which contribute towards ill health, and we have developed clearer integrated strategies for tackling illness, working increasingly with our NHS and other public sector partners to improve the effectiveness of those strategies.

By April 2013 primary care trusts (PCTs) like ours were set to disappear from the NHS landscape while new organisations were coming to the fore, such as our GP-led clinical commissioning groups, NHS England, the council-based Health and Wellbeing Boards, and national and local Healthwatch bodies.

In the restructuring of the NHS, as required by the Health and Social Care Act 2012, it was vital that our legacy of knowledge and expertise was not lost. So we have been working tirelessly to ensure that the legacy was passed on. I have been impressed by the professional commitment of those working in the cluster and for the emerging organisations.

Our area's three clinical commissioning groups (CCGs). Leicester City CCG, West Leicestershire CCG, and East Leicestershire and Rutland CCG have already achieved authorisation to become NHS bodies, and have shown themselves to be capable, confident professional organisations, deeply committed to tackling the diverse range of healthcare issues facing our area, including its 'health inequalities', that is, the difference between the most and least healthy sections of the population.

I would like to thank Catherine Griffiths and David Sharp for their leadership as Chief Executive, and the PCT Cluster Board members for their dedication and commitment to seeing these many complex changes through in the relatively short time demanded. I would also like to thank the former staff of our PCT Cluster, many of whom have found roles within the new structure of the NHS, to ensure that the legacy of expertise has not been lost.

It is with a deep sense of pride that I can sign off as the Cluster Chair, knowing how much has been achieved in the field of local healthcare, and that we have so many skilled and dedicated people ready to face the challenges of the future.

Cathy Ellis
Chair, NHS Leicester, Leicestershire and Rutland. PCT Cluster

Introduction by Area Director
NHS England, Leicestershire & Lincolnshire

When I was appointed as the first local area director for Leicestershire and Lincolnshire in July 2012, I was also set to take on the responsibilities of the Chief Executive of the Leicester, Leicestershire and Rutland PCT Cluster, the role held by Catherine Griffiths. I am deeply grateful to her for the support and assistance she gave me in those first months, and for the excellent foundations which she and her team laid down for the transition to a new commissioning model.

Catherine has been a tower of strength and wisdom in her career with the PCT during a time of many changes and challenges, and I would like to congratulate her on her achievements and thank her personally for all she has achieved.

It has taken a great deal of work and commitment by the PCT Cluster Board, the executive directors and their staff to ensure a smooth transition to the new structure, while maintaining the required level and high quality of care which local people need and deserve. All of those involved can look back and say that was a job well done.

And what of the future? The NHS faces many challenges, locally and nationally, especially responding effectively to the increase in demand for care from an ageing population and adapting to new technologies, while making better use of resources and staying within strict budget limits at a time if economic restraint. NHS England (NHSE) is already playing a crucial role in meeting those challenges.

The main aim of NHS England is to improve the health outcomes for people in England. Our role includes many that were undertaken by the former PCT Cluster, including commissioning GP services, dental services, pharmacies, ophthalmologists, care for armed services, prison healthcare and secure psychiatric services.

We believe the approach we are taking will really make a difference and deliver the improved health outcomes which we all want to see. Central to our ambition is to place the patients and the public at the heart of everything we do. We are what we want the NHS to be – open, evidence-based and inclusive, to be transparent about the decisions we make, the way we operate and the impact we have.

In meeting the challenges facing the NHS, we are grateful to the local legacy handed to us by all the former employees of the Leicester, Leicestershire and Rutland PCT Cluster.

David Sharp
Interim Cluster Chief Executive & Director (Leicestershire and Lincolnshire Area)
NHS England

NHS Reforms and organisational change

The Health and Social Care Act 2012 received Royal Assent on 27 March 2012 and defines much of the Government's policy in primary legislation. The Act legislates for the NHS reforms first set out in the White Paper, *Equity and Excellence: Liberating the NHS*, which was published in July 2010. The following summary outlines the new structure of the NHS created by the Act and subsequent policy decisions.

NHS England

A new national body called NHS England oversees all GP-led clinical commissioning groups. It sets commissioning guidelines based on evidence from NICE, and holds CCGs to account for their performance. The Board, through its network of local offices, also takes direct responsibility for commissioning GP services, dental services, pharmacies, ophthalmologists, care for armed services, prison healthcare and secure psychiatric services. Each year this Board issues a mandate, setting out its healthcare aims and its budget. Like the CCGs, the Board has a legal duty to ensure 'continuous improvement' to service quality and health outcomes. There is also a legal duty to involve and consult patients and the public on healthcare decisions. It has been confirmed that NHS England will have 27 area teams in England, with staff working from a number of office bases across their geographical area. There are eight area teams in the Midlands and East region, with Lincolnshire and Leicestershire (including Leicester and Rutland) forming one of them. Ten area teams now have responsibility for specialised commissioning including the Leicestershire and Lincolnshire team. All area teams have the same core functions including CCG development and assurance, emergency planning, resilience and response, quality and safety, partnerships, configuration and system oversight.

Clinical commissioning groups

CCGs have responsibility for commissioning local NHS healthcare services such as hospitals, mental healthcare, NHS continuing healthcare (eg, care homes) and community health services. As they are GP-led they will not commission their own GP services, but have a responsibility to ensure high standards of GP care locally. They have the flexibility to commission services in the ways that they judge will deliver the best health outcomes for patients. Although each CCG is a separate 'body corporate' in law, they can work together and share costs. CCGs buy in services from public, private or voluntary organisations. There are 211 CCGs in England. For more information on the three CCGs in our area, see the following chapter.

Monitor

Monitor is the economic regulator for all NHS funded services. All providers of NHS healthcare services, unless exempted, will need to hold a licence with Monitor, which maintains and publishes a register of licence holders. It can set different conditions for different types of licences, depending on the services provided or the areas in which services are delivered. Conditions are likely to include a requirement to do, or not do, specified things to prevent anti-competitive behaviour which acts against the interests of patients.

Health and Wellbeing Boards

Each city and county council has set up a Health and Wellbeing Board as one of its permanent committees. The Board must have representatives of the council, the local commissioning groups, plus directors of adult and children's services, public health

directors, and the local Healthwatch (see below). Its role is to co-ordinate and oversee local health and social care policy.

Healthwatch

This new national body has been created within the Care Quality Commission to bring together the views of people who use health or social care services about their needs and experiences. It is doing this partly by creating a network of local Healthwatch organisations, which have taken over from the former Local Involvement Networks (LINks) acting as a point of contact for patients, community and voluntary groups while monitoring complaints handling by NHS commissioners and providers. They also provide non-clinical advice to patients and offer advocacy services to complainants who require support.

Public Health

The Act lays the legal foundations to create a distinct public health service – known as Public Health England. This was set out in the White Paper *Healthy Lives, Healthy People* (December 2010) and includes abolishing the Health Protection Agency. City and county councils have taken on many of the main local responsibilities for public health work formerly carried out by them in conjunction with PCTs. The Health and Social Care Bill required the transition of public health functions from PCTs to local authorities, Public Health England and NHS England by 1 April 2013. As part of this process there was a requirement to produce and implement a transition plan for both NHS Leicester City and NHS Leicestershire County and Rutland. The transition required the transfer of responsibilities, staff, contracts and finances, all of which have been completed on time.

Foundation Trusts

All NHS healthcare provider trusts, such as hospitals and mental healthcare services, need to become Foundation Trusts, which means they will have increased control over their own affairs and budgets, with a degree of autonomy from central control. Monitor is the approving body and regulator.

Care Quality Commission

The Care Quality Commission (CQC) will continue to act as the quality inspectorate across health and social care. The Act removes the CQC's responsibility for assessing the performance of NHS commissioners, which has been taken on by NHS England, and for carrying out periodic reviews of NHS services. The CQC's remit is distinct from Monitor in that its focus will be on quality, it registers health and adult social care services to ensure quality standards and maintains inspections to make sure those standards continue to be met.

Regulating social care

The Act sets out a raft of regulations for social workers and the social care service in general, mainly by amending existing legislation, aimed at integrating social care more closely with healthcare.

National Institute for Health and Care Excellence

The National Institute for Health and Clinical Excellence (NICE) largely remains the same but becomes a non-departmental public body. NICE's role continues to consider evidence in order to make recommendations on medicines, treatments and procedures. Its remit is extended to include social care and its name has changed to the National Institute for Health and Care Excellence although the normal acronym, NICE, is retained.

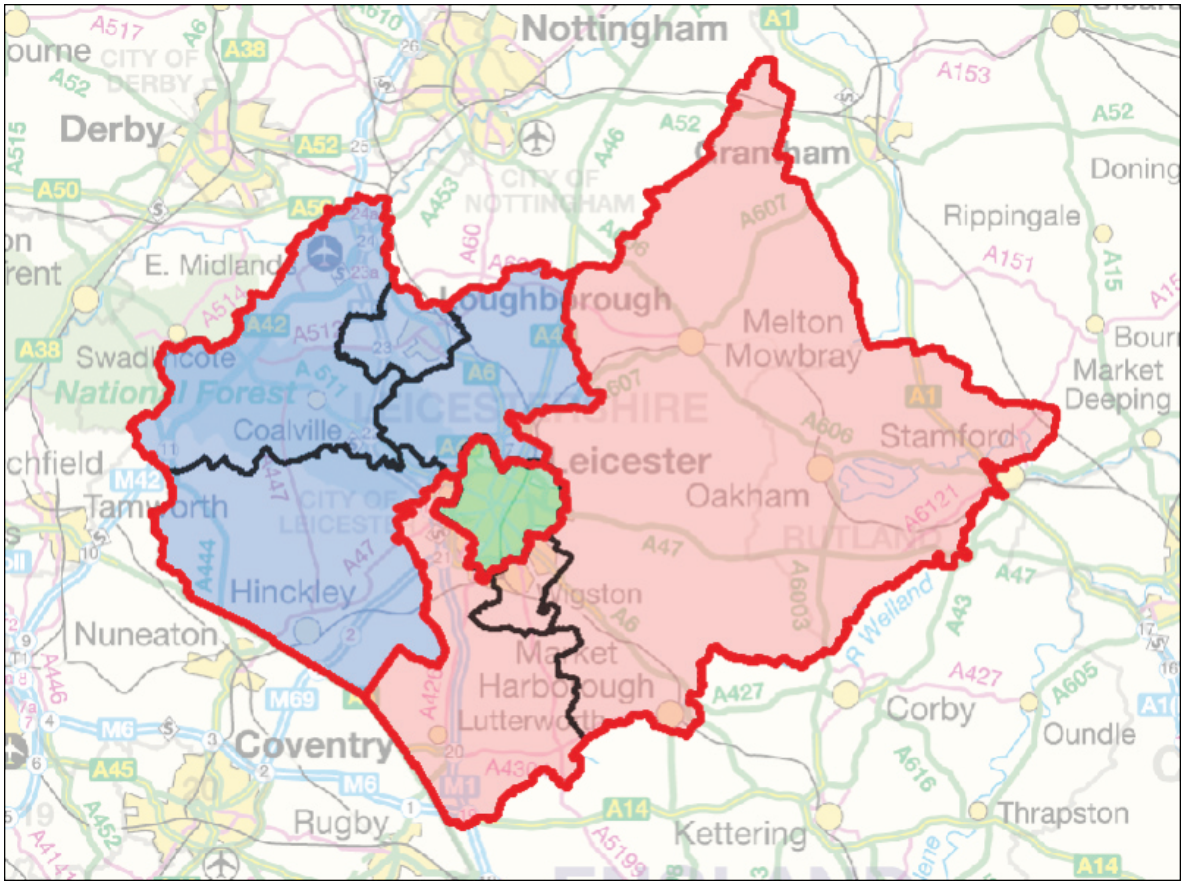
Maintaining quality during transition

The NHS and members of the National Quality Board (NQB) developed guidelines on "How To Maintain Quality during Transition: Preparing for Handover" published in May 2012. It set out the requirements for a quality handover document and guidance with timetables. Our PCT Cluster document was approved on the 14 June 2012 at the LLR Cluster Board. To ensure guidance was followed and progress was monitored the LLR Cluster convened a Task and Finish group. This group oversaw the content and the completion of the quality handover document by March 2013.

The Cluster and the CCGs ensured quality was the driving force behind our service redesign and reconfiguration priorities and embedded in all work streams and contractual arrangements. The joint objectives of the Cluster, local authorities, providers and CCGs were to continue to improve health outcomes, clinical quality, safety and patient experience. The Cluster and CCGs aimed to ensure quality through strategies to improve patient choice, responding effectively to patient feedback, developing patient safety mechanisms by maximising shared learning opportunities and ensuring the implementation of evidence based practice amongst providers. The Cluster maintained this through effective implementation of quality impact assessments, risk monitoring and the implementation of early warning scores. The strategic direction for quality included ensuring sustained measurable improvements in patient safety, patient experience and clinical effectiveness. All development opportunities were reviewed to ensure that they have a positive or neutral impact on the quality of care for patients and reflect best use of resources.

Clinical Commissioning Groups

There are three clinical commissioning groups (CCGs) covering the same area as the primary care trusts cluster for Leicester, Leicestershire and Rutland.



West Leicestershire CCG

Leicester City CCG

East Leicestershire and Rutland CCG

CCG authorisation process

In early May 2012 the Department of Health announced that all three CCGs in the Leicester, Leicestershire and Rutland area had been chosen to be among the first wave of 35 CCGs in England to start the assessment process for authorisation to carry out their full duties as statutory bodies. During 2012 all three CCGs underwent rigorous assessments of 119 criteria to measure their readiness and ability to make the key investments to tackle the area's healthcare needs. They were among the first to achieve authorisation out of a total of 211 CCGs in England. By December 2012 all three had passed the authorisation process. LC CCG passed without conditions, and our other two CCGs passed with conditions, which have since been met, bringing them both to full authorisation status.

Leicester City Clinical Commissioning Group

LC CCG brings together all 63 practices and more than 200 family doctors in the city in to a single membership body that is coterminous with the local authority, Leicester City Council. It serves a patient population of approximately 365,000, which includes around 50,000 patients who live outside of Leicester but choose to be registered with a GP in the city.

In December 2012 LC CCG achieved authorisation to act as an NHS statutory body from April 2013. Leicester City Clinical Commissioning Group was authorised without any conditions being imposed, which means that the NHS England was fully satisfied with the CCG's performance against the criteria.

At the site visit in September 2012, the assessment panel complemented the CCG on effectively establishing the organisation, the engagement of member practices, its relationships with partners and stakeholders and the real improvements that were already being made to patient care in the city as a result of clinically-led commissioning.

Examples of these early achievements include reducing the number of avoidable hospital admissions; identifying more than 1600 patients with previously undiagnosed conditions through its improved health checks programme for 40-74 year olds, and delivering more care in the community rather than in a traditional hospital setting – such as GP-led musculoskeletal clinics.

For more information of LC CCG, see their web site www.leicestercityccg.nhs.uk .

West Leicestershire Clinical Commissioning Group

WL CCG represents the 50 GP practices who serve around 356,000 patients in Charnwood North, Charnwood South, North West Leicestershire, and Hinckley and Bosworth.

In December 2012 WL CCG achieved authorisation to become an NHS statutory body from April 2012. The authorisation was on the condition that more work was done on finalising their integrated plan for 2013/14 and beyond for delivering healthcare and improving their area's health. The CCG submitted a report to NHS England on how to achieve them. These conditions have since been fully met.

WL CCG's body of clinical experience has contributed to greater co-operation with local hospitals and other secondary care professionals. This greater joint working means more patients receiving the right care in the right place at the time they need it, and improvements in the way that emergency care is delivered.

WL CCG has already involved patients more directly in shaping health care services, and as a result there is a growing number of patients in new and existing patient participation groups, based at GP surgeries. This has influenced improvements, such as making healthcare more proactive, and the redevelopment and relocations of a walk-in centre into an urgent care centre for Loughborough.

See the CCG website www.westleicestershireccg.nhs.uk and go to the "Get Involved" section on becoming a public member and the patient participation group section.

East Leicestershire and Rutland Clinical Commissioning Group

(ELR CCG) is a group of GPs from 34 practices in the south and east of Leicestershire and Rutland, serving over 318,000 patients in Melton, Rutland, Market Harborough, Blaby District, Lutterworth, and Oadby and Wigston.

In December 2012 ELR CCG achieved authorisation to act as an NHS statutory body from April 2013. Their authorisation was granted on condition that the CCG needed to show more evidence of accountability between their CCG and its member practices, and that they were in ongoing discussions with healthcare providers about long-term strategies and plans. These conditions have since been met.

After listening to feedback patients and carers, its staff and clinicians and partner organisations, ELR CCG reported that it was confident that it had developed a set of aims and plans that respond to the health needs of the local people. They include enhancing the quality of life for people with long-term conditions, delivering excellent community health services and improving the quality of primary care, as well as closer working between health and social care, and between acute, primary and community care.

In December East Leicestershire and Rutland CCG launched its own website to explain its role, www.eastleicestershireandrutlandccg.nhs.uk.

Commissioning support

CCGs and other commissioning organisations are not expected to employ all the staff needed to carry out their functions effectively. However, they still need a broad range of commissioning support services, which they may buy in from suitable providers, public or private or a mix of both. Our PCT Cluster has taken part in the creation of a Commissioning Support Unit (CSU) drawing on our legacy of NHS expertise and experience. It is part of a large regional 'hub and spoke' model spanning the 'Greater East Midlands' (GEM), the area covered by Leicestershire and Rutland, Derbyshire, Nottinghamshire, Lincolnshire, Northamptonshire, including all cities in those areas.

Known as GEM CSU it has taken on many of our PCT Cluster staff and is hosted by NHS England. Its aims are to provide a range of essential 'back office' and support functions to help all the region's clinical commissioning groups in their new roles. Based in local offices throughout the region, it includes business support, communications and engagement, continuing care and care homes, equality and diversity, finance, information, information governance, human resources, organisational development, performance management, procurement and strategic informatics.

Healthcare – how well have we been doing?

Our priorities for 2012-2013

Our focus during 2012-13 was to ensure that we achieved and improved our key performance indicator targets, working with our main health care providers and ensuring our population receives the best possible care. Throughout the year responsibility for performance was undertaken by the area's three clinical commissioning groups (CCGs) on behalf of the PCT Cluster.

The Department of Health has moved towards outcome measures for performance, and the new NHS Outcomes Framework it is divided into five 'domains'. Each domain includes a range of key performance indicators, some of which are summarised below where we show some of our achievements and shortfalls for the year 2012-13.

- Domain 1: Preventing people from dying prematurely
- Domain 2 Enhancing quality of life for people with long-term conditions
- Domain 3 Helping People from episodes of ill health or following injury
- Domain 4 Ensuring People have a positive experience of care
- Domain 5: Treating and caring for people in a safe environment; and
- protecting them from avoidable harm

Key performance indicators

Performance has exceeded national standards in a number of service areas during 2012/13.

People have been seen within 18 weeks from referral for treatment in hospital for most conditions. Waiting times for diagnostics including those with suspected cancer have been within the maximum in the majority of cases.

However, the standard of 85% of patients being seen within 62 days (from referral to treatment) for cancer has been slightly underachieved in Leicester, Leicestershire and Rutland, but showed an improving trend during the year. The number of long waits has now stabilised, and further remedial actions are being reviewed by clinicians within the CCGs.

Infection rates have also been maintained, with improvement in the number of clostridium difficile (C.diff) cases. Mental Health targets have been achieved for early intervention, including the number of people under adult mental illness specialties on an enhanced 'care programme approach' receiving a follow-up within seven days of discharge from hospital.

Public Health targets have been achieved for childhood immunisation and mothers still breastfeeding their babies at 6-8 weeks after birth.

Locally CCGs have offered extended opening hours at GP surgeries, while improving on the number of NHS Health Checks (for heart disease and associated conditions) offered to eligible patients, and utilising the online 'Choose & Book' system to allow patients a choice of location and appointment time for their hospital treatment.

In the A&E unit at Leicester Royal Infirmary the standard of 95% of patients being seen within four hours of arrival has not been achieved during 2012/13, with year-end position at 91.94%. Improvements have been made to patient flow through A&E, including single front-door access, where patients are triaged to assess the needs, a review of intermediate care services and improved discharge arrangements.

Ambulance 'category A' emergency call response times have not been achieved by the end of 2012-13. EMAS achieved the A8 measure which requires the ambulance service to get a response to 75% of all immediately life threatening calls across the East Midlands within eight minutes of the call being picked up, achieving 75.21%. The Category A19 performance standard measures the time it takes for an ambulance to arrive on scene so a patient can be transported to hospital. EMAS fell short of the 95% standard required achieving 91.85%.

Actions are in place to improve performance including additional staff, fast response vehicles and the support of voluntary and private services. Improvements to the A&E unit, in terms of speed of patient handling, are likely to have a positive impact on EMAS in 2013-14 by reducing queuing by ambulances on arrival at Leicester Royal Infirmary.

The 13% standard of patients accessing psychological therapies has been slightly underachieved for both city and county patients. In the city this is due to changes in definitions during the year for monitoring. However, in the county, the provider Rethink has improved processes for those patients moving to recovery. This has improved services for patients. Overall both service provision is very positive.

Our workforce

In line with the abolition of our two primary care trusts by the start of April 2013, the past year saw the migration of many of our staff to organisations within the new NHS and public health structures.

Number of Primary Care Trust staff on the payroll at 31 March 2013:

	Employer		
Future destination ↓	**LC**	**LCR**	**Total**
Left on or before 31/03/13	2	5	7
Bank termination	8	30	38
Redundant	21	9	30
NED Leaver	3	4	7
Transferring to receivers *	150	317	467
ILM Transfer to CCG's	5	6	11
Grand Total	**189**	**371**	**560**

* These staff numbers are broken down by receiver organisation in the table below:

	Number of Employees from Sender Organisation		
Receiver Organisation ↓	**LC**	**LCR**	**Totals**
NHS England	24	58	82
NHS England (FHS)	2	2	4
NHS Business Services Authority **	24	107	131
East Leicestershire and Rutland CCG	9	54	63
Leicester City CCG	51	15	66
West Leicestershire CCG	9	55	64
Leicester City Council	23	0	23
Leicestershire County Council	0	16	16
Public Health England	2	2	4
Health Education England	0	6	6
NHS Property Services Ltd	1	0	1
Nottingham University Hospitals	0	1	1
Lincolnshire West CCG	0	1	1
University Hospitals of Leicester	5	0	5
Total Staff transferring from Sender to Receiver Organisations	**150**	**317**	**467**

** The NHS Business Service Authority is the employer for the organisation known as the NHS Greater East Midlands Commissioning Support Unit (GEM CSU).

Staff sickness absence figures for calendar year 2012
for NHS Leicester City and NHS Leicestershire County and Rutland

Source: Information Centre - Sickness Absence Publications and iView Workforce Staff in Post - based on data from the ESR Data Warehouse
Period covered: January to December 2012
Data items: ESR does not hold details of normal number of days worked by each employee. (Data on days lost and days available produced in reports are based on a 365-day year.)
The number of FTE-days available has been estimated by multiplying the average FTE for 2012 (from iView staff in post) by 225.
The number of FTE-days lost to sickness absence has been estimated by multiplying the estimated FTE-days available by the average sickness absence rate.
The average number of sick days per FTE has been estimated by dividing the estimated number of FTE-days sick by the average FTE.
There may be inconsistencies between these data and the statutory basis for accounts, in terms of the organisation against which staff are reported for a particular month.

		Statistics Produced by IC from ESR Data Warehouse		Figures Converted by DH to Best Estimates of Required Data Items		
		Quarterly Sickness Absence Publications	iView Staff in Post			
Organisation name	Organisation type	Average of 12 Months (2011 Calendar Year)	Average FTE 2011	FTE-Days Available	FTE-Days Lost to Sickness Absence	Average Sick Days per FTE
Leicester City PCT	**PCT**	2.6%	571	128,423	3,314	5.8
Leicester County & Rutland PCT	**PCT**	1.7%	326	73,298	1,249	3.8

IC Note:
Sickness absence rate is calculated by dividing the sum total sickness absence days (including non-working days) by the sum total days available per month for each member of staff.

Equality in the workplace
In line with the Equality Act 2010 our cluster aimed to ensure that no job applicant or employee received less favourable treatment on the grounds of race, age, gender, sexual orientation, faith, religion, beliefs or disability. The selection and recruitment procedures ensured that individuals were selected or promoted on the basis of their relevant merits and abilities. All employees were given equality of opportunity and, where appropriate, training was given. The cluster made adaptations, if needed, to enable staff to progress within the organisation.

Our resources, relationships and risks

Resources

Apart from its staff and legacy of expertise and experience, the key resources of our PCT Cluster included its building assets, whether owned or leased, including fixtures, furniture and fittings, IT equipment, documentation, information and data.

NHS Leicester City estate
The NHS LC estate included buildings developed by a public-private partnership scheme called Leicester LIFT. Past city developments include the Merridale Medical Centre, St Peter's Health Centre, Westcotes and Humberstone Health Centres, and the Merlyn Vaz Health and Social Care Centre. Recent activity includes new buildings in Belgrave and at De Montfort University.

Most of Leicester's 63 GP practices are responsible for their own premises. So are the city's pharmacies, dental practices and optometry practices.

NHS Leicestershire County and Rutland estate
The NHS LCR estate consisted of a number of mixed tenure facilities, with very different age profiles. A large proportion of the estate was turn of the 20th century construction with only a handful having been constructed within the last 20 years. In all, the estate was spread across a footprint area of 95,000 square metres, with a total of 107 separate buildings.

There were 84 GP practices working from 116 main, branch and outlying consulting facilities. Out of these:

- 74 were owned by the independent contractors
- 30 were rented by independent contractors from third parties
- 12 were rented from the PCT.

The standard of GP premises varies considerably across the counties from those that are new purpose-built to the outlying consulting facilities held in premises used primarily for other purposes. Many practices were also facing increased workload from population growth and the need to provide additional and expanded range of services.

NHS LCR did not provide financial support for the premises of dentists, pharmacists or optometrists with the exception of business rates for dental practices, which were reimbursed in relation to the percentage of their NHS commitment. However, ultimately NHS LCR had a responsibility for the use of resources from a sustainability perspective.

Rationalisation of the NHS estate
The cluster recognised that the NHS service and estate capacity configuration across the entire LLR area was the product of fragmented, incremental development over many years. Analysis showed low levels of occupancy together with material backlog maintenance challenges which was neither affordable nor sustainable. To safeguard services within a significantly smaller costs envelope, LLR partners agreed to review and tackle the issues of capacity and assets, right-sized to accommodate clinically redesigned

care pathways. The cluster worked to simplify, standardise and, where possible, share Estates and Facilities Management (FM).

In August 2011, the cluster set out to commission a single provider for all estates and FM services for partners, such as cleaning, catering and porters, as well as the delivery of transformational estate solutions in response to intelligent clinical pathway redesign. In December 2012 it was announced that the £300m seven-year contract had been won by Interserve FM.

The contract will provide investment to improve the buildings and facilities used to deliver services to thousands of patients every day, as well as significant savings for the NHS.

Interserve is an international support services and construction group, and one of the world's largest support services and construction companies, operating in the public and private sectors in the UK and internationally. They are based in the UK and employ over 50,000 people worldwide.

Interserve is now responsible for delivering comprehensive facilities management services, including the delivery of catering, cleaning, maintenance and security across more than 550 NHS buildings and properties, totalling 490,000m^2 and nearly 3,100 beds.

The contract also includes a new partnership with Interserve to make the best use of the NHS buildings and estate. This partnership operates through the LLR Facilities Management Collaborative and supports the NHS in delivering its clinical strategy as part of Better Care Together. For the first time, developments in clinical services will be matched with developments in the facilities that help to deliver them.

Interserve mobilised their operation with a service handover and staff transfer on 1 March 2013 (effectively midnight 28 February 2013).

Relationships

Primary care

The PCT Cluster commissioned healthcare services by entering into contracts with the following primary care providers across Leicester, Leicestershire and Rutland:

Primary Care Contractors and types of contracts	NHS Leicester City	NHS Leicestershire County and Rutland
General Practices	**63**	**84**
Dental Practices	**70**	**135**
Pharmacies	**79**	**132**
Optometry Practices	**56**	**90**

Out-of-hours GP services

Under a national programme to transform community health services, the responsibility for providing local out-of-hours services (OOH) transferred to each GP contract holder in LLR from 1 April 2011. This has been enacted by local GPs opting back in to provide medical

services in the out of hours period, and the GPs then opted to sub-contract their OOHs responsibilities, using their professional body the Leicestershire Medical Committee as their commissioning agent, to Central Nottinghamshire Clinical Services, which was established in January 2005 as a not-for-profit Community Benefit Society to take forward the provision of unscheduled primary care services.

NHS 111
A contract was signed in March 2013 to provide a freephone helpline for medical advice in Leicester, Leicestershire and Rutland. From the autumn of 2013 patients will be able to call 111 for every kind of non-emergency healthcare inquiry, and it will be available 24 hours a day, all year round.

The contract for the first period of the service was awarded to Derbyshire Health United to provide the call-centre services. Trained staff will handle calls supported by a team of experienced nurses. Derbyshire Health United won the contract following a rigorous procurement process, devised to ensure that the successful organisation could provide a reliable, efficient, high quality service.

After the launch of 111, the out-of-hours service will become one of the range of options which 111 call-centre staff can provide to patients after an assessment of their condition. Patients will not need go through a second assessment by the out-of-hours service. NHS 111 will provide a single point of contact and assessment. The second phase of the contract aimed to be for both NHS 111 and out-of-hours primary care services.

Acute care
The main acute provider across Leicester, Leicestershire and Rutland is University Hospitals of Leicester (UHL). The 2012-13 contract is an annual contract which ended on 31 March 2012. The three Clinical Commissioning Groups across Leicester, Leicestershire and Rutland, in conjunction with the PCT Cluster, have been negotiating the future contract under collaborative arrangements. However, through the NHS reforms transition period, the PCTs remained the statutory bodies for the purposes of holding acute contracts, and NHS LCR remained the co-ordinating commissioner for the contract with UHL, with NHS LC as an associate to that contract. However, during the last year the UHL contract has been managed collaboratively by the three CCGs with the assigned lead director being the Managing Director of the Leicester City CCG.

Leicestershire Partnership NHS Trust
The main provider of mental health services is Leicestershire Partnership NHS Trust. The LPT contract has been collaboratively managed by the three local CCGs with the lead director being the Managing Director for West Leicestershire CCG.

Community health services transferred to LPT on 1 April 2011 as part of the Transforming Community Services programme. LPT has received the bulk of services, with children's services, health promotion and prevention, adult community nursing and therapy services, intermediate care and community hospital beds transferring from the PCTs.

The Health Informatics Service
The area's main IT providers for the NHS, the Health Informatics Service, was transferred to LPT with a new Service Level Agreement in place with effect from 1 June 2012. Agreed

structures involved the three CCGs, GEM CSU and PCT Cluster as stakeholders in the shared service along with LPT and have been established.

Integrated Equality Service
The Equality Act 2010 placed on our PCT Cluster a specific duty to publish Equality Objectives by the 6 April 2012. The Integrated Equality Service (IES), part of LPT, developed equality objectives, based on available evidence and identified those that were highest priority in a consultation with both members of staff, members of the public and stakeholders.

The PCT Cluster was an early adopter of the Equality Delivery System (EDS). The IES commenced engagement both internally and with external stakeholders. An action plan was developed for an online resource allowing different levels of engagement, from 'easy read' to 'deep engagement' with raw data. This was supported by a programme of community events to both build capacity and enable grading of the EDS self-assessment by our two PCT's to take place.

The IES has embedded delivering compliance with the Equality Act duties into its structure and its service level agreement with the PCT Cluster so that the PCT and CCGs were well placed to meet the legal requirements of the Equality Act 2010.

The EDS framework is made up of four main goals, which are broken down into focused outcomes, and which pose questions for NHS organisations to answer, providing evidence where necessary. The goals are:

Goal 1: Better health outcomes for all
Goal 2: Improved patient access and experience
Goal 3: Empowered, engaged and well-supported staff
Goal 4: Inclusive leadership at all levels

The EDS uses a rating system based the factors which need to be evidenced to achieve the following assessment levels: undeveloped, developing, achieving and excelling. The results were published on the websites for both primary care trusts.

Specialised care
Specialised secondary care activity at providers within the East Midlands was commissioned and contracted by the East Midlands Specialised Commissioning Group (EMSCG) on behalf of NHS LC and NHS LCR. There were also a small number of highly specialised acute services which EMSCG also contracts on behalf of LLR from other national providers. In 2012 EMSCG clustered with its equivalent organisation in Lincolnshire to create the East of England Specialised Commissioning Group, and is now hosted by NHS Lincolnshire. Most specialised care commissioning responsibilities moved the local area team of NHS England from April 2013.

East Midlands Ambulance Service
East Midlands Ambulance Service is the main provider of ambulance transport across LLR. EMAS provides the emergency 999 service.

The emergency ambulance contract was managed by Derbyshire County PCT as the host commissioner on behalf of the East Midlands PCTs. The East Midlands Procurement and

Commissioning Transformation team (see EMPACT below) worked with Derbyshire PCT on revising and managing this important contract.

Non-emergency patient transport
Planned patient transport services take eligible patients to appointments such as out-patient and renal dialysis sessions. In December 2011, following a regional tendering and procurement process, a private sector operator, Arriva Transport Solutions, was announced as the preferred bidder for this service, and a new five-year contract was signed in March 2012, taking effect from July 2012.

Voluntary sector contracts
Many of the providers in this sector operate in specialist or local market segments and are particularly skilled at working with 'difficult to reach' service users.

SBS and EMPACT
These are two separate organisations with which our PCTs had special arrangements for services shared with other NHS organisations.

Shared Business Services (SBS) is an external company which provided single-point financial services, such as processing purchasing orders and invoices, along with payroll and expenses claims, for both NHS LC and LCR. SBS is a joint venture between the Department of Health and Steria, which provides finance and accounting, payroll and e-procurement solutions, as well as support for family health services to a wide range of NHS organisations across the country.

EMPACT was the East Midlands Procurement and Commissioning Transformation team, a support unit based in Castle Donington, and hosted by NHS LCR. It was established as a collaborative venture by and for all the nine PCTs (ie, pre-clustering) in the East Midlands, and supported by the Strategic Health Authority. East Midlands PCTs provided funding to EMPACT via annual subscriptions and contributed to the costs of collaborative projects. Its functions now form part of the GEM CSU.

"Better care together"

LLR PCT Cluster spent money on people, treatment and buildings. Over the next three years it was estimated that the LLR Health Economy faced a predicted gap between planned expenditure and anticipated income of £210.9m. Given the financial climate and need to rise to the challenge of growing demand, LLR partners agreed to work together and focus on those areas of significant spend that could or should be able to operate more efficiently. We call this programme "Better care together".

The cornerstone of a sustainable LLR system will be reconfigured services and sites operating at a lower cost base, without detriment to quality of care. To support and co-ordinate the necessary LLR wide action, a Programme Board and a Programme Management Office (PMO) have been established. The establishment of a LLR Programme Board reflects the commitment of all LLR partners towards clinical and system transformation within a robust governance framework.

Detailed analysis has shown significant opportunity for productivity improvements, low overall levels of occupancy and material estate backlog maintenance challenges. The LLR space occupancy review identified an average overall LLR occupancy level of 53%. Better

use of space is required. This may ultimately mean that acute services will be consolidated on the Royal Infirmary and Glenfield sites, and the General will be redesigned as a Health and Social Care Campus for the city. This facility will include day case capacity for the wider LLR population.

The aims of the Reconfiguration Programme are to deliver an appropriate distribution and scaling of services by moving care to lower cost settings supporting the delivery of the agreed healthcare vision. The improved outcomes and benefits anticipated include:

- more care closer to home
- more opportunity to have minimally invasive day case procedures closer to home avoiding a trip to the main acute hospital
- more integrated care for frail elderly
- better integrated care in care homes
- less requirement to attend UHL for routine outpatient appointments
- savings in the cost of occupancy
- reduction of backlog maintenance
- improvement in overall occupancy
- better access to services
- better take up of technology
- faster communication

Risk management

The PCTs had an established mechanism in place that enabled the Cluster Board, executive directors and committees to monitor the ongoing performance of the organisation and performance against the transition plans to support successor bodies, eg, Clinical Commissioning Groups and Health and Wellbeing Boards. This mechanism included the use of formal policies, procedures and reporting arrangements through the integrated committee structure to identify, evaluate, and address and monitor risks.

Risk management was led by the Senior Management Team who monitored and challenged organisational performance and achievement of strategic objectives. The Senior Management Team was accountable and reported directly to the PCT Cluster Board. This team consisted of all executive directors of the organisation, chaired by the Chief Executive, and had overall responsibility for managing risk with the specific objective to monitor the implementation of risk management policies and systems across the organisation. All three CCGs adopted the PCT Cluster's risk management processes during transition and established sub-groups within their structures to review risks.

Risk and risk taking was inherent in everything the PCT Cluster and the CCGs did, for instance, determining service priorities, managing a project, taking decisions about future strategies, or even deciding not to take any action at all. Therefore, a structured, systematic and consistent approach to risk management, which encompasses all the PCT Cluster's functions and activities, was adopted. The resources available for managing risk were finite and so the aim was to achieve an optimum response to risk, prioritised in accordance with an evaluation of the risks and to take action to manage risk in a way, which it could justify to a level which is tolerable.

The key to effective risk management lay with the LLR PCT Cluster and the CCGs knowing what risks were likely to occur so that they could proactively manage them. An effective mechanism to capture and report risks was therefore essential. Risks were identified in two ways from internal and external sources using proactive or reactive methods:

- top down – for example, proactive identification of risks that directly affected the PCT Cluster's and CCGs' achievement of their objectives, eg, considering the political, economic, social and technological environment, as well as horizon scanning used to identify emerging opportunities and threats.
- bottom up – for example, assessment through directorate and CCG Risk Registers, claims and litigation, a cluster of incidents or complaints, and through performance management arrangements.

Strategic risks identified were those that represented major threats to achieving the PCT Cluster's strategic objectives including risks escalated from the CCGs' Risk Registers. Strategic risks were recorded in the PCT Cluster's Board Assurance Framework reports to the PCT Cluster Board and the Cluster Audit Committee during 2012-13 and were reviewed monthly through the Senior Management Team and the Cluster Board.

Operational risks were by-products of the day-to-day running of the PCT Cluster and CCGs and included a broad spectrum of risks including clinical, fraud, security, financial, information and legal risks arising from employment law and health and safety legislation and the risk of damage to assets or system failures. They were the responsibility of management and were identified and managed by Executive Directors at directorate or local CCG level and only considered by the Cluster Board on an exception basis.

In terms of governance and monitoring arrangements, a risk report was received at Senior Management Team on a monthly basis, which included a report on directorate level risks, including CCG function level risks, and updates on strategic risks contained within the Board Assurance Framework. Senior Management Team had a remit to ensure oversight of risks and provided the forum where cluster leads and CCG leads confirmed and challenged the content of the risk registers and the Board Assurance Framework. This was to ensure that the risks were captured and articulated accurately, that evaluation of risk scores were appropriate, that controls and assurances were in place, and to identify whether further resources and actions were required to address the identified risks. The Audit Committee received a report on risk at every meeting, usually held on a bi-monthly basis. The Cluster Board received an update on the Board Assurance Framework following Senior Management Team on a monthly basis.

Health and Safety

At the Cluster Board meeting in July 2012 an update was presented in relation to the health and safety action plan highlighting progress made and areas of risk. One of the areas of risk related to the findings of the Health and Safety Executive's (HSE) investigation where the HSE inspector identified "a material breach of Regulation 2 of the Health and Safety (Display Screen Equipment (DSE)) Regulations 1992 (as amended 2002)." The Cluster Board and the HSE were informed of actions taken to enhance the controls in place which included the purchase of DSE e-learning package for all staff and the establishment of the Health and Safety, Fire and Security Committee. In a letter

received in early August 2012 the HSE inspector has confirmed that the actions taken by the PCT Cluster are appropriate and that no further action was required by the HSE.

Cluster business continuity and major emergency planning
The Civil Contingencies Act 2004 established a single framework for civil protection in the UK. This legislation and its accompanying guidance was designed to improve the UK's ability to deal with the consequences of major disruptive emergencies by improving the planning processes at a local level, building better contacts between agencies and improving the links between local areas and central government. The Act sets out the roles and responsibilities of local responders, ensuring consistency in civil protection activity and improving performance.

The Business Continuity Management Policy was updated in early 2012 from the NHS Leicestershire County and Rutland and NHS Leicester City's business continuity polices to reflect the new cluster arrangements. As a Category 1 responder under the Civil Contingencies Act, it is a requirement to have a business continuity policy. This policy identified the importance of business continuity planning for LLR Cluster PCT. The key factors were that the LLR Cluster PCT needed a robust process for crisis management and a corporate business continuity plan to help manage major incidents. Each directorate needed a specific plan regularly reviewed and understood by staff at all levels.

The PCT Cluster had a senior multi-disciplinary group who led on business continuity, major incidents and pandemic flu as an ongoing commitment, backed by a suitable plan, which was refreshed within the past year. The policy identified what was required in a business continuity plan which can be summarised as:

- a description and a score of the risk identified
- detailed action plans to control the risk
- details of who was responsible for overseeing contingency planning and activating plans
- details of who should be informed that the plan had been activated
- details of external organisations to be involved
- a description of the escalation procedures.

The policy was clear about the need for training and exercising of business continuity plans and processes and set out a clear monitoring framework. The Health Emergency Planning Group, chaired by the Public Health Director for NHS Leicestershire County and Rutland, oversaw the implementation of the policy and reporting to the LLR area Local Resilience Forum of emergency services and allied organisations. The planning group was renamed the 'Local Health Resilience Partnership' in the past year.

Sustainability and the environment
The NHS produced the Carbon Reduction Strategy in 2009 which set out the requirement for all NHS organisations to take action on reducing carbon emissions. As the leader of the local health economy, the cluster recognised its corporate and social responsibility to protect the environment for future generations, to make our economy more environmentally sustainable and improve quality-of-life and wellbeing. Leicester City PCT Board and Leicestershire County and Rutland PCT Board approved a three-year Sustainable Development Strategy, to significantly reduce its carbon footprint and create a legacy for the local NHS in February 2010 and March 2010 respectively. The strategy identified a range of priorities relating to the management of energy and other resources, procurement, travel, building design and our staff and partners. During the past two years,

there has been a need to substantially reduce staffing numbers. As we adapted to the call for major reforms of the NHS commissioning process, including the abolition of primary care trusts like ours, we put some aspects of our sustainability programme on hold. The resulting reduction in required office space due to redundancies, retirements and natural wastage, and the need to reduce other 'back office' costs, have prompted a full-scale review of NHS buildings across the local health economy (see Better care together) with the predicted effect of also reducing NHS office space and energy usage.

For the Sustainability Report on NHS Leicester City, please see Appendix 2.

Our Directors, Boards and committees

Cluster Board

Non-Executive Directors (NED)

Mrs Cathy Ellis	Chair, LLR PCT Cluster (until 31 March 2013)
Mr David Mell	NED, LLR PCT Cluster (until 31 March 2013)
Ms Ruth Ingman	NED, LLR PCT Cluster (until 31 March 2013)
Mr Paul Hackwood	NED, LLR PCT Cluster (until 31 March 2013)
Mr Brian Wilson	NED, LLR PCT Cluster (until 31 March 2013)
Mr Barry Finan	NED, LLR PCT Cluster (until 31 March 2013)
Ms Gill Brigden	NED, LLR PCT Cluster (until 31 March 2013)

Executive Directors

Ms Catherine Griffiths	Chief Executive, NHS LC and NHSLCR (until October 2012)
Ms Liz Rowbotham	Director of Quality, Communications and Engagement (until October 2012, then Director of Transition)
Ms Sue Bishop	Director of Finance and Estates (until October 2012 then Director of Finance and Estates - Transition)
Dr Peter Marks	Director of Public Health (NHS LCR)
Ms Deb Watson	Director of Public Health and Heath Improvement (NHS LC)
Dr Aly Rashid	PCT Cluster Medical Director (until October 2012 then Area Medical Director, Leicestershire and Lincolnshire, NHS England)
Ms Vikki Taylor	Director of Commissioning Development (until October 2012)
Mr Nigel Skea	Director of Organisational Development and Workforce (until October 2012 then Director of Organisational Development and Workforce - Transition)
Mr David Sharp	Area Director (Leicestershire and Lincolnshire) NHS Commissioning Board from October 2012
Mr Andy Leary	Area Director of Finance (Leicestershire and Lincolnshire) NHS England (from October 2012)
Ms Maggie Boyd	Director of Nursing and Quality (Leicestershire and Lincolnshire) NHS England (from October 2012)
Ms Trish Thompson	Area Director of Operations and Delivery, Leicestershire and Lincolnshire, NHS England (from October 2012)
Mr Peter Huskinson	Area Director Commissioning, Leicestershire and Lincolnshire, NH Commissioning Board (from October 2012)

Committees of the Board

Audit Committee of the PCT Cluster

Audit Committees review the effectiveness of internal controls and risk management

systems relating to finance and non-financial risks.

Mr Brian Wilson	NED, Chair of the Committee
Mr Barry Finan	NED
Mr Paul Hackwood	NED
Mr David Mell	NED

Remuneration and Terms of Service Committee (members only)

This body oversees pay and terms and conditions of employment.

Ms Ruth Ingman	NED, Chair of the Committee
Ms Cathy Ellis	NED
Mr Barry Finan	NED

Reference Committee

This body helps ensure the quality of clinical services and looks into issues of 'fitness to practice'.

Ms Gill Brigden	NED, Chair of the Committee
Ms Ruth Ingman	NED, Deputy Chair
Dr Ian Cross	GP Representative LLR PCT Cluster
Mrs Liz Rowbotham	Director of Quality, Communications and Engagement
Prof Aly Rashid	Medical Director
Ms Vikki Taylor	Director of Commissioning Development

Quality and Clinical Governance Committee

David Mell	Chair of the Committee
Ms Gill Brigden	NED
Mrs Liz Rowbotham	Director of Quality, Communications and Engagement
Prof Aly Rashid	Medical Director
Ms Sharon Robson	Associate Director of Quality and Safeguarding
Caroline Trevithick	Associate Director of Quality
Dr Mike McHugh	Consultant in Public Health

Competition and Procurement Committee

This body oversees fairness and compliance with all competition and procurement policies and legislation.

Barry Finan	Chair of Committee
Mr Brian Wilson	NED
Ms Vikki Taylor	Director of Commissioning Development
Ms Sue Bishop	Director of Finance and Estates
Mrs Liz Rowbotham	Director of Quality, Communications and Engagement

Statutory Declarations

Statement of Interim Chief Executive as Accountable Officer

Statement of the Interim Chief Executive's responsibilities as the accountable officer of the Leicester City NHS Primary Care Trust, operating as "NHS Leicester City" within a cluster arrangement with Leicestershire County and Rutland NHS Primary Care Trust, which is operating as "NHS Leicestershire County and Rutland".

The Secretary of State has directed that the Chief Executive should be the Accountable Officer to these Primary Care Trusts. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Department of Health. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance
- value for money is achieved from the resources available to the Trust
- the expenditure and income of the authority has been applied to the purposes intended by Parliament and conform to the authorities which govern them
- effective and sound financial management systems are 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 responsibilities set out in my letter of appointment as an Accountable Officer.

Mr David Sharp
Area Director (Leicestershire and Lincolnshire), NHS England

Annual Governance Statement

The NHS Chief Executive, in his capacity as Accounting Officer for the NHS in the Department of Health requires NHS trust accountable officers to give him assurance about the stewardship of their organisations.

In previous years he has received this assurance primarily from Statements on Internal Control. For 2012-13, in line with changes to HM Treasury guidance, this statement is replaced by an Annual Governance Statement. Accountable Officers are required to include the governance statement in their annual report and accounts, or make them available upon request.

Each governance statement records the stewardship of the organisation to supplement the accounts. It gives a sense of how successfully it has coped with the challenges it faces and of how vulnerable the organisation's performance is or might be. This statement draws together position statements and evidence on governance, risk management and control, to provide a more coherent and consistent reporting mechanism.

The full Annual Governance Statements for NHS Leicester City and NHS Leicestershire County and Rutland are available on request by writing to:

Area Team of NHS England
Fosse House
6 Smith Way
Grove Park
Enderby
Leicester LE19 1SX

Compliance with NHS Code of Conduct and Accountability

We are committed to the NHS Code of Conduct and Accountability, the NHS Code of Practice in Openness in the NHS, and the Freedom of Information Act 2000. Under these, Board members are required to declare any interests relevant to the organisations' business. Apart from publication in this report they are also kept in a register at our headquarters.

We will respond to all requests for available information about the services that we commission and provide. This includes information regarding our performance against standards and targets, the way in which we commission and provide services and care, and any proposed service changes. The day-to-day management of the organisations is the responsibility of the Chief Executive, working closely with the Boards of both organisations, which in turn work to develop strategy and oversee performance.

Register of Interests 2012 – 2013

Directors are required to disclose other positions they occupy outside their NHS roles, and which may conflict with their NHS work.

Mrs Cathy Ellis - Chair, LLR PCT Cluster

- Member Institute of Chartered Accountants England and Wales.
- Director and Trustee of Leicestershire Independent Education Trust (Dixie Grammar School).

Mr David Mell - (NED, LLR PCT Cluster)

- Director of Belvoir Networking CIC – a not-for-profit Community Interest Company aiming to bring the benefits of fast broadband to the people, businesses and communities of the Vale of Belvoir.
- Freeman of the Worshipful Company of Information Technologist s – a Livery Company of the City of London.
- Wife is Chair of the Patients' Participation Group of The Sand's Surgery Long Clawson.

Ms Ruth Ingman - (NED, LLR PCT Cluster)

- Director of Utilios a company providing web-based sector specific support to GP practice managers in the field of HR, health and safety and CQC.
- Director of Ruth Ingman Ltd a non-trading company providing employment law support to the SME business market.
- Non-Executive Director of the Leicestershire Chamber of Commerce.

- Non-Executive Trustee Director of the St Philip's Centre, a Christian mutli-faith centre.
- Non-Executive Trustee Director of Leicester Charity Link, a charity linking resource to those in need.
- Fellow of the Royal Society for the Promotion of Commerce and Manufactures.
- Member of the Honourable Society of the Inner Temple, one of four Inns of Court.
- Member of the Advisory Group Common Purpose Leicestershire, organisation promoting leadership in Civic Society.
- Patron of the Guild of St Martin, organisation promoting the work of Leicester Cathedral.
- Member of the Business Advisory Group for the Philharmonia Orchestra in Leicestershire.

Mr Paul Hackwood - (NED, LLR PCT Cluster) from
- Director Chair Church Urban Fund.
- Director Zurbaran Trust.
- Director Thrive Together Birmingham.
- Director Near Neighbours.
- Chapter Member Leicester Cathedral
- Director Hackwood Associates

Mr Brian Wilson (NED, LLR PCT Cluster)
- Non-executive Director, Clockwise Credit Union.
- Non-executive Director, Riverside English Churches Houses Group.
- Company Secretary, The Monday Club Leicestershire (a social club for clients with Asperger's Syndrome)

Mr Barry Finan - (NED, LLR PCT Cluster)
- Owner and Director, Finan & Co. Ltd (a company that provides interim finance director and management consultancy services).
- Son and daughter-in-law are qualified doctors working for the NHS in Lancashire.
- Fellow of the Institute of Chartered management Accountants

Ms Gill Brigden - (NED, LLR PCT Cluster)
- Chair, Management Committee (Board of Directors) for Soft Touch Arts. This is a not-for-profit community arts company operating from Leicester City working with disadvantaged communities, in partnership with statutory sector services.

Ms Catherine Griffiths - Chief Executive (until October 2012)
- No direct or indirect relevant and material interests to declare.

Ms Judith Hill - Director of Nursing (from October 2011)
- Member of Marie Curie UK Advisory Board

Mrs Liz Rowbotham - Director of Quality, Communications and Engagement
- Husband is an employee of the University of Leicester, the Director for Research and Development for the University Hospitals of Leicester NHS Trust and a Director of the Leicestershire Northamptonshire and Rutland (National Institute for Health Research) Comprehensive Local Research Network.

Ms Sue Bishop - Director of Finance and Estates

- Personal relationship with the business manager of the Market Harborough Medical Centre.
- Public Sector Director of Leicester LIFTCo Ltd.

Professor Aly Rashid - Medical Director

- No direct or indirect relevant and material interests to declare.

Dr Peter Marks - Director of Public Health (NHS LCR)

- No direct or indirect relevant and material interests to declare.

Ms Deb Watson - Director of Public Health and Health Improvement (NHS LC)

- Director of Public Health and Health Improvement is a joint appointment between NHS Leicester City and Leicester City Council (employed by NHS Leicester City).
- For the whole of 2012/2013 I have acted as the Interim Director of Adult Social Care for Leicester City Council in addition to me responsibilities as DPH.
- Fellow of the Faculty of Public Health and registered as a Public Health Specialist with the UK Public Health Register.
- Member of the Board of Leicester Sports Partnership Trust which was formed as a partnership in 2010-11. The partnership is currently unincorporated but is expected to seek the status of Charitable Trust during 2013-14.
- Honorary Life Member of Leicestershire AIDS Support Service.

Mr Nigel Skea - Director of Organisational Development and Workforce

- Chartered Fellow of the Chartered Institute of Personnel and Development.
- Director and owner of Consult N Skea Limited, an independent HR Consultancy.

Ms Vikki Taylor - Director of Commissioning Development (until October 2012)

- No direct or indirect relevant and material interests to declare.

Mr David Sharp - Area Director (Leicestershire and Lincolnshire) NHS England

- My partner is an employee of the EMPACT division of LCR PCT
- Fellow of the Chartered Certified Accountants.
- Chartered Public Finance Accountant
- I am a recipient of 2 NHS research grants as an Associate post-doctoral researcher of Warwick Business School.

Ms Trish Thompson - Area Director of Operations and Delivery (Leicestershire and Lincolnshire) NHS England

- No direct or indirect relevant and material interests to declare.

Mr Andrew Leary - Area Director of Finance (Leicestershire and Lincolnshire) NHS England

- No direct or indirect relevant and material interests to declare.

Ms Maggie Boyd - Area Director of Nursing and Quality (Leicestershire and Lincolnshire) NHS England

- No direct or indirect relevant and material interests to declare.

Mr Peter Huskinson - Area Director of Commissioning (Leicestershire and Lincolnshire) NHS England

- No direct or indirect relevant and material interests to declare.

Information governance

We were members of the Joint Information Governance Steering Group, ensuring that information assets are securely maintained through effective procedures and safeguards. The group annually reviewed its policy, strategy and action plans to ensure they complied with national and local policies. Any exceptions were included in a performance report. The Joint Information Governance Steering Group reported into the Quality and Governance Committee to ensure early identification of risks.

Incidents relating to matters of confidentiality

Primary care trusts had a legal duty to provide information on serious breaches of information governance policies and procedures during the course of each year, such as loss of confidential data about staff and patients, which needed to be reported and escalated to the Strategic Health Authority. However, during 2012-13 there were no such serious breaches by NHS Leicester City or its PCT Cluster partner, NHS Leicestershire County and Rutland.

Complaints handling

Complaints were handled by our cluster's joint Customer Services teams. In 2010 NHS Leicester City merged the Patient Advice and Liaison Service (PALS) and complaints functions, which has allowed greater responsiveness to the needs of our patients. Patients were no longer transferred between departments, but benefitted from the 'one stop shop' approach. The PCT Cluster was also able to collate and draw up on data about the larger concerns landscape using combined PALS data. This method worked so well that from 1 April 2011 Leicestershire County and Rutland and NHS Leicester City joined forces to create one Customer Services team for the area.

Our cluster ensured that any complainant was treated fairly and valued equally, irrespective of their age, gender, race, ethnicity or national origins, domestic circumstances, social and employment status, religion or belief, sexual orientation, disability or on other grounds which cannot be justified. We also ensured that any member of staff involved in a complaint was supported and treated fairly and valued equally.

During 2012-13 LLR Cluster's joint Customer Services team received 463 complaints. Of these, 243 were about GP services and 50 were about dentistry, while 170 were regarding a range of services including prison healthcare, continuing healthcare and secondary care. The Customer Services team acknowledged 100% of these complaints within the target period of 72 hours. As a result of the complaints received many recommendations have been made to service providers to improve the level of service they are offering.

Principles for Remedy

Our cluster's Customer Services was passionate about representing the patient and aimed to promote this approach across the organisation and the patient is at the heart of what we did. We were fully committed to the Principles for Remedy, which the Parliamentary and

Health Service Ombudsman set out for public bodies to use when considering remedies for injustice or hardship resulting from maladministration or poor service. The six Principles for Remedy are:

- getting it right
- being customer focused
- being open and accountable
- acting fairly and proportionately
- putting things right
- seeking continuous improvement.

Freedom of Information Act (FOI) 2000 - Policy and Publication Scheme

The FOI Act 2000 is part of the Government's commitment to greater openness in the public sector, which is supported by the PCT Cluster. As such, a single harmonised Freedom of Information Act Policy has been developed for the LLR Cluster, which was approved by the Senior Management Team in March 2012 and uploaded onto the NHS LC and NHS LCR intranet sites for staff. This policy continued to meet the requirements of the legal requirements of the FOI Act 2000 as well as the requirements of the annual Connecting for Health - Information Governance Toolkit standard. The main changes to the policy related to the governance structures across the cluster and the scope of the policy, which cover the Clinical Commissioning Groups.

Requests for information under the Freedom of Information Act were handled by the Corporate Governance Team, for both LC and LCR. The PCT Cluster received and dealt with a total of 403 requests under the Freedom of Information Act during 2012-13, and 378 requests were dealt with in the required time limit. Reasons for delays were explained to those who requested information, including the length and complexity of the information being sought.

Never events

"Never events" are defined as *'*serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. To be a never event, an incident must fulfil the following criteria:

- the incident has clear potential for or has caused severe harm/death
- there is evidence of occurrence in the past (i.e. it is a known source of risk)
- there is existing national guidance and/or national safety recommendations on how the event can be prevented and support for implementation
- the event is largely preventable if the guidance is implemented
- occurrence can be easily defined, identified and continually measured.

Their occurrence is an indication that an organisation may have not put in place the right systems and processes to prevent the incidents from happening and thereby prevent harmful outcomes. It is also an indicator of how safe the organisation is and the patient safety culture within that setting.

Leicestershire Partnership Trust reported 0 (zero) never events during 2011/12 and 2012/13. University Hospitals of Leicester (UHL) has reported seven never events during the year compared to two during 2011/12, these are:

*2011/12 total number reported (Nationally)	UHL 2011-12 number	UHL 2012-13 number	Type
41	0	1	Wrong Implant/Prosthesis
70	0	2	Wrong Site Surgery
23	0	1	Misplaced naso-gastric tube not detected prior to use
<10	0	1	Inappropriate administration of daily oral methotrexate
161	1	2	Retained foreign object post-operation
<10	1	0	Wrong route administration of chemotherapy

* Source: Never Events Policy Framework (October 2012)

The majority of the in-year never events reported by UHL fall into the top four categories of never events reported nationally, the only exception being the inappropriate administration of methotrexate.

The learning derived from these incidents includes:

- The surgeon must select the size and type of lens required for every patient and not a member of the theatre team.
- There must only ever be one lens in theatre at any one time.
- Additional barriers need to be put into place to strengthen the checking process and make it more robust to prevent the incorrect lens being implanted into a patient
- To introduce with immediate effect a definitive pause prior to the point of knife to skin to ensure that the intended surgery is once again checked against the consent form
- Electronic prescribing is implemented on the acute medical unit in line with the agreed UHL electronic prescribing programme
- Implement face to face contact by the operating surgeon with the patient prior to anaesthetic

Learning has been shared more widely than the organisation in relation to the methotrexate event. The final investigation report was shared with the lead consultant responsible for post graduate education in acute medicine to enable learning to be integrated into post graduate training.

In addition UHL pharmacy are undertaking a ‘contributions audit’ to include capturing of data on methotrexate prescribing interventions undertaken by pharmacy to feed into local and regional learning.

Directors' responsibilities

The directors are required under the National Health Service Act 1977 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 organisation and the net operating cost, recognised gains and losses and cash flows for the year. In preparing these accounts, directors are required to:

- 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.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the organisation and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the health authority and hence for taking reasonable steps for the prevention of fraud and other irregularities.

Each director must state that as far as he/she is aware there is no relevant audit information of which the NHS body's auditors are unaware and he/she has taken all the steps that he/she ought to have taken as a director in order to make himself aware of any relevant audit information and to establish that the NHS body's auditors are aware of that information.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the financial statements.

By order of the Board.

Cathy Ellis
Chair, NHS Leicester, Leicestershire and Rutland PCT Cluster

David Sharp
Interim Chief Executive, and Area Director, NHS England, Leicestershire and Lincolnshire

Andy Leary
Area Director of Finance, NHS England, Leicestershire and Lincolnshire

Operating and Financial Review

As 2012/13 was the last year that Leicester City and Leicestershire County and Rutland PCTs existed, this section outlines the successful year we have had in terms of financial performance, as well as the work we have done to ensure our successor organisations are well placed to take over our financial responsibilities. It also reflects upon the financial legacy we are leaving for our successor bodies.

When the 2012-13 NHS funding allocations were announced, both NHS LC and NHS LCR were given 2.8% growth funding each. Over and above this, separate funding was allocated to the PCTs to be used on joint working with local authorities on social care. Our total financial resources for the year were £583m for NHS LC & £1.004m for NHS LCR.

I am delighted to be able to report that both PCTs in the cluster have achieved their 2012-13 financial targets with surpluses of £9.6m (NHSLC) and £13.1m (NHS LCR). In addition, our major local secondary healthcare providers Leicestershire Partnership Trust (LPT) and the University Hospitals of Leicester (UHL) also delivered planned surplus' demonstrating that the overall local health economy has been able to deliver its key financial targets. This is a particular achievement for the University Hospitals of Leicester after the considerable financial difficulties they experienced during the early part of the financial year.

As part of ensuring a smooth transition from the PCTs, commissioning budgets were restructured and delegated to the newly formed CCGs during 2012-13. This provided them with 100% of the resource allocation and 'shadow budget' for the services they will be expected to commission when they became statutory organisations in April 2013.

Our role as a system manager

During 2012-13 we have been monitoring the financial performance of UHL very closely. The CCGs and the Area Team of NHS England are supportive of the work that the trust has carried out, and continues working to help resolve their internal financial issues. During the year we supported the trust by investing £7.5m of our transformation funds in the organisation. As part of the 2013-14 contract agreement with the trust, CCG commissioners have invested £10m over and above national expectations in order to increase the actual level of income due to the trust under their contract by £2m. Our clinical leaders have also been asked to confirm that they are satisfied that the trust's savings proposals do not adversely affect patient safety and the quality of their patient services. During 2013-14 the Area Team and the CCGs will continue to support our main local providers to pursue foundation trust status. As part of these processes it is really important that we make sure our organisational financial strategies continue to be aligned so that the underlying financial position of all organisations is secure into the future (work which has already begun and will continue through the "Better Care Together" programme).

Quality, innovation, productivity and prevention (QIPP)

Our QIPP strategy during 2012-13 has been the continuation of a whole health economy approach, based on collaborative planning and agreement, with delivery hard-wired into both provider cost-improvement programmes and CCG demand management and contract volume targets.

The QIPP has five key workstreams as follows:

- urgent care
- right care
- care of the frail elderly
- a LLR formulary (ie, table of preferred medications) to reduce prescribing costs
- maternity and paediatric service redesign.

.
All five schemes have been on-going during 2012-13. Each has a sponsoring CCG, a clinical chair and a programme of work.

In addition to previous years' savings a further £18m has been delivered during 2012-13.

The approach has been successful in that targets have been, wherever possible, assigned to individual organisations with only a small number of high impact schemes undertaken across the wider health and social care economy.

A major achievement has been the LLR Shared Services programme for the delivery and management of facilities management and estates services across the local health system. The procurement was completed in December 2012 when contracts for a new out-sourced service were signed. The operational service provided by Interserve, and the shared management of the new contractual framework through the LLR Facilities Management Collaborative (LLRFMC), went live with effect from 1 March 2013.

Moving to a new commissioning architecture

During 2012/13 financial year the LLR PCT Cluster developed financial plans, and consequently, budgets for the new successor commissioning organisations. This enabled these emerging bodies to operate with full 'shadow' budgets in 2012/13 and to understand exactly where they are spending their money, where their financial risk sits, and for them to be able to monitor their progress in the delivery of financial targets that will, in some cases, become statutory responsibilities in 2013-14. This information will provide useful 2012-13 comparative information for use in the CCGs' own statutory accounts in 2013-14, if required. This work has required fundamental changes to the PCTs' information systems, including the general ledger, during the year and the figures have been fully reconciled and supplied to the Department of Health for use in the 2013-14 revenue funding allocations process (known as the DH disaggregation returns of July 2012).

The LLR PCT Cluster and the LLR CCGs entered into a memorandum of understanding in April 2012. This outlined, among other things, how financial control would be managed between them during 2012-13. This agreement, alongside the planning and budgeting referred to above, has enabled the new commissioning organisations to operate autonomously throughout 2012-13 in all areas formally delegated to them by the LLR PCT Cluster Board. As described above, a performance monitoring framework has operated throughout the year through meetings of the Performance Collaborative. In addition the CCGs have taken detailed financial reports to their own CCG Board meetings. These reports are available to readers through the CCGs' own websites.

Looking forward to 2013-14

Following the work done to restructure commissioning budgets in 2012-13, the 2013-14 commissioning plans have been developed by the three CCGs along with the LLR cluster.

This has enabled our successor bodies to immediately create their own opportunities for service benefits and to address health inequalities.

The PCT Cluster is proud to pass on a strong financial legacy to the new organisations tasked with commissioning healthcare for local people from 1 April 2013.

Andy Leary
Area Director of Finance
NHS England (Leicestershire & Lincolnshire Area Team)

Notes on Summary Financial Statements

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. 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.

In the preparation of these financial statements, estimates and assumptions have been made by management concerning the selection of useful lives of fixed assets, provisions necessary for certain liabilities and other similar evaluations. Actual amounts could differ from those estimates. Examples where judgement has been applied are in relation to prescribing, NHS Continuing Care claims, Independent Sector Treatment Centres and legal charges.

Both primary care trusts signed up to the Prompt Payments Code.

Losses and special payments

The PCT Cluster did not incur any material losses or special payments during 2012-13.

Contingent liabilities

NHS Leicester City's contingent liability is for part-eligible NHS Continuing Care retrospective claims, for which it is assumed there may be some liability, but not of sufficient certainty to require provision to be made.

Stakeholder pension

There were no NHS Leicester, Leicestershire and Rutland employees who had stakeholder pensions in place of being a member of the NHS Pension Scheme.

Compensation payments

NHS Leicester City has disclosed in its accounts £1.6m of redundancy/early retirement costs that relate to compensation incurred for the loss of office during 2012-13. Further information on compensation payments, also known as exit packages, is included in the full published accounts. They are available by a request in writing. Please write to:-

Finance Directorate
Area Team of NHS England
Fosse House, 6 Smith Way
Grove Park, Enderby
Leicestershire LE19 1SX

Summary Financial Statements & Remuneration Reports

The following financial statements within this report may not contain sufficient information for a full understanding of either NHS Leicester City's or NHS Leicestershire County and Rutland's financial position and performance. Copies of the full accounts, including the complete Annual Governance Statement, may be obtained by a request in writing. Please write to:-

Finance Directorate, Area Team of NHS England
Fosse House, 6 Smith Way, Grove Park, Enderby, Leicestershire LE19 1SX

For these reports, see the associated files:
5PC PART 02 NHS Leicester CITY Summary Financial Statements 2012-2013.xls
5PC PART 03 NHS Leicester CITY Remuneration Report 2012-2013.xls

International financial reporting standards

Until 2008-2009 the NHS used UK Generally Accepted Accounting Principles (UK GAAP). However from 2009-2010 the NHS uses International Financial Reporting Standards (IFRS) in line with international accounting. NHS Leicester City and NHS Leicestershire County and Rutland restated their 2008-2009 balance sheet and reported their 2009-2010 accounts in line with IFRS.

Running costs

The Board's definition of running costs include any cost incurred that is not a direct payment for the provision of healthcare or healthcare related services.

Carrying amount and the market value of land

The Directors do not consider there are any significant differences between the carry amount and market value of land.

Remuneration Report

As a public sector bodies, primary care trusts were required to disclose information about senior managers' remuneration. The disclosure includes the remuneration of 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body', this has been interpreted as Executive Directors and Non-Executive Directors substantively in post during the financial year. The remuneration of directors is in accordance with Very Senior Manager (VSM) pay guidance issued by the Department of Health, details are included later in this annual report.

Severance payments

There have been no special severance payments requiring treasury approval.

Salary entitlements of very senior managers

This table of salary entitlements includes:

- all amounts paid or payable including recharges from any other health body
- the gross cost of any arrangement whereby a senior manager receives a net amount and an NHS body pays income tax on their behalf
- any financial loss allowances paid in place of remuneration
- performance related bonuses, and any allowance subject to UK taxation and
- any ex-gratia payments.

But the table of salary entitlements excludes:

- recharges to any other health body
- reimbursement of out-of-pocket expenses
- reimbursement of travelling and other allowances (paid under determination order) including home-to-work travel costs
- employers' superannuation and National Insurance contributions
- 'golden hellos' and compensation for loss of office, and
- any amount paid which a director must repay.

NHS Leicester City and NHS Leicestershire County and Rutland median remuneration reports

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce. The way that we have calculated this relationship is determined by the Department of Health in the NHS Manual of Accounts.

The banded remuneration of the highest-paid director in **NHS Leicester City** in the financial year 2012-13 was £89,240. This was 2.8 times the median remuneration of the workforce, which was £32,013. Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

In 2012-13, two employees received remuneration in excess of the highest-paid director. Remuneration ranged from £97,000 to £112,000. In line with Department of Health requirements, NHS Leicestershire County and Rutland operated in a cluster arrangement with NHS Leicester City, and many joint costs, including senior management remunerations, were split between the two organisations.

The total banded remuneration of the Cluster's Chief Executive was £139,000. This cost was shared by both PCTs. This total remuneration was 4.3 times the median remuneration of the workforce of NHS Leicester City and 4.1 times the median remuneration of the workforce of NHS Leicestershire County and Rutland

The banded remuneration of the highest-paid director in **NHS Leicestershire County and Rutland** in the financial year 2012-13 was £132,500. This was 3.8 times the median remuneration of the workforce, which was £35,184. Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

In 2012-13, four employees received remuneration in excess of the highest-paid director. These employees' banded remunerations ranged from £103,000 to £139,000. In line with Department of Health requirements, NHS Leicestershire County and Rutland now operates in a cluster arrangement with NHS Leicester City, and many joint costs, including senior management remunerations, are split between the two organisations.

The total banded remuneration of the Cluster's Chief Executive was £139,000. This cost was shared by both PCTs. This total remuneration was 4.1 times the median remuneration of the workforce of NHS Leicester City and 4.3 times the median remuneration of the workforce of NHS Leicestershire County and Rutland.

Remuneration and Terms of Service Committee and senior managers' salaries

The Remuneration and Terms of Service Committee was responsible for setting all aspects of the remuneration of the senior managers of the organisation. For the purposes of this committee, senior managers are defined as the Chief Executive and members of the executive team and other senior staff who report directly to the Chief Executive.

In January 2011 a joint Remuneration and Terms of Service Committee for both NHS Leicester City and NHS Leicestershire County and Rutland was established. Membership comprises of three Non-Executive Directors from both organisations.

The Chief Executive and Director of Organisational Development and Workforce also attended to support the work of the joint committee which was chaired by one of the Non-Executive Directors. The remuneration of senior managers working in Leicester, Leicestershire and Rutland PCT Cluster was set in accordance with the national NHS Very Senior Managers (VSM) framework.

In accordance with national pay policy there was no cost of living pay award made to very senior managers. No individual performance awards were made to senior managers, as defined for these reporting requirements. Provision was made in the accounts during the year for redundancy payments for very senior managers whose posts were declared redundant following the restructure of the Leicester, Leicestershire and Rutland PCT Cluster. The standard notice period within VSM contracts is six months notice from the organisation to the employee and three months notice from the employee to the organisation.

For a clearer picture of senior staff remuneration, see the banding figures in the published accounts.

Pension entitlements of senior managers

The pension scheme is an unfunded, defined benefits scheme that covers NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. As a consequence it is not possible for NHS Leicester City to identify its share of the underlying scheme assets and liabilities.

Therefore the scheme is accounted for as a defined contribution scheme and the cost of the scheme is equal to the contributions payable to the scheme for the accounting period. The full accounting policy can be found in the full statement of accounts.

Reporting related to the Tax Arrangements of Public Sector Appointees

As part of their annual reports, public bodies such as ours must present two sets of data, covering both the main department and its arm's length bodies on off-payroll engagements at a cost of over £58,200 per annum that were in place as of 31 January 2012.

It should include the number of engagements that were in place as of 31 January 2012 with a breakdown to show the number of these that have, between 31 January 2012 and 31 March 2013:

- come onto the organisation's payroll
- been re-negotiated/re-engaged, to include contractual clauses allowing the department to seek assurance as to their tax obligations
- have not been successfully re-negotiated, and therefore continue without contractual clauses allowing the department to seek assurance as to their tax obligations
- come to an end.

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

- the number of new engagements.
- the number of new engagements which include contractual clauses giving the department the right to request assurance in relation to income tax and National Insurance obligations.
- the number for whom assurance has been requested and received.
- the number for whom assurance has been requested but not received.
- the number that have been terminated as a result of assurance not being received.

In any cases where, exceptionally, the organisation has engaged without including contractual clauses allowing the department to seek assurance as to their tax obligations – or where assurance has been requested and not received, without a contract termination – the organisation should set out the reasons.

This data can be seen in tables at Appendix 1.

Auditors

The external auditors are appointed independently of NHS Leicester City and NHS Leicestershire and Rutland. Their scope of work includes the audit of the financial statements, corporate governance and arrangements to secure the economic, efficient and effective use of resources.

The external auditor for NHS Leicester City is KPMG.

The external auditor for NHS Leicestershire County and Rutland is PricewaterhouseCooper.

INDEPENDENT AUDITOR'S REPORT TO THE RESPONSIBLE OFFICER OF LEICESTER CITY PCT ON THE SUMMARY FINANCIAL STATEMENT

We have examined the summary financial statement for the year ended 31 March 2013 which comprises the Statement of Financial Position, Statement of Comprehensive Net Expenditure, Statement of Changes in Taxpayers' Equity, the Statement of Cashflows and notes (financial performance targets, Better Payment Practice Code, running costs and audit fees).

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

Respective responsibilities of directors and auditor

The Responsible Officer is responsible for preparing the Annual Report. Our responsibility is to report to you our opinion on the consistency of the summary financial statement within the Annual Report with the statutory financial statements.

We also read the other information contained in the Annual Report and consider the implications for our report if we become aware of any misstatements or material inconsistencies with the summary financial statement.

Basis of opinion

We conducted our work in accordance with Bulletin 2008/03 "The auditor's statement on the summary financial statement in the United Kingdom" issued by the Auditing Practices Board. Our report on the statutory financial statements describes the basis of our opinion on those financial statements.

Opinion

In our opinion the summary financial statement is consistent with the statutory financial statements of Leicester City PCT for the year ended 31 March 2013 on which we have issued an unqualified opinion.

Neil Bellamy for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
1 Waterloo Way
Leicester
LE1 6LP

10 June 2013

Appendix 1

Reporting related to the Tax Arrangements of Public Sector Appointees

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

Leicestershire County & Rutland ONLY	
No. In place on 31 January 2012	14
Of which:	
No. that have since come onto the Organisation's payroll	2
Of which:	
No. that have since been re-negotiated/re-engaged to include to include contractual clauses allowing the (department) to seek assurance as to their tax obligations	3
No. that have not been successfully re-negotiated, and therefore continue without contractual clauses allowing the (department) to seek assurance as to their tax obligations	0
No that have come to an end	9
Total	14

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

Leicester City ONLY	
No. In place on 31 January 2012	8
Of which:	
No. that have since come onto the Organisation's payroll	0
Of which:	
No. that have since been re-negotiated/re-engaged to include to include contractual clauses allowing the (department) to seek assurance as to their tax obligations	2
No. that have not been successfully re-negotiated, and therefore continue without contractual clauses allowing the (department) to seek assurance as to their tax obligations	0
No that have come to an end	6
Total	8

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

Joint between NHS LC & NHS LCR	
No. In place on 31 January 2012	3
Of which:	
No. that have since come onto the Organisation's payroll	0
Of which:	
No. that have since been re-negotiated/re-engaged to include to include contractual clauses allowing the (department) to seek assurance as to their tax obligations	1
No. that have not been successfully re-negotiated, and therefore continue without contractual clauses allowing the (department) to seek assurance as to their tax obligations	0
No that have come to an end	2
Total	3

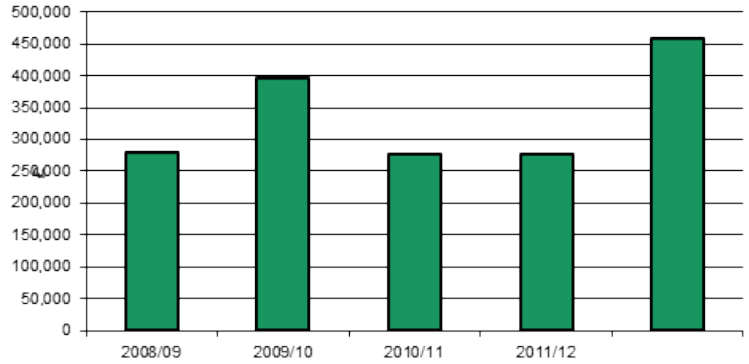
For all new off-payroll engagements between 23 August 2012 and 31 March 2013, for more than £220 per day and more than 6 months:

Joint between NHS LC & NHS LCR	
No. of new engagements	11
Of which:	
No. of new engagements which include contractual clauses giving the department the right to request assurance in relation to income tax and National Insurance obligations	11
Of which:	
No. for whom assurance has been accepted and received	11
No. for whom assurance has been accepted and not received	0
No. that have been terminated as a result of assurance not being received	0
Total	11

Appendix 2 – Sustainability Report

Our carbon footprint has increased in the last year:

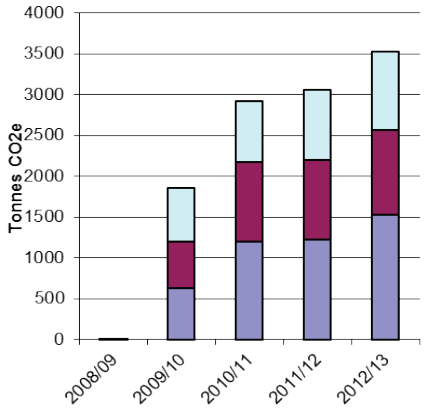
30%



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

Our total energy consumption has risen during the year, from 7,753 to 8,425 MWh

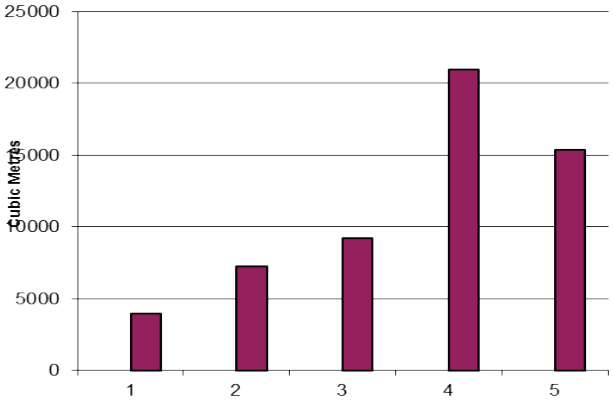
Sustainability Report continued



Our measured greenhouse gas emissions have increased by 467 tonnes this year.

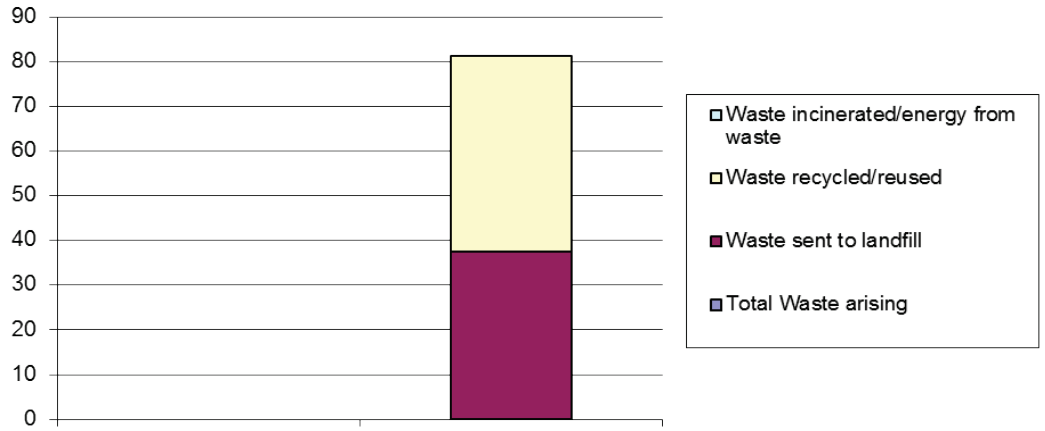
Our water consumption has decreased by 4,567 cubic meters in the recent financial year.

In 2012/13 we spent £37,580 on water.



Sustainability Report continued

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



Our organisation has an up to date Sustainable Development Management Plan.

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

NHS organisations have a statutory duty to assess the risks posed by climate change. Risk assessment, including the quantification and prioritisation of risk, is an important part of managing complex organisations.

Sustainability Report continued

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

Our last staff awareness campaign was conducted in 2012. Staff awareness campaigns have been shown to deliver cost savings and associated reductions in carbon emissions.

The NHS places a substantial burden on the transport infrastructure, whether through patient, clinician or other business activity. This generates an impact on air quality and greenhouse gas emissions. It is therefore important that we consider what steps are appropriate to reduce or change travel patterns.

Do you need help understanding this report?

Our annual report can be provided in other languages and formats on request, including large print.

If you require help understanding the contents of this report, please telephone 0116 295 7626 and ask for help with translation or other formats.

هذا هو التقرير السنوي للعام 2012-13 لخدمات الصحة الوطنية (NHS) بمقاطعة ليسيسترشاير و روتلاند. إذا كنت ترغب في ترجمة المعلومات، برجاء الاتصال بفريق المشاركة على الرقم 0116 295 7626.

এটি হল NHS লেস্টারশায়ার কাউন্টি ও রাটল্যান্ডের জন্য বার্ষিক রিপোর্ট 2012-13 আপনি যদি এই তথ্যকে অনুবাদ করাতে চান তাহলে অনুগ্রহ করে 0116 295 7626 এ এঙ্গেজমেন্ট টিমের সাথে যোগাযোগ করুন।

這是國民保健服務 (NHS) 萊賈斯特郡和羅特蘭 2012-13 年度報告。如果您想要將這些資訊翻譯爲您的語言，請致電我們的項目小組 (Engagement Team) 0116 295 7626。

આ એનએચએસ લેસ્ટરશાયર કાઉન્ટિ અને રુટલેન્ડ માટે 2012-13 નો વાર્ષિક અહેવાલ છે. જો તમે આ માહિતીને અનુવાદ કરેલી જોઇતી હોય તો 0116 295 7626 પર એન્ગેજમેન્ટ ટીમનો સંપર્ક કરવા વિનંતી.

यह NHS लीसेस्टरशायर काउंटी और रुटलैंड के लिए वार्षिक रिपोर्ट 2012-13 है। यदि आप इस जानकारी का अनुवाद करवाना चाहते हैं, तो कृपया 0116 295 7626 पर एंगेजमेंट टीम से संपर्क करें।

Jest to raport roczny za okres 2012-13 przygotowany dla NHS Leicestershire County & Rutland. Jeżeli chcieliby Państwo otrzymać niniejszy dokument w tłumaczeniu na język obcy, prosimy skontaktować się z nami telefonicznie pod numerem 0116 295 7626.

ਇਹ NHS ਲਿਸੈਸਟਰਸ਼ਾਇਰ ਕਾਊਂਟੀ ਅਤੇ ਰਟਲੈਂਡ ਵਾਸਤੇ ਸਾਲਾਨਾ ਰਿਪੋਰਟ ਹੈ। ਜੇ ਤੁਸੀਂ ਇਸ ਜਾਣਕਾਰੀ ਦਾ ਅਨੁਵਾਦ ਕਰਵਾਉਣਾ ਚਾਹੁੰਦੇ ਹੋ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਇਨਗੇਜਮੈਂਟ ਟੀਮ ਨਾਲ 0116 295 7626 'ਤੇ ਸੰਪਰਕ ਕਰੋ।

Kani waa warbixinta sanadka 2012-13 ee NHS Leicestershire County iyo Rutland. Haddii aad rabtid in macluumaadka laguu turjumo fadlan kooxda dhex-gelidda kala xiriir 0116 295 7626.

یہ NHS لیسسٹرشائر کاؤنٹی اور رٹلینڈ کی 2012-13 کی سالانہ رپورٹ ہے۔ اگر آپ کو ان معلومات کا ترجمہ درکار ہے تو براہ کرم انگیجمنٹ ٹیم سے 0116 295 7626 پر رابطہ کریں۔

NHS LEICESTER CITY - ACCOUNTS Y/E 31 March 2013

				2012/13				2011/12		
Name	Title	Date started if not in post all year	Date left if not in post all year	Salary	Other remuneration	Bonus Payments	Benefits in Kind	Salary	Bonus Payments	Benefits in kind
50% share of Cluster Board charged to NHS Leicester City	Board			(in bands of 5000) (£'000)		(in bands of 5000) (£'000)	(rounded to nearest £00)	(in bands of 5000) (£'000)	(in bands of 5000) (£'000)	(rounded to nearest £00)
Mandy Ashton	Director of Corporate Governance & Executive Nurse	n/a	14/08/2011	0	0	0	0	15 - 20	0	0
Cheryl Davenport	Director of Strategy	n/a	01/10/2011	0	0	0	0	45 - 50	0	0
Susan Bishop	Director of Finance	n/a	31/03/2013	50 - 55	10 - 15	0	0	55-60	0	0
Simon Freeman [1]	Director of Contracting, Performance and Information	n/a	31/03/2012	0	0	0	0	50-55	0	0
Catherine Griffiths [2]	Chief Executive	n/a	30/09/2012	65 - 70	15 - 20	0 - 5	10	85-90	0	10
Judith Hill [3]	Director of Nursing	n/a	31/05/2012	0 - 5	0 - 5	0	0	10 - 15	0	0
Aly Rashid	Medical Director	n/a	31/03/2013	60 - 65	15 - 20	0	0	80-85	0	0
Elizabeth Rowbotham	Director of Quality	n/a	31/03/2013	45 - 50	0 - 5	0 - 5	0	50 - 55	0	0
Patricia Roseblade	Director of Finance	n/a	31/05/2011	0	0	0	0	5 - 10	0	0
Toby Sanders [1]	Director of Primary and Community Care	n/a	31/03/2012	0	0	0	0	55-60	0	0
Nigel Skea	Director of OD and Workforce	n/a	31/03/2013	40 - 45	0 -5	0 - 5	0	45-50	0	0
Vikki Taylor [5]	Director of Commissioning	n/a	30/09/2012	20 - 25	0 - 5	0	0	45-50	0	0
Deb Watson [4]	Director of Public health and Improvement	n/a	31/03/2013	85 - 90	15 - 20	0	0	90 - 95	0	0
Cathy Ellis [6]	Chairman	n/a	31/03/2013	20 - 25	0	0	0	20-25	0	0
Gill Brigden [6]	Non Executive Director	n/a	31/03/2013	0 - 5	0	0	0	0-5	0	0
Barry Finnan [6]	Non Executive Director	n/a	31/03/2013	0 - 5	0	0	0	0-5	0	0
Brian Wilson [6]	Non Executive Director	n/a	31/03/2013	5 - 10	0	0	0	5-10	0	0
Paul Hackwood [6]	Non Executive Director	n/a	31/03/2013	0 - 5	0	0	0	0-5	0	0
Ruth Ingman [6]	Non Executive Director	n/a	31/03/2013	0 - 5	0	0	0	0-5	0	0
David Mell [6]	Non Executive Director	n/a	31/03/2013	0 - 5	0	0	0	0-5	0	0

This table shows the cost of the cluster board to NHS Leicester City in 2012/13

Notes:
1 Seconded to CCGs
2 Seconded to Midlands and East SHA
3 Staff member is not a member of the NHS Pension scheme
4 100% of costs are assigned to NHSLC
5 Seconded to Derbyshire & Nottinghamshire Area Team
6 These posts do not attract NHS Pensions

Other remuneration includes recruitment and retention payments and clinical excellence awards. This was included in salary costs in 2011/12, but is disclosed separately in 2012/13.

Department of Health

NHS

Leicester City Primary Care Trust

2012-13 Accounts

Published to gov.uk, in PDF format only.

www.gov.uk/dh

Leicester City 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.

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

Signed.....R P.....Designated Signing Officer

Name: david sharp

Date.....5/6/13.....

STATEMENT OF RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

Primary Care Trusts as NHS bodies are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the primary care trust and the net operating cost, recognised gains and losses and 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.

5/6/13 Date ..... Signing Officer

5/6/13 Date ..... Finance Signing Officer

INDEPENDENT AUDITOR'S REPORT TO THE RESPONSIBLE OFFICER OF LEICESTER CITY PCT

We have audited the financial statements of Leicester City PCT for the year ended 31 March 2013 on pages 5 to 49. 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 responsible officer of Leicester City PCT in accordance with Part II of the Audit Commission Act 1998. Our audit work has been undertaken so that we might state to the responsible officer of the PCT those matters we are required to state to him in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the responsible officer of the PCT for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer's Responsibilities, the Accountable 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 Leicester City PCT as at 31 March 2013 and of its expenditure and income for the year then ended; and

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

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

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

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

In our opinion:

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

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

Matters on which we are required to report by exception

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

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

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

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

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

- our review of the Governance Statement; and

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

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

Certificate

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

Neil Bellamy for and on behalf of KPMG LLP, Statutory Auditor

KPMG LLP
1 Waterloo Way
Leicester
LE1 6LP

6 June 2013

Name of Organisation: Leicester City Primary Care Trust

Organisation Code: 5PC

Annual Governance Statement

Scope of Responsibility

1. As Accountable Officer of Leicester City Primary Care Trust (PCT), 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.

2. In line with the guidance from the Department of Health I took on management responsibility, as the Accountable Officer, for the Leicester, Leicestershire and Rutland PCT Cluster from 1st October 2012 managing both 2012/13 operational delivery and planning for 2013/14. These new arrangements commenced from 1st October 2012 following a written and face-to-face handover of responsibilities from the departing Accountable Officer at the end of September 2012.

3. The Annual Governance Statement for 2012–2013 has been prepared against a backdrop of the most significant transformation across the NHS following the publication of the white paper followed by the Health and Social Care Act 2012. The organisation has had to operate at an incredible pace to ensure the safe disestablishment of the PCT and support for the successor organisations in handover including the support for new emerging organisation such as the Clinical Commissioning Groups. The Board Assurance Framework and risk management processes have been pivotal to ensuring the preparation for handover and disestablishment is undertaken safely, efficiently and effectively.

4. Leicester City PCT continued to work within the PCT Cluster arrangements with Leicestershire County and Rutland PCT. Culturally and organisationally had been embracing the new vision for the NHS and was well ahead on all aspects of transition.

5. As the organisation moved through the transition the executive function of the PCT Cluster transferred to the Local Area Team directors for the last 6 months of the year. The PCT Cluster Director of Finance, Director of Transition (previously Director of Quality for the first 6 months) and Director Workforce and Organisational Development continued in post to support the transition to the new health and care system and ensure continuity until 31st March 2013.

6. A single Chair and Non-Executive Directors continued to serve both the statutory Board of Leicester City PCT and Leicestershire County and Rutland PCT under the Cluster Board arrangements.

7. In 2012–2013 Leicester City PCT continued to work collaboratively with NHS organisations across the East Midlands in order to take a strategic view of the local health economy with the objective of improving and maximising efficiency in the commissioning of healthcare services.

8. The organisation was performance managed by NHS Midlands and East Strategic Health Authority and the NHS Commissioning Board and information provided on a regular basis to inform our position and progress against plans. The organisation relied on good systems of control and accurate information to be able to accurately inform its position.

9. Leicester City PCT worked in partnership with other organisations across Leicester, Leicestershire and Rutland (LLR) including the local authorities; primary health care providers; the voluntary sector; the police; probation service; community groups and private sector organisations to promote interagency working to improve the health of the population of Leicester City. Including new successor organisations such as the Clinical Commissioning Groups across LLR (i.e. East Leicestershire and Rutland CCG, West Leicestershire CCG and Leicester City CCG); Health and Well Being Boards etc. Local Authority partners provided scrutiny and challenge through the local Health and Social Care Overview and Scrutiny arrangements.

10. The organisation had an established mechanism in place that enabled the Board, Executive Directors and Committees to monitor the ongoing performance of the organisation and performance against the transition plans to support successor bodies e.g. Clinical Commissioning Groups; National Commissioning Board; and Health and Well Being Boards. This mechanism included the use of formal policies, procedures and reporting arrangements through the single joint committee structure across the PCT Cluster to identify, evaluate, and address and monitor risks.

The governance framework of the organisation

11. Leicester City PCT, in collaboration with Leicestershire County and Rutland PCT, continued to review its Corporate Governance Framework (i.e. Standing Orders, Scheme of Delegation and Standing Financial Instructions) throughout 2012 – 2013 ensuring that governance arrangements remain sound and robust during the transition to successor organisations.

12. The overall responsibility for the management of risk lies with me as the Accountable Officer. The Board collectively and individually ensured that robust systems of internal control and management were in place. This responsibility was supported through an effective Board and committee structure.

13. The Cluster Board model introduced in August 2011 continued throughout 2012 – 2013. For the last 6 months of the year the composition of the Cluster Board included executives from the Local Area Team as opposed to the Executive Directors from the PCT Cluster. The Chair and Non-executive Directors remained the same throughout the year.

14. Board development sessions have taken place regularly during 2012 – 2013 providing an opportunity for Board members to, for example, review new guidance relating to the transition in greater depth and its implications on the Board's

business; develop further insight into performance issues with key providers; enhance their knowledge on a specific topic; and receive detailed information on key national documents (e.g. on the summary of the Francis Inquiry). Board members' attendance record at both Board development sessions and the public Board meetings are positive, all Cluster Board meetings throughout 2012 – 2013 have been quorate with all or the majority of the Board members being present.

15. The Board sought assurance through regular review of the Board Assurance Framework at the Board, outcomes from the Transition Management Team meetings (e.g. through reports relating to performance, monthly finance reports etc) and the Audit Committee (e.g. in relation to effectiveness of internal control mechanisms). The Quality and Clinical Governance committee received assurance reports to monitor areas of risk e.g. safeguarding, care homes, patient safety, serious incidents etc. Regular reports from the Quality and Clinical Governance Committee were presented to the Board drawing the Board's attention to key risks, in addition to reports on safeguarding adults and children and serious incident reports. The Board reviewed these reports and sought assurance to demonstrate that providers are learning from incidents. The Competition and Procurement Committee assured the Board that safeguards are in place in relation to procurement processes. All these groups had a role to provide regular monitoring to identify themes and trends for learning and sustained improvements.

16. The organisation continued to operate through its comprehensive committee structure which ensures identification, robust management, reporting and accountability for risk management.

17. During 2012 – 2013 the 3 LLR Clinical Commissioning Groups continued to operate as sub-committees of the Cluster Board as they all progressed successfully through the authorisation process and confirmed as fully authorised. The PCT Cluster continued to delegate responsibilities to the CCGs preparing and supporting them through the authorisation in readiness for taking on full statutory functions from 1st April 2013. This included supporting the CCGs to establish committee structures reporting to their Boards to ensure oversight and monitoring of patient safety, patient experience, clinical governance, financial, performance and corporate governance risks. Regular Board to Board meetings with the CCGs enabled the PCT Cluster to review and monitor progress made by the CCGs.

18. During 2012 – 2013 the committee structure for the identification and management of risks has been as follows:

    a) *The Audit Committee* continued as a joint committee of the PCT Cluster. The Audit Committee has responsibility for reviewing and ensuring that the organisation has established and is maintaining robust and effective systems of integrated governance, risk management and internal control across all areas of its business. It is responsible for providing assurance to the Cluster Board that the Executive Team has appropriate and adequate systems in place to ensure links between risk management, financial risk, corporate and clinical governance. The Audit Committee reviewed the Board Assurance Framework to provide assurance to the Board that the organisation's risk management

processes are effective and risks are being effectively controlled. It received regular reports on the work and findings of the internal and external auditors; reports from counter fraud team; reports from management in relation to follow-up and progress in relation to implementation of audit recommendations. The Audit Committee receives a formal opinion from the Head of Internal Audit on the degree of assurance that can be derived from the system of internal control. The Audit Committee is chaired by a Non-Executive Director.

b) *The Transition Management Team,* membership of which consists of all the Executive Directors across the Cluster, has delegated responsibility for ensuring a sound system of risk management is developed and implemented across the organisation; and for monitoring business risks, including health and safety. The Transition Management Team (TMT) also oversees the operation of directorate level processes and ensures risk management is a key feature of the performance management process. This supported the identification of operational risks that need to be factored into wider business planning processes and then into commissioning negotiations and ensure that divisions are working collaboratively to manage risks. This Group evolved into two separate groups in the last 6 months of the year. A senior management team whose primary role was on going operational issues for the PCT and the Area Team; and the Transition leads meeting consisting the Director of Transition, Director of Finance, Director of Workforce and Organisational Development and including lead officers. The Transition Leads meeting is the Group overseeing the operational face-to-face and written handover and closure documents including the risks relating to functions transferring to other organisations. Regular reports are presented to the Cluster Board providing update, progress and risks in relation to the transition.

c) *The Performance collaborative* monitors the organisation's compliance with national and local targets; QIPP; workforce metrics; financial management arrangements; identifies and monitors key risks that are raised in relation to performance and financial management ensuring adequate systems of control and assurances are in place; and has regular oversight of the corporate and directorate risks. All Executive Directors form the membership of the Group along with CCG Managing Directors and lead officers. The Performance Collaborative plays a key role in ensuring strong financial management systems are in place to enable the organisation to meet its financial statutory duties. It also included the performance management, including remedial action plans for areas of non-compliance against national and local targets and identifies and monitors key risks that are raised in relation to performance and financial management, ensuring adequate systems of control and assurances are in place.

d) *The Quality and Clinical Governance Committee,* chaired by a Non-Executive Director, provided assurance to the Cluster Board in relation to patient safety, patient experience and clinical effectiveness across commissioned services. Its key function is to ensure that quality assurance and clinical governance is integral to performance monitoring arrangements for all commissioned services. It monitored risks in relation to patient safety (e.g. themes and trends

from clinical incidents, health and safety incidents, serious untoward incidents), quality of care and patient experience (e.g. themes and trends from patient surveys, complaints) and ensured systems and processes change to mitigate these risks. Risks identified through this committee were brought to the attention of the Cluster Board and monitored through the committee. Information Governance reports are presented and reviewed at the Quality and Clinical Governance Committee providing assurance in relation to information governance risks.

e) The *Information Governance Committee* was responsible for ensuring that the organisation managed information effectively through appropriate policies, procedures and structures. This provided a robust governance framework for information management ensuring compliance with the national Information Governance Toolkit standards. This Group reported into the Quality and Clinical Governance Committee.

f) *The Remuneration and Terms of Service Committee* determined and agreed with the Board the framework or broad policy for the remuneration of the PCT Cluster Chief Executive, the Executive Directors and other such posts that report to the Chief Executive. This included: all aspects of salary, including any performance related elements and bonuses; and provisions for other benefits. The Committee also determined on behalf of the Cluster Board, the financial arrangements for termination of employment, including the terms of any compensation package and other contractual terms excluding ill health and normal retirement for all employees, including very senior managers. The Committee consisted of 3 Non-Executive Directors. The Director of Organisational Development and Workforce attended to act as a support to the Committee in its work and was occasionally joined by me as and when required. The Committee Chair reported formally to the Confidential Cluster Board on its proceedings and maked recommendations to the Cluster Board to agree all decisions that have been made.

g) *The Competition and Procurement Committee* ensures safeguards are in place in relation to procurement processes. This Committee was chaired by a Non-Executive Director.

h) *The Leicester City CCG Board* – had delegated authority from the statutory Board to develop commissioning capacity and capability to enable it to become statutory organisation having successfully completed authorisation in December 2012, to provide clinical leadership for the development of its commissioning vision and strategic direction; to identify and monitor risks that may arise through this process and transition period. Furthermore it is responsible for ensuring health inequalities and governance issues are addressed for the benefit of patients promoting equitable and transparent access to health services. Hence it has a responsibility to identify and monitor risks relating to commissioning of safe and effective services.

19. The Cluster Board recognised that the overall governance framework across the Cluster had become more robust and fit for purpose for supporting the Cluster through the transition to successor bodies. The Cluster Board continued to

comply with the Corporate Governance Code, this is evident, for example through the following:

- there was clear division of responsibilities between the running of the Board and the executive responsibilities for running the organisation. The Chair was responsible for leading the Board and ensuring it is effective in its role, and appropriate development sessions support the Board's role.
- The Board Committees consisted of a balance of skill, knowledge, independence and experience for them to carry out duties and responsibilities.
- Information was supplied to the Board and its committees in a timely manner and of a quality that enables the Board to discharge its duties.
- The Board assessed the nature and extent of the significant risks it is willing to take in achieving its strategic objectives; and it maintains a sound system of risk management and internal control.
- The Remuneration Committee had oversight of the arrangements in relation to policy on executive remuneration.

Risk assessment

20. The Risk Management Strategy and Policy was approved in April 2012, detailing the principles, systems and processes, has been applied during 2012 – 2013. This can be demonstrated through the risk reports presented to the Performance Collaborative, to the Transition Team, to the Audit Committee and to the Cluster Board. The PCT Cluster has continued to maintain a corporate risk register (i.e. the Board Assurance Framework). The Risk Management Strategy and Policy include emerging organisations within its scope and has been adopted by the CCGs for use locally.

21. The key to effective risk management lies with the LLR PCT Cluster knowing what risks are likely to occur so that they could proactively manage them. An effective mechanism to capture and report risks is therefore essential. Risks were identified in two ways from internal and external sources using proactive or reactive methods:
    - top down – for example, proactive identification of risks that directly affect the PCT Cluster's and CCGs' achievement of their objectives, e.g., considering the political, economical, social and technological environment, as well as horizon scanning used to identify emerging opportunities and threats.
    - bottom up – for example, assessment through directorate and CCG Risk Registers, claims and litigation, a cluster of incidents or complaints, and through performance management arrangements.

22. Strategic risks identified in the Board Assurance Framework represented major threats to achieving the PCT Cluster's strategic objectives including risks escalated from the CCGs' Risk Registers. Strategic risks were recorded in the PCT Cluster's Board Assurance Framework reports to the PCT Cluster Board and the Cluster Audit Committee during 2012-13 and were reviewed monthly through the Performance Collaborative and the Cluster Board. During 2012 – 2013 the following risks were escalated to the Board Assurance Framework as new risks (these are detailed within the Board Assurance Framework):

a) Unable to achieve strategic synergy and plans for achieving Better Care Together objectives.
b) Unable to reach a clear vision for future of LLR estate that will achieve a £211m reduction.
c) Various risks relating to transition to successor organisations were identified.

23. In March 2013 the Cluster Board received the Board Assurance Framework which was updated to reflect and identify the residual risks in preparation for handover to successor organisations; and also risks that have been closed prior to handover.

24. The Operational risks are by-products of the day-to-day running of the PCT Cluster and CCGs and include a broad spectrum of risks including clinical, fraud, security, financial, information and legal risks arising from employment law and health and safety legislation and the risk of damage to assets or system failures. They were the responsibility of management and were identified and managed by Executive Directors at directorate and / or local CCG level and only considered by the Cluster Board on an exception basis.

25. In terms of governance and monitoring arrangements, during the first 6 months of the year a risk report was received at performance collaborative on a monthly basis which includes a report on directorate level risks, including CCG function level risks, and updates on strategic risks that are contained within the Board Assurance Framework. the performance collaborative and the executive team has a remit to ensure oversight of risks and provides the forum where cluster leads and CCG leads confirm and challenge the content of the risk registers and the Board Assurance Framework. This was to ensure that the risks were captured and articulated accurately, that evaluation of risk scores were appropriate, that controls and assurances were in place, and identify whether further resources and actions were required to address the identified risks.

26. During the year formal Board to Board meetings were in place to ascertain how the CCGs are progressing with their performance which included a progress update on governance and risk management systems and processes.

27. The Audit Committee received a report on risk at every meeting, usually held on a bi-monthly basis. The Cluster Board received an update on the Board Assurance Framework on a monthly / bi-monthly basis.

28. Updates in controls, assurance, evaluations of risks, update on actions and identification of risk within the Assurance framework were reported monthly and reviewed regularly to ensure it covered all areas of risk for which the Board should be receiving assurance. This information was supplemented and enhanced by the performance reports, finance reports, workforce metrics etc that were also reviewed at the Performance Collaborative / Transition Group. These reports along with the Assurance Framework were presented to the Cluster Board at agreed intervals.

29. The system of internal control was designed to deliver strategic objectives by managing the organisation's strategic risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it could therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control was based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Leicester City PCT, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control had been in place in Leicester City PCT for the year ended 31 March 2013 and will continue to be in place up to the date of approval of the Annual Report and accounts in line with the national guidance relating to the disestablishment of the PCT.

30. Monthly quality and performance dashboard reports; and provider contract and performance reports were presented to the Cluster Board identifying progress and areas of risk. The Transition Groups presented reports on the Assurance Framework to the Cluster Board, Audit Committee and the Performance collaborative on a monthly basis or at agreed intervals.

31. Leicester City PCT continually reviewed its commissioning practices and procedures, upgrading and enhancing them where appropriate to ensure that they are fit for purpose. This was in order to provide management with assurance that health services are commissioned in such a way as to minimise clinical risk and maximise use of resources. During 2012 – 2013 responsibility for key commissioning decisions had been incrementally devolved to Leicester City CCG supported by a scheme of delegation and robust performance monitoring arrangements, including regular Board-to-Board meetings with the CCG Board, which included regular risk reports from the CCG. The PCT remained the accountable body.

32. The organisation had in place a Trust Board approved Risk Management Strategy and Policy. This provided guidance to staff in managing risk and was supported by corporate induction and local training for staff in managing the risks appropriate to their areas of responsibility. The strategy clearly set out the authority levels and accountability arrangements and identified key individuals within the organisation who had specific duties with regard to the management of risk. The strategy and associate policies were reviewed on an annual basis to ensure they remained fit for purpose and reflective of changes within the organisation.

The risk and control framework

33. Risk management is an integral part of good management processes and the proactive and continuous management of risk is essential to the efficient and effective delivery of an organisation's objectives. Risk management is the key to delivering the requirements of governance. The organisation's Risk Management Strategy and Policy set the strategic and operational frameworks of successful management and evaluation of risk.

34. Leicester City PCT adopted a common framework for the assessment and analysis of all risks whether they are clinical, financial, information or

organisational. The actions required to treat the risks were documented on the risk registers, which was updated as risks continued to be assessed and treated.

35. The Risk Management Strategy and Policy was reviewed on an annual basis to ensure that the governance arrangements for managing corporate business risks and operational risks were robust and reflected the changing requirements of the organisation; it captured best practice, for instance as described in "Taking it on Trust" (Audit Commission, April 2009); and ensured that the organisation continued to strengthen its risk management processes to enable it to be forward looking.

36. Delivery of the Risk Management Strategy and Policy was also achieved through the implementation of associated policies and procedures, for example, health and safety policies / procedures, incident reporting, claims policy, Counter Fraud Policy, HR policies etc. Progress and performance in achieving the aims of the strategy and adherence to the policy was monitored by the Transition Management Team / Transition Group, the Director of Quality (who then was appointed the Director of Transition) and ultimately the Cluster Board.

37. The policies and procedures in place across the PCT aimed to, as far as possible, prevent risks from arising; policies, procedures and codes of conduct made available to staff through various mechanisms including through the PCT intranet site. Mandatory training included raising awareness about countering fraud, identifying potential risks and also identifying where risks may have materialised (for example, through the incident reporting process). Relevant systems and processes were implemented to support the policies and procedures, for instance the Corporate Governance Framework (i.e. Standing Orders, Scheme of Delegation and Standing Financial Instructions) clearly stipulated the delegations to, for example, budget holders which was then reflected within the SBS system to ensure appropriate level of authorisation is obtained for approval of invoices. Where risks have materialised the Executive Team would review the controls in place to determine how the controls need to be improved and whether assurances need to be sought from alternative sources.

38. A two-tier process involving local directorate based registers and a corporate register (Assurance Framework) had been implemented to reflect the organisation's risk profile. The aim of the two tier approach was to ensure that the strategic picture do not become clouded by the day to day risk management issues that can and were dealt with as a matter of course at local level, whilst still providing a clear route for significant local issues to influence the strategic risk profile.

39. The Assurance Framework (corporate risk register), which aligned to the PCT Cluster objectives, provided the organisation with a comprehensive method for the effective and focused management of the principle risks with action plans in place to mitigate risks identified. It also demonstrated how risks are communicated throughout the organisation. The Assurance Framework identified which of the organisation's objectives were at risk due to inadequacies in the operation of controls or where the organisation had insufficient assurance. The Assurance Framework continued to be kept up to date through the transition

period and provided structured assurances about where risks were being managed effectively and objectives being delivered. During 2012 – 2013, in line with the review of the organisation's business objectives, the risks associated with the objectives have been collated within the updated Assurance Framework for the PCT Cluster ensuring risks identified across CCGs in Leicester, Leicestershire and Rutland are also captured within the Framework.

40. Each Directorate and CCG had a Directorate (operational) Risk Register where they monitored their local risks. Risks were linked to strategic objectives and the likelihood and impact were assessed to ascertain risk appetite, inherent risk and residual risk and individual leads are assigned to actions. The Assurance Framework was built around the proactive and reactive assessment of risks that may have an impact on the achievement of corporate objectives. This simplified Board reporting and the prioritisation of action plans which, in turn, allowed for more effective performance management.

41. Risk identification and management had been incorporated into key processes within Leicester City PCT ensuring embeddedness of the principles of risk management and encouraging a proactive approach to identifying risks. The core business processes, for instance, included the review of risk and the impact on strategic decision making. The organisation's "case of need toolkit" requires leads to identify the risk of not implementing a scheme and the benefits realisation of the scheme. In addition, the toolkit included the requirement to undertake equality impact assessments for each case of need. The completion of an equality impact analysis and having "due regard" was also a key requirement within the Policy for the Development of Policies.

42. Strategic and operational risks on the corporate and local risk registers were regularly reviewed by management with the objective of ensuring risks were effectively managed. These registers were used to record risks using the 5 x 5 risk scoring matrix. Risks were reported and escalated in line with the Risk Management Strategy and Policy.

43. Summary updates and reports on the status of key risks were presented to the Executive Team via the Performance collaborative and the transition leads Group and at agreed intervals to the Audit Committee and the Cluster Board.

44. Whilst Leicester City PCT considered risks to the organisation in meeting its objectives and to its staff, it also considered those to whom a service is provided, the organisations and also the patients themselves. The PCT received risk reports and, where appropriate, assurances and mitigation plans from those organisations from which it commissioned a service. For instance, the PCT relied on reports under International Standards on Assurance Engagements (ISAE) 3402 circulated by NHS SBS in relation to payroll, financial and accounting systems services and Family Health Services as well as certain IT services.

45. The organisation continued the process of implementing a targeted training and awareness programme across the organisation to ensure that staff were able to appropriately manage risks within their roles. For instance all staff were encouraged to undertake the e-learning module to enhance awareness about

- fraud issues, acceptable business practices, lessons learnt from fraud cases etc. This formed part of individual development plans.

46. Specialist advice on risk assessment and management is available to the organisation through, for instance, the organisation's Associate Director of Corporate Governance / Company Secretary, Fire and Safety Manager, Health and Safety Adviser (external) and the Associate Director of Information Security and Governance. Over the last year there has been continued increase in awareness at all levels of the organisation of the importance and relevance of risk management to operational processes.

47. Specific gaps in controls and assurance that have been highlighted within the Board Assurance Framework 2012 – 2013. The Board Assurance Framework details gaps in control relating to, for instance, policies and procedures. In a number of instances gaps in assurance relate to where further guidance is to be issued. Actions were in place to ensure that the gaps highlighted within the Assurance Framework are addressed in a timely manner. The Board Assurance Framework as at March 2013 also identifies the residual risk score of risks at the point of handover.

48. The Internal Audit programme of work has been completed and the Head of Internal Audit has provided an opinion of significant assurance.

49. Leicester City PCT had in place an Information Governance Strategy and Policy with an Information Governance Committee overseeing the implementation of the strategy and policies. During 2012 – 2013 update reports have been provided to the Quality and Governance Committee, including Information Governance Toolkit Action Plans and end of year assessments. The final year end self-assessment for 2012 – 2013 was agreed at the Joint Information Governance Steering Group in March 2013. Specific requirements were submitted to Internal Audit for which the Auditor's provided an opinion of "significant assurance". Information risks are clearly defined within the Risk Management Strategy and Policy including the role of the Senior Information Risk Officer and the Information Asset Owners, which supports the requirements for identifying and managing information risk.

50. The NHS Data Mapping exercise was reviewed annually and involved identification of personal identifiable information (PII) data flows into and out of the organisation and between sites and departments within the organisation. Systems and processes are in place to ensure the security of the bulk data transfers; and to ensure encryption of all electronic PII data transfers e.g. via email and PII held on mobile devices such as laptops.

51. The organisation had developed systems both through its reporting processes and policies for managing risks that involve public stakeholders. The Patient and Public Involvement Strategy had been applied with the help of stakeholders to ensure that the organisation proactively works with stakeholders, where possible, to develop complementary systems. Stakeholder involvement and engagement was gained through active communication with the population of Leicester,

involvement of the Non-Executive Directors in key business activities of the PCT and an active involvement with the Local Involvement Networks.

52. As an employer with staff entitled to membership of the NHS pension scheme, control measures were in place to ensure all employer obligations contained within the scheme regulations were complied with. This included ensuring that deductions from salary, employer's contributions and payments in to the scheme were in accordance with the scheme rules, and that member pension scheme records were accurately updated in accordance with the timescales detailed in the regulations.

53. Control measures were in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation complied with. Early implementation of the Equality Delivery System by the PCT Cluster and the CCGs underpins this.

Review of the effectiveness of risk management and internal control

54. 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 Head of Internal Audit Opinion for 2012 – 2013 provides an opinion of "significant assurance". Executive Directors within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by audit reviews conducted by External Auditors, Internal Auditors, self-assessment against the Information Governance Toolkit standards, PCT Cluster Board Committees and sub-committees and the overall performance management framework within the organisation.

55. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Audit Committee, the performance collaborative, the transition leads meeting, Quality and Clinical Governance Committee, Competition and Procurement Committee, the CCG Board. A plan to address weaknesses and ensure continuous improvement of the system is in place.

56. The process that has been applied in maintaining and reviewing the effectiveness of the system of internal control is detailed below.

57. The Cluster Board has ultimate responsibility for risk management and for agreeing the Annual Governance Statement. It needs to be satisfied that appropriate strategies and policies are in place and that internal control systems are functioning effectively so that key risks that may threaten the achievement of strategic objectives are identified, recorded and minimised.

58. Furthermore, it must be noted that there have been no incidents reported in 2012 – 2013 which were categorised as a serious incident relating to data security and

were reported to the Information Commissioner in line with policy and guidance. Lessons have been learnt from previous years and systems and controls have been enhanced to prevent such an incident occurring. Should such an incident occur, immediate action would be taken; an investigation would take place to identify the root causes of each incident; and lessons learnt shared across the organisation to ensure the incident does not recur.

59. Significant control issues across the PCT Cluster have not been identified however risks and control issues were identified during the review of the following areas by Internal Audit and were therefore provided with an opinion of "limited assurance":

    a. Continuing Healthcare
    b. Governance and Business Continuity of East Midlands Specialised Commissioning (split opinion of significant and limited)
    c. Estates Review (capital expenditure)
    d. Review of Agency and Contractor Usage (SO1s).

60. Immediate action was taken when risks were identified in the above areas and action plans developed for each area to address the risks identified. The Continuing Healthcare audit review highlighted a number of areas of concern and therefore to ensure patient safety was not compromised a detailed and robust plan of action has been developed in conjunction with the CCGs. The PCT Cluster Audit Committee received assurance that the CCGs will be prioritising the action plan relating to Continuing Healthcare in early 2013 – 2014 to ensure recommendations are implemented.

61. My review confirms that Leicester City PCT had a generally sound system of internal control that supported the achievement of its policies, aims and objectives; areas of concern have been addressed and as a result controls have been, and continue to be, strengthened.

Accountable Officer:	**David Sharp**
Organisation:	**Leicester City Primary Care Trust**
Signature:	R P
Date:	5/6/13

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	**9,192**	9,932
Other costs	5.1	**586,749**	564,960
Income	4	**(25,265)**	(19,051)
Net operating costs before interest		**570,676**	555,841
Investment income	9	**(732)**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**3,500**	3,146
Net operating costs for the financial year		**573,444**	558,987
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		**573,444**	558,987
Of which:			
Administration Costs			
Gross employee benefits	7.1	**7,065**	7,576
Other costs	5.1	**16,025**	14,224
Income	4	**(10,663)**	(9,842)
Net administration costs before interest		**12,427**	11,958
Investment income	9	**(732)**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**3,500**	3,146
Net administration costs for the financial year		**15,195**	15,104
Programme Expenditure			
Gross employee benefits	7.1	**2,127**	2,356
Other costs	5.1	**570,724**	550,736
Income	4	**(14,602)**	(9,209)
Net programme expenditure before interest		**558,249**	543,883
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**0**	0
Net programme expenditure for the financial year		**558,249**	543,883

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**389**	0
Net (gain) on revaluation of property, plant & equipment	**0**	(4,264)
Net (gain) on revaluation of intangibles	**0**	0
Net (gain) on revaluation of financial assets	**0**	0
Net (gain)/loss on other reserves	**0**	0
Net (gain)/loss on available for sale financial assets	**0**	0
Net (gain) /loss on Assets Held for Sale	**0**	
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*	**573,833**	554,723

The notes on pages 5 to 49 form part of this account.

Statement of Financial Position at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	12	**48,767**	51,020
Intangible assets	13	**41**	17
investment property		**0**	0
Other financial assets	20	**1,508**	1,203
Trade and other receivables	18	**0**	0
Total non-current assets		**50,316**	52,240
Current assets:			
Inventories	17	**0**	0
Trade and other receivables	18	**5,347**	6,807
Other financial assets	20	**0**	0
Other current assets	21	**0**	0
Cash and cash equivalents	22	**7,826**	13
Total current assets		**13,173**	6,820
Non-current assets held for sale	23	**0**	0
Total current assets		**13,173**	6,820
Total assets		**63,489**	59,060
Current liabilities			
Trade and other payables	24	**(47,712)**	(44,379)
Other liabilities	25	**0**	0
Provisions	31	**(2,695)**	(3,234)
Borrowings	26	**(551)**	(507)
Other financial liabilities	27	**0**	0
Total current liabilities		**(50,958)**	(48,120)
Non-current assets plus/less net current assets/liabilities		**12,531**	10,940
Non-current liabilities			
Trade and other payables	24	**0**	0
Other Liabilities	25	**0**	0
Provisions	31	**(3,532)**	(2,426)
Borrowings	26	**(39,068)**	(39,618)
Other financial liabilities	27	**0**	0
Total non-current liabilities		**(42,600)**	(42,044)
Total Assets Employed:		**(30,069)**	(31,104)
Financed by taxpayers' equity:			
General fund		**(37,867)**	(39,614)
Revaluation reserve		**7,798**	8,510
Other reserves		**0**	0
Total taxpayers' equity:		**(30,069)**	(31,104)

The notes on pages 5 to 49 form part of this account.

The financial statements on pages 1 to 4 were approved by the Audit Committee on behalf of the Board on 5 June 2013 and signed on its behalf by

Chief Executive: R P Date: 5/6/13

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	**(39,614)**	**8,510**	**0**	**(31,104)**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(573,444)			**(573,444)**
Net gain on revaluation of property, plant, equipment	0	0		**0**
Net gain on revaluation of intangible assets	0	0		**0**
Net gain on revaluation of financial assets	0	0		**0**
Net gain on revaluation of assets held for sale	0	0		**0**
Impairments and reversals	0	(389)		**(389)**
Movements in other reserves	0	0	0	**0**
Transfers between reserves*	323	(323)		**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	**(573,121)**	**(712)**	**0**	**(573,833)**
Net Parliamentary funding	574,868			**574,868**
Balance at 31 March 2013	**(37,867)**	**7,798**	**0**	**(30,069)**
Balance at 1 April 2011	**(32,358)**	**4,246**	**0**	**(28,112)**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(558,987)			(558,987)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment	0	4,264		4,264
Net Gain / (loss) on Revaluation of Intangible Assets	0	0		0
Net Gain / (loss) on Revaluation of Financial Assets	0	0		0
Net Gain / (loss) on Assets Held for Sale	0	0		0
Impairments and Reversals	0	0		0
Movements in other reserves			0	0
Transfers between reserves*	0	0		0
Release of Reserves to Statement of Comprehensive Net Expenditure		0		0
Reclassification Adjustments				
Transfers to/(from) Other Bodies within the Resource Account Boundary	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	(558,987)	4,264	0	(554,723)
Net Parliamentary funding	551,731			551,731
Balance at 31 March 2012	**(39,614)**	**8,510**	**0**	**(31,104)**

Statement of cash flows for the year ended 31 March 2013

	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities		
Net Operating Cost Before Interest	**(570,676)**	(555,841)
Depreciation and Amortisation	**2,402**	2,470
Impairments and Reversals	**226**	2,502
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	**(3,500)**	(3,146)
Release of PFI/deferred credit	**0**	0
(Increase)/Decrease in Inventories	**0**	364
(Increase)/Decrease in Trade and Other Receivables	**1,460**	542
(Increase)/Decrease in Other Current Assets	**0**	0
Increase/(Decrease) in Trade and Other Payables	**3,445**	4,096
(Increase)/Decrease in Other Current Liabilities	**0**	0
Provisions Utilised	**(2,240)**	(3,338)
Increase/(Decrease) in Provisions	**2,807**	1,808
Net Cash Inflow/(Outflow) from Operating Activities	**(566,076)**	(550,543)
Cash flows from investing activities		
Interest Received	**146**	0
(Payments) for Property, Plant and Equipment	**(857)**	(1,330)
(Payments) for Intangible Assets	**(43)**	(6)
(Payments) for Other Financial Assets	**0**	0
(Payments) for Financial Assets (LIFT)	**0**	0
Proceeds of disposal of assets held for sale (PPE)	**0**	0
Proceeds of disposal of assets held for sale (Intangible)	**0**	0
Proceeds from Disposal of Other Financial Assets	**281**	0
Proceeds from the disposal of Financial Assets (LIFT)	**0**	0
Loans Made in Respect of LIFT	**0**	0
Loans Repaid in Respect of LIFT	**0**	0
Rental Revenue	**0**	0
Net Cash Inflow/(Outflow) from Investing Activities	**(473)**	(1,336)
Net cash inflow/(outflow) before financing	**(566,549)**	(551,879)
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**(506)**	(450)
Net Parliamentary Funding	**574,868**	551,731
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	**574,362**	551,281
Net increase/(decrease) in cash and cash equivalents	**7,813**	(598)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**13**	3
Opening balance adjustment - TCS transactions		608
Restated Cash and Cash equivalents (and bank overdraft) at beginning of the period		611
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	**7,826**	13

1 Accounting policies

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

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

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

1.1 Accounting Conventions

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

Transforming Community Services (TCS) transactions

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

Acquisitions and Discontinued Operations

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

Critical accounting judgements and key sources of estimation uncertainty

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

Critical judgements in applying accounting policies

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

All arrangements containing leases have been correctly identified in accordance with the relevant interpretation issued by the International Financial Reporting Interpretations Committee (IFRIC 4). Having reviewed all leases, they have been classified as an operating or finance lease, in accordance with the relevant International Accounting Standard (IAS 17).

The LIFT ("Local Finance Improvement Trust") lease plus contracts relate to the lease of healthcare facilities along with the provision of various services for a 25 year period. The PCT has determined that this contract should be considered as an IFRIC 12 service concession since the contract is for the provision of services, which are controlled by the PCT, in relation to the infrastructure asset. The PCT also has a significant interest in the residual value of the asset, via an option to buy the facilities in the last 6 months of the contract.

The PCT considers it is reasonably likely that this option will be exercised, and therefore has recorded the finance option price of the building as a bullet lease payment. The assets are being depreciated using the Department of Health LIFT model which assumes the life of the assets over the life of the lease i.e. 25 years but also builds in an estimated residual value of the asset. The District Valuer has assumed a useful life of 50 years for these assets and there will be a difference between the residual value of the asset at the conclusion of the lease using the DV valuation and the LIFT model. However due to the uncertainty in determining future values of land and buildings, the LIFT model has been used at it builds in estimated future indices.

1 Accounting policies (continued)

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

The PCT routinely estimates full year spend for items such as prescribing costs, where only part year information is available at the time of the annual accounts preparation. The prescribing accrual is based on NHS Business Services Authority Information. Any difference between accruals made and actual expenditure incurred will be accounted for in the following year's expenditure within the appropriate successor organisation. Such differences are not expected to have a material impact.

In the preparation of these financial statements, estimates and assumptions have been made by management concerning the selection of useful lives of fixed assets, provisions necessary for certain liabilities and other similar evaluations. Actual amounts could differ from those estimates.

Under IAS37, a provision is recognised when an entity has a present obligation as a result of a past event, it is probable that an outflow of resources embodying economic benefits will be required to settle the obligation and a reliable estimate can be made of the obligation. Details of the PCT's provisions and an assessment of the likelihood of payments being made against them are shown at note 31.

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 pooled budgets with Leicester City Council (Learning Disabilities & Community Equipment), Leicester County Council (Community Equipment), Rutland County Council (Community Equipment) and Leicestershire County and Rutland PCT (Community Equipment). Under the arrangements funds are pooled under S31 of the Health Act 1999 for Learning Disabilities and Community Equipment activities and memoranda notes to the accounts provide details of the joint income and expenditure.

The Learning Disability Pool and the Community Equipment Pool are hosted by Leicester City Council. As a commissioner of healthcare services, the Primary Care Trust makes contributions to the pool, which are then used to purchase healthcare services. The Primary Care Trust accounts for its share of the assets, liabilities, income and expenditure of the pool as determined by the pooled budget agreement. Details of Income and Expenditure are shown at Note 39.

For 2012/13 (and 2011/12), the funding for LD commissioning has been passed directly to Local Authorities by the Department of Health. Previously, this income and associated expenditure would have been shown by the PCT.

1.4 Taxation

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

1.5 Administration and Programme Costs

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

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

1 Accounting policies (continued)

1.6 Property, Plant & Equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation

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

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

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

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive net expenditure in the Statement of Comprehensive Net Expenditure

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1 Accounting policies (continued)

1.7 Intangible Assets

Recognition

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

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at amortized historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.8 Depreciation, amortisation and impairments

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

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the PCT expects to obtain economic benefits or service potential from the asset. This is specific to the PCT and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives or, where shorter, the lease term. As stated in Note 1.1 LIFT assets are depreciated over the life of the lease i.e. 25 years using the Department of Health LIFT model but which also provides a residual value.

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

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

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME) from 2011-12. This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.
AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1 Accounting policies (continued)

1.9 Donated assets

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

This accounting policy change has been applied retrospectively and consequently the 2010-11 results have been restated.

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 / weighted average] 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 31.

1 Accounting policies (continued)

1.16 Employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

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.

1.21 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 on-going 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.

Financial assets at fair value through profit and loss

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

Held to maturity investments

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

Available for sale financial assets

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

Loans and receivables

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

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

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

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

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

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

1 Accounting policies (continued)

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

Financial liabilities are initially recognised at fair value.

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

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

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

1.26 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 PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

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

b) PFI and 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 PFI 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

1.28 Going concern

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

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.

2 Operating segments

There are no segments to report for Leicester City PCT.

3 Financial Performance Targets

3.1 Revenue Resource Limit

	2012-13 £000	2011-12 £000
The PCT's performance for the year ended 2012-13 is as follows:		
Total Net Operating Cost for the Financial Year		558,987
Net operating cost plus (gain)/loss on transfers by absorption	**573,444**	
Adjusted for prior period adjustments in respect of errors	**0**	0
Revenue Resource Limit	**583,074**	562,652
Under/(Over)spend Against Revenue Resource Limit (RRL)	**9,630**	3,665

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	**1,110**	11,764
Charge to Capital Resource Limit	**788**	11,580
(Over)/Underspend Against CRL	**322**	**184**

3.3 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**574,868**	551,731
Cash Limit	**574,568**	551,731
Under/(Over)spend Against Cash Limit	**(300)**	**0**

The cash limit was subject to a late reduction of £300k by DH, which occurred after the cash limit for the year had been drawn down.

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

	2012-13 £000
Total cash received from DH (Gross)	502,783
Less: Trade Income from DH	0
Less/(Plus): movement in DH working balances	0
Sub total: net advances	**502,783**
(Less)/plus: transfers (to)/from other resource account bodies (free text note required)	0
Plus: cost of Dentistry Schemes (central charge to cash limits)	14,021
Plus: drugs reimbursement (central charge to cash limits)	58,064
Parliamentary funding credited to General Fund	**574,868**

4 Miscellaneous Revenue

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Fees and Charges	**0**	0	0	0
Dental Charge income from Contractor-Led GDS & PDS	**2,801**		2,801	2,864
Dental Charge income from Trust-Led GDS & PDS	**0**		0	0
Prescription Charge income	**3,184**		3,184	3,101
Strategic Health Authorities	**165**	92	73	183
NHS Trusts	**990**	0	990	471
NHS Foundation Trusts	**130**	4	126	14
Primary Care Trusts Contributions to DATs	**0**		0	0
Primary Care Trusts - Other	**2,735**	74	2,661	1,805
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	**48**	0	48	0
Recoveries in respect of employee benefits	**0**	0	0	0
Local Authorities	**0**	0	0	46
Patient Transport Services	**0**		0	0
Education, Training and Research	**702**	256	446	1,783
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	**104**	87	17	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	**5,475**	5,475	0	1,437
Other revenue	**8,931**	4,675	4,256	7,347
Total miscellaneous revenue	**25,265**	**10,663**	**14,602**	**19,051**

5 Operating Costs

5.1 Analysis of operating costs:

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
Goods and Services from Other PCTs				
Healthcare	**102,900**		102,900	89,454
Non-Healthcare	**1,934**	1,934	0	0
Total	**104,834**	**1,934**	**102,900**	**89,454**
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	**267,511**	0	267,511	267,649
Goods and services (other, excl Trusts, FT and PCT))	**95**	0	95	16
Total	**267,606**	**0**	**267,606**	**267,665**
Goods and Services from Foundation Trusts	**1,901**	0	1,901	2,287
Purchase of Healthcare from Non-NHS bodies	**34,287**	0	34,287	25,997
Social Care from Independent Providers	**0**	0	0	0
Expenditure on Drugs Action Teams	**5,608**	0	5,608	5,528
Non-GMS Services from GPs	**2,173**	104	2,069	4,987
Contractor Led GDS & PDS (excluding employee benefits)	**19,122**	0	19,122	18,810
Salaried Trust-Led PDS & PCT DS (excluding employee benefits)	**0**	0	0	0
Chair, Non-executive Directors & PEC remuneration	**115**	115	0	73
Executive committee members costs	**0**	0	0	0
Consultancy Services	**1,038**	346	692	176
Prescribing Costs	**48,852**	0	48,852	50,210
G/PMS, APMS and PCTMS (excluding employee benefits)	**52,827**	0	52,827	52,906
Pharmaceutical Services	**0**	0	0	485
Local Pharmaceutical Services Pilots	**0**	0	0	0
New Pharmacy Contract	**14,549**	0	14,549	14,272
General Ophthalmic Services	**5,054**	0	5,054	4,808
Supplies and Services - Clinical	**1,910**	19	1,891	186
Supplies and Services - General	**2,442**	1,815	627	2,029
Establishment	**1,033**	869	164	593
Transport	**39**	36	3	20
Premises	**7,862**	6,366	1,496	8,375
Impairments & Reversals of Property, plant and equipment	**217**	217	0	2,502
Impairments and Reversals of non-current assets held for sale	**0**	0	0	0
Depreciation	**2,392**	2,392	0	2,460
Amortisation	**10**	10	0	10
Impairment & Reversals Intangible non-current assets	**9**	9	0	0
Impairment and Reversals of Financial Assets	**0**	0	0	0
Impairment of Receivables	**808**	808	0	(113)
Inventory write offs	**0**	0	0	0
Research and Development Expenditure	**555**	0	555	977
Audit Fees	**136**	136	0	147
Other Auditors Remuneration	**26**	26	0	30
Clinical Negligence Costs	**0**	0	0	0
Education and Training	**1,547**	103	1,444	812
Grants for capital purposes	**0**	0	0	0
Grants for revenue purposes	**521**	2	519	190
Impairments and reversals for investment properties	**0**	0	0	0
Other	**9,276**	718	8,558	9,084
Total Operating costs charged to Statement of Comprehensive Net Expenditure	**586,749**	**16,025**	**570,724**	**564,960**
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	**960**	960	0	1,104
Other Employee Benefits	**8,232**	6,105	2,127	8,828
Total Employee Benefits charged to SOCNE	**9,192**	**7,065**	**2,127**	**9,932**
Total Operating Costs	**595,941**	**23,090**	**572,851**	**574,892**

5.1 Analysis of operating costs: (continued)

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
Analysis of grants reported in total operating costs				
For capital purposes				
Grants to fund Capital Projects - GMS	**0**	0	0	0
Grants to Local Authorities to Fund Capital Projects	**0**	0	0	0
Grants to Private Sector to Fund Capital Projects	**0**	0	0	0
Grants to Fund Capital Projects - Dental	**0**	0	0	0
Grants to Fund Capital Projects - Other	**0**	0	0	0
Total Capital Grants	**0**	**0**	**0**	**0**
Grants to fund revenue expenditure				
To Local Authorities	**500**	0	500	115
To Private Sector	**0**	0	0	75
To Other	**21**	2	19	0
Total Revenue Grants	**521**	**2**	**519**	**190**
Total Grants	**521**	**2**	**519**	**190**

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**15,195**	13,726	1,469
Weighted population (number in units) *	**337,774**	337,774	337,774
Running costs per head of population (£ per head)	**44.99**	**40.64**	**4.35**
PCT Running Costs 2011-12			
Running costs (£000s)	**15,104**	13,642	1,462
Weighted population (number in units)	**337,774**	337,774	337,774
Running costs per head of population (£ per head)	**44.72**	**40.39**	**4.33**

* Weighted population figures are not available for 2012-13 as the weighted capitation formula for PCT allocations was not updated for 2012-13. This was because it was decided to give all PCTs the same percentage growth in their allocations in this transitional year rather than differential growth based on a weighted capitation formula. Therefore, 2011-12 weighted populations have been used when calculating the Running Costs per head of population in 2012-13.

5.2 Analysis of operating expenditure by expenditure classification

	2012-13	2011-12
	£000	£000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	52,827	52,906
Prescribing costs	48,852	50,210
Contractor led GDS & PDS	19,122	18,810
Trust led GDS & PDS	0	0
General Ophthalmic Services	5,054	4,808
Department of Health Initiative Funding	0	0
Pharmaceutical services	0	485
Local Pharmaceutical Services Pilots	0	0
New Pharmacy Contract	14,549	14,272
Non-GMS Services from GPs	2,069	4,983
Other	0	233
Total Primary Healthcare purchased	**142,473**	146,707
Purchase of Secondary Healthcare		
Learning Difficulties	22,849	23,958
Mental Illness	52,564	49,965
Maternity	16,354	24,278
General and Acute	186,557	185,809
Accident and emergency	5,793	7,660
Community Health Services	48,201	46,191
Other Contractual	79,984	52,871
Total Secondary Healthcare Purchased	**412,302**	390,732
Grant Funding		
Grants for capital purposes	0	0
Grants for revenue purposes	521	190
Total Healthcare Purchased by PCT	**555,296**	**537,629**
PCT self-provided secondary healthcare included above	0	0
Social Care from Independent Providers	0	0
Healthcare from NHS FTs included above	1,901	2,287

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				**1,017**	1,055
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**1,017**	**1,055**
Payable:					
No later than one year	**0**	**1,006**	**7**	**1,013**	1,020
Between one and five years	**0**	**1,401**	**2**	**1,403**	2,155
After five years	**0**	**4,023**	**0**	**4,023**	4,331
Total	**0**	**6,430**	**9**	**6,439**	**7,506**

Total future sublease payments expected to be received	0	0

The PCT has entered into certain financial arrangements involving the use of GP and dentists premises. Under:

IAS 17 Leases.

SIC 27 Evaluating the substance of transactions involving the legal form of a lease.

IFRIC 4 Determining whether an arrangement contains a lease.

The PCT has determined that these 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 is as follows:

	2012-13 £000	2011-12 £000
GMS/ PMS Leases	**3,772**	3,810
Dental	**105**	134

6.2 PCT as lessor

Following TCS, some CHS services are still provided from buildings which the PCT owns. The PCT has charged organisations a fee for using those buildings. These charges have been treated as operating leases in the accounts, following the application of IAS 17.

	2012-13 £000	**2011-12 £000**
Recognised as income		
Rental Revenue	**5,475**	1,437
Contingent rents	**0**	0
Total	**5475**	1,437
Receivable:		
No later than one year	**5,475**	1,437
Between one and five years	**0**	0
After five years	**0**	0
Total	**5,475**	1,437

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	**7,853**	6,042	1,811	**7,226**	5,521	1,705	**627**	521	106
Social security costs	**522**	399	123	**522**	399	123	**0**	0	0
Employer Contributions to NHS BSA - Pensions Division	**817**	624	193	**817**	624	193	**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 employee benefits	**9,192**	**7,065**	**2,127**	**8,565**	**6,544**	**2,021**	**627**	**521**	**106**
Less recoveries in respect of employee benefits	**0**	0	0	**0**	**0**	**0**	**0**	**0**	**0**
Total - Net Employee Benefits including capitalised costs	**9,192**	**7,065**	**2,127**	**8,565**	**6,544**	**2,021**	**627**	**521**	**106**
Employee costs capitalised	**0**	0	0	**0**	0	0	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**9,192**	**7,065**	**2,127**	**8,565**	**6,544**	**2,021**	**627**	**521**	**106**
Recognised as:									
Commissioning employee benefits	**9,192**			**8,565**			**627**		
Provider employee benefits	**0**			**0**			**0**		
Gross Employee Benefits excluding capitalised costs	**9,192**			**8,565**			**627**		

Employee Benefits - Prior- year	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	**6,969**	6,775	194
Social security costs	**633**	633	0
Employer Contributions to NHS BSA - Pensions Division	**1,029**	1,029	0
Other pension costs	**0**	0	0
Other post-employment benefits	**0**	0	0
Other employment benefits	**0**	0	0
Termination benefits	**1,301**	1,301	0
Total gross employee benefits	**9,932**	**9,738**	**194**
Less recoveries in respect of employee benefits	**0**	0	0
Total - Net Employee Benefits including capitalised costs	**9,932**	**9,738**	**194**
Employee costs capitalised	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**9,932**	**9,738**	**194**
Recognised as:			
Commissioning employee benefits	**9,932**		
Provider employee benefits	**0**		
Gross Employee Benefits excluding capitalised costs	**9,932**		

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	**1**	1	0	**1**	1	0
Ambulance staff	**0**	0	0	**0**	0	0
Administration and estates	**161**	161	0	**184**	180	4
Healthcare assistants and other support staff	**0**	0	0	**1**	1	0
Nursing, midwifery and health visiting staff	**6**	6	0	**15**	15	0
Nursing, midwifery and health visiting learners	**0**	0	0	**0**	0	0
Scientific, therapeutic and technical staff	**2**	2	0	**7**	7	0
Social Care Staff	**0**	0	0	**0**	0	0
Other	**12**	0	12	**0**	0	0
TOTAL	**182**	**170**	**12**	**208**	**204**	**4**
Of the above - staff engaged on capital projec	**0**	0	0	**0**	0	0

	2012-13 Number	2011-12 Number
Number of persons retired early on ill health grounds	**1**	0
	£000s	**£000s**
Total additional pensions liabilities accrued in the year	**110**	0

7.3 Exit Packages agreed during 2012-13

	2012-13			2011-12		
Exit package cost band (including any special payment element)	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band
	Number	Number	Number	Number	Number	Number
Lees than £10,000	**7**	**0**	**7**	6	11	**17**
£10,001-£25,000	**9**	**1**	**10**	10	4	**14**
£25,001-£50,000	**6**	**1**	**7**	11	4	**15**
£50,001-£100,000	**3**	**2**	**5**	3	0	**3**
£100,001 - £150,000	**2**	**2**	**4**	2	0	**2**
£150,001 - £200,000	**1**	**1**	**2**	0	0	**0**
>£200,000	**0**	**0**	**0**	1	0	**1**
Total number of exit packages by type (total cost	**28**	**7**	**35**	**33**	**19**	**52**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Total resource cost	1,017	612	**1,629**	1,269	257	**1,526**

This note provides an analysis of Exit Packages agreed during the year. Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme or the MARS Scheme, subject to the qualifying circumstances of affected employees. 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.

7.4 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	**6,627**	**48,665**	6,706	44,888
Total Non-NHS Trade Invoices Paid Within Target	**6,319**	**46,266**	6,316	42,569
Percentage of NHS Trade Invoices Paid Within Target	95.35%	95.07%	94.18%	94.83%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3,897**	**333,885**	2,847	308,072
Total NHS Trade Invoices Paid Within Target	**3,781**	**330,185**	2,747	304,681
Percentage of NHS Trade Invoices Paid Within Target	97.02%	98.89%	96.49%	98.90%

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	**732**	**732**	**0**	0
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	**732**	**732**	**0**	0
Total investment income	**732**	**732**	**0**	0

10 Other Gains and Losses

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Gain/(Loss) on disposal of assets other than by sale (PPE)	**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	**0**	**0**	**0**	0
Gain/(loss) on foreign exchange	**0**	**0**	**0**	0
Change in fair value of financial assets carried at fair value through the SoCNE	**0**	**0**	**0**	0
Change in fair value of financial liabilities carried at fair value through the SoCNE	**0**	**0**	**0**	0
Change in fair value of investment property	**0**	**0**	**0**	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	**0**	**0**	**0**	0
Total	**0**	**0**	**0**	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	**2,893**	**2,893**	**0**	2,742
- contingent finance cost	**607**	**607**	**0**	404
Interest on late payment of commercial debt	**0**	**0**	**0**	0
Other interest expense	**0**	**0**	**0**	**0**
Total interest expense	**3,500**	**3,500**	**0**	**3,146**
Other finance costs	**0**	**0**	**0**	0
Provisions - unwinding of discount	**0**		**0**	
Total	**3,500**	**3,500**	**0**	**3,146**

12.1 Property, plant and equipment

2012-13	Land	Buildings excluding dwellings	Assets under construction and payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:							
At 1 April 2012	**7,101**	**42,065**	**0**	**307**	**3,396**	**1,399**	**54,268**
Additions of Assets Under Construction			0				**0**
Additions Purchased	0	268		2	459	16	**745**
Additions Donated	0	0	0	0	0	0	**0**
Additions Government Granted	0	0	0	0	0	0	**0**
Additions Leased	0	0		0	0	0	**0**
Reclassifications	0	27	0	0	0	(27)	**0**
Reclassifications as Held for Sale	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	0	0	**0**
Upward revaluation/positive indexation	0	0	0	0	0	0	**0**
Impairments/negative indexation	0	(389)	0	0	0	0	**(389)**
Reversal of Impairments	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	**0**
At 31 March 2013	**7,101**	**41,971**	**0**	**309**	**3,855**	**1,388**	**54,624**
Depreciation							
At 1 April 2012	**275**	**0**	**0**	**148**	**2,162**	**663**	**3,248**
Reclassifications		0		0	0	0	**0**
Reclassifications as Held for Sale	0	0		0	0	0	**0**
Disposals other than for sale	0	0		0	0	0	**0**
Upward revaluation/positive indexation	0	0		0	0	0	**0**
Impairments	0	14	0	0	203	0	**217**
Reversal of Impairments	0	0	0	0	0	0	**0**
Charged During the Year	0	1,789		27	458	118	**2,392**
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	**0**
At 31 March 2013	**275**	**1,803**	**0**	**175**	**2,823**	**781**	**5,857**
Net Book Value at 31 March 2013	**6,826**	**40,168**	**0**	**134**	**1,032**	**607**	**48,767**
Purchased	6,826	40,168	0	132	1,032	607	**48,765**
Donated	0	0	0	2	0	0	**2**
Government Granted	0	0	0	0	0	0	**0**
Total at 31 March 2013	**6,826**	**40,168**	**0**	**134**	**1,032**	**607**	**48,767**
Asset financing:							
Owned	2,100	10,921	0	134	1,032	607	**14,794**
Held on finance lease	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	4,726	29,247	0	0	0	0	**33,973**
PFI residual: interests	0	0	0	0	0	0	**0**
Total at 31 March 2013	**6,826**	**40,168**	**0**	**134**	**1,032**	**607**	**48,767**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Assets under construction & payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	**1,731**	**6,714**	**0**	**28**	**0**	**37**	**8,510**
Movements (specify)	0	(716)	0	4	0	0	**(712)**
At 31 March 2013	**1,731**	**5,998**	**0**	**32**	**0**	**37**	**7,798**

Additions to Assets Under Construction in 2012-13

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

12.2 Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	Assets under construction and payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	**£000**
Cost or valuation:							
At 1 April 2011	**6,046**	**33,282**	**669**	**307**	**2,874**	**1,084**	**44,262**
Additions - purchased	1,055	9,676	0	0	522	315	**11,568**
Additions - donated	0	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	0	**0**
Reclassifications	0	669	(669)	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	0	**0**
Revaluation & indexation gains	0	4,264	0	0	0	0	**4,264**
Impairments	0	0	0	0	0	0	**0**
Reversals of impairments	0	0	0	0	0	0	**0**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluation	0	(5,826)	0	0	0	0	**(5,826)**
At 31 March 2012	**7,101**	**42,065**	**0**	**307**	**3,396**	**1,399**	**54,268**
Depreciation							
At 1 April 2011	**0**	**1,766**		**136**	**1,652**	**558**	**4,112**
Reclassifications		0		0	0	0	**0**
Reclassifications as Held for Sale	0	0		0	0	0	**0**
Disposals other than for sale	0	0		0	0	0	**0**
Upward revaluation/positive indexation	0	0		0	0	0	**0**
Impairments	275	2,227	0	0	0	0	**2,502**
Reversal of Impairments	0	0	0	0	0	0	**0**
Charged During the Year	0	1,833		12	510	105	**2,460**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluation	0	(5,826)	0	0	0	0	**(5,826)**
At 31 March 2012	**275**	**0**	**0**	**148**	**2,162**	**663**	**3,248**
Net Book Value at 31 March 2012	**6,826**	**42,065**	**0**	**159**	**1,234**	**736**	**51,020**
Purchased	6,826	42,065	0	156	1,234	736	**51,017**
Donated	0	0	0	3	0	0	**3**
Government Granted	0	0	0	0	0	0	**0**
At 31 March 2012	**6,826**	**42,065**	**0**	**159**	**1,234**	**736**	**51,020**
Asset financing:							
Owned	2,100	11,569	0	159	1,234	736	**15,798**
Held on finance lease	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	4,726	30,496	0	0	0	0	**35,222**
PFI residual: interests	0	0	0	0	0	0	**0**
At 31 March 2012	**6,826**	**42,065**	**0**	**159**	**1,234**	**736**	**51,020**

12.3 Property, plant and equipment

A revaluation of land and buildings was carried out as at 31 March 2013. The valuations were carried out by the Valuation Office in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury. The valuations have been carried out using the Modern Equivalent Asset basis. An impairment review was carried out in year to arrive at the current carrying values (see note 14). Impairment funding was made available by the Department of Health.

In accordance with the latest RICs guidance, depreciated replacement cost valuations are based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Economic Lives of Non-Current Assets

	Min life Years	**Max life Years**
Property, Plant and Equipment		
Buildings excl Dwellings	1	80
Dwellings	0	0
Plant & Machinery	1	10
Transport Equipment	0	0
Information Technology	1	4
Furniture and Fittings	1	15

13.1 Intangible non-current assets

2012-13	Software internally generated	Software purchased	Licences & trademarks	Patents	Development expenditure	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2012	**0**	**0**	**59**	**0**	**0**	**59**
Additions - purchased	0	0	43	0	0	**43**
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**	**0**	**102**	**0**	**0**	**102**
Amortisation						
At 1 April 2012	**0**	**0**	**42**	**0**	**0**	**42**
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	9	0	0	**9**
Reversal of impairments charged to operating expenses	0	0	0	0	0	**0**
Charged during the year	0	0	10	0	0	**10**
In-year transfers to NHS bodies	0	0	0	0	0	**0**
At 31 March 2013	**0**	**0**	**61**	**0**	**0**	**61**
Net Book Value at 31 March 2013	**0**	**0**	**41**	**0**	**0**	**41**
Net Book Value at 31 March 2013 comprises						
Purchased	0	0	41	0	0	**41**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	**0**
Total at 31 March 2013	**0**	**0**	**41**	**0**	**0**	**41**

Revaluation reserve balance for intangible non-current assets

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

13.2 Intangible non-current assets

2011-12	Software internally generated	Software purchased	Licences & trademarks	Patents	Development expenditure	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2011	**0**	**0**	**47**	**0**	**0**	**47**
Additions - purchased	0	0	12	0	0	**12**
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**	**0**	**59**	**0**	**0**	**59**
Amortisation						
At 1 April 2011	**0**	**0**	**32**	**0**	**0**	**32**
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	0	10	0	0	**10**
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**	**0**	**42**	**0**	**0**	**42**
Net Book Value at 31 March 2012	**0**	**0**	**17**	**0**	**0**	**17**
Net Book Value at 31 March 2012 comprises						
Purchased	0	0	17	0	0	**17**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	**0**
Total at 31 March 2012	**0**	**0**	**17**	**0**	**0**	**17**

13.3 Intangible non-current assets

The PCT had licences & trademarks with a life of between 0.6 and 5 years (2012: 1.6 years) at the beginning of the period.

13.4 Revaluation reserve balance for intangible assets

There was no balance on the revaluation reserve for intangible assets at 31 March 2013 (2012: £Nil)
There were no movements on the revaluation reserve for intangible assets in either of the years ended 31 March 2013 or 2012.

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	217	217	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	**217**	**217**	**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**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Loss or damage resulting from normal operations	389		
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 PPE charged to reserves	**389**		
Total Impairments of Property, Plant and Equipment	**606**	**217**	**0**
Intangible assets impairments and reversals charged to SoCNE			
Loss or damage resulting from normal operations	9	9	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	**9**	**9**	**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	**9**	**9**	**0**

14 Analysis of impairments and reversals recognised in 2012-13

	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	0		0
Total charged to Annually Managed Expenditure	**0**		**0**
Total impairments of non-current assets held for sale	**0**	**0**	**0**
Inventories - impairments and reversals charged to SoCNE			
Loss or Damage Resulting from Normal Operations	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen Obsolescence	0		0
Loss as a Result of a Catastrophe	0		0
Other (Free text note required)*	0		0
Changes in Market Price	0		0
Total charged to Annually Managed Expenditure	**0**		**0**
Total impairments of Inventories	**0**	**0**	**0**
Investment Property impairments charged to SoCNE			
Loss or Damage Resulting from Normal Operations	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen Obsolescence	0		0
Loss as a Result of a Catastrophe	0		0
Other (Free text note required)*	0		0
Changes in Market Price	0		0
Total charged to Annually Managed Expenditure	**0**		**0**
Total Investment Property impairments charged to SoCNE	**0**	**0**	**0**

14 Analysis of impairments and reversals recognised in 2012-13

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000
Investment Property impairments and reversals charged to the Revaluation Reserve			
Loss or Damage Resulting from Normal Operations	0		
Over Specification of Assets	0		
Abandonment of Assets in the Course of Construction	0		
Unforeseen Obsolescence	0		
Loss as a Result of a Catastrophe	0		
Other (Free text note required)*	0		
Changes in Market Price	0		
TOTAL impairments for Investment Property charged to Reserves	**0**		
Total Investment Property Impairments	**0**	**0**	**0**
Total Impairments charged to Revaluation Reserve	389		
Total Impairments charged to SoCNE - DEL	226	226	0
Total Impairments charged to SoCNE - AME	0		0
Overall Total Impairments	**615**	**226**	**0**
Of which:			
Impairment on revaluation to "modern equivalent asset" basis	**0**	0	0
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

15 Commitments

15.1 Capital commitments

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

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

15.2 Other financial commitments

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

	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

16 Intra-Government and other balances

	Current receivables £000s	**Non-current receivables £000s**	**Current payables £000s**	**Non-current payables £000s**
Balances with other Central Government Bodies	1,679	0	13,562	0
Balances with Local Authorities	6	0	634	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	1,077	0	6,625	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	2,585	0	26,891	0
At 31 March 2013	**5,347**	**0**	**47,712**	**0**
prior period:				
Balances with other Central Government Bodies	2,803	0	6,329	0
Balances with Local Authorities	38	0	4,388	0
Balances with NHS Trusts and Foundation Trusts	1,811	0	5,023	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	2,155	0	28,639	0
At 31 March 2012	**6,807**	**0**	**44,379**	**0**

17 Inventories

The PCT has not held any significant values of inventory since responsibility for community equipment transferred to Leicester City Council on 1st April 2011.

18.1 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	**2,247**	3,702	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**0**	0	**0**	0
Non-NHS receivables - revenue	**1,890**	781	**0**	0
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**1,568**	1,481	**0**	0
Provision for the impairment of receivables	**(865)**	(101)	**0**	0
VAT	**509**	908	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	**0**	0	**0**	0
Interest receivables	**(2)**	0	**0**	0
Finance lease receivables	**0**	0	**0**	0
Operating lease receivables	**0**	0	**0**	0
Other receivables	**0**	36	**0**	0
Total	**5,347**	6,807	**0**	0
Total current and non current	**5,347**	6,807		
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

18.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	**312**	2,092
By three to six months	**0**	0
By more than six months	**0**	0
Total	**312**	2,092

18.3 Provision for impairment of receivables

	2012-13 £000	**2011-12 £000**
Balance at 1 April 2012	**(101)**	(223)
Amount written off during the year	**44**	9
Amount recovered during the year	**65**	151
(Increase)/decrease in receivables impaired	**(873)**	(38)
Balance at 31 March 2013	**(865)**	(101)

19 NHS LIFT investments

	Loan	Share capital	Total
	£000	£000	£000
Balance at 1 April 2012	**1,201**	**2**	**1,203**
Additions	**575**	**0**	**575**
Disposals	**0**	**0**	**0**
Loan repayments	**(270)**	**0**	**(270)**
Revaluations	**0**	**0**	**0**
Loans repayable within 12 months	**0**	**0**	**0**
Balance at 31 March 2013	**1,506**	**2**	**1,508**
Balance at 1 April 2011	1,201	2	1,203
Additions	0	0	0
Disposals	0	0	0
Loan repayments	0	0	0
Revaluations	0	0	0
Loans repayable within 12 months	0	0	0
Balance at 31 March 2012	**1,201**	**2**	**1,203**

20.1 Other financial assets - Current

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

20.2 Other Financial Assets - Non Current

	31 March 2013	31 March 2012
	£000	£000
Opening balance 1 April	**1,203**	1,189
Additions	575	14
Revaluation	0	0
Impairments	0	0
Impairment Reversals	0	0
Transferred to current financial assets	0	0
Disposals	(270)	0
Transfers (to)/from Other Public Sector Bodies in year	0	0
Total Other Financial Assets - Non Current	**1,508**	1,203

20.3 Other Financial Assets - Capital Analysis

	31 March 2013	31 March 2012
	£000	£000
Capital Expenditure	**575**	0
Capital Income	**(270)**	0

21 Other current assets

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

22 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**13**	3
Net change in year	**7,813**	10
Closing balance	**7,826**	13
Made up of		
Cash with Government Banking Service	**7,826**	13
Commercial banks	**0**	0
Cash in hand	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**7,826**	13
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**7,826**	13
Patients' money held by the PCT, not included above	**0**	0

23 Non-current assets held for sale

The PCT held no non-current assets for sale at 31 March 2012 (31 March 2011: £nil)

24 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	**19,742**	10,929	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**0**	0	**0**	0
Family Health Services (FHS) payables	**9,866**	10,909		
Non-NHS payables - revenue	**514**	286	**0**	0
Non-NHS payables - capital	**61**	173	**0**	0
Non-NHS accruals and deferred income	**17,084**	21,657	**0**	0
Social security costs	**185**	91		
VAT	**0**	0	**0**	0
Tax	**260**	106		
Payments received on account	**0**	0	**0**	0
Other	0	228	0	0
Total	**47,712**	44,379	**0**	0
Total payables (current and non-current)	**47,712**	**44,379**		

Other payables include £0 (2011-12: £nil) in respect of payments due in future years under arrangements to buy out the liability for early retirements over 5 instalments; and £103k (2011-12: £nil) in respect of outstanding pensions contributions at 31 March 2013.

25 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 *[specify]*	**0**	0	**0**	**0**
Total	**0**	0	**0**	0
Total other liabilities (current and non-current)	**0**	**0**		

26 Borrowings

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Bank overdraft - Government Banking Service	**0**	**0**		
Bank overdraft - commercial banks	**0**	**0**		
PFI liabilities:				
Main liability	**0**	**0**	**0**	0
Lifecycle replacement received in advance	**0**	**0**	**0**	0
LIFT liabilities:				
Main liability	**551**	**507**	**39,068**	39,618
Lifecycle replacement received in advance	**0**	**0**	**0**	0
Finance lease liabilities	**0**	**0**	**0**	0
Other (describe)	**0**	**0**	**0**	0
Total	**551**	**507**	**39,068**	**39,618**
Total other liabilities (current and non-current)	**39,619**	**40,125**		

Borrowings/Loans - Payment of Principal Falling Due in:

	DH £000s	**Other £000s**	**Total £000s**
0 - 1 Years	0	551	**551**
1 - 2 Years	0	561	**561**
2 - 5 Years	0	1,831	**1,831**
Over 5 Years	0	36,676	**36,676**
TOTAL	**0**	**39,619**	**39,619**

27 Other financial liabilities

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

28 Deferred income

	Current		Non-current	
	31 March	31 March	**31 March**	31 March
	2013	2012	**2013**	2012
	£000	£000	**£000**	£000
Opening balance at1 April 2012	**329**	3,756	**0**	0
Deferred income addition	**0**	329	**0**	0
Transfer of deferred income	**(329)**	(3,756)	**0**	0
Current deferred Income at 31 March 2013	**0**	329	**0**	0
Total other liabilities (current and non-current)	**0**	**329**		

29 Finance lease obligations

The PCT had no obligations under finance leases at 31 March 2013 (31 March 2012: £nil)

30 Finance lease receivables as lessor

The PCT had no finance lease receivables at 31 March 2013 (31 March 2012: £nil)

31 Provisions

	Total £000s	Legal Claims £000s	Continuing Care £000s	Other £000s	Redundancy £000s
Balance at 1 April 2012	**5,660**	43	112	2,257	3,248
Arising During the Year	**5,489**	12	3,688	0	1,789
Utilised During the Year	**(2,240)**	0	0	(396)	(1,844)
Reversed Unused	**(2,682)**	(14)	0	(86)	(2,582)
Unwinding of Discount	**0**	0	0	0	0
Change in Discount Rate	**0**	0	0	0	0
Transferred (to)/from other Public Sector bodies	**0**	0	0	0	0
Balance at 31 March 2013	**6,227**	**41**	**3,800**	**1,775**	**611**
Expected Timing of Cash Flows:					
No Later than One Year	**2,695**	**41**	**1,900**	**143**	**611**
Later than One Year and not later than Five Years	**3,403**	**0**	**1,900**	**1,503**	**0**
Later than Five Years	**129**	**0**	**0**	**129**	**0**

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at 31 March 2013	0
As at 31 March 2012	484

Amounts included in provisions were determined having regard to professional advice on the likelihood and timing of liabilities. The amounts provided may be dependent upon the outcome of litigation, and negotiations with relevant third parties.
Other provisions includes £ 1.6m (2012: £1.7m) in respect of dilapidations on leasehold property, £170k (2012: £243,000) in respect of NHS Shared Business Services transition and SLA termination costs.

The continuing care provision has increased to £3.8m from £112k at 31st March 2012. The increase is due to Department of Health deadlines for individuals submitting retrospective claims for costs. The PCT has made a provision based on the claims received and an assessment of the liability due.

32 Contingent liabilities and assets

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities		
Equal Pay	**0**	0
Other	**960**	0
Amounts Recoverable Against Contingent Liabilities	**0**	0
Net Value of Contingent Liabilities	**960**	0

The contingent liability is for part eligible Continuing Care Retrospective Care claims for which it is assumed there may be some liability, but not of sufficient certainty to require a provision be made.

The PCT had no contingent assets at 31 March 2013 (2012: £nil).

33 PFI and LIFT - additional information

	31 March 2013 £000	31 March 2012 £000
33.1 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 not expected to be materially different from those which the Trust is committed 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
33.2 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	**1,006**	946
Total	**1,006**	946

	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	**1,071**	1,042
Later than One Year, No Later than Five Years	**4,814**	4,587
Later than Five Years	**30,814**	31,679
Total	**36,699**	37,308

The estimated annual payments in future years are not expected to be materially different from those which the Trust is committed 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	**3,409**	3,400
Later than One Year, No Later than Five Years	**13,435**	13,487
Later than Five Years	**75,684**	76,042
Subtotal	**92,528**	92,929

Less: Interest Element	**(49,913)**	(52,804)
Total	**42,615**	40,125

34 Impact of IFRS treatment - 2012-13

	Total	Admin	Programme
	£000	£000	£000
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g. LIFT/PFI)			
Depreciation charges	**738**	738	0
Interest Expense	**3,466**	3,466	0
Impairment charge - AME	**0**		0
Impairment charge - DEL	**0**	0	0
Other Expenditure	**913**	913	0
Revenue Receivable from subleasing	**0**	0	0
Total IFRS Expenditure (IFRIC12)	**5,117**	**5,117**	**0**
Revenue consequences of LIFT/PFI schemes under UK GAAP / ESA95 (net of any sublease income)	**(4,886)**	(4,886)	0
Net IFRS change (IFRIC12)	**231**	**231**	**0**

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

35 Financial Instruments

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

Currency risk

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

Interest rate risk
PCTs are not permitted to borrow. 100% of the PCT's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. Leicester City PCT is not, therefore, exposed to significant interest-rate risk.

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.

Most of the PCT's net operating costs are incurred under annual service agreements with local Primary Care Trusts, NHS Trusts and NHS Foundation Trusts, and are financed from resources voted annually by Parliament or directly financed from resources voted annually by Parliament. The PCT also largely finances its capital expenditure from funds made available from Government. Leicester City Primary Care Trust is not, therefore, exposed to significant liquidity risks.

The PCT's risk regarding its ability to pay liabilities is also minimal in that all contractual commitments (healthwise and otherwise) are undertaken within the constraints of the revenue and capital resources allocated to the PCT. The PCT budget plan is approved by the Trust Board at the commencement of each financial year in line with the resources allocated, contingency provisions are accounted for within the budget plan. Monthly financial monitoring is provided to the Trust Board which highlights areas of risk and mitigation plans. The PCT has a statutory duty to remain within its cash limit. The PCT manages its cash balances in line with Treasury guidance by ensuring that no significant balances are held on account at the end of each financial period. This ensures that all funds drawn down from the Department of Health and income receipted during the period are fully utilised for payment of all creditors, NHS and independent contractors. Drawing down of cash against the PCT cash limit is profiled evenly across the financial year, which also matches the payment profile of the majority of contractual commitments.

The PCT therefore considers itself to be a low credit risk to external organisations.

35.1 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		2,247		**2,247**
Receivables - non-NHS		4,116		**4,116**
Cash at bank and in hand		7,826		**7,826**
Other financial assets	0	0	2	**2**
Total at 31 March 2013	**0**	**14,189**	**2**	**14,191**
Embedded derivatives	0			0
Receivables - NHS		3,702		3,702
Receivables - non-NHS		4,220		4,220
Cash at bank and in hand		13		13
Other financial assets	0	0	2	2
Total at 31 March 2012	0	7,935	2	7,937

35.2 Financial Liabilities	**At 'fair value through profit and loss' £000**	**Other £000**	**Total £000**
Embedded derivatives	0		**0**
NHS payables		19,742	**19,742**
Non-NHS payables		27,970	**27,970**
Other borrowings		39,619	**39,619**
PFI & finance lease obligations		0	**0**
Other financial liabilities	6,227	0	**6,227**
Total at 31 March 2013	**6,227**	**87,331**	**93,558**
Embedded derivatives	0		0
NHS payables		11,233	11,233
Non-NHS payables		33,074	33,074
Other borrowings		40,125	40,125
PFI & finance lease obligations		0	0
Other financial liabilities	6,045	0	6,045
Total at 31 March 2012	**6,045**	84,432	90,477

Financial liabilities are trade and other payables, as shown in note 24, and LIFT scheme obligations as shown in note 33. All trade liabilities are expected to be short term and the carrying amount is deemed to be its fair value.

36 Related party transactions

Leicester City PCT is a body corporate established by order of the Secretary of State for Health.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Leicester City PCT (2011/12 none).

The Department of Health is regarded as a related party. During the year, as in the previous year, Leicester City PCT has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent department. These entities are listed below.

	Revenue 2012-13 £'000	Expenditure 2012-13 £'000	Receivable Mar-13 £'000	Payable Mar-13 £'000
East Midlands Strategic Health Authority	82	96	0	0
University Hospitals of Leicester NHS Trust	871	163,353	645	4,156
Leicestershire Partnership NHS Trust	4,898	95,635	182	1,501
Leicestershire County & Rutland Primary Care Trust	2,717	115,320	1,103	13,064
East Midlands Ambulance Service NHS Trust	0	10,377	0	268
NHS Litigation Authority	0	85	0	0
NHS Pensions Agency	0	817	0	103

In addition, Leicester City PCT has had a significant number of material transactions with other Government Departments and other central and local Government bodies. These included Leicester City Council and HMRC.

During the year financial transactions took place between parties related to members of the key management staff or on their behalf as

Name / Role	Third Party	Payments to Related Party	Amounts owed to Related Party	Amounts due from Related Party
		£'000	£'000	£'000
Azhar Farooqi - CCG Board - Co Chair	Dr Longworth & Partners	1,715	0	20
Dr AJJ Bentley - CCG Board - Locality lead	Dr B Chauhan & Partners	1,038	6	15
Dr PJ Danaher - CCG Board-GP Board Member	Dr AJJ Bentley & Partners	1,206	1	8
Dr D Jawahar - CCG Board - Locality lead	Dr H V Trivedi & Partners	2,099	1	17
Dr N Joshi - CCG Board-GP Board Member	Melbourne RD Health Centre	1,651	18	13
Dr R Kapur - CCG Board - Locality lead	Dr UK Roy	997	9	6
Dr TK Khong - CCG Board-GP Board Member	Dr ID Patchett & Partners	349	1	36
Dr A Prasad - CCG Board - Co Chair	Dr Astles & Partners	651	10	5
Dr UK Roy - CCG Board - Locality lead	Dr TK Khong	772	17	2
Dr G Singh - CCG Board-GP Board Member	Dr G Singh	752	17	15

Note: All the Above individuals are Senior Partners within the respective GP Practice.

Prior Year comparators
The following notes appeared in the accounts of Leicester City PCT for the year ended 31st March 2012.

Leicester City PCT is a body corporate established by order of the Secretary of State for Health.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Leicester City PCT (2010/11 none).

The Department of Health is regarded as a related party. During the year, as per last year, Leicester City PCT has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent department. These entities are listed below.

East Midlands Strategic Health Authority
University Hospitals of Leicester NHS Trust
Leicestershire Partnership NHS Trust
Leicestershire County & Rutland Primary Care Trust
East Midlands Ambulance Service NHS Trust
NHS Litigation Authority
NHS Business Services Authority
NHS Pensions Agency
NHS Supply Chain

In addition, Leicester City PCT has had a significant number of material transactions with other Government Departments and other central and local Government bodies. These included Leicester City Council and HMRC.

During the year financial transactions took place between parties related to members of the key management staff or on their behalf as

Name / Role	Third Party	Payments to Related Party	Amounts owed to Related Party	Amounts due from Related Party
		£'000	£'000	£'000
Azhar Farooqi - CCG Board - Co Chair	Dr Longworth & Partners	3,124	65	20
Dr AJJ Bentley - CCG Board - Locality lead	Dr AJJ Bentley & Partners	1,861	51	15
Dr PJ Danaher - CCG Board - Locality lead	Dr ID Patchett & Partners	1,894	62	8
Dr D Jawahar - CCG Board - Locality lead	Dr H V Trivedi & Partners	3,427	84	17
Dr N Joshi - CCG Board - Locality lead	Dr Astles & Partners	2,701	69	13
Dr R Kapur - CCG Board - Locality lead	Melbourne Rd Health Centre	1,708	33	9
Dr TK Khong - CCG Board - Locality lead	Dr TK Khong	503	11	2
Dr A Prasad - CCG Board - Locality lead	Dr B Chauhan & Partners	1,067	35	5
Dr UK Roy - CCG Board - Locality lead	Dr UK Roy	437	14	2
Dr G Singh - CCG Board - Locality lead	Dr G Singh	1,200	36	15

Note: * All the Above individuals are Senior Partners.

37 Losses and special payments

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

	Total Value of Cases £s	Total Number of Cases
Losses - PCT management costs	44,224	8
Special payments - PCT management costs	0	0
		0
Losses in respect of the provision of family practitioner services	0	
Special payments in respect of he provision of family practitioner services	0	0
Total losses	44,224	8
Total special payments	0	0
Total losses and special payments	44,224	8

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

	Total Value of Cases £s	Total Number of Cases
Losses - PCT management costs	9,434	11
Special payments - PCT management costs	0	0
		0
Losses in respect of the provision of family practitioner services	0	
Special payments in respect of he provision of family practitioner services	0	0
Total losses	9,434	11
Total special payments	0	0
Total losses and special payments	9,434	11

38 Third party assets

The PCT held £nil cash and cash equivalents at 31 March 2013 on behalf of patients (2012: £nil).

39 Pooled budget local arrangements

Leicester City Primary Care Trust has a pooled budget arrangement with Leicester City Council and other organisations in respect of Integrated Community Equipment Services (ICES). Leicester City Council is the host organisation. Memorandum Accounts are shown below:-

LEICESTER, LEICESTERSHIRE AND RUTLAND (LLR) ICES
POOLED BUDGET MEMORANDUM ACCOUNT
FOR THE PERIOD 1st APRIL to 31st MARCH

	2012-13 £000	2011-12 £000
Income :		
Leicester City Council	547	559
Leicestershire County Council	1,243	1,037
Rutland County Council	94	79
Leicestershire County and Rutland PCT	2,545	2,139
Leicester City PCT	1,135	847
	5,564	4,661
Expenditure :		
Service Costs	1,817	1,167
Administrative Costs	92	77
Equipment Costs	3,655	3,417
In respect of the Pool	5,564	4,661
Net under/(over) spend	0	0

Certificate of Director Of Finance :
I certify that the above pooled fund memorandum account accurately discloses the income and expenditure incurred.

Signed: A GREENHILL
Date : 30/04/13
Host Organisation : Leicester City Council

Leicester City Primary Care Trust has a pooled budget arrangement with Leicester City Council in respect of Learning Disabilities (LD) Services. Leicester City Council is the host organisation. Memorandum Accounts are shown below:-

LEICESTER CITY - LEARNING DISABILITIES CHC SERVICES
POOLED BUDGET MEMORANDUM ACCOUNT
FOR THE PERIOD 1st APRIL to 31st MARCH

	2012-13 £000	2011-12 £000
Income :		
Leicester City Council	3,084	3,691
Leicester City PCT	3,500	4,040
	6,584	7,731
Expenditure :		
Adult placement (long & short stay)	62	57
Direct Payments	337	382
Homecare	37	132
Residential (permanent & short stay)	3,503	3,725
Supported living	1,913	2,602
Day Services	655	633
Other		200
In respect of the Pool	6,507	7,731
Net under/(over) spend	77	0
Carried forward as Receipts in Advance from the PCT	-77	
Net nil balance in the 2012/13 General Ledger	0	0

NB; The Council is still seeking an opinion as to whether the service users/patients in Castlebeck should be charged to the pool.

Certificate of Director Of Finance :
I certify that the above pooled fund memorandum account accurately discloses the income and expenditure incurred.

Signed: A GREENHILL
Date : 30/04/13
Host Organisation : Leicester City Council

40 Events after the end of the reporting period

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

The main functions carried out by Leicester City PCT in 2012-13 are to be carried out in 2013-14 by the following public sector bodies:

Transferee Organisation	**Key functions transferred**
Leicester City Clinical Commissioning Group	Acute and non acute healthcare commissioning
Leicester City Council	Public Health commissioning
Community Health Partnerships	LIFT buildings
NHS Property Services	Property
Leicestershire Partnership NHS Trust	Property
NHS England	Primary Care and specialised services commissioning