Department of Health

NHS

Cambridgeshire Primary Care Trust

2012-13 Annual Report and Accounts

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Cambridgeshire Primary Care Trust

2012-13 Annual Report

NHS Cambridgeshire annual report 2012-13

Foreword by Chair and Chief Executive

Welcome to this year's annual report for NHS Cambridgeshire which reflects upon the achievements for healthcare in Cambridgeshire and looks forward to the year ahead for clinical commissioning.

This has been an exciting year in the development of clinical commissioning and we have worked side by side with GPs to establish Cambridgeshire and Peterborough Clinical Commissioning Group (CCG), culminating in formal authorisation on 23 January 2013.

The new Clinical Commissioning Group became a statutory organisation on 1 April 2013, taking over most of the responsibilities of the former Primary Care Trusts, NHS Cambridgeshire and NHS Peterborough. The CCG takes over responsibility for the £850 million budget for Cambridgeshire, Peterborough and parts of Hertfordshire and Northamptonshire from this date.

Throughout all of these changes quality has remained our focus as well as ensuring that our patients continue to receive quality healthcare services they need. This report details our performance over the past year and how we have been doing in our final year as commissioners of your healthcare.

This final year has been a momentous one for the country with both the Queen's Diamond Jubilee and the Olympics. Both of these events have given us opportunities to promote healthy living in Cambridgeshire and give advice to the public about choosing the right healthcare service at the right time.

In June 2012, the carer's prescription service developed jointly between the NHS, Cambridgeshire County Council and Crossroads charity was visited by Paul Burstow, the Minister of State for Care Services.

The carer's prescription service allows GPs to prescribe a short break from caring, to allow carers to take part in everyday activities such as shopping, working, training or leisure, with carers from Crossroads providing care while carers take a break. The service has been nationally recognised for the valuable support it offers to carers, and the way that different agencies have come together to offer an integrated service.

Record numbers of people were helped to give up smoking by Camquit, the county's NHS stop smoking service with 3,942 people using the service.

In September a new stroke service which aimed to improve the outcome for stroke patients in Huntingdon went live. Developed in consultation with the public, the new stroke service means that all suspected stroke patients in the Huntingdon area are taken to Addenbrooke's or Peterborough hospitals for their hyper acute care (immediately after a stroke and normally up to three days afterwards), and when

clinically appropriate will be taken to Hinchingbrooke for acute care and rehabilitation.

We continually monitor and measure our performance against agreed local and national targets to ensure that the services we commission on your behalf meet your needs and we are continuing to work hard in an increasingly challenging environment.

From April 2013 the commissioning of most of the healthcare services for Cambridgeshire will be in the hands of clinicians in Cambridgeshire and Peterborough Clinical Commissioning Group, we wish them well and know that working alongside staff, GPs and partner organisations they will continue to improve outcomes for the people of Cambridgeshire.

In preparation for the end of the PCT we have produced a close down report and legacy document.

Finally, we would like to thank our staff, our Board, our partners and all those who we work with for their help and support over the past year.

John Barratt

Chair

Andrew Reed

Accountable Officer

Our organisation

NHS Cambridgeshire is the Primary Care Trust for Cambridgeshire and was established in 2006. NHS Cambridgeshire is the leader of the local NHS and commissions (buys) care from a range of providers on behalf of the people of Cambridgeshire.

This has been our final year in existence with the NHS Reforms seeing commissioning of healthcare services being handed over to GPs as part of the new Clinical Commissioning Groups. As a Primary Care Trust our role has been to buy and oversee primary care services (GPs, dentists, pharmacists and opticians), secondary care services such as hospitals and mental health services, and health services in the community such as district nursing and home care. We also fund, buy and oversee other specialist treatments from providers in the independent sector.

Our vision

NHS Cambridgeshire's strategic vision is:

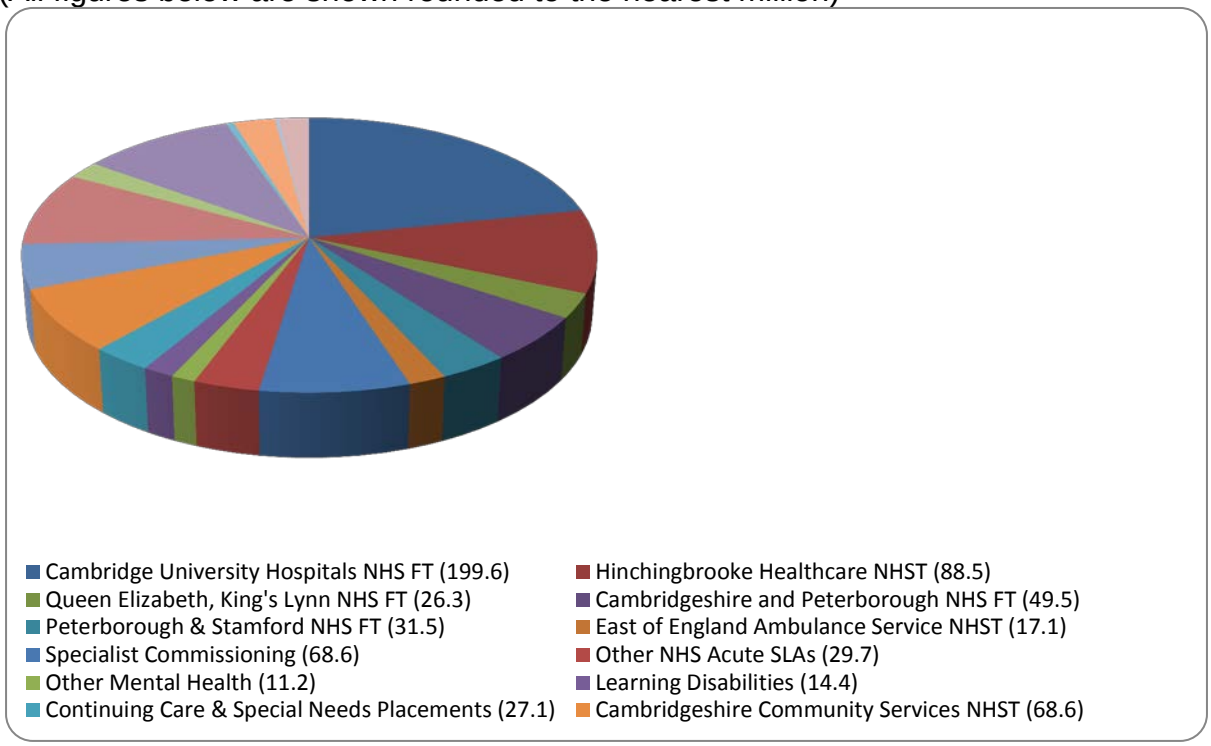
'Everyone in Cambridgeshire as healthy as can be.'

Our values

- We are here to help, inform and facilitate people in improving their health whilst recognising that ultimately each person is responsible for the lifestyle choices they make.
- We recognise that our populations are diverse and we will aim to commission (buy) a choice of high-quality responsive health services which meet their needs.
- Resources will be distributed fairly and targeted to those with the highest health need.
- We will deliver the best possible value for money.
- Working in partnership is critical to making real improvements in health and care.
- We value our staff and will provide them with good opportunities for personal development.

Where did the money go in 2012-13?

(All figures below are shown rounded to the nearest million)



Total spend was £916,700,000

Sustainability

NHS Cambridgeshire was a sustainable organisation which was committed to:

- Establishing and publishing its organisational carbon footprint through the activities and assets to which the primary care trust has direct responsibility i.e. business travel, electric, gas, oil and water consumption as well as waste disposal.

- By 2015 reducing carbon emissions by 10% from a 2007-08 baseline.
- Reducing the amount of waste produced by 5% by 2010 and by 25% by 2020.
- Increasing recycling figures to 50% of domestic waste arising by 2015 then by 75% by 2020.
- Reducing carbon emissions from the PCT owned and leased estate by 10% by 2015 then 30% by 2020.

Although the organisation ceased to exist before the deadline for these targets the work done in helping to achieve them has now been carried forward into Cambridgeshire and Peterborough CCG who have taken over the commitment to deliver them.

Governance

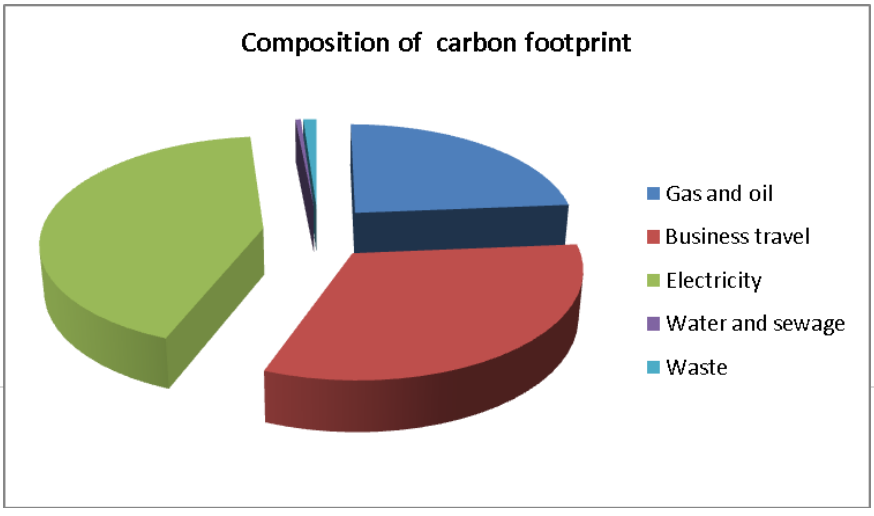
As a sustainable organisation committed to improving health outcomes and reducing carbon emissions we have structured and organised the on-going journey of sustainability through:

- An established sustainable development management plan which sets out the key priority areas and the metrics by which we can judge success.
- A project management structure that enables the Director of Finance to give the Board assurance that progress is being made.
- The appointment of a Non-Executive Director with lead responsibility for sustainability.
- Regular reports to NHS Midlands and East and the Department of Health.

Progress this year

Although we established the composition of our carbon footprint in 2011/12 which is set out below, we were unable to do this in 2012/2013 as the information was not recorded. This means that although we established that we had already met our overall 2015 targets for reducing carbon emissions in 2011/12, we are unable to report if we have maintained this reduction during 2012/13

Figures for 2011/12



Since the last annual report we have:

- Already exceeded the 2015 50% recycling target across the county for example by consistently achieving recycling rates of 54% for sites in Cambridgeshire.

- Seen an increase in costs associated with waste destined for landfill and dry recycling through higher collection charges and increased volumes of waste being generated. Currently there is a £60 per tonne price differential in favour of recycling over landfill, so there is a real financial incentive to promote and undertake recycling.

- Continued to work collaboratively with Cambridgeshire County Council on raising staff awareness and behavioural changes on the use of energy and recycling.

- Continued pilot work for GP Practices to reduce energy and to access national framework energy contracts.

- Not been able to undertake any substantive work on identifying the extent of carbon emissions generated through clinical commissioning activity and procurement strategies. However, we have established some key areas of work that we believe will need to be taken forward by the Cambridgeshire and Peterborough Clinical Commissioning Group in partnership with Local Commissioning Groups, Local Authorities and service provider organisations in county.

Legacy

We have been working with the Clinical Commissioning Group on how best to build on the work accomplished to date, but to also consider the opportunities and work streams ensuring that the Clinical Commissioning Group is at the forefront of sustainable development. The Clinical Commissioning Group has identified the following priority areas which it has committed to taking forward:

- Developing local understanding of the sustainability agenda by measuring the environmental impacts of the organisations activities and assessing the potential impact of environmental change on future care needs and services.

- Empowering staff to take responsibility for reducing the environmental impact of their own activities. This will be taken forward through the Good Corporate Citizen Model and Self-Assessment.

- Actively exploiting the synergies between environmental sustainability and other objectives. For example, by identifying changes that may bring health or financial benefits as well as environmental ones.

- Exploring the opportunities presented by new technologies such as telehealth and telecare, and by the use of new technologies in managing the core business of the Clinical Commissioning Group.

- Improving medicines management and prescribing practices to reduce inefficient or wasteful use of pharmaceuticals.

- Commissioning services that will support sustainable practices in service providers and the supply chain. Promoting the importance of using contractual levers with our main providers to encourage/incentivise change.

- Engaging with patients and the public to build wider support for environmentally sustainable approaches to delivering care.

Emergency preparedness

Emergency planning, resilience and response are important aspects of protecting the health of local people. NHS Cambridgeshire has worked with NHS Peterborough during 2012-13 to ensure that the transition to the new organisation in the NHS on 1 April 2013 is as smooth as possible, while maintaining and operating the current Joint Major Incident Plan and Business Continuity Plan until 31 March 2013.

NHS Cambridgeshire jointly led the Health and Social Care Emergency Planning Group with NHS Peterborough, this is a sub-group of the Cambridgeshire and Peterborough Local Resilience Forum (CPLRF), which has membership from local hospitals and community health services and co-ordinates emergency planning across the health system in Cambridgeshire and Peterborough.

Examples of recent activity included planning and preparation for the Olympics, and for the potential impact of any industrial action, whilst also participating in a number of emergency planning exercises and organisational workshops.

In accordance with the Department of Health directives, a new Cambridgeshire and Peterborough Local Health Resilience Partnership (CP LHRP) has been formed to be a strategic forum for organisations in the local health sector, including private and voluntary sector where appropriate. It facilitates health sector preparedness and planning for emergencies at Cambridgeshire and Peterborough Local Resilience Forum (CPLRF) level. It supports the NHS, Public Health England (PHE) and local authority (LA) representatives on the CPLRF in their role to represent health sector Emergency Planning, Resilience and Response (EPRR) matters.

In order to take forward tactical and operational Health and Social Care emergency planning issues, the CPLRF Health and Social Care emergency planning Group will work to both the CPLRF and the CP LHRP to ensure that a consistent approach is taken, links to both the CPLRF and LHRP are maintained and that the attendance by emergency planning practitioners is optimised.

Equality and diversity

NHS Cambridgeshire is committed to developing an organisational culture that promotes equality and diversity in commissioning of our services, workforce and service provision with involvement of the local community sector representative of protected characteristic groups. This will ensure future NHS organisations i.e. Clinical Commissioning Groups are equipped to meet their public sector equality duty relating to the Equalities Act 2010 but importantly all patients experience good patient care.

During the year NHS Cambridgeshire has been working using the Equality Delivery System (EDS) national framework through engagement with staff and local interest groups to help the NHS to improve the way in which people from different groups are treated as patients, carers and employees. All EDS work achieved during 2012-13 contributed to the CCG authorisation process successfully. The CCG will therefore start as the new responsible organisation following the demise of Peterborough and Cambridgeshire PCTs from 1 April 2013 and take forward the EDS legacy already set into the future for Cambridgeshire.

EDS is designed to make improvements for patients and staff and applies to people afforded protection, by the Equality Act 2010, from unfavourable treatment because of specified 'protected' characteristics.

Protected characteristics

- Age
- Disability
- Gender re-assignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race including national identity and ethnicity
- Religion or belief
- Sex/gender
- Sexual orientation

NHS Cambridgeshire is working closely with the CCG to support it through this year of transition, before it takes over fully from the Primary Care Trusts from April 2013. Cambridgeshire Clinical Commissioning Group will be led locally by clinicians in partnership with their communities, commissioning quality services that ensure value for money and the best possible outcomes for those who use them. This means EDS is a core part of that vision and therefore ensures engagement and inclusion of protected characteristics group in commissioning of local services to meet local need.

Achievements in 2012-13:

As reported last year all systems were put in place for embedding EDS into NHS Cambridgeshire. This included top level buy-in, high level governance structure with a Non Executive Board champion, EDS leads, the Cambridgeshire wide provider cluster group, local interest group and staff partnerships. The same process will be applied to fit the CCG during 2013-14. Achievements for 2012-13 are presented below:

- Engagement and feedback events with staff and local interests including the local LINk.
- Rating events jointly with staff, local interest groups representative of protected characteristic groups, PCT and provider leads.
- Established annual improvement plans approved by the Board and Scrutiny Committee.
- Progress reported regularly to the Board, Scrutiny Committee.
- Over 40 equality impact assessments completed.
- Established equality and diversity training as a mandatory requirement.
- Delivered embedding ambassadors in community health three times successfully through two trained trainers from the local community. Further funding was received for year two.
- The EDS Leads are also trained trainers for the HealthWrap training, part of the PREVENT, Department Of Health requirement and Cancer Champions, part of the Anglia Cancer Network regional initiative.
- The Cambridgeshire rating and feedback event with local interest groups was held on 29 January 2013.
- Met the requirements by 6 April 2012 to publish a compliance statement, annual and assurance reports and improvement plan for EDS. These will be published for April 2013.

In October 2012 Geeta Pankhania and Suchitra Rampal received a regional award from Sir Neil McKay under the organisation category for the creative and innovative approach used for staff engagement across NHS Peterborough and NHS Cambridgeshire for their ‘INSTYLE’ events.

The future of health in Cambridgeshire

On 1 April 2013 the future of healthcare in Cambridgeshire and Peterborough was handed over to Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) enabling GPs to be in the driving seat of healthcare changes.

Cambridgeshire and Peterborough CCG serves a population of 830,000 people, has a budget of £850 million, 109 member practices and eight local commissioning groups and is one of the largest Clinical Commissioning Groups in the country.

We have a federation of eight local commissioning groups which are:

- Borderline
- Cam Health
- CATCH
- Hunts Care Partners
- Hunts Health
- Isle of Ely
- Peterborough
- Wisbech

The Local Commissioning Groups are sub-committees of the Governing Body and report quarterly to the Governing Body on provider performance and are responsible for ensuring that there is patient and public involvement at a local level.

They also have delegated budgets for local decision making with central accountability and governance.

CCG: Our vision:
Led locally by clinicians in partnership with their communities, commissioning quality services that ensure value for money and the best possible outcomes for those who use them.

CCG: Our Mission:
To empower our communities to keep healthy and to commission good quality healthcare for all those who need it.

CCG Our Values:

- Patient focused – Our population, patients and their families are at the centre of our thoughts and actions we will commission care tailored to their need.
- Quality driven – We will constantly strive to be the best we can be as individuals and as an organisation and we will ensure that this is reflected in our commissioning decisions.
- Work locally – Through our Local Commissioning Groups working within their communities.
- Excellent – Our aim is to be an excellent organisation, for our communities, clinicians and our staff.

CCG: Our priorities:
Clinicians and managers worked together using public health intelligence to develop three main priorities for the CCG to focus on. These are:

- Frail elderly

- End of life care
- Tackling inequalities focussing on heart disease

We have set up three Programme Boards with representatives from partner health organisations, local authorities and patients all involved to help drive through our work around these three priority areas.

At the same time as providing a CCG wide focus for our work each local commissioning group should work towards these priorities reflecting their different population needs and services.

Patient reference group

To ensure that the patient voice is at the heart of everything we do we have developed a patient reference group which is a formal sub-committee of the Shadow CCG Governing Body.

It is chaired by the CCG Lay Member with responsibility for patient and public involvement, Rebecca Stephens. The membership is made up of eight Patient Reps from LCG Boards and seats for Health watch reps from the LCG areas.

The patient reference group will:

- Ensure meaningful engagement locally and CCG wide.
- Comment on and advise on service change proposals.
- Provide intelligence to the CCG Governing Body on patient concerns.
- Ensure join up between LCG work on service redesign.
- Does not replace statutory duties to inform, engage & consult.
- Report formally to Board in public.

Involving you

NHS Cambridgeshire is committed to involving people and listening to their views on the way we commission and provide their health care services. We recognise too that people can expect better health outcomes if they are involved in decisions about their own health care.

We also have a statutory duty to engage with our local population about how we plan, commission and provide services to them.

The views of local people are invaluable to us - and we would like to thank everyone who took the time to contribute to one of our consultations or attended one of our public engagement events during 2012-13.

GP practice procurements for Cathedral and Maple surgeries

NHS Cambridgeshire held patient meetings in each location to listen to the patient views and to explain the procurement process. Patient representatives have taken part in the procurement exercise.

Authorisation for Cambridgeshire and Peterborough Clinical Commissioning Group

During this transition year as the Primary Care Trust comes to an end and hands over the responsibility for commissioning to the Clinical Commissioning Group for Cambridgeshire and Peterborough we have engaged widely with GPs, clinicians, key organisations and stakeholders, as well as patients and the wider public so that people understand the new health system as it develops. We have discussed these changes widely, and asked people what they thought about these changes. We have strived to explain what is happening as the new legislation took shape and new organisations were able to emerge.

Local Commissioning Groups

During this year we have been supporting the eight local commissioning groups with their patient groups. These are groups of people who inform and influence decisions and proposals made by NHS Cambridgeshire and contribute to the planning and development of existing and new services. If you would like to be involved in patient groups, or want more information please contact our engagement team using the contact information below.

Hunts Patient Congress

These are groups of people who are informed on health services and who can influence decisions and proposals made by NHS Cambridgeshire and contribute to the planning and development of existing and new services. The Patient Congress represents patients from most Patient Participation Group in the Huntingdonshire area. If you would like to be involved in these forums, or want more information please contact our engagement team using the contact details below.

Patient reference group

During this period of transition Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) has identified as a priority and has a duty to take account of representation made by persons who represent the interests of the communities it serves. The Governing Body of the CCG has established a sub-committee of the Governing Body which is known as the Patient Reference Group.

The focus of the Patient Reference Group (PRG) will be on providing an independent view of the work of the CCG that is external to the day-to-day running of the organisation. It will also help to ensure that, in all aspects of the CCG's business the public voice of the local population is heard and that opportunities are created and protected for patient and public empowerment in the work of the CCG.

Cambridgeshire Adults Wellbeing and Health Overview Scrutiny Committee (OSC) Cambridgeshire Local Involvement Network (LINk)

NHS Cambridgeshire involves these two key stakeholders in all consultations and engagement work from the outset. The Cambridgeshire LINk (Local Involvement

Network) continues to have representation at NHS Cambridgeshire and NHS Peterborough Cluster Board level.

Getting involved
If you want to have more of a say on your local health services, then why not get involved with the NHS? You can either respond to our consultations individually (these will be advertised locally and will be available on our website), or you can become more directly involved by contacting our Engagement Team on 01223 725323 or e-mail engagement@cambridgehireandpeterborough.nhs.uk.

PALS/Complaints report 2012-13

Patient experience

NHS Cambridgeshire has remained committed to monitoring patients' experience as an indicator of the quality of care and services we commission within Primary Care and acute NHS Trusts.

The key areas of focus have been:

- Patient Advice and Liaison Service (PALs) comments and enquires; and
- Complaints

We have reviewed our Complaints policy to ensure that it incorporates the Parliamentary and Health Service Principles of Remedy: Getting it right, being customer focused, being open and accountable, acting fairly and proportionately, putting things right and seeking continuous improvement.

Data around PALs comment and enquires and complaints are collated regularly and provide a more holistic view of care through the patients' eyes. Combined with other quality and safety measures and outcomes, we are able to determine where our own services and commissioned services are excelling and areas for improvement.

PALs enquires received 2012-13

The total number of PALS enquires across NHS Cambridgeshire in 2012-13 were 3,370. The key themes identified through PALS enquires were:

- Accessing treatment
- Dissatisfaction with the complaints process
- Staff attitude
- General information on registering with a dental practice

All PALS enquires were followed up and responded to by the patients' experience team.

NHSC received several calls where service users wished to express their gratitude. These included development or care within a children's day surgery and a GP surgery, both of which were sent on to the relevant organisations.

Annual Complaints for Commissioner Services

The table below shows the number of complaints received by the NHSC:

2012 - 2013	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total
Commissioner – formal	6	3	6	2	**17**
Commissioner – concerns (informal)	3	3	5	5	**16**
Conciliation Cases	0	0	0	0	**0**

There were a total of 17 formal complaints (compared to 23 the previous year) as outlined below according to themes and departments.

	AUDIOL	COMMU	CONTIN	CONTRC	EXCEP	MISCELL	PRISON	WHEEL	Total
Access to medical staff	0	1	0	0	0	0	0	0	1
Staff Attitude	0	0	1	0	0	0	0	0	1
Clinical Care	0	0	0	0	0	1	1	0	2
Patient Charges	0	0	2	0	0	0	0	0	2
Communication/Information	1	0	1	1	1	2	0	0	6
Delay in diagnosis/treatment or referral	0	0	0	0	1	0	1	0	2
Other	0	0	2	0	0	0	0	1	3
Totals:	1	1	6	1	2	3	2	1	17

Each complaint was investigated by the relevant lead, and a response made by the Primary Care Trust or Prison services. A key outcome has been an improvement in quality and quantity of information provided to patients relating to local policies and procedures.

Trends

The number of cases received this year is slightly lower than this year. The main reduction has been in prison complaints where different organisations are now providing services within the prison and dealing with their own complaints directly. The largest number of complaints concern Continuing Healthcare Funding.

Medical services - complaints

There was an increase in the number of complaints received from the primary care services this year compared with 2011-12. A total of 80 complaints were made against GPs or practice staff during April 2012 and March 2013. The table below provide an overview of complaints according to each category:

Complaints by Subject	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	Total
Abuse	0	0	0	1	**1**
Access to Medical Staff	2	0	0	1	**3**
Administration	1	0	0	1	**2**
Staff Attitude	3	5	1	5	**14**
Clinical Care	10	10	3	5	**28**
Communication/Information	1	0	3	0	**4**
Delay diagnosis/treatment/referral	6	2	4	4	**16**
Equipment Issues	1	0	0	0	**1**
System Failure	1	0	0	0	**1**
Medication/Pharmacy	3	2	0	0	**5**
Medical Records	1	1	0	0	**2**
Other		1	1	1	**3**
Total:	**29**	**21**	**12**	**18**	**80**

The key themes were:

- Delayed diagnosis/treatment referrals
- Ineffective communication
- Concerns with clinical care
- Poor staff attitude

Most of the complaints were resolved by providing detailed explanation and apologies. For the more complex and multi-agency cases the use of independent conciliators was required, and in nearly all such cases independent clinical advice sought.

An example, with actions taken and lessons learnt, is outlined below:

“There was a breakdown in communication following the referral of a patient for a scan resulting in a delay. Once the problem was identified a second referral was made immediately and the patient was fast-tracked for a further investigation to avoid additional delays. However, this resulted in the patient receiving insufficient explanation (from the GP) as to the reason for the investigation. An apology was given for the distress caused. The key learning for the Practice was for GPs to reflect on the possibility of post-operative complications as part of the differential diagnosis in the future.”

A key outcome from other cases includes one Practice that has reviewed its weekly prescription procedure and altered the collection day to earlier in the week. This will ensure any problems can be addressed before the weekend, thus helping to avoid patients running out of medication.

Dental services - complaints review

A total of 37 complaints were made against dental practices and staff during April 2012 and March 2013.

The table below provide an overview of complaints according to categories:

Complaints by Subject	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	Total
Access	0	0	0	1	**1**
Administration	1	0	0	0	**1**
Staff Attitude	4	0	0	0	**4**
Clinical Care	2	4	1	1	**8**
Patient Charges	1	2	0	1	**4**
Communication/Information	1	0	0	0	**1**
Delay	0	0	1	3	**4**
Dental Issues	2	3	6	2	**13**
Records	0	0	1	0	**1**
Total:	**11**	**9**	**9**	**8**	**37**

The key themes which emerged were around general dental issues, clinical care and staff attitude.

Most of the complaints were resolved by providing detailed explanation and apologies. For the more complex cases difficult to resolve, the involvement of the Independent Dental Advisor was required.

An example, with actions taken and lessons learnt, is outlined below:

“A father and his daughter were concerned that their dental practice will no longer see them as according to a letter, the dental practice’s records showed they had missed appointments. The father was quite sure that they had not received any appointment letter or telephone reminders even though the practice said they had. The practice has a strict company policy on removing patients from the list if they do not attend twice. PALS liaised with the practice manager and the records showed the patients had missed two appointments. Further investigation showed there were incorrect contact details for the family. These were rectified and the dentist agreed to see both father and daughter. The ‘did not attend’ policy was reiterated to the father, and he was satisfied with the outcome. The learning for the practice was the importance of confirming the contact details for patients, particularly if they have missed an appointment.”

Key outcomes from other cases include:

- All patients in one Practice are now issued with full treatment plans and regular audits will be carried out to ensure patients fully aware of their NHS/private treatment options
- A locum specialist has been employed in one Practice to offer increased appointments at more convenient times for patients.

Other services- complaints review

Pharmaceutical complaints

Total cases for pharmaceutical complaints were four in 2012-13. This is a downward trend from 2011-12.

Complaints by Subject	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	Total
Medication/Pharmacy	2	2	0	0	**4**
Total:	**2**	**2**	**0**	**0**	**4**

There were no ophthalmic complaints for 2012-13.

Parliamentary and Health Service Ombudsman

Two cases were progressed to the Parliamentary and Health Service Ombudsman, and related to continuing care funding, and commissioning of medication.

Our staff

Sickness rates:

	2012 Number	2011 Number
Total Days Lost	**1,203**	1,833
Total Staff Years	**320**	325
Average working Days Lost	**3.76**	5.64

The data for staff sickness absence is supplied by the Department of Health on a calendar year basis.

Staff in post at 31 March 2012:

Employee numbers by head count	NHS Cambridgeshire	Hosted	Total
Scientific and Technical	17		17
Additional Clinical Services	1		1
Administrative and Clerical	207	88	295

Medical and Dental	9	5	14
Nursing and Midwifery	23		23
Total	**257**	**93**	**350**

The table above shows employee numbers by headcount, while those in note 7.2 within the accounts shows whole time equivalent.

Improving quality

Having quality as the keystone for all healthcare organisations is a central pillar of the requirements for transition to clinical commissioning enacted in the Health and Social Care Act 2012. NHS Cambridgeshire has robust systems for holding commissioned providers to account for the quality of their services and to improve outcomes for patients.

Transition to clinical commissioning

NHS Cambridgeshire's Healthcare Governance team has undergone transition into the Quality, Safety and Patient Experience team required as part of the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and the associated Local Commissioning Groups (LCGs). The new team combines a mixture of new staff bringing innovative skills and existing members retaining organisational memory. The new team has worked with all the LCGs to support their focus on quality, including development of quality standards, GP support, and management of intelligence relating to local commissioned services.

Quality monitoring

NHS Cambridgeshire is working with all providers to make the best use of the tools available to improve the quality of care for our patients and service users. This includes use of dashboards and frameworks to identify areas of good practice, and any concerns.

Each of our providers gives us monthly performance reports about the quality of their clinical care. We hold monthly clinical quality review meetings with all our hospitals and other service providers, where concerns and risks are analysed and addressed. There is also opportunity for reviewing good practice, to be disseminated across the health economy.

Learning is shared through a range of health economy wide forums. The Directors of Nursing have developed a strong communication network which is used to share, learn and challenge where necessary.

Announced and unannounced quality and patient safety visits

We continue to go into provider organisations to observe practice and talk to staff and patients about the quality and outcomes of care. The visits are both unannounced and announced, and can be driven by intelligence received about concerns in specific areas, or can be part of a regular review of all providers.

Examples of announced visits included themed reviews looking at systems in place to manage clinical audit and risk management in providers. Unannounced visits have been driven by concerns raised over issues such as healthcare acquired infections and themes from serious incidents.

Deep Dive investigations

Where there are specific concerns about a provider's services, NHS Cambridgeshire has carried out an in-depth review - a deep dive - to get to the root cause of problems and identify improvements required. For example a review of district nursing in Cambridgeshire and Peterborough included feedback from GPs and analysis of workforce metrics to ensure a complete picture of the service was obtained to allow strategic joined-up improvement goals to be set.

Learning from incidents

It is important that we learn from situations where care given to patients was not as expected so that we can minimise the risk of similar incidents happening in the future. In order to do this, there needs to be a process for reporting such incidents so that analysis can take place and appropriate changes made as required.

In addition there are clear national processes and timeframes for providers to follow when more serious incidents (SIs) occur. These are monitored rigorously and themes are identified. For example, analysis led to a detailed review of antenatal and new-born screening incidents with pathways strengthened as a result.

A review of providers' processes was undertaken in 2012 to ensure that they were robust and that learning was being implemented. There have also been visits to providers to review learning from never events (events that should not occur if care is of a high standard) to share information and learning.

Learning events were held quarterly with providers to share information and learning across the health economy and newsletters and targeted emails were also distributed to share learning as required.

Commissioning for quality and innovation (CQUIN)

The Commissioning for Quality and Innovation (CQUIN) payment framework is an incentive scheme, giving Trusts resources to achieve improvements in care over and above those stipulated in their contract as part of accepted care. These focus on quality across the areas of safety, effectiveness and patient experience.

The CQUIN schemes were negotiated with providers, incorporating national, local and provider specific schemes. Monitoring of achievement of the requirements for each provider was undertaken on a quarterly basis.

National schemes included:

- Screening of patients for developing a venous thromboembolism and receiving preventative measures as required.
- Involvement and feedback from patients about their experience of the service and care received – the friends and family test.
- Screening patients for dementia, appropriate assessment and referral.
- Safety thermometer – review of the numbers of patients with pressure ulcers, falls, urinary catheter infections and venous thromboembolisms.

Quality accounts

All providers of acute, mental health, learning disability, community services and ambulance services produce and publish a Quality Account each year, showing the quality of the services they have provided, and setting priorities for improvement in quality for the next year.

The aim of the Quality Account is to:

- Increase NHS accountability by making a greater level of information about the quality of healthcare services available to the public.
- Support provider boards and senior managers to focus on quality improvements by reporting nationally on quality across the entire range of their services. They are also required to state what improvements they plan to make.

Each Trust which publishes an account receives a statement from NHS Cambridgeshire, which they are required to publish in their account. This gives commentary on the improvements highlighted in the account, the priorities for future improvement, and details of the joint working between the organisations, and any concerns or issues that have been highlighted.

Infection prevention and control

Infection prevention and control has remained an important indicator of quality care and service delivery to patients. Mandatory reportable infections MRSA bacteraemia and Clostridium difficile, are monitored monthly against the annual trajectory targets set by the Department of Health to ensure a continual reduction is maintained. The period of 2012-13 has proved to be a difficult year to maintain the reduction seen in previous years and all providers have failed to meet the Clostridium difficile targets.

Evidence of assurance was requested against the 10 recommendations as set out in **Clostridium difficile: How to deal with the problem (DH, 2009).** Remedial action plans have been required from providers to address the situation and to ensure good practice is embedded to reduce risks to patients.

Harm free care meetings were held with providers to discuss this issue and safety thermometer data which includes pressure ulcers, catheter associated urinary tract infections, falls and venous thrombosis evaluation.

Pre 72 hour pressure ulcers

During the year the infection prevention and control team has also taken on the role of change champions for the NHS Midlands and East pressure ulcer ambition to eliminate avoidable grade 2, 3 & 4 pressure ulcers. Root cause analysis is completed for pre 72 hour (community onset) cases to determine the level of need by those patients in their own home and through primary care practice. It has also helped to challenge practice of providers.

Findings from this include:

- Better communication between health care providers is required; and
- Inconsistent practice in care homes (residential and nursing).

Areas for attention include:

- Awareness in primary care;
- Education and support to care homes on prevention; and
- Patient education leaflets regarding risks from changes to nutrition and fluid intake and use of pressure relieving equipment.

Safeguarding children

Safeguarding children has remained a priority for NHS Cambridgeshire during 2012-13 and will continue through the transition into the Clinical Commissioning Group.

Quality assurance is provided in several ways:

- NHS Cambridgeshire and all health provider organisations are fully compliant with national statutory standards.
- Safeguarding children standards are included within all health contracts and service level agreements.
- Quality indicators for safeguarding children are included within the NHS Cambridgeshire's quality monitoring processes.
- A GP resource pack has been produced and distributed quarterly to support GP practices in their safeguarding children work.
- NHS Cambridgeshire chairs the multi-agency Local Safeguarding Children's Board Health Safeguarding Subcommittee. There is a full engagement with multi agency working on safeguarding children demonstrated by the attendance at the Local Safeguarding Children Boards and other sub groups.

- NHS Cambridgeshire plays a central role in the serious case reviews process by reviewing health economy investigations, monitoring actions and disseminating the learning.
- NHS Cambridgeshire co-ordinate the child death review process, including rapid response service which ensures that relevant issues are identified and addressed to improve the safety of children in the county.

Safeguarding vulnerable adults

Safeguarding vulnerable adults has received an increasingly high profile nationally, with attention focussing on the care of vulnerable groups in both hospitals and residential settings. Additionally, there are responsibilities for health providers to register with the Care Quality Commission (CQC). This includes a self-assessment of their ability to safeguard vulnerable adults. NHS Cambridgeshire continues to monitor safeguarding practice against the CQC standards in partnership with Local Authorities.

NHS Cambridgeshire is represented at the Safeguarding of Vulnerable Adults Partnership Board which provides strategic leadership in adult safeguarding. In recent months our representation has increased in recognition of the new arrangements for Clinical Commissioning Groups.

An Adult Safeguarding Lead Nurse has been appointed for Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) who has responsibility to ensure there are comprehensive arrangements in place for safeguarding adults in all commissioned services.

A training strategy is in the process of being developed in relation to Adult Safeguarding which includes the Mental Capacity Act and can be used for guidance in adherence to good practice by GPs and other providers.

Improving quality in primary care

As part of the new structure of the NHS, the National Commissioning Board (now called NHS England) will be playing a different role from the clinical commissioning groups in exercising its commissioning functions, as it will not be in a position to provide any primary care development support to practices. This was identified as a potential gap in the system, as CCGs will need to deliver on the improving quality in primary care agenda.

In NHS Cambridgeshire we have recruited a primary care quality improvement team that enables us to retain local provider knowledge and whose team members already have effective, trustworthy relationships with GP practices. We hope that this will bridge the gap and provide LCGs and their constituent practices with the level of support required to meet this agenda.

Improving the quality of primary care is a key indicator within the operating plans for the CCG. We are committed to ensuring that the local health care system is founded

on high quality primary care provision that will facilitate the delivery of more pathways of care being provided in primary care.

General practice is delivering a wider range of services in primary care settings especially in the area of the management of long-term conditions and is increasingly playing an important role in co-ordinating care provided in other settings.

Reducing variation and improving access

The primary care quality improvement team will support LCGs and practices to address the following:

- **Reduce variability in quality of primary care**: Quality of primary care is variable across Cambridgeshire with evidence of some excellent practice. It is critical that this variability in quality of provision is reduced if we are to improve the health outcomes for our population. The CCG will be utilising an agreed set of quality indicators to support this agenda.
- **Improvements in access**: Levels of satisfaction with access to our primary care providers in Cambridgeshire is variable. The team will work closely with practices to identify potential areas for improvement in order to meet the needs of their practice populations.

Monitoring and improvement of quality

There are a number of agencies that will have a role to play in both the monitoring and the improvement of quality in primary care in the restructured NHS. The quality of primary care will be assessed by:

- **"The regulator"**- the Care Quality Commission (from April 2013) with the aim of ensuring that general practices like all other NHS organisations are providing care that meets essential standards of quality and safety apply across both health and adult social care.
- **"The commissioner"** - the NHS England, will have responsibility for monitoring performance and that practices are meeting the requirements of their contract whilst the Health and Well-Being Boards of the local authorities will be reviewing the provision of primary care from the perspective of local people.
- **Clinical Commissioning Groups (CCGs)** will have duty to collaborate with the NHS England in continuously improving the quality of primary care and Cambridgeshire & Peterborough CCG will take be taking a pro-active approach to this.

Complex case management

Complex case management is responsible for NHS Continuing Healthcare. This is a process whereby a patient is deemed to have a primary health need and meets the criteria for full funding from NHS Cambridgeshire. The team is also responsible for

assessing patients in nursing homes to determine if they have nursing needs and meet the criteria for an allowance.

The team also assess patients for specialised rehabilitation for a period of time to promote independence and improve their quality of life. Another responsibility is the assessing of patients who may have both health and social needs, and the health needs cannot be met by local services or funded by the local authority. Over the past year the team have dealt with requests from the public for assessments of their relatives for un-assessed periods known as 'retrospective assessments'. We received 818 requests for assessments from the public who believe that their relative should have been funded by NHS Cambridgeshire or NHS Peterborough. The team have responded to the initial requests in a timely manner.

The team have also enabled many people who sadly are at the end of their life to achieve their end of life choice to die at home or in a nursing home.

The team endeavours to ensure that patients and their relatives are involved in the assessment process and they know them best.

The team have also in collaboration with other stakeholders played a significant role in assessing and promoting good practice in nursing homes.

Our performance

We continually monitor and measure our performance against local and national targets to ensure that the services we commission on your behalf meet your needs.

During 2012-13 we have focused our attention on:

- Ensuring that all key performance measurements are regularly communicated to all our stakeholders.
- Ensuring that monthly performance reviews take place with the major providers of health services in Cambridgeshire and cover service performance and clinical quality.
- Holding providers from whom we commission services to account for the responsiveness and quality of services provided.
- Ensuring delivery of our population's NHS Constitutional rights.

During the year we have also worked closely with GP leads from the Clinical Commissioning Group (CCG) to manage the transition to April 2013 and to involve them in the process of contract management and reviewing services commissioned.

Clinical Commissioners are regular members of the Finance and Performance Committee.

Key performance information is also reported to the CCG Governing Body.

We also began to prepare and consider the key indicators associated with the NHS Outcomes Framework for 2013-14, the CCG Outcomes Indicator Set for 2013-14 and Everyone Counts: Planning for Patients 2013-14.

We are continuing to work hard to meet increasingly challenging targets. The CCG will continue this work in 2013-14 with focus on the main risk areas of Referral to Treatment, Cancer Waits, A&E standards and Infection Control. The tables below summarise 2012-13 performance on key indicators and compare performance to 2011-12.

Access to Emergency Care in 2012-13

Figures here relate to Ambulance responses (East of England Ambulance Service) and maximum waiting times at Accident & Emergency (A&E).

Performance Target	11-12 Actual	12-13 Actual	12-13 Target
All ambulance trusts to respond to 75% of Category A calls (immediately life threatening) within 8 minutes	75.4%	74.2%	75%
All ambulance trusts to respond to 95% of Category A calls (immediately life threatening) within 19 minutes	94.9%	93.5%	95%

Ambulance underperformance has been contributed to, across the region, by ambulances being delayed at hospitals whilst trying to hand patients over. This mainly affected the rural areas, as when the East of England Ambulance Service Trust (EEAST) vehicle resources are responding to/conveying a patient, the resource is no longer available for dispatch. There are certain parts of the region where the rurality and the resource required to respond conspire to make the 8 minute target challenging to achieve. The Trust has been pushing forward with plans to increase unit hour production, for staffing of shifts.

EEAST is working with commissioners and all acute trusts to try and limit the impact hospital delays have on their ability to respond. Delays are being monitored on a 30 minute basis, with acute trusts, rather than the previous 60 minutes to ensure maximum number of vehicles being released on time. EEAST have been undertaking rota reviews to ensure that their workforce planning is as effective as possible, considering the match of demand against supply of responders. This is part of a wider unit hour production review. Recovery plans are being monitored by NHS England.

Four-hour Maximum wait in A&E from arrival to admission, transfer or discharge in 2012-13

NHS Cambridgeshire's A&E performance was affected by underperformance at CUHFT and QEH as outlined in the table below.

Provider	11-12 Actual	12-13 Actual	12-13 Target
Cambridge University Hospitals Foundation Trust	95%	94.7%	95%
Hinchingbrooke Healthcare NHS Trust	96.8%	97.7%	95%
Queen Elizabeth Hospital, Kings Lynn	95.1%	92.8%	95%

CUHFT under performed in Q4 12/13 against the A&E four hour national operating standard, therefore missing the standard over the full year. In March 2013, the pressure was in part down to attendance numbers being higher than in January and February and partly down to the nature of the patients being seen. Sicker patients with respiratory and cardiac issues and the frail and elderly were more time and resource intensive, in the department. The Trust struggled to free up bed capacity to care for the increased number of medical emergency admissions it decided to admit from A&E. Financial consequences were applied for non-delivery of the standard in March 2013 and CUHFT are producing a recovery plan.

Actions to improve performance include:

- A planned review of A&E minors and zero length of stay admissions.
- The Trust will quicken the proposed roll out of further ambulatory care pathways.
- The Trust will ensure Trust wide Programmes for Length of Stay & Unplanned care are focussed on implementation plans not just review processes.
- Implementation of Elderly care CQUINs.

With regard to QEH, the under performance is being primarily managed by their lead commissioner arrangements in Norfolk. The PCT is aware that remedial action plans are in place which are monitored and reviewed through the local urgent care networks.

Access to Planned Care in 2012-13

Figures here relate to patients receiving care within the NHS system starting from your GP to receiving treatment at your local hospital.

Performance Target	11-12 Actual	12-13 Actual	12-13 Target
Percentage of patients seen within 18 weeks for admitted pathways	88.6%	91.6%	90%
Percentage of patients seen within 18 weeks for non-admitted pathways	98.3%	98.2%	95%
Percentage of patients on incomplete non-emergency	96.3%	96.4%	92%

pathways (yet to start treatment) waiting no more than 18 weeks from referral			

Access to Cancer Services in 2012-13

Figures here relate to how long patients have to wait for treatment.

Performance Target	11-12 Actual	12-13 Actual	12-13 Target
Patients seen within two weeks from an urgent GP referral for suspected cancer to date first seen	96.4%	96%	93%
Patients seen within two weeks from a referral for evaluation of “breast symptoms” by a primary care professional to date first seen	96.7%	96%	93%
Patients receiving their first definitive treatment for cancer within one month (31 days) of a decision to treat	97.6%	97.8%	96%
Patients receiving their subsequent Chemotherapy treatment for cancer within one month (31 days) of a decision to treat	99.9%	99.8%	98%
Patients receiving their subsequent Surgical treatment for cancer within one month (31 days) of a decision to treat	96.3%	95.9%	94%
Patients receiving their subsequent Radiotherapy treatment for cancer within one month (31 days) of a decision to treat	97.2%	96%	94%
Patients receiving their first definitive treatment for cancer within two months (62 days) of GP or dentist urgent referral	84.6%	85%	85%
Patients receiving their first definitive treatment for cancer within two months (62 days) of a National Screening referral	93.4%	99.2%	90%

Access to Cardiovascular Services in 2012-13

Figures here relate to how long patients have to wait for treatment.

Performance Target	11-12 Actual	12-13 Actual	12-13 Target
Percentage of people having transient ischaemic attack (TIA) Scanned & Treated within 24 hours	28.9%	61%	60%
Percentage of stroke patients who spend at least 90% of their time on a specialist stroke unit	77.6%	75.2%	80%

NHS Cambridgeshire's performance was affected by underperformance at CUHFT who failed to meet the standard for 7 months out of 12. This was primarily due to bed placement, timely and correct diagnosis in the Emergency Department, gaps in the nurse bleep rota and a lack of community rehabilitation (the Ely rehabilitation unit remained closed until the end of March 2013 due to staff shortages) and Early Supported Discharge services.

In terms of bed placement and a lack of capacity on the stroke unit, operational leads have confirmed the use of a daily stroke bed plan and escalation plan with the operation centre in order to improve the bed placement of confirmed strokes.

In order to improve timely and correct diagnosis, the Stroke Nurse Consultant will continue an education programme within the Emergency Department regarding the use of the ROSIER (an assessment tool to enable medical and nursing staff to differentiate between patients with stroke and stroke mimics). Stroke services have made a request for this to be included as part of the new doctors' training package.

Sickness and maternity leave meant that there were gaps on the nurse bleep rota and currently this rota is funded largely through research funds. The service is putting a bid together to obtain NHS funding for this bleep so that there is increased coverage to 24/7.

CUHFT are working to increase Early Supported Discharge for patients to ensure capacity on the Unit.

To summarise, CUHFT are working to:

- Ring-fence stroke beds and support nurse bleep to assist the operations centre with out of hours cover and correct bed placement.
- Reinforce stroke education for diagnosis and referral of all strokes across the Emergency Department and Medicine Junior doctors.
- Provide out of hours bleep support to the Emergency Department who can request consultation if they are unsure of stroke diagnosis.
- Develop a multidisciplinary approach to the Root Cause Analysis process of patients who miss the Stroke Metrics.

Patient Safety 2012-13

Figures here relate to the number of incidences of Clostridium difficile and MRSA applicable to NHS Cambridgeshire.

Performance Target	11-12 Actual	12-13 Actual	12-13 Ceiling
Number of incidences of Clostridium difficile	101	127	103
Number of incidences of MRSA in patients aged 2 or over	7	9	4

Clostridium difficile
All of our providers exceeded the ceilings confirmed in the 2012/13 Trust plans and contractual consequences have been applied as appropriate. Remedial action plans are in place which are monitored monthly through Clinical Quality Review meetings.

Examples of actions being taken to improve performance are as follows:

- Mandatory training for all staff on Clostridium difficile procedures
- Infection control training for all clinical staff
- Monthly hand hygiene audits in clinical areas
- Deep clean programmes for clinical areas, to assure continued high standards of environmental cleanliness
- Regular audits of the cleaning of high risk items of equipment to reduce the risk of cross infection
- Formal monthly review of all Clostridium difficile cases between providers and NHS Cambridgeshire (to include root cause analysis)

There is no single change which will improve performance however the key issues identified have been around communication across and between all services and the need to have a fuller understanding of the disease burden.

MRSA
Standard contractual consequences are being applied for MRSA. Root Cause Analyses are being reviewed in monthly Clinical Quality Review meetings and remedial action plans are in place.

Examples of actions being taken to improve performance are as follows:

- Identification of patients at increased risk of MRSA infection through proactive review and labelling of notes
- MRSA screening of attendees at Hepatology Clinics to ensure early identification of positive patients
- Measuring whether secondary transmission is occurring amongst Hepatology patients through two weekly screening of all patients on hepatology specialties
- Embracing whole genome sequencing opportunities to investigate the epidemiology of MRSA within the Trust and surrounding area (at CUHFT)

Who's Who?

Our Members – NHS Cambridgeshire and NHS Peterborough Cluster Board and Shadow Clinical Commissioning Group (CCG) Governing Body

Non-Executive Directors/Lay Members		
Name	**Title**	**Attends Board Sub Committee**
Maureen Donnelly (To July 2012)	PCT Cluster Chair (to July 2012) *CCG Lay Chair (from July 2012)*	Finance & Performance Committee, Quality & Patient Safety Committee Shadow CCG Governing Body
John Barratt	Audit Committee Chair & Non-Executive Director (to July 2012) PCT Cluster Chair (from July 2012)	Audit Committee Chair (To July 2012), Finance & Performance Committee, Quality & Patient Safety Committee
Malcolm Burch	Non-Executive Director	Remuneration & Terms of Service Committee, Quality and Patient Safety Committee
Glen Clark	Non-Executive Director (to August 2012) CCG Lay Member Representative (from August 2012) – Speaking rights only	Finance & Performance Committee, Quality & Patient Safety Committee, Remuneration & Terms of Service Committee (To August 2012) Governance & Compliance Committee
Prof Colin Coulson-Thomas	Non-Executive Director	Audit Committee, Finance & Performance, Committee Remuneration & Terms of Service Committee (From August 2012)
Robert Kynnersley	Non-Executive Director	Remuneration & Terms of Service Chair, Governance & Compliance Chair
Edward Libbey (From July 2012)	Non-Executive Director	Audit Committee (Chair), Finance & Performance Committee
Peter Southwick (To December 2012)	Non-Executive Director (to August 2012) CCG Lay Member Representative (from August to December 2012) – Speaking Rights only	Finance & Performance, Audit Committee, Remuneration & Terms of Service (August 2012), Quality & Patient Safety
Sally Williams	Non-Executive	Quality & Patient Safety (Chair to

	Director	December 2012), Audit Committee, Finance & Performance Committee, Shadow CCG Governing Body (to July 2012)
Executive/Other (Voting):		
Dr Sushil Jathanna (Until September 2012)	Chief Executive	Finance & Performance Committee, Shadow CCG Governing Body
Sheila Bremner (From October 2012)	Chief Executive (Accountable Officer – Local Area Team Director)	PCT Cluster Board
Dr Simon Hambling (To June 2012)	Chair of Shadow Clinical Commissioning Group (Until June 2012)	Shadow CCG Governing Body
Dr Neil Modha (From June 2012)	CCG Accountable Officer Designate (from June to January 2013: Chief Clinical Officer from January 2013: Shared vote with Medical Director	Quality & Performance Committee, Finance & Performance Committee, Shadow CCG Governing Body
Dr Liz Robin	Director of Public Health – Cambridgeshire: Shared Vote	Quality & Patient Safety Committee, Governance & Compliance Committee, Shadow CCG Governing Body
Dr Andy Liggins	Director of Public Health – Peterborough: Shared Vote	Quality & Patient Safety Committee, Shadow CCG Governing Body
John Leslie (Until January 2013)	Director of Finance	Finance & Performance Committee, Audit Committee, Governance & Compliance Committee
Adrian Marr (from January 2013)	Director of Finance	Finance & Performance Committee, Audit Committee
Alan Mack	Director of Corporate Development and Performance/Deputy Chief Executive: Shared vote with Medical Director	Finance & Performance Committee, Governance & Compliance Committee, Quality & Patient Safety Committee, Shadow CCG Governing Body
Dr Christine	Medical Director:	Quality & Patient Safety,

Macleod	Shared vote with Deputy Chief Executive	Governance & Compliance Committee, Shadow CCG Governing Body
Andy Vowles	Chief Operating Officer – NHS Cambridgeshire	Finance & Performance Committee, Quality & Patient Safety Committee, Shadow CCG Governing Body
In Attendance with Speaking Rights (Non-Voting):		
Jessica Bawden (From May 2012)	Director of Communications & Engagement	Quality & Patient Safety, Shadow CCG Governing Body
Dr Geraldine Linehan	Vice-Chair Shadow CCG Governing Body	Finance & Performance Committee, Shadow CCG Governing Body
Russ Platt (Until August 2012)	Chief Operating Officer - Peterborough	Finance & Performance Committee
Jill Houghton	Director of Nursing and Quality	Quality & Patient Safety Committee, Governance & Compliance Committee, Shadow CCG Governing Body
Peter Wightman	Interim Director of Primary Care	PCT Cluster Board
Mike Hewins	Cambridgeshire LINk	PCT Cluster Board
Gordon Lacey	Peterborough LINk	PCT Cluster Board

Other Shadow Clinical Commissioning Group Governing Body Members Not Included Above
Name
Dr Arnold Fertig, GP Member, Cam Health LCG
Dr Geraldine Linehan, GP Member, CATCH LCG
Dr David Roberts, GP Member, Hunts Health LCG
Dr John Jones, GP Member, Isle of Ely LCG
Dr David Irwin, GP Member, Hunts Care Partners LCG
Dr Tim Webster, GP Member, Wisbech LCG (from February 2013)
Dr Richard Withers, GP Member, Borderline LCG
Dr Andrew Wordsworth, GP Member, Wisbech LCG (To November 2012)
Harper Brown, Director of Commissioning & Contracting

Victoria Corbishley, Director of Performance & Delivery
Tim Woods, Chief Finance Officer
Rebecca Stephens, CCG Lay Member
Dr Christopher Scrase, Secondary Care (Hospital) Doctor

Declarations of Interest

A register of Interests for NHS Cambridgeshire was maintained.

Board Members and other Sub-Committee members who hold a Company Directorship with companies who are likely to do business or seek (or may seek) to do business with the NHS, plus any other relevant interests are set out below.

The list below also includes the GP Members of the Shadow CCG Governing Body.

Name	Title	Declaration of Interest
Non-Executive Directors		
John Barratt	Non-Executive Director PCT Cluster Chair (From July 2012)	Cambridge Business Ventures Ltd, Spouse employed by Alconbury & Brampton Surgery
Malcolm Burch	Non-Executive Director	Director of Malcolm Burch Associates Limited
Glen Clark	Non-Executive Director (to August 2012) CCG Lay Member Representative (from August 2012)	Marshall of Cambridge Aerospace Ltd, Marshall of Cambridge (Engineering) Limited, Aeropeople Ltd, Marshal Aerospace US Inc, Marshall Aerospace Netherlands BV, Marshall Aerospace Canada Inc, Marshall Aerospace Australia Pty Ltd, AeroAcademy Ltd, Slingsby Aerospace Ltd, Slingsby Aviation Ltd, Slingsby Ltd, Slingsby Advanced Composites Ltd, Slingsby Holdings Ltd, Marshall Specialist Vehicles Ltd, Marshall Vehicle Engineering Ltd, Marshall SDG Ltd, LifTow Ltd; and Marshall Land Systems Ltd.
Prof Colin Coulson-Thomas	Non-Executive Director	Chairman, Director and Shareholder Adaptation Ltd, Chairman, Director and Shareholder Policy Publications Ltd, Chairman, Director and Shareholder Cotoco Ltd, Chairman, Director and Shareholder Bryok Systems Ltd, Partner Governor

		Peterborough and Stamford Hospitals NHS Foundation Trust Adjunct Visiting Professor Manipal University, Professor, Business School, University of Greenwich
Robert Kynnersley	Non-Executive Director	Chair of Anglia Support Partnership (to April 2012)
Peter Southwick (To December 2012)	Non-Executive Director (to August 2012): CCG Lay Member (From August 2012 to December 2012)	Member of the corporation (Governor) Hills Road Sixth form College Trustee of the BAS Breakwell Charitable Trust Company, Spouse is a Trustee of the BAS Breakwell Charitable Trust Company.
Sally Williams	Non-Executive Director	Intermittently works for an individual who provides organisational development input to CCG and LCGs. Independent Adjudicator with Independent Sector Complaints Adjudication Service (ISCAS)
Other PCT Cluster Board Members (Voting and Non-Voting Members)		
Dr Michael Caskey (To September 2012)	GP Representative	GP Principal and Senior Partner in Park Medical Centre, GP with Special Interest in Neurology, Member of Sutton Parish Council, Director Peterborough Doctors Commissioners Ltd.
Dr Simon Hambling (To June 2012)	Chair of Shadow CCG (To June 2013)	Senior Partner Doddington Medical Centre, UCC Occasional Sessional work.
Mike Hewins,	Cambridgeshire LINk	President of Cambridgeshire LINk, Treasurer & Trustee of Inspire – Wellbeing Through Arts
Dr Sushil Jathanna (To September 2012)	Chief Executive	Wife is a GP in Colchester
Gordon Lacey	Peterborough Local Involvement Network	Vice Chair, Peterborough LINk
Dr Andy Liggins	Director of Public Health, joint appointment with Peterborough City Council	Company Member of Peterborough Environment City Trust

Dr Geraldine Linehan,	Vice-Chair of CCG Governing Body	Member of Steering Group of Research Application Board. PCT, Cambs University and CATCH, member of Cambridgeshire Local Medical Committee
Dr Neil Modha	CCG Accountable Officer (From June 2013) & Shadow CCG Governing Body Member	General Practitioner Thistlemoor Healthcare & Management Limited Secretary Graham Young Limited Secretary
Andy Vowles	Director of Strategy and Delivery	Spouse is an employee of Cambridgeshire University Hospitals NHS Foundation Trust
CCG Governing Body (GP Members and Lay Members (if not included above))		
Dr Arnold Fertig	Shadow CCG Governing Body Member	Locum work – Nuffield Road Medical Centre Initial set-up of Propdoc Limited
Dr David Irwin	Shadow CCG Governing Body Member	General Practice senior partner of Buckden and Little Paxton surgeries Partner of Dermatology Clinic Community Service Ltd (DCCSL)
Dr John Jones	Shadow CCG Governing Body Member	Partner, Staploe Medical Centre (PMS, Dispensing, Clinical Trials, Teaching Practice) Director Eagletie Ltd Director Eaglebond Ltd Director Staploe Medical Services Ltd Director Protix Ltd Shareholder and Director in Holding Company (Eagletie Ltd) that owns the pharmacy operating from Staploe Medical Centre
Dr David Roberts	Shadow CCG Governing Body Member	GP Senior Partner (Primary Care NHS Contract) Director Aquarius Systems Ltd
Dr Tim Webster (From February 2013)	Shadow CCG Governing Body Member	Partner North Brink Practice Director North Brink Pharmacy
Dr Richard Withers	Shadow CCG Governing Body Member	Partner at GP Yaxley Group Practice. Member of Cambridgeshire Local Medical Committee.
Dr Andrew Wordsworth (To November 2012)	Shadow CCG Governing Body Member	Partner at Trinity Surgery, Wisbech
Rebecca Stephens	Shadow CCG	Owner/Director - Syntax

	Governing Body Lay Member	Communications Ltd Member – Cambridgeshire and Peterborough NHS Foundation Trust Member of Peterborough & Stamford Hospitals NHS Foundation Trust Currently contracted by Greater Peterborough Partnership on CSR Workstream

Annual governance statement

1. Scope of responsibility

As Accountable Officer, and Chief Executive of the Board of NHS Cambridgeshire, 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.

NHS Cambridgeshire and NHS Peterborough became a Cluster PCT in December 2011. The PCT Cluster Board arrangements were approved by each PCT Board and are described in an Establishment Agreement which was approved by the PCT Cluster Board in December 2011. This is in line with the guidance from the Department of Health in relation to clustering of Primary Care Trusts. NHS Cambridgeshire remains a statutory organisation in its own right.

This Annual Governance Statement reflects arrangements from 1 April 2012 to 31 March 2013.

NHS Cambridgeshire has worked closely with other organisations throughout the year through a variety of relationships such as:

- Service level agreements and contracts with other NHS organisations to deliver health services to agreed specifications;
- Legal agreements with Cambridgeshire County Council;
- Performance management arrangements with the NHS Midlands and East Strategic Health Authority cluster;
- With patients through the Cambridgeshire Local Involvement Network;
- With partners such as social care, GP Clusters (NHS Cambridgeshire's New Commissioning Model) and with specialised commissioning groups carrying out joint needs assessments, strategic planning and joint commissioning;

- Accountability to the Secretary of State and to parliament for the performance of functions and meeting statutory duties;

- With local partners to promote the objectives of our local health plans and Local Area Agreement through partnership working, formal Partnership Boards and pooled funding arrangements;

- And wider communities through public engagement, through our Board meetings in public, publication of various corporate documents and plans, and production of the Annual Report and Annual Accounts;

- Through clustering arrangements with NHS Peterborough in line with the Establishment Agreement set out above; and

- Through the development and publication of a Multi-Agency Information Sharing Framework to facilitate effective information sharing and enabling efficient use of information to promote service delivery.

2. The Governance Framework of the Organisation

The PCT Cluster Board met bi-monthly in public. There was good attendance from all Board members at each meeting and attendance is recorded within the minutes of each meeting.

The Board was served by the following Committees:

- Joint Audit Committee;
- Joint Finance & Performance Committee;
- Joint Governance & Compliance Committee;
- Joint Quality & Patient Safety Committee;
- Shadow CCG Governing Body; and
- Joint Remuneration and Terms of Service Committee.

There was good attendance at Sub-Committee meetings and this is recorded within the minutes of each meeting.

The Joint Audit Committee is chaired by the Audit Committee Chair (Non-Executive Director), and is responsible for overseeing compliance with the development of systems and providing assurance to the Board of compliance with approved internal control mechanisms. GP attendance was included in the Committee to reflect the role of the Shadow CCG Governing Body and the future role of the CCG following authorisation.

The Joint Finance & Performance Committee is chaired by a Non-Executive Director, and is responsible for providing assurance on the overall financial wellbeing and performance of the PCT. GP attendance was included in the Committee to reflect the role of the Shadow CCG Governing Body and the future role of the CCG following authorisation.

The Joint Governance and Compliance Committee is chaired by a Non-Executive Director, and has overall responsibility for ensuring effective implementation of the PCT's Risk Management Strategy and associated policies. GP attendance was included in the Committee to reflect the role of the Shadow CCG Governing Body and the future role of the CCG following authorisation.

The Joint Quality and Patient Safety Committee, chaired by a Non-Executive Director, oversees all areas related to the three cornerstones of clinical activity, namely clinical effectiveness, patient safety and patient experience. The Committee supports NHS Cambridgeshire and NHS Peterborough to ensure that patient safety and quality is at the top of the agenda for providers as their highest priority. GP membership was strengthened to reflect the role of the Shadow CCG and the future role of the CCG following authorisation.

The Shadow CCG Governing Body has responsibility for Clinical Commissioning during the shadow year, in line with the scheme of delegation approved by the PCT Cluster Board.

The Joint Remuneration and Terms of Service Committee, chaired by a Non-Executive Director, is responsible, on behalf of the Board, for agreeing Very Senior Managers' Pay and for overseeing Executive Directors' performance.

The Board met in public on a bi-monthly basis. The Board Agenda was divided into four key areas – General Issues, Quality and Governance, Finance and Performance and Strategy and Delivery. The Board receives reports on the activities of all its Sub-Committees on a regular basis.

The Board also receives detailed overview reports on the work of the Joint Audit Committee which includes progress against External Audit progress reports, internal audit and counter fraud and the Board Assurance Framework. The Joint Audit Committee reviews its Audit Committee Self-Assessment Check-List regularly.

The PCT has met throughout the year with the NHS Midlands and East SHA cluster and its predecessor, to review the PCT's performance against key national and local targets, with a particular focus on performance, including financial performance and progress against the PCT's Financial Recovery Plan. In addition, the PCT has an Annual Accountability Review meeting with representatives of the SHA Board to formally review and record the PCT's performance.

The Board is committed to ensuring that it complies with all aspects of Corporate Governance. This is maintained through the Code of Conduct and Accountability, Register of Interests, Register of Gifts and Hospitality, Whistleblowing Policy and the Complaints Policy.

The Board holds regular Board Development Sessions. Board to Board meetings with our main providers are also conducted.

The Board conducted a formal review of its effectiveness. An annual self-assessment was undertaken against the Corporate Governance Code during May to July 2012. The outcomes of the self-assessment were reported and discussed at the Board Development Session in August 2012.

3. PCT Transition and Close Down

In line with guidance received from the Department of Health on 22 February 2013, Cambridgeshire PCT transferred functions to the relevant body on 1 April 2013 in accordance with the Health and Social Care Act 2012. Technically, functions are conferred by legislation and so do not transfer from one body to another. Instead Cambridgeshire PCT ceases to be responsible and either another body (for example, the Cambridgeshire & Peterborough CCG, NHS England, Cambridgeshire County Council, NHS Property Services) is made responsible for it in the future or the function ceases to exist.

A Transition and Closedown process was established with three key programmes:-

Changing the Architecture;
Leadership, Support and Relationship Management; and
Managing the Business

An Action Plan was developed covering three key areas and was reported through the Cluster Executive Team, Governance & Compliance Committee and Audit Committee to provide assurance to the PCT Cluster Board.

Risks around the Transition and Close Down process were included on the Board Assurance Framework, with gaps in assurance identified and managed via Action Plans.

The PCT assured itself through the Audit Committee and Board that they had transferred staff, property, and all other assets and liabilities associated with these functions to the appropriate receiving organisation via transfer schemes. This process was managed by a Task and Finish Group led by the Trust Board Secretary. The PCT engaged with receivers to complete full handover and knowledge transfer for those functions, through receiving of assets and liabilities and through three key documents approved by the PCT Board, namely the Handover Document, Quality Handover Document and Public Health Handover Document.

At the demise of the PCT, the final Transfer Scheme had not been received and, in line with Guidance the PCT Board signed off, via delegated approval to the Audit Committee, the latest submitted version of Annex 3 and Annex A and a copy of the Property Transfer Scheme Generic Provisions. A process to finalise the Transfer Schemes is now being overseen by the Midlands and East Legacy Team. A process for identifying “Discovered Assets and Liabilities” has been implemented.

The PCT Staff Transfer Scheme, which transfers all of the PCT's staff that are not made redundant to nominated receivers, was completed in line with national guidance. Extensive consultations were conducted with Staff in relation to the Staff Transfer Scheme.

Provision of formal notification to each member of staff currently employed by each PCT, confirming their destination in the new system, or alternatively notification of redundancy arrangements has taken place. PCTs have been asked to reflect their predicted 31 March 2013 staffing position in their returns to the People Transition Programme. Those employees made redundant as at 31 March 2013 received redundancy payments from Cambridgeshire PCT. Redundancy payments have been approved by the PCT Cluster's Remuneration and Terms of Service Committee. Where staff have not transferred and there are potentially on-going employee relations issues then these have been notified to the DH as potentially "residual employment liabilities".

Financial liabilities around the Local Government Pension Scheme were included on the Transfer Scheme to transfer to the Department of Health. Subsequently, it has been identified that Admission Agreements should also have transferred to the CCG. This has now been addressed through the Discovered Assets and Liabilities Log process established by the Department of Health.

4. The purpose of the system of internal control

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

- identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives; and
- 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 has been in place in NHS Cambridgeshire for the year ended 31 March 2013 and up to the date of approval of the Annual Report and Annual Accounts.

5. Capacity to handle risk

The PCT Board provides leadership to ensure that risk management is embedded within the organisation. This includes development of the Integrated Plan which identifies the key objectives and related risks.

As Accountable Officer, I ensure that sufficient resources are invested in managing risk, and I am supported in this task by the Medical Director (Caldicott Guardian) who holds Board-level responsibility for clinical risk and the Director of Corporate Development and Performance (Senior Information Risk Owner) who also holds Board-level responsibility for non-clinical risks.

In preparation for the authorisation of the CCG, the Director of Nursing, Quality and Patient Experience has been appointed as the Caldicott Guardian and the Director of Performance & Delivery has been appointed as the CCG's Senior Information Risk Owner.

Leadership is given to the risk management process through Executive and Non-Executive Directors via the Joint Audit Committee, Joint Quality and Patient Safety Committee and Joint Governance and Compliance Committee.

Staff are trained and equipped to manage risk in a way that is appropriate to their authority and duties and this is done through a documented system of risk assessment, formal and ad hoc training and from meetings with them to identify and manage risk. Guidance is provided to staff by the Governance Team who provide templates on how to undertake risk assessments, produce risk registers and business continuity plans and embed risk management in the activity of the organisation.

The PCT is supported by Risk Management resources within SERCO, which provides support in terms of advice, development and training to Peterborough and Cambridgeshire PCTs and Cambridgeshire and Peterborough NHS Foundation Trust. This aims to provide a consistent approach across the organisations.

6. The risk and control framework

Risk management is demonstrated by:

- adopting an integrated approach to risk management, whether the risk relates to clinical, organisational, health and safety or financial risk, through the processes and structures detailed in the PCT's Risk Management Strategy;

- managing risk as part of the routine line management responsibilities and consideration of funding to address 'risk' issues (based on a risk assessment) as part of the normal business planning process;

- undertaking risk assessments on both existing, new and proposed activities to ensure that:

    i) significant risks are identified in accordance with the Risk Management Strategy which provides full details on what constitutes a hazard or risk, how it should be identified and assessed;
    ii) assessments are made of their potential frequency and severity;

iii) control measures are implemented in accordance with the Risk Management Strategy;
iv) risks are always minimised; and
v) risks are recorded on the Directorate Risk Registers and escalated to the BAF as appropriate;
vi) risks are recorded on the CCG Assurance Framework and LCG Risk Registers and escalated as appropriate.

The risk and control framework is described in Cambridgeshire PCT's Risk Management Strategy and within the Board Assurance Framework (BAF). The key features of this are that risks are systematically identified throughout the organisation. Directorate Risk Registers are maintained to support the BAF and both include action plans which are monitored and reported regularly through to the Cluster Executive Team, Audit Committee (Joint Committee from 1 December 2011) and the Board.

Staff at all levels of the organisation contribute to the identification and assessment of risk through Directorates, Provider Performance Management Days. The Risk Management actions that have been taken this year include:

- Strengthening of LCG Risk Registers and the development of the CCG Assurance Framework
- Maintenance of governance policies and the Risk Management Strategy;
- Testing of our emergency planning and business continuity planning arrangements; and
- Development of our information governance arrangements and Information Governance Toolkit scores for both the PCT Cluster and CCG

The control environment is supported by regular review of Standing Orders, Scheme of Delegation and Standing Financial Instructions, directions on fraud, programme of internal audit, budgetary control systems and information to support performance and risk monitoring processes.

The BAF identifies the PCT's strategic objectives and risks, the controls that are currently in place to minimise the risk and the sources of assurance to those controls, and identifies where there are gaps and the assurance in place where appropriate. The system of regular review of the BAF by the Board provides evidence to the Annual Governance Statement. The Board has reviewed gaps in key controls and assurance and progress on management actions to address the gaps. The BAF assesses the likelihood of an event occurring combined with the possible consequences to provide a standard approach to the assessment of risk. Calculating the risk supports the prioritisation of action plans and the reduction of risks is therefore managed through this process.

The Internal Audit review of the BAF provided substantial assurance. The BAF is regularly reviewed by the Cluster Executive Team and input is also provided by the Joint Quality & Patient Safety Committee and Joint Finance and Performance Committees as required. It is scrutinised at each Joint

Audit Committee and is presented at each Board meeting in public through the Chief Executive's Report.

Recommendations arising from the Internal Audit review that were designed to further develop and strengthen the BAF will be taken forward during 2013-2014 by successor organisations.

The BAF identified a number of High Risks which are being managed through robust action plans to mitigate these risks. The risks are as follows:-

- Risk to delivery of the QIPP and System Reform Plan
- Risk to delivering financial balance in 2012/13
- Risk to contract negotiation process for 2013/14 due to transition process
- Failure to achieve key performance targets
- Insufficient capacity and capability to deliver all goals – linked to the Health and Social Care Bill and transition to CCG
- Risk of skilled workforce not available within commissioned services when needed
- Risk of potential poor governance in services which the PCT commissions
- Quality and performance issues in relation to Cambridge University Hospitals NHS Foundation Trust (CUHFT)
- Failure to safeguard children and adults
- Risk to maintaining the quality of community services
- Risk around retrospective review of Continuing Healthcare cases
- Risk around failure to implement NHS 111 Service

From the above High Risks, the BAF identifies a number of gaps in controls. The Management Action Plans to address these are as follows:-

- Each strategic risk listed above has been included in the CCG Assurance Framework and will continue to be reported and monitored through the robust governance structures established for the new organisation,
- Improved QIPP monitoring and reporting processes have been implemented in the latter part of the year to provide the PCT, through the Joint Finance and Performance Committee ,with a clearer picture of QIPP savings that could realistically be delivered for 2012/13. Early and significant focus has also been given to QIPP Planning for 2013/14, which will continue to be taken forward by the CCG and the Local Commissioning Groups (LCGs) next year.
- Appointment of staff to the CCG commenced in June 2012 and is almost complete.
- In terms of CUHFT a rapid response review has been completed and action plans developed and implemented. Regular review meetings with CUHFT are held.
  The Shadow CCG Governing Body has been responsible for progressing 2013/14 contract negotiations.

NHS Cambridgeshire continues its commitment to ensuring that Information Governance is an integral part of the PCT's Risk Management Strategy and operational planning. The Joint Information Governance and IM&T Steering Group prioritises its work programme and provides regular exception reporting to the Joint Governance and Compliance Committee.

NHS Cambridgeshire and NHS Peterborough (as a Cluster PCT) submitted and published a GREEN 'satisfactory' rating for its self-assessment on the Information Governance Toolkit for 2012-2013. The Action Plan in place to improve this score which will be implemented for the CCG to take forward and be monitored by the Information Governance and IM&T Steering Group

NHS Cambridgeshire is developing processes to align to the guidance set out in "Managing the Transition – Sharing Legacy Information" and "Maintaining and improving quality during the transition: safety, effectiveness, experience". The final cut of the Handover Document was presented to NHS Midlands and East SHA at the end of March 2013.

NHS Cambridgeshire is required to publish all Serious Incidents (SIs) relating to loss of personal data involving confidentiality breaches in its Annual Report. There were no breaches involving loss of data reported during 2012-2013.

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

Members of the public are reminded about managing their own risks through warning signs and notices as appropriate throughout the PCT's premises and through their participation as patients in the consent process.

In addition, the PCT complies with is statutory duties under the Civil Contingencies Act 2004. A Joint Major Incident Plan is in place and is reviewed annually, with formal endorsement received by the PCT Board. A Business Continuity Plan is in place and is reviewed annually, with formal endorsement received by the PCT Board. Emergency Planning and Business Continuity Planning is overseen by the Emergency Planning Sub-Group which reports to the Governance and Compliance Committee (Joint Committee from 1 December 2011).

Responsibility for carbon reduction and sustainability falls within the portfolio of the Director of Finance who acts as the Board lead. The PCT has an approved Sustainability Strategy and the Sustainability Strategy Delivery Plan is monitored by the Board on a bi-annual basis.

The PCT has undertaken a climate change risk assessment and developed an Adaption Plan, to support its emergency preparedness and civil contingency requirements, as based on the UK Climate Projections 2009 (UKCP09), to ensure that this organisation's obligations under the Climate Change Act are met.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. As Accountable Officer, I am assured by the relevant aspects of the NHS Constitution that the Board (through the Finance and Performance Committee (Joint Committee from 1 December 2011)) receives assurance on and regular monitoring of workforce performance. A mechanism is also in place for undertaking and reviewing equality impact assessments. An Equality and Delivery System is now in place.

7. Review of effectiveness of risk management and control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the BAF and on the controls reviewed as part of the Internal Audit work. Executive Directors within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance.

The BAF itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its corporate objectives have been reviewed. My review is also informed by Internal and External Audit. I have been advised of the implications of the result of my review of the effectiveness of the system of internal control by the Board and the Joint Audit Committee as described in Section 1. A plan to address weaknesses and ensure continuous improvements of the system of internal control will be put in place. The Board and its associated Committees, together with Internal Audit, maintain a regular review of the effectiveness of the process of internal control.

My review is also informed by:

- The Information Governance Toolkit Assessment;
- Our Research Governance Framework;
- Any external reviews;
- Review of key governance meetings;
- Reports from Internal Audit and the Head of Internal Audit Opinion;
- NHSLA Membership and Risk Management Assessment; and
- External Audit's assessment of the PCT's arrangements for economy, efficiency and effectiveness in the use of its resources.

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

- The Board, which has responsibility for setting the overall direction, agreeing the PCT's corporate objectives, assessing and managing strategic risks to the delivery of those objectives and monitoring progress through regular performance monitoring reports;
- The Joint Audit Committee which works to a well-developed Audit Plan and provides assurance to the Board;
- The Joint Finance and Performance Committee meets monthly and is responsible for reviewing financial risk and performance of providers commissioned to provide services to the patients of NHS Cambridgeshire;
- The Joint Governance and Compliance Committee which meets bi-monthly and is responsible for overall implementation of the Risk Management Strategy which includes reviewing Information Governance and IT Security Risks.;
- The Joint Quality & Patient Safety Committee, which is responsible for ensuring clinical risk is managed. The Committee meets monthly;
- The Joint Remuneration and Terms of Service Committee (which is responsible for agreeing Very Senior Managers Pay and monitoring Executive Director performance;
- The Cluster Executive Team which meets regularly to support the achievement of the Operational Plan and deals with day to day risk;
- Executive Directors and Assistant Directors; and
- Internal Audit has reviewed the effectiveness of the design and operation of controls in the areas covered by its risk based Operational Plan.

Internal Audit's overall opinion for the year ended 31 March 2013 is that ***Significant Assurance*** can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. Progress against implementation of all Internal Audit recommendations is regularly reviewed by the Joint Audit Committee). Actions taken are confirmed by specific, formal follow-up by Internal Audit and this is independently reported to the Audit Committee.

The PCT met its statutory financial duty to break even in 2012-2013, and has ended the year with a surplus of £2,835k.

With the exception of the internal control issues that I have outlined in this Annual Governance Statement, my review confirms that NHS Cambridgeshire has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives. The control issues have been or are being assessed.

8. Significant Issues

In respect of the PCT Close down and completion of the Cambridgeshire PCT Transfer Scheme I am assured that the organisation has carried out due diligence to identify all property, rights and liabilities currently held and up to 31st March 2013 in relation to the Cambridgeshire PCT. The organisation has assigned all property, rights and liabilities according to function, to the

best of its ability and understanding, to the most appropriate permitted receiver in the new NHS system architecture. Sign-off of this process was approved on the basis of assurance from the Deputy Chief Executive that the Governance Team and Legal Task and Finish Group had completed the documentation to the best standard possible and had completed due diligence required in line with the Guidance from the Department of Health.

The PCT achieved £25.0m of efficiencies through a range of savings schemes including contribution from QIPP (quality, innovation, productivity and prevention) initiatives. Nevertheless this was insufficient in regards to the total saving needed and therefore, the PCT was reliant on the use of non-recurrent savings to achieve a break-even position for 2012/13. Although a significant improvement in the management, control and robustness of reporting on QIPP programme delivery was identified in the latter part of 2012/13, the auditors were required to consider the PCT's performance over the full-year. In doing so they identified that savings plans had not been entirely fit for purpose, supported by effective delivery plans or consistently and effectively monitored for the full 12 months For this reason the external auditors have been unable to conclude that the PCT's arrangements satisfy the Audit Commission's specified criteria for securing financial resilience and challenging how it secures economy, efficiency and effectiveness in the use of its resources, and their value for money conclusion for 2012/13 has been qualified in this respect. In making this judgement the auditors were also required to take into account the PCT's previous track record for delivering QIPP Programme savings.

I am however assured that the ownership and robustness of the detailed QIPP plans together with the reporting processes now in place, which were demonstrated in the final months before the demise of the PCT, will be taken forward by the Cambridgeshire and Peterborough Clinical Commissioning Group for the purpose of achieving the cost savings targets identified for 2013/14.

9. Annual Accounts Closedown and Sign Off Arrangements

A detailed financial closedown report was developed in line with the Department of Health Checklist. The closedown process was monitored through the Finance & Performance Sub-Committee and assurance sought through the PCT Cluster's Audit Committee.

Staff have been retained under RETS to manage the Annual Accounts process until the 30 June 2013. Audit Committee membership to continue this process has been agreed and three existing Non-Executive Directors have been appointed by the Department of Health to form the basis of this Committee to approve the Annual Report and Annual Accounts for 2012-2013 for the PCT.

The Accountable Officer for sign off of the Annual Accounts will be the NHS England East Area Team Area Director in line with guidance issued by the Department of Health.

Accountable Officer: Andrew Reed
Organisation: Director of Area Team
Signature:
Date:

NHS Cambridgeshire

Operating and Financial Review

The 2012-13 financial year represents the seventh and final full year of operations for NHS Cambridgeshire following its establishment in October 2006.

The PCT has a number of key financial duties:

- Remain within an agreed revenue and capital resource limit;
- Manage within an annual cash limit; and
- Achieve operating financial balance (or better).

In summary the PCT made an operating surplus of £2.835m compared to a surplus of £0.499m for 2011/12. The PCT also remained within its capital resource limit and delivered an underspend of £0.251m (£0.133m 2011/12). Details of the summary positions are outlined below.

In its final year, the PCT has continued to invest additional funding in a range of service areas to achieve the national and local performance targets and in developing services for the local population.

Operating environment

Nature of the business

We are responsible for commissioning a range of hospital and mental health services and for improving primary care and the general health of the local population. Cambridgeshire has a broad mix of urban and rural areas and although on the whole the population is generally healthy and affluent, there are areas where there is significant deprivation and this can have a detrimental effect on people's health and well-being. In line with national trends there is also an increasing ageing population. Life expectancy for both men and women in the local population is above the national average, even in our more deprived areas.

The main organisations from which the PCT commissions services include:

Organisation	What services are commissioned	SLA Expenditure value 2012/13 (£000)
Cambridge University Hospitals NHS Foundation Trust	Specialist, general, acute	199,619
Hinchingbrooke Healthcare NHS Trust	General and acute	88,460
Cambridgeshire and Peterborough NHS Foundation Trust	Mental health services	50,033
Peterborough and Stamford Hospitals NHS Foundation Trust	General and acute	31,506
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	General and acute	26,283
East of England Ambulance Service NHS Trust	Emergency ambulance service	17,139
South East Essex PCT	Specialist commissioning	68,617
Cambridgeshire County Council	Learning Disabilities Services	14,379

Our three main functions are to:

- work with our local population to improve their health and well-being;
- commission a comprehensive and equitable range of effective services within our resources; and
- provide high quality responsive and efficient services where this gives best value.

The 2012/13 financial year was another particularly challenging one for the PCT. Continued recovery of the residual debt of £8m remaining from the 2006/07 overspend and the delivery of £48.4m of the PCT's savings programme were essential to ensure the PCT created the platform necessary to meet the service and clinical challenges.

NHS Cambridgeshire's statutory financial duty is to remain within its Revenue Resource Limit. For the financial year 2012/13 NHS Cambridgeshire ended with a surplus of £2,835k (11/12 surplus of £499k) against an available resource limit of £919.5m (11/12 £896.6m).

A summary of the position is outlined below:

	2012/13	**2011/12**
	£000	**£000**
Total net operating cost for the financial year	916,646	896,152
Revenue Resource Limit	919,481	896,651
Under spend against revenue resource limit	**2,835**	**499**

Capital Resource Limit

Another key financial measure is the statutory requirement to remain within the Capital Resource Limit (CRL). For the year 2012/13 the PCT reported a £0.251m underspend (11/12 £0.133m underspend).

Capital Resource Limit	**2012/13**	**2011/12**
	£000's	**£000's**
Gross Capital Expenditure	2,002	2,398
Less: Net book Value of Non-Current Assets Disposed of to Non NHS Bodies	0	(953)
Less Adjustments due to in year gain from sale of assets	0	(1,672)
Less: Capital Grants received	0	0
Charge against the Capital Resource Limit	**2,002**	**(227)**

Capital Resource Limit	2,253	(94)
Under spend against Capital Resource Limit	**251**	**133**

External Audit

NHS Cambridgeshire's external auditors are PricewaterhouseCoopers LLP (PwC). Their fees, excluding VAT, for the 2012/13 statutory audit totalled £157,751 (2011/12 £195,624).

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

Public Sector Payment Policy (CBI Better Payment Practice Code)

The PCT has a requirement to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice whichever is later.

Better Payment Practice Code – measure of compliance - Non NHS Creditors	**2012/13 Number**	**2012/13 £000's**	**2011/12 Number**	**2011/12 £000's**
Total Bills paid in year	19,663	113,413	18,745	96,609
Total bills paid within target	18,726	101,161	18,286	95,033
Percentage of bills paid within target	**95.2%**	**89.2%**	**97.6%**	**98.4%**
NHS Creditors				
Total Bills paid in year	4,994	609,348	4,890	607,456
Total bills paid within target	4,110	595,070	4,580	603,697

Percentage of bills paid within target	**82.3%**	**97.7%**	**93.7%**	**99.4%**

Future View

The PCT continued its strategy identified over the last few years to take account of the impact of the economic downturn. For the future this strategy will be renewed and taken forward in the new commissioning architecture of the NHS.

These commissioning arrangements were introduced by the NHS Health and Social Care Act 2012 and a new Clinical Commissioning Group (CCG) covering the geographical areas of Cambridgeshire and Peterborough has been created; this was approved in January 2013 and formally became a legal entity on 1 April 2013.

The CCG has been created with a specific focus on local decision making and accountability and has eight locality commissioning groups ensuring a local focus on commissioning. The process of transition has been successful, with the CCG assuming the statutory duty to commission services from 2013-14 onwards. This will be supported by services commissioned through the NHS England and Local Authorities.

The Department of Health has agreed that the PCT will transfer the majority of its assets to Cambridgeshire Community Services NHS Trust (CCS), which is the major occupier of these sites. The remainder, in line with DH guidance, transfer to the NHS Property Services (NHSP) which from 1 April 2013 will assume responsibility for the residual NHS estate.

PCT Debt Repayment

During 2012/13 the PCT repaid the final amount of £8m of its historic debt through a reduction in its RRL. This agreement with the East of England Strategic Health Authority on the repayment profile for the historic debt was as follows:

	2007/08 £m	**2008/09 £m**	**2009/10 £m**	**2010/11 £m**	**2011/12 £m**	**2012/13 £m**
Accumulated Debt	(52.2)	42	35	26	17	8
Repayment	(10.2)	(7)	(9)	(9)	(9)	(8)

Debt Carried Forward	**42**	**35**	**26**	**17**	**8**	**-**

The above debt is not included in the PCT's Statement of Financial Position as a liability, as arrangements within the NHS mean the PCT receives a reduction through its RRL, which is negotiable with the Strategic Health Authority.

Going Concern

As the PCT's functions, assets and liabilities transfer to other public sector organisations, Government accounting requires that the accounts are prepared on a "going concern" basis. The financial position reported has therefore been drawn up on the same basis as previous years and as if the organisation was continuing.

Conclusion

Overall the PCT has delivered a good performance during the course of 2012/13 meeting the majority of its key targets. The PCT ceased as a legal entity after the 31st March and these accounts are the final ones for Cambridgeshire PCT. It's functions in the future will be adopted by NHS England, the Cambridgeshire and Peterborough CCG, NHS Property Services Ltd and Cambridgeshire County Council.

A copy of the PCT's full annual accounts may be obtained free of charge from the Director of Finance, NHS Cambridgeshire, Lockton House, Clarendon Road, Cambridge CB2 8FH. Telephone: 01223 725400.

Salary and pension entitlements of senior managers

Cambridgeshire PCT is a member of the NHS Pension Scheme. The scheme is unfunded with defined benefits. Full details of the treatment of the PCT pension policy can be found in note 7.4 of the annual accounts. The following Remuneration Report shows the salary and pension entitlements of the senior managers of the PCT. The PCT also has an agreed long term liability with the Cambridgeshire County Council Government Pension Scheme, relating to the staff under its employment during 2004 and 2010, before their transfer to Cambridgeshire Community Services NHS Trust. Details of the PCT's accounting policy are given in note 7.4 of the annual accounts.

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	**21,549**	19,441
Other costs	5.1	**919,041**	902,717
Income	4	**(24,121)**	(24,444)
Net operating costs before interest		**916,469**	897,714
Other Losses/(Gains)	9	**0**	(1,672)
Finance costs	10	**177**	110
Net operating costs for the financial year		**916,646**	896,152
Of which:			
Administration Costs			
Gross employee benefits	7.1	**10,481**	15,445
Other costs	5.1	**4,120**	5,414
Income	4	**(1,239)**	(6,574)
Net administration costs before interest		**13,362**	**14,285**
Other Losses/(Gains)	9	**0**	0
Net administration costs for the financial year		**13,362**	**14,285**
Programme Expenditure			
Gross employee benefits	7.1	**11,068**	3,996
Other costs	5.1	**914,921**	897,303
Income	4	**(22,882)**	(17,870)
Net programme expenditure before interest		**903,107**	**883,429**
Other Losses/(Gains)	9	**0**	(1,672)
Finance costs	10	**177**	110
Net programme expenditure for the financial year		**903,284**	**881,867**

Other Comprehensive Net Expenditure		**2012-13 £000**	**2011-12 £000**
Net actuarial loss/(gain) on pension schemes	7.5	**519**	(1,165)
Total comprehensive net expenditure for the year*		**917,165**	**894,987**

*This is the sum of the rows above plus net operating costs for the financial year.
The notes from pages 60 onwards 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	11	**43,318**	43,672
Intangible assets	12	**0**	0
Total non-current assets		**43,318**	43,672
Current assets:			
Inventories	16	**182**	182
Trade and other receivables	17	**8,168**	6,386
Cash and cash equivalents	21	**12**	13,959
Total current assets		**8,362**	20,527
Total assets		**51,680**	64,199
Current liabilities			
Trade and other payables	23	**(54,295)**	(63,019)
Provisions	29	**(5,730)**	(292)
Total current liabilities		**(60,025)**	(63,311)
Non-current assets plus/less net current assets/liabilities		**(8,345)**	888
Non-current liabilities			
Trade and other payables	23	(5,140)	(4,758)
Provisions	29	(1,006)	(878)
Total non-current liabilities		**(6,146)**	(5,636)
Total Assets Employed:		**(14,491)**	(4,748)
Financed by taxpayers' equity:			
General fund		(27,083)	(17,988)
Revaluation reserve		12,592	13,240

Total taxpayers' equity:	**(14,491)**	(4,748)

The notes from page 60 onwards form part of this account.

The financial statements on pages 53 to 121 were approved by the Audit Sub-Committee of the DH Audit and Risk Committee on 7th June 2013 and signed on its behalf by

Andrew Reed
Designated Accountable Officer:
(on Behalf of Department of Health)

Date: **7 June 2013**

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

	NOTE	General fund	Revaluation reserve	Total reserves
		£000	£000	£000
Balance at 1 April 2012		**(17,988)**	**13,240**	**(4,748)**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	3.1	(916,646)		**(916,646)**
Transfers between reserves	11.1	648	(648)	**0**
Net actuarial gain/(loss) on pensions	7.4.2	(519)		**(519)**
Total recognised income and expense for 2012-13		**(916,517)**	**(648)**	**(917,165)**
Net Parliamentary funding		907,422		**907,422**
Balance at 31 March 2013		**(27,083)**	**12,592**	**(14,491)**
Balance at 1 April 2011		**(9,744)**	**14,736**	**4,992**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	3.1	(896,152)		(896,152)
Transfers between reserves		1,496	(1,496)	0
Net actuarial gain/(loss) on pensions	7.4.2	(1,165)		(1,165)
Total recognised income and expense for 2011-12		(895,821)	(1,496)	(897,317)
Net Parliamentary funding		887,577		887,577
Balance at 31 March 2012		**(17,988)**	**13,240**	**(4,748)**

The general fund reflects the cumulative overspend incurred by the PCT as the balance from the Statement of Comprehensive Net Expenditure is transferred to this fund each year and the PCT's Parliamentary funding is accounted for in this reserve. The balance cannot be released back to the Statement of Comprehensive Net Expenditure. The reported actuarial gains / (losses) attributable to the PCT in relation to the Cambridgeshire County Council Local Government Pension Scheme are separately disclosed in the general fund.

The revaluation reserve reflects movements in the value of property, plant and equipment and intangible assets as set out in the PCT's accounting policy (see note 1.6). The revaluation reserve balance relating to each asset is released to the general fund on disposal of that asset.

Statement of cash flows for the year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities			
Net Operating Cost Before Interest		**(916,469)**	(897,714)
Depreciation and Amortisation	11.1	**1,798**	1,653
Impairments and Reversals		**558**	0
(Increase)/Decrease in Inventories		**0**	13
(Increase)/Decrease in Trade and Other Receivables	17.1	**(1,700)**	1,019
(Decrease)/Increase in Trade and Other Payables	23	**(8,794)**	5,707
Provisions Utilised	29	**(238)**	(292)
Increase/(Decrease) in Provisions	29	**5,804**	0
Net Cash Inflow/(Outflow) from Operating Activities		**(919,041)**	**(889,614)**
Cash flows from investing activities			
(Payments) for Property, Plant and Equipment		**(2,328)**	(2,196)
Proceeds of disposal of assets held for sale (PPE)		**0**	2,625
Net Cash (Outflow)/Inflow from Investing Activities		**(2,328)**	**429**
Net cash (outflow) before financing		**(921,369)**	**(889,185)**
Cash flows from financing activities			
Net Parliamentary Funding		**907,422**	887,577
Net Cash Inflow from Financing Activities		**907,422**	**887,577**
Net increase/(decrease) in cash and cash equivalents		**(13,947)**	**(1,608)**
Cash and Cash Equivalents at Beginning of the Period		**13,959**	**15,567**
Cash and Cash Equivalents at year end		**12**	**13,959**

1. Accounting policies

Under the provisions of The Health and Social Care Act 2012 (Commencement No.4.Transitional, Savings and Transitory Provisions) Order 2013, Cambridgeshire PCT was dissolved on 1st April 2013. The PCT's functions, assets and liabilities transferred to other public sector entities as outlined in note 35. Where reconfigurations of this nature take place within the public sector, Government accounting requires that the activities concerned are to be considered as continuing operations, and so the closing entity prepares accounts on a "going concern" basis.

The Statement of Financial Position has therefore been drawn up at 31 March 2013 on the same basis as in previous years, reporting balances on the same basis as would a continuing entity. The estate has been revalued but this was required as part of the routine cycle of revaluation. No other assets and liabilities have been revalued and no disclosures have been made under IFRS 5 Non-current Assets Held for Sale and Discontinued Operation.

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

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

1.1 Accounting Conventions

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

Acquisitions and Discontinued Operations

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

Critical accounting judgements and key sources of estimation uncertainty

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

Critical judgements in applying accounting policies

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

In considering the amounts to be accounted for under provisions and contingent liabilities the PCT makes a judgement on the likelihood of liabilities arising in respect of claims under continuing care. This is detailed in Note 29 and 30.

The PCT also considers that all assets will continue in use following the dissolution of the PCT at 1 April 2013 and subsequently transferred onto the successor organisations, as such there are no impairments to report (other than those identified in the revaluation of the estate). Liabilities and provisions have been assessed for the demise of the PCT, and no provision is deemed necessary for an onerous contract.

For the purpose of these accounts the liability relating to the Local Government Pension Scheme is judged to have crystallised at 1st April 2013 upon its transfer to the Department of Health. It has been accounted for as a continuing operation as at 31st March 2013 in line with the FReM requirements to prepare accounts on a going concern basis.

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
Property valuation - The PCT's estate has been valued on the basis explained in note 1.6 to the financial statements.
Property, Plant & Equipment (see note 11.1) are depreciated over estimated useful lives, details of which are given in note 1.6.
Allowances for impaired receivables - Allowances are made for impaired receivables for estimated losses arising from the subsequent inability or refusal of debtor organisation to make the required payment. Further details are given in note 17.3 to the accounts.
Provisions - Details of estimating provisions required at the Statement of Financial position date, and of provisions made, are given in notes 1.24 and 29 respectively. The Continuing Healthcare provision was an area of particular uncertainty and this has been described fully including sensitivity analysis in note 29.
The PCT includes in full the liability relating to the Cambridgeshire Local Government Pension Scheme at the Statement of Financial Position date as valued by its actuary. In deriving the value of this liability a number of assumptions and estimates are made. The estimates and assumptions are based on historical experience and other factors considered reasonable at the time but actual results may differ from those estimates. Revisions to these estimates are made in the period in which they are recognised. The main assumptions and judgements made are disclosed in note 7.4 to these accounts.
1. Accounting policies (continued)

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 two pooled budget agreements with Cambridgeshire County Council. Under the arrangement funds are pooled under S75 of the NHS Act 2006 for Integrated Community Equipment Services (ICES) and the Learning Disability Partnership (LDP).

The ICES and LDP are hosted by Cambridgeshire County Council. As a commissioner of healthcare services, the PCT makes contributions to the pools, which are then used to purchase healthcare services. The PCT accounts for its share of the assets, liabilities, income and expenditure of the pool as determined by the pooled budget agreement.

The pool for Integrated Community Services for Older People (ICSOP) with Cambridgeshire County Council ended on 31st March 2012.

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.

1.6 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

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.
Cambridgeshire PCT had a full revaluation of its estate as at 31st March 2010, applying these new valuation requirements.
This valuation was carried out by Boshier and Company, Chartered Surveyors of Kent in accordance with Royal Institute of Chartered Surveyors (RICS).
This valuation is reflected in the financial statements.

In the years between formal valuations, the continuing appropriateness of fair values based on the previous valuation is assessed by reference to market trends and professional advice. Further details have been given in Note 11.3.

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 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.

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.

1.7 Intangible Assets

Recognition

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

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

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

Measurement

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

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

1.8 Depreciation, amortisation and impairments

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

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

Assets held under finance leases are depreciated over their estimated useful lives.

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

A transfer is required from the revaluation reserve to the general fund of an amount representing the lower of the impairment charged and the balance for the asset in the revaluation reserve.

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 are 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.

Land is not depreciated. Depreciation on other assets is calculated using the straight line method to allocate their cost of revalued amounts to their residual values over their estimated useful lives, as follows:

	Min lives (years)	Max lives (years)
Buildings excluding Dwellings	10	35
Plant & Machinery	1	12
Transport	3	7
Information Technology	1	3
Furniture & Fittings	1	3
Intangible Assets (Software)	1	5

1.9 Donated assets

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. Donated income is deferred only where conditions attached to the donation have not been met.

1.10 Government grants

The value of assets received by means of a government grant are credited directly to income. Government Grant income is deferred only where conditions attached to the grant have not been met.

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 the general fund.

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

1.12 Inventories

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

1.13 Cash and cash equivalents

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

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

1.14 Losses and Special Payments

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

Losses and special payments are charged to the relevant functional headings including losses which would have been made good through insurance cover had PCTs not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).
The losses and special payments note has been compiled on an accruals basis excluding any provisions in relation to such payments.

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 and not in the accounts of the individual NHS bodies. 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 29.

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.

Local Government Pension Scheme (LGPS):

The Local Government Pension Scheme is a defined benefit scheme administered in accordance with the Local Government Pension Scheme regulations. The scheme assets and liabilities attributable to the employees can be identified and are recognised in the PCT's financial statements. The assets are measured at fair value, and the liabilities at the present value of future obligations.

Up to 31 March 2010, the PCT employed a number of staff who had previously worked for Cambridgeshire County Council and who transferred under TUPE regulations into the NHS in April 2004 as part of the Cambridgeshire wide section 75 pooled budget arrangement for the provision of Health and Social Care for Older People. These staff were members of the Local Government Pension Scheme (LGPS) and in accordance with IAS19 ‘Employee Benefits’, the PCT has accounted for all of the pension assets and liabilities associated with their employment.

On 1 April 2010, the date of establishment of Cambridgeshire Community Services NHS Trust (‘CCS’), these staff transferred employment from the PCT to CCS.

The PCT, CCS and Cambridgeshire County Council (as administering authority to the Cambridgeshire Local Government Pension Scheme) have agreed the following split of responsibilities for the net LGPS pension liability:

CCS became an admitted body of the scheme on 1 April 2010 and took on responsibility for the pension liabilities of staff who were active members of the scheme as at 31 March 2010.

As part of the LGPS admission agreement for CCS, effective from 1 April 2010, CCS was admitted on a ‘fully funded’ basis, and an equal value of gross pension assets and gross pension liabilities were transferred from the PCT to CCS with effect from 1 April 2010. This transfer of pension asset and liabilities was taken into account when calculating the IAS19 merger accounting entries for.

The increase in the liability arising from pensionable service earned during the year is recognised within operating costs. The expected gain during the year from scheme assets is recognised as investment income. The interest cost during the year arising from the unwinding of the discount on scheme liabilities is recognised as a finance cost. The net finance cost (note 10) of £177,000 in 2012/13 (£110,000 in 2011/12) is shown within the Statement of Comprehensive Net expenditure. Actuarial gains and losses during the year are recognised in the Statement of Taxpayers' Equity within the General Fund and reported in the Statement of Comprehensive Net Expenditure as an item of 'other comprehensive net expenditure'.

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 2.35% 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 arising 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.

The PCT will continue to incur costs post 31st March 2013 in relation to its closure and accounts completion. Specific guidance has been received from the Department of Health that these costs are not to be provided for by the PCT but are to be borne by the Department of Health.

1.25 Financial Instruments

Financial assets

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

Financial assets are initially recognised at fair value.

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

The PCT only holds financial assets classed as loans and receivables.

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.

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.

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.

1.26 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.

Standards applicable from 2013/14:

IAS 1 Presentation of financial statements (amendment).
IAS 12 Income Taxes (amendment).
IAS 19 (Revised) Employee Benefits
For NHS bodies that recognise defined benefit pension liabilities e.g. where they have staff who are members of the Local Government pension scheme, the standard may have a significant impact for 2013/14 due to the changes in measurement of the net finance cost.

IFRS 7 Financial Instruments: Disclosures (amendment)
IFRS 13 Fair Value Measurement – this standard should be applicable for 2013/14, however, HM Treasury has delayed its adoption by government bodies while it finalises some adaptions. The impact on the financial statements is unknown until these adaptions are finalised.
IAS 27 Consolidated and separate financial statements – removal of dispensation from consolidating NHS charitable funds.
Annual Improvements to IFRS 2011. This standard is potentially applicable to 2013/14 but has not yet been endorsed by the EU and therefore by HM Treasury policy is not available for NHS bodies to apply.

Standards applicable from 2014/15:

IFRS 10 Consolidated Financial Statements (see IAS27 above)
IFRS 11 Joint Arrangements
IFRS 12 Disclosure of Interests in Other Entities
IAS 27 Separate Financial Statements (amendment)
IAS 28 Investments in Associates and Joint Ventures (amendment)
IAS 32 Financial instruments: Presentation (amendment)

Other standards in issue:

IFRS 9 Financial Instruments – this standard will eventually replace IAS 39. It is applicable for periods beginning on or after 1 January 2015, but the standard has not yet been EU endorsed and therefore by HM Treasury policy is not available for NHS bodies to apply.
IPSAS 32 - Service Concession Arrangement
[This standard isn't mandatory because it is not an IFRS standard, however, HM Treasury may voluntarily choose to adopt certain principles in the FReM]

2 Operating segments

Segmental reporting is required to reflect the content and form of information that is reported to the PCT's Chief Operating Decision Maker (CODM). The PCT considers the Board to be the CODM as the Board is responsible for reporting the PCT's budget and for allocating resources to operating segments and assessing their performance. Financial management information presented to the Board is designed to report on the PCT's performance against its annual Revenue Resource Limit (as determined each year by the Department of Health) and does not analyse the PCT's net assets by segment. The segment information provided to the Board for the year is summarised below:

	2012/13 Originally reported		Adjustments	Final position
	£'000			
Acute Commissioning	393,888		-614	393,274
Other Commissioning	195,981		-551	195,430
NCB Specialist Commissioning	68,624		0	68,624
NCB Primary Care other	136,732		455	137,187
NCB Primary Care Prescribing	79,767		275	80,042
Running Costs	18,570		0	18,570
Other Budget Areas	24,613		-1,094	23,519
Total Expenditure	**918,175**	**0**	**(1,529)**	**916,646**
Revenue Resource Limit	919,513		-32	**919,481**
Under-spend against Revenue Resource Limit	**1,338**		**1,497**	**2,835**

Other budget areas include £4,192k of hosted services which is not reported within the finance report.

The internal reporting of the organisation has changed and therefore comparators for 2011/12 expenditure are unavailable. The 2011/12 reported figures were:

	2011/12 Originally reported	Adjustments	Final position
	£'000	£'000	£'000
Main SLAs	575,706	0	575,706
Other Commissioning Budgets	84,715	(653)	84,062
Primary Care Prescribing (including Pharmacy)	100,534	(26)	100,508
Primary Care	87,132	120	87,252
Dental	24,874	0	24,874
Other	23,145	605	23,750
Total Commissioning Expenditure	896,106	46	896,152
Revenue Resource Limit	896,600	51	896,651
Under-spend against Revenue resource Limit	494	5	499

The PCT's income is largely in the form of Parliamentary funding allocated by the Department of Health which is accounted for in the PCT's general Fund. Income is not allocated to operating segments in the financial information reported to the Board.

3. Financial Performance Targets

3.1 Revenue Resource Limit

	2012-13 £000	2011-12 £000
The PCTs' performance for the year ended 2012-13 is as follows:		
Total Net Operating Cost for the Financial Year	**916,646**	896,152
Revenue Resource Limit	**919,481**	896,651
Under/(Over)spend Against Revenue Resource Limit (RRL)	**2,835**	499

The revenue resource limit of £919,481k includes a reduction of £8m relating to the recovery of the PCT's historic debt (i.e. its accumulated overspends against the revenue resource limits incurred in previous years). Additional information relating to this debt and its agreed repayment is included in the Annual Report.

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	**2,253**	(94)
Charge to Capital Resource Limit	**2,002**	(227)
(Over)/Underspend Against CRL	**251**	**133**

3.3 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**907,422**	887,577
Cash Limit	**916,217**	887,577
Under/(Over)spend Against Cash Limit	**8,795**	**0**

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

	2012-13 £000
Total cash received from DH (Gross)	806,569
Less: Trade Income from DH	(3,067)
Less/(Plus): movement in DH working balances	298
Sub total: net advances	**803,800**
Plus: cost of Dentistry Schemes (central charge to cash limits)	24,424
Plus: drugs reimbursement (central charge to cash limits)	79,198
Parliamentary funding credited to General Fund	**907,422**

4 Miscellaneous Revenue

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Dental Charge income from Contractor-Led GDS & PDS	**7,699**	0	7,699	7,457
Prescription Charge income	**895**	0	895	1,057
Strategic Health Authorities	**5,849**	0	5,849	5,531
NHS Trusts	**295**	0	295	145
NHS Foundation Trusts	**450**	0	450	207
Primary Care Trusts - Other	**1,446**	101	1,345	949
English RAB Special Health Authorities	**221**	221	0	221
Department of Health - Other	**3,067**	0	3,067	2,849
Recoveries in respect of employee benefits	**637**	628	9	755
Local Authorities	**54**	0	54	1,377
Education, Training and Research	**66**	0	66	67
Rental revenue from operating leases	**2,802**	0	2,802	2,808
Other revenue	**640**	289	351	1,021
Total miscellaneous revenue	**24,121**	**1,239**	**22,882**	**24,444**

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	**70,225**	0	70,225	64,949
Non-Healthcare	**343**	343	0	393
Total	**70,568**	**343**	**70,225**	**65,342**
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	**186,432**	57	186,375	190,313
Goods and services (other, excl Trusts, FT and PCT))	**184**	36	148	285
Total	**186,616**	**93**	**186,523**	**190,598**
Goods and Services from Foundation Trusts	**329,896**	24	329,872	320,444
Purchase of Healthcare from Non-NHS bodies	**82,677**	0	82,677	74,271
Non-GMS Services from GPs	**6,244**	0	6,244	5,272
Contractor Led GDS & PDS (excluding employee benefits)	**32,110**	0	32,110	32,331
Chair, Non-executive Directors & PEC remuneration	**89**	57	32	80
Executive committee members costs	**99**	99	0	179
Consultancy Services	**177**	69	108	162
Prescribing Costs	**76,956**	0	76,956	80,337
G/PMS, APMS and PCTMS (excluding employee benefits)	**87,665**	0	87,665	87,252
Pharmaceutical Services	**4,694**	0	4,694	5,367
New Pharmacy Contract	**16,875**	0	16,875	15,861
General Ophthalmic Services	**4,498**	0	4,498	4,519
Supplies and Services - Clinical	**2,519**	3	2,516	2,575
Supplies and Services - General	**2,540**	769	1,771	85
Establishment	**2,800**	612	2,188	1,773
Transport	**14**	12	2	4
Premises	**4,507**	1,029	3,478	4,384
Impairments & Reversals of Property, plant and equipment	**558**	0	558	0
Depreciation	**1,798**	304	1,494	1,653
Impairment of Receivables	**1,218**	0	1,218	1,520
Audit Fees*	**189**	189	0	196

Other Auditors Remuneration	**38**	38	0	133
Grants for capital purposes	**837**	0	837	0
Grants for revenue purposes	**0**	0	0	637
Other	**2,859**	479	2,380	7,742
Total Operating costs charged to Statement of Comprehensive Net Expenditure	**919,041**	**4,120**	**914,921**	**902,717**
Employee Benefits (excluding capitalised costs)				
PCT Officer Board Members	**861**	861	0	1,062
Other Employee Benefits	**20,688**	9,620	11,068	18,379
Total Employee Benefits charged to SOCNE	**21,549**	**10,481**	**11,068**	**19,441**
Total Operating Costs	**940,590**	**14,601**	**925,989**	**922,158**

Analysis of grants reported in total operating costs				
For capital purposes				
Grants to Fund Capital Projects - Other	**837**	0	837	0
Total Capital Grants	**837**	**0**	**837**	**0**
Grants to fund revenue expenditure				
To Other	**0**	0	0	637
Total Revenue Grants	**0**	**0**	**0**	**637**
Total Grants	**837**	**0**	**837**	**637**

	Total	**Commissioning Services**	**Public Health**
PCT Running Costs 2012-13			
Running costs (£000s)	**13,362**	11,794	1,568
Weighted population (number in units)**	**523,353**	523,353	523,353
Running costs per head of population (£ per head)	**25.54**	**22.54**	**3.00**
PCT Running Costs 2011-12			
Running costs (£000s)	**14,285**	12,701	1,584
Weighted population (number in units)	**523,353**	523,353	523,353

Running costs per head of population (£ per head)	**27.30**	**24.27**	**3.03**

*Audit Fees above include VAT. Audit Fees excluding VAT are £157,751 (2011/12 £195,624).

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

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

5.2 Analysis of operating expenditure by expenditure classification	2012-13 £000	2011-12 £000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	87,665	87,252
Prescribing costs	76,956	80,337
Contractor led GDS & PDS	32,110	32,331
General Ophthalmic Services	4,498	4,519
Pharmaceutical services	4,694	5,367
New Pharmacy Contract	16,875	15,861
Non-GMS Services from GPs	6,244	5,272
Total Primary Healthcare purchased	**229,042**	230,939
Purchase of Secondary Healthcare		
Learning Difficulties	16,824	15,218
Mental Illness	74,071	74,609
Maternity	23,191	23,228
General and Acute	395,467	376,958
Accident and emergency	31,662	30,693
Community Health Services	112,995	103,278
Other Contractual	8,376	19,129
Total Secondary Healthcare Purchased	**662,586**	643,113
Grant Funding		
Grants for capital purposes	837	0
Grants for revenue purposes	0	637
Total Healthcare Purchased by PCT	**892,465**	**874,689**
Included above:		
Healthcare from NHS FTs included above	325,075	317,320

6. Operating Leases

The PCT holds a number of operating leases for properties and vehicles. None of the lease arrangements contain contingent rate clauses, nor any renewal or purchase options or any restrictions. The leases may be renewed on expiry.

6.1 PCT as lessee	Buildings £000	Other £000	2012-13 Total £000	2011-12 £000
Payments recognised as an expense				
Minimum lease payments	**858**	**68**	**926**	1,034
Total	**858**	**68**	**926**	**1,034**
Payable:				
No later than one year	**858**	**47**	**905**	958
Between one and five years	**2,177**	**42**	**2,219**	2,780
After five years	**3,202**	**0**	**3,202**	3,688
Total	**6,237**	**89**	**6,326**	**7,426**

Total future sublease payments expected to be received	0	0

The General Medical Services contract entered into by the PCT with GP's includes conditions relating to the use of GP premises. Under IFRIC 4 'Determining whether an arrangement contains a lease', the PCT has determined that those conditions are operating leases. As the GMS contract does not have a defined term, it is not possible to analyse the financial impact of these arrangements over future years. The lease payments for the year (included in premises costs in note 5.1 to the accounts) were £6,392k (2011/12 £6,187k).

6.2 PCT as lessor

The rental income relates to income received under a short term operating lease with Cambridgeshire Community NHS Trust for properties they occupy. The rental income is charged to recover the PCT's costs associated with the buildings, namely depreciation and interest charges.

	2012-13 £000	2011-12 £000
Recognised as income		
Rental Revenue	**2,802**	2,808
Contingent rents	**0**	0
Total	**2,802**	2,808
Receivable:		
No later than one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Total	**0**	0

7. Employee benefits and staff numbers

7.1 Employee benefits

2012-13								
				Permanently employed			Other	
	Total	Admin	Programme	Total	Admin	Programme	Total	Admin	Programme
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Employee Benefits - Gross Expenditure									
Salaries and wages	**16,953**	8,779	8,174	**13,415**	8,164	5,251	**3,538**	615	2,923
Social security costs	**1,155**	703	452	**1,155**	703	452	**0**	0	0
Employer Contributions to NHS BSA - Pensions Division	**1,641**	999	642	**1,641**	999	642	**0**	0	0
Other pension costs	**21**	0	21	**21**	0	21	**0**	0	0
Termination benefits	**1,779**	0	1,779	**1,779**	0	1,779	**0**	0	0
Total employee benefits	**21,549**	**10,481**	**11,068**	**18,011**	**9,866**	**8,145**	**3,538**	**615**	**2,923**
Less recoveries in respect of employee benefits (table below)	**(637)**	(628)	(9)	**(637)**	**(628)**	**(9)**	**0**	**0**	**0**
Total - Net Employee Benefits including capitalised costs	**20,912**	**9,853**	**11,059**	**17,374**	**9,238**	**8,136**	**3,538**	**615**	**2,923**
Employee costs capitalised	**0**	0	0	**0**	0	0	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**21,549**	**10,481**	**11,068**	**18,011**	**9,866**	**8,145**	**3,538**	**615**	**2,923**
Recognised as:									
Commissioning employee benefits	**21,549**			**18,011**			**3,538**		
Provider employee benefits	**0**			**0**			**0**		
Gross Employee Benefits excluding capitalised costs	**21,549**			**18,011**			**3,538**		

The termination benefits above relate to payments made to staff who successfully applied for Voluntary Redundancy under a scheme run in line with the NHS Agenda for Change terms and conditions. The scheme was time limited.

2012-13				Permanently employed			Other		
	Total	Admin	Programme	Total	Admin	Programme	Total	Admin	Programme
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Employee Benefits - Revenue									
Salaries and wages	**637**	628	9	**637**	628	9	**0**	0	0

TOTAL excluding capitalised costs	**637**	**628**	**9**	**637**	**628**	**9**	**0**	**0**	**0**

Employee Benefits - Prior- year

	Total £000	**Permanently employed £000**	**Other £000**
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	**16,355**	13,464	2,891
Social security costs	**1,102**	1,102	0
Employer Contributions to NHS BSA - Pensions Division	**1,648**	1,648	0
Other pension costs	**0**	0	0
Other post-employment benefits	**0**	0	0
Other employment benefits	**0**	0	0
Termination benefits	**336**	336	0
Total gross employee benefits	**19,441**	**16,550**	**2,891**
Less recoveries in respect of employee benefits	**(755)**	(755)	0
Total - Net Employee Benefits including capitalised costs	**18,686**	**15,795**	**2,891**
Employee costs capitalised	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**19,441**	**16,550**	**2,891**
Recognised as:			
Commissioning employee benefits	**19,441**		
Provider employee benefits	**0**		
Gross Employee Benefits excluding capitalised costs	**19,441**		

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	**10**	10	0	**10**	10	0
Administration and estates	**284**	265	19	**280**	271	9
Nursing, midwifery and health visiting staff	**20**	20	0	**21**	19	2
Scientific, therapeutic and technical staff	**17**	16	1	**16**	16	0
Other	**17**	1	16	**12**	1	11
TOTAL	**348**	**312**	**36**	**339**	**317**	**22**
Of the above - staff engaged on capital projects	**0**	0	0	**0**	0	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	**1**	**1**	**2**	0	0	**0**
£10,001-£25,000	**4**	**2**	**6**	0	1	**1**
£25,001-£50,000	**3**	**3**	**6**	0	1	**1**
£50,001-£100,000	**4**	**4**	**8**	0	0	**0**
£100,001 - £150,000	**3**	**0**	**3**	0	1	**1**
£150,001 - £200,000	**1**	**0**	**1**	0	1	**1**
>£200,000	**1**	**0**	**1**	0	0	**0**
Total number of exit packages by type (total cost	**17**	**10**	**27**	**0**	**4**	**4**
	£	**£**	**£**	**£**	**£**	**£**
Total resource cost	1,311,183	468,119	**1,779,302**	0	336,000	**336,000**

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

The termination benefits of other departures agreed relate to payments made to staff who successfully applied for Voluntary Redundancy under a scheme run in line with the NHS Agenda for Change terms and conditions. The scheme was time limited and had HM Treasury approval.

This disclosure reports the number and value of exit packages agreed with staff 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

7.4.1 NHS Pension Scheme

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.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) 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 to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.
In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.
Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.
On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2011 is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data.

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

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.

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 statement of comprehensive income at the time the PCT commits itself to the retirement, regardless of the method of payment.

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.

7.4.2 Cambridgeshire Local Government Pension Scheme

The LGPS is a defined benefit statutory scheme administered in accordance with the Local Government Pension Scheme Regulations.

The fund provides defined benefits relating to pay and service and the contribution rate is determined by the Fund's actuary based on triennial actuarial valuations. The last review took place as at 31 March 2010 and concluded the fund was in deficit and that increased contribution rates would be required to meet the cost of further benefit accrual.

For 2012-13 the employer's contribution rate was 26.6% and the employer's contribution to the fund was £310k (2011-12: £311k).

The proposed contribution rate put forward by the actuaries is 26.6% for 2013-14.

The inflation assumption has been derived by considering the difference in gross redemption yields of traditional and index-linked gilt-edged securities as at 31 March 2013. Salary increases are assumed to be 1% in line with the assumption used in the latest formal valuation of the fund. The discount rate employed for the 2012-13 financial year is the yield available on long-dates, high quality corporate bonds (as measured by the yield on Iboxx Sterling Corporate Index, AA over 15 years), at the IAS19 valuation date.

For the purposes of calculating the IAS19 disclosures at 31 March 2013, the actuary (Hymans Robertson) has included an assumption for the effect of 25% of future retirement members electing to exchange up to HMRC limits of their LGPS pension for additional tax free cash at retirement, as permitted by the change in LGPS regulations effective from April 2006 and also for life expectancy improvements based on the PMA/PFA92 table projected to calendar year 2017.

An allowance is included for future retirements to elect to take 25% of the maximum additional tax -free cash up to HMRC limits for pre-April 2008 service and 63% of the maximum tax-free cash for post-April 2008 service.

The liability arising from the LGPS is believed to have crystallised as at 1st April 2013 following the transfer to the Department of Health. The liability as at 31st March 2013 has however been accounted for on a going concern basis as required by NHS accounting policies. The financial impact of crystallisation will be recognised by the Department of Health.

The assets of the scheme have been calculated at market value and the liabilities calculated using the following principal actuarial assumptions. These are included in the IAS 19 actuarial report as at 31 March 2013:

	At 31/03/2013	At 31/03/2012
Inflation / Pension Increase rate	2.8%	2.5%
Salary Increases rate	5.1%	4.8%
Expected Return on assets	4.5%	5.6%
Discount rate	4.5%	4.8%

The assets in the scheme and the expected rate of return were:

	Long-term rate of return expected at 31/03/2013	Long-term rate of return expected at 31/03/2012
Equities	4.5%	6.3%
Bonds	4.5%	3.3%
Property	4.5%	4.4%
Cash	4.5%	3.5%

The expected return on assets is based on the long term future expected investment return for each asset class as at the beginning of the period (i.e. as at 31 March 2012 for the year to 31 March 2013).

Investment Returns

The return on the Fund in market value terms for the year to 31 March 2013 is estimated based on actual fund returns as
provided by the Administering Authority and index returns where necessary. Details are given below:

	At 31/03/2013	At 31/03/2012
Actual return for the period from 1 April to 31 December	5.4%	5.6%
Estimated return for the year from 1 April to 31 March	15.0%	0.5%

Mortality

For mortality rate, life expectancy is based on the SAPS year of birth tables with improvements from 2007 in line with Medium Cohort and a 1% p.a. underpin.
The average life expectancies at age 65 for current pensioners are 21.0 years (males) (2011/12: 21.0 years) and 23.8 years (females) (2011/12: 23.8 years).
The average life expectancies at age 65 for future pensioners are 22.9 years (males) (2011/12: 22.9 years) and 25.7 years (females) (2011/12: 25.7 years).

The scheme assets and liabilities attributable to those employees can be identified and are recognised in the PCT's accounts. The assets are measured at fair value and the liabilities at present future obligation.

	31 March 2013	31 March 2012
Present value of defined benefit obligation	**£'000**	**£'000**
Opening defined benefit obligation	10,264	9,103
Current Service Cost	0	
Past Service Cost	0	
Interest Cost	489	496
Actuarial (Gains) / Losses	1,043	834
Contributions by employee	6	
Benefits paid	(176)	(172)
Losses on Curtailments	0	
Estimated Unfunded Benefits Paid	(4)	(4)
Closing Defined Benefit Obligation	**11,622**	

Reconciliation of opening and closing fair value of plan assets:

	31 March 2013	31 March 2012
Fair value of plan assets	**£'000**	**£'000**
Opening fair value of plan assets	5,506	5,330
Expected return on plan assets	312	361
Actuarial gains / (losses)	524	(331)
Contributions by employer	310	311
Contributions by employee	6	7
Contributions in respect of unfunded benefits	4	4
Benefits paid	(176)	(172)
Unfunded benefits paid	(4)	(4)
Closing value of plan assets	**6,482**	**5,506**

	31 March	31 March 2012
Fair value of plan assets comprises:		

	2013			
	Split of assets	£'000	Split of assets	£'000
Equities	76%	4,927	72%	3,964
Bonds	14%	907	14%	771
Property	7%	454	9%	496
Cash	3%	194	5%	275
Total	**100%**	**6,482**	**100%**	**5,506**

Movement in net pension liability during the year:	**31 March 2013**		**31 March 2012**	
	£'000	**£'000**	**£'000**	**£'000**
Deficit (-) in the scheme at beginning of the year		(4,758)		(3,773)
Movement in year:				
Current service cost	0		0	
Contributions	314		315	
Settlements & curtailments	0		0	
Past service costs	0		0	
Expected return on plan assets net of interest	(177)		(135)	
Net amount charged to the year's Statement of Net Comprehensive Expenditure		137		180
Actuarial gain/(loss) on net pension liability (charged to the General Fund)		(519)		(1,165)
Scheme deficit at the end of the year (see note 23)		(5,140)		(4,758)

Amounts for the Current and Previous Accounting Periods

IAS 19 requires a five year history to be shown disclosing the present value of the scheme liabilities, the fair value of the scheme assets and the surplus or deficit in the scheme. The IAS 19 accounting entries were restated in 2010/11 to reflect arrangements under the transfer of community services. It is not considered practicable to determine a five year history on this basis. A three year history is given as follows:

	31 March 2013 £'000	31 March 2012 £'000	31 March 2011 £'000
Fair Value of Plan Assets	6,482	5,506	5,330
Present Value of Defined Benefit Obligation	(11,622)	(10,264)	(9,103)
Surplus / (Deficit)	(5,140)	(4,758)	(3,773)
Experience Gains / (Losses) on Assets	524	(331)	(2,254)
Experience Gains / (Losses) on Liabilities	36	(228)	5,276

The cumulative net actuarial loss recognised in the General Fund is £519k (2011-12: £1,165k).

The projected amount to be charged to the Statement of Comprehensive Net Expenditure for the year to 31 March 2014 is £231k.

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	**19,663**	**113,413**	18,745	96,609
Total Non-NHS Trade Invoices Paid Within Target	**18,726**	**101,161**	18,286	95,033
Percentage of NHS Trade Invoices Paid Within Target	95.23%	89.20%	97.55%	98.37%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**4,994**	**609,348**	4,890	607,456
Total NHS Trade Invoices Paid Within Target	**4,110**	**595,070**	4,580	603,697
Percentage of NHS Trade Invoices Paid Within Target	82.30%	97.66%	93.66%	99.38%

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. Other Gains and Losses

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Gain on disposal of assets other than by sale (PPE)	**0**	**0**	**0**	1,672
Total	**0**	**0**	**0**	1,672

10. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest				
Other interest expense	**177**	**0**	**177**	**110**
Total interest expense	**177**	**0**	**177**	**110**
Other finance costs	**0**	**0**	**0**	0
Provisions - unwinding of discount	**0**		**0**	0
Total	**177**	**0**	**177**	**110**

11.1 Property, plant and equipment

2012-13	Land	Buildings excluding dwellings	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:							
At 1 April 2012	**11,075**	**37,306**	**200**	**34**	**3,124**	**59**	**51,798**
Additions Purchased	0	2,002	0	0	0	0	**2,002**
Disposals other than for sale	0	(822)	(106)	(34)	(3,124)	(30)	**(4,116)**
At 31 March 2013	**11,075**	**38,486**	**94**	**0**	**0**	**29**	**49,684**
Depreciation							
At 1 April 2012	**0**	**4,875**	**131**	**34**	**3,048**	**38**	**8,126**
Disposals other than for sale	0	(822)	(106)	(34)	(3,124)	(30)	**(4,116)**
Impairments	0	558	0	0	0	0	**558**
Charged During the Year	0	1,711	9	0	76	2	**1,798**
At 31 March 2013	**0**	**6,322**	**34**	**0**	**0**	**10**	**6,366**
Net Book Value at 31 March 2013	**11,075**	**32,164**	**60**	**0**	**0**	**19**	**43,318**
Purchased	11,075	32,164	60	0	0	19	**43,318**
Total at 31 March 2013	**11,075**	**32,164**	**60**	**0**	**0**	**19**	**43,318**
Asset financing:							
Owned	11,075	32,164	60	0	0	19	**43,318**
Total at 31 March 2013	**11,075**	**32,164**	**60**	**0**	**0**	**19**	**43,318**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	**3,989**	**9,244**	**6**	**0**	**0**	**1**	**13,240**
Excess Depreciation to General Fund	0	(641)	(6)	0	0	(1)	**(648)**
At 31 March 2013	**3,989**	**8,603**	**0**	**0**	**0**	**0**	**12,592**

11.2 Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	**£000**
Cost or valuation:							
At 1 April 2011	**11,475**	**35,508**	**191**	**9**	**3,158**	**59**	**50,400**
Additions - purchased	0	2,398	0	0	0	0	**2,398**
Reclassifications	0	0	9	25	(34)	0	**0**
Reclassified as held for sale	(400)	(600)	0	0	0	0	**(1,000)**
At 31 March 2012	**11,075**	**37,306**	**200**	**34**	**3,124**	**59**	**51,798**
Depreciation							
At 1 April 2011	**0**	**3,342**	**112**	**9**	**3,022**	**35**	**6,520**
Reclassifications		0	9	25	(34)	0	**0**
Reclassifications as Held for Sale	0	(47)	0	0	0	0	**(47)**
Charged During the Year	0	1,580	10	0	60	3	**1,653**
At 31 March 2012	**0**	**4,875**	**131**	**34**	**3,048**	**38**	**8,126**
Net Book Value at 31 March 2012	**11,075**	**32,431**	**69**	**0**	**76**	**21**	**43,672**
Purchased	11,075	32,431	69	0	76	21	**43,672**
At 31 March 2012	**11,075**	**32,431**	**69**	**0**	**76**	**21**	**43,672**
Asset financing:							
Owned	11,075	32,431	69	0	76	21	**43,672**
At 31 March 2012	**11,075**	**32,431**	**69**	**0**	**76**	**21**	**43,672**

11.3 Property, plant and equipment

The PCT's estate was subject to a full revaluation as at 31 March 2010 by Boshier & Co, who are members of the Royal Institute of Chartered Surveyors. The valuation was carried out in accordance with the Royal Institute of Chartered Surveyors Valuation Standards (sixth edition) and International Valuation Standards insofar as these are consistent with the requirements of HM Treasury's Financial Reporting Manual.

The PCT and Boshier & Co have determined that the vast majority of the PCT's estate is non-specialised. The estate was valued at 31 March 2010 at fair value by reference to Market Value with Existing Use (MVEU). MVEU is defined as the estimated amount for which a property should exchange on the date of valuation between a willing buyer and a willing seller in an arm's-length transaction, after proper marketing wherein the parties had acted knowledgeably, prudently and without compulsion, assuming that the buyer is granted vacant possession of all parts of the property required by the business and disregarding potential alternative uses and other characteristics of the property that would cause its market value to differ from that needed to replace the remaining service potential at least cost. The PCT is of the view that the MVEU of any of its properties as at 31 March 2013 is not materially different from their open market values.

The PCT commissioned an independent desktop valuation in the year to 31 March 2013, carried out by Boshier & Co. This valuation is a computed update of property values based on the full valuation in 2010 which included a full inspection of assets. This supported the valuation recognised in the 2012/13 financial statements prior to the revaluation and did not provide evidence to suggest that the fair value of the estate at 31 March 2013 is inappropriately stated. The PCT's policy is to undertake a full independent inspection and valuation every five years.

The estimated useful economic lives of the PCT's property, plant and equipment are shown in note 1.8 to the accounts. There have been no changes to asset lives or estimated residual values during the year.

The PCT has not received any compensation during the year from third parties for assets impaired, lost or given up. (2011/12: nil). The PCT has received an increase of £558,000 in its resource limits for assets impaired in the financial year to 31 March 2013 (2011-12: none).

The Buildings impairment in note 11.1 relates to the boiler house at Princess of Wales Hospital, Ely in 2012/13 of £558k. (2011/12: nil)

12.1 Intangible non-current assets

2012-13	Software purchased	Total
	£000	£000
At 1 April 2012	**41**	**41**
Disposals other than by sale	(41)	**(41)**
At 31 March 2013	**0**	**0**
Amortisation		
At 1 April 2012	**41**	**41**
Disposals other than by sale	(41)	**(41)**
At 31 March 2013	**0**	**0**
Net Book Value at 31 March 2013	**0**	**0**
Net Book Value at 31 March 2013 comprises		
Purchased	0	**0**
Total at 31 March 2013	**0**	**0**

Revaluation reserve balance for intangible non-current assets

	Software purchased	Total
	£000	£000
At 1 April 2012	**0**	**0**
Movements	0	**0**
At 31 March 2013	**0**	**0**

12.2 Intangible non-current assets

2011-12	Software purchased	Total
	£000	£000
At 1 April 2011	**41**	**41**
At 31 March 2012	**41**	**41**
Amortisation		
At 1 April 2011	**41**	**41**
At 31 March 2012	**41**	**41**
Net Book Value at 31 March 2012	**0**	**0**
Net Book Value at 31 March 2012 comprises		
Purchased	**0**	**0**
Total at 31 March 2012	**0**	**0**

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

	2012-13 Total	2012-13 Admin	2012-13 Programme
	£000	£000	£000
Unforeseen obsolescence of Buildings	558	0	558
Total charged to Annually Managed Expenditure	**558**	**0**	**558**
Total Impairments of Property, Plant and Equipment	**558**	**0**	**558**
Total Impairments charged to Revaluation Reserve	0	0	0

Total Impairments charged to SoCNE - DEL	0	0	0
Total Impairments charged to SoCNE - AME	558	0	558
Overall Total Impairments	**558**	**0**	**558**
Of which:			
Impairment on revaluation to "modern equivalent asset" basis	**0**	0	0

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.

14 Commitments

14.1 Capital commitments

The PCT does not have any capital commitments at the Balance Sheet date (2011/12 nil)

14.2 Other financial commitments

The PCT has not entered into any non-cancellable contracts (2011/12: nil).

15 Intra-Government and other balances

	Current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with other Central Government Bodies	4,672	470	0
Balances with Local Authorities	242	3,136	0
Balances with NHS Trusts and Foundation Trusts	1,586	17,004	0
Balances with bodies external to government	1,668	33,685	5,140
At 31 March 2013	**8,168**	**54,295**	**5,140**
prior period:			
Balances with other Central Government Bodies	2,448	982	0
Balances with Local Authorities	180	9,351	0
Balances with NHS Trusts and Foundation Trusts	760	15,241	0
Balances with bodies external to government	2,998	37,445	4,758
At 31 March 2012	**6,386**	**63,019**	**4,758**

The PCT had no non-current receivables (2011/12: nil).

16 Inventories

	Other £000	Total £000
Balance at 1 April 2012	**182**	**182**
Additions	0	**0**
Balance at 31 March 2013	**182**	**182**

17.1 Trade and other receivables

	Current	
	31 March 2013 £000	31 March 2012 £000
NHS receivables - revenue	**5,878**	3,208
NHS receivables - capital	**82**	0
Non-NHS receivables - revenue	**303**	5
Non-NHS prepayments and accrued income	**205**	211
Provision for the impairment of receivables	**(3,208)**	(2,110)
VAT	**229**	114
Other receivables	**4,679**	4,958
Total	**8,168**	6,386
Total current and non-current	**8,168**	6,386
Included above:		
Prepaid pensions contributions	**0**	0

Other receivables include 2012/13 balances for Local Authority debtors £3,280k (2011/12 £1,715k), Learning Disabilities Partnership Pooled budget £0k (2011/12 £999k), Patient Dental Charge income £1,049K (2011/12 £1,027k) and Prescription Charge income £163k (2011/12 £244k).
The great majority of trade is with other NHS bodies, including other Primary Care Trusts as commissioners for NHS patient care services. As Primary Care Trusts are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.
There are no non-current trade and other receivables.

17.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	**18**	64
By three to six months	**23**	50
By more than six months	**4**	90
Total	**45**	204

No collateral was held in respect of these assets

17.3 Provision for impairment of receivables

	2012-13 £000	2011-12 £000
Balance at 1 April 2012	**(2,110)**	(595)
Amount written off during the year	**120**	5
Amount recovered during the year	**420**	15
(Increase)/decrease in receivables impaired	**(1,638)**	(1,535)
Balance at 31 March 2013	**(3,208)**	(2,110)

As at 31 March 2013, receivables of £3,208k (11/12 £2,110k) were impaired and provided for. Individually impaired receivables relate to invoices raised to Cambridgeshire County Council and Cambridge University Hospitals NHS FT.
The ageing of these receivables is as follows:

	31 March 2013 £000	31 March 2012 £000
3 to 6 months	**1,624**	1,535
over 6 months	**1,584**	575
	3,208	2,110

18 NHS LIFT investments

The PCT has no PFI or LIFT Schemes.

19.1 Other financial assets - Current

The PCT does not hold any other financial assets (2011/12 nil)

20 Other current assets

The PCT does not hold any other current assets (2011/12 nil)

21 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**13,959**	15,567
Net change in year	**(13,947)**	(1,608)
Closing balance	**12**	13,959
Made up of		
Cash with Government Banking Service	**3**	13,958
Commercial banks	**0**	1
Cash in hand	**9**	0
Cash and cash equivalents as in statement of financial position	**12**	13,959
Cash and cash equivalents as in statement of cash flows	**12**	13,959
Patients' money held by the PCT, not included above	**0**	0

22 Non-current assets held for sale

	Land	Buildings, excl. dwellings	Total
	£000	£000	£000
Balance at 1 April 2012	0	0	**0**
Plus assets classified as held for sale in the year	0	0	**0**
Less assets sold in the year	0	0	**0**
Balance at 31 March 2013	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2013	**0**	**0**	**0**
			0
Balance at 1 April 2011	0	0	**0**
Plus assets classified as held for sale in the year	400	553	**953**
Less assets sold in the year	(400)	(553)	**(953)**
Balance at 31 March 2012	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2012	0	0	**0**

In 2011/12 Wessex Place, Cambridge, a vacant property, was classified as a non-current asset held for sale and subsequently sold in January 2012. The gain recognised at the sale was £1672k.

23 Trade and other payables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
NHS payables - revenue	**17,405**	13,883	**0**	0
NHS accruals and deferred income	**69**	2,340	**0**	0
Family Health Services (FHS) payables	**24,281**	25,993	0	0
Non-NHS payables - revenue	**5,506**	12,396	**0**	0
Non-NHS payables - capital	**321**	565	**0**	0
Non-NHS accruals and deferred income	**6,054**	6,442	**0**	0
Social security costs	**45**	187	**0**	0
Tax	**23**	233	**0**	0
Payments received on account	**461**	537	**0**	0
Other	**130**	443	**5,140**	4,758
Total	**54,295**	63,019	**5,140**	4,758
Total payables (current and non-current)	**59,435**	**67,777**		

The amount disclosed as non-current relates to the liability due to the Local Government Pension Scheme, details of which are set out in Note 7.4.2

At the time of preparing these accounts the value will be transferred to the Secretary of State for Health on 1st April 2013.

24 Other liabilities

The PCT has no Other Liabilities (2011/12 nil)

25 Borrowings

The PCT has no Borrowings (2011/12 nil)

26 Other financial liabilities

The PCT has no Other financial liabilities (2011/12 nil)

27 Deferred income

The PCT has no Deferred income (2011/12 nil)

28 Finance lease obligations

The PCT has no Finance lease obligations (2011/12 nil)

29 Provisions

	Total £000s	Pensions Relating to Other Staff £000s	Continuing Care £000s	Other £000s
Balance at 1 April 2012	**1,170**	749	0	421
Arising During the Year	**6,224**	0	5,734	490
Utilised During the Year	**(238)**	(237)	0	(1)
Reversed Unused	**(420)**	0	0	(420)
Unwinding of Discount	**0**	0	0	0
Change in Discount Rate	**0**	0	0	0
Transferred (to)/from other Public Sector bodies	**0**	0	0	0
Balance at 31 March 2013	**6,736**	**512**	**5,734**	**490**
Expected Timing of Cash Flows:				
No Later than One Year	**5,730**	**240**	**5,000**	**490**
Later than One Year and not later than Five Years	**1,006**	**272**	**734**	**0**
Later than Five Years	**0**	**0**	**0**	**0**

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at 31 March 2013	298
As at 31 March 2012	553

Pensions Relating to Other Staff

The provision for pensions relating to other staff relates to the capitalised cost of pension entitlements for staff who took early retirement prior to 31 March 1995. This liability is being settled by payment of quarterly invoices from the NHS Pensions Agency.

Continuing Care

On 15th March 2012 the Department of Health announced the introduction of deadlines for individuals to request an assessment of eligibility for NHS Continuing Healthcare funding for cases during the period 1 April 2004 - 31 March 2012. The PCT invited requests from individuals or their representatives to notify NHS Peterborough in respect of previously un-assessed periods of time where there is evidence that they should have been assessed for eligibility for NHS Continuing Healthcare funding.
The time periods for notifying Cambridgeshire PCT were as follows:

Period	Deadline
1 April 2004-31 March 2011	30 September 2012
1 April 2011-31 March 2012	31 March 2013

For the period April 2004 to March 2011 Cambridgeshire PCT received 455 notifications of intention to make a claim. In the majority of instances the PCT has not been able to perform a full assessment and make an accurate estimate of the likely outcome of claims on an individual basis due to insufficient information and time constraints. The PCT has made a best estimate based on the information available and has employed a range of assumptions in order to calculate the provision at 31 March 2013.
After 28 weeks 238 of the potential claimants have failed to produce sufficient information to progress the claim further and make an accurate assessment of the potential liability. The PCT has assessed the likelihood of these claims becoming payable to be between 5% and 15% based on historical knowledge within the Continuing Healthcare (CHC) team and the length of time that has elapsed since the original claim was made without further information being provided. Assumed probability rates and the average cost of similar settled cases over a 2 year period has been considered in calculating a provision for the accounts. On this basis a provision of £825,788 has been included for these claimants.
217 of the claimants have produced sufficient information to progress claims and the PCT is currently accessing data such as medical and care home records in order to fully assess these claims. On the basis of historical knowledge within the Continuing Healthcare (CHC) team of the likely success of claimants the PCT has assumed a 65% success rate for residential home claims and 75% for nursing home claims. Assumed probability rates and the average cost of similar settled cases over a 2 year period has been considered in calculating a provision for the accounts. On this basis a provision has been included in the accounts for £4,784,816.
For the period April 2011 to March 2012 16 claims were received. As the closing date for notification of claims was 31 March 2013 it has not been possible to assess any claims received. Based on the likelihood of previous claims above and the maximum total claim possible a provision has been included for £123,370.

Continuing Care Sensitivity

The eventual outturn on claims could vary from that estimated due to either variance in the average cost of successful claims, or in the proportion of claims that are successfully upheld. In order to show the possible impact of this we have included sensitivity analysis below of a range of possible outcomes due to a combination of the areas of uncertainty above.

	Provision per accounts	10% Decrease	20% Decrease	10% Increase	20% Increase
	£'000	£'000	£'000	£'000	£'000
Total	£5,734	£5,161	£4,587	£6,307	£6,881
Movement	-	-£573	-£1,147	£573	£1,147

Other Provisions

This relates to the potential settlement of a contractual dispute.

30 Contingencies

Contingent liability

Continuing Care

As explained in Note 29, requests for assessments of Continuing Care liabilities have been received by the PCT and this is a key area of uncertainty. Due to the inherent limitations in assessing the outcome of claims it is deemed necessary to disclose a contingent liability in regards to the potential cost that may be incurred over and above the provision that cannot be quantified.

Legal Case settlement

This relates to an on-going legal case the value of which cannot be reasonably estimated.

31 Financial Instruments

Financial risk management

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

Currency risk

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

Interest rate risk

PCTs are not permitted to borrow. The PCT therefore has low exposure to interest-rate fluctuations. However, there is an element of risk associated with the Local Government Pension Scheme Liability.

Credit Risk

Because the majority of the PCT's income comes from funds voted by Parliament the PCT has low exposure to credit risk. The maximum exposure at 31 March 2013 is in relation to receivables. An analysis of the ageing of receivables and provisions for impairment is shown in Note 17.3.

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.

31.1 Financial Assets	Loans and receivables	Total
	£000	£000
Receivables - NHS	5,878	**5,878**
Receivables - non-NHS	303	**303**
Cash at bank and in hand	12	**12**
Other financial assets	1,700	**1,700**
Total at 31 March 2013	**7,893**	**7,893**
Receivables - NHS	3,208	3,208
Receivables - non-NHS	5	5
Cash at bank and in hand	13,959	13,959
Other financial assets	2,962	2,962
Total at 31 March 2012	20,134	20,134

31.2 Financial Liabilities	Other	Total
	£000	£000
NHS payables	17,405	**17,405**
Non-NHS payables	5,506	**5,506**
Other financial liabilities	36,332	**36,332**
Total at 31 March 2013	**59,243**	**59,243**
NHS payables	13,883	13,883
Non-NHS payables	12,961	12,961
Other financial liabilities	35,930	35,930
Total at 31 March 2012	62,774	62,774

32 Related party transactions

Cambridgeshire Primary Care Trust is a body corporate established by order of the Secretary of State for Health.

During the year the Board Members or members of the key management staff or parties related to them have undertaken material transactions with Cambridgeshire Primary Care Trust as follows:

Certain local GPs sit on Cambridgeshire PCT's Shadow CCG Leadership Group (from 1st September 2012, CCG Governing Body). During the year payments were made to those General Practitioners practices, in line with the practices' role as independent contractors. The payments below were made to the practices and not to the doctors personally for services provided by those practices. In addition, there have been transactions in the ordinary course of the PCT's business with a number of provider Trusts with which Directors of the PCT are connected. Details of directors' and senior managers' remuneration are given in the Remuneration Report included in the PCT's Annual Report.

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party at year end	Amounts due from Related Party at year end	Amts due Provided as Doubtful Debts at year end
	£	£	£	£	£
Dr Simon Hambling, Doddington Medical Centre	1,151,747	0	17,610	0	0
Dr David Roberts, Great Staughton Surgery	793,701	0	8,512	0	0
Dr David Irwin, Mayfield Surgery, Buckden	1,445,420	0	46,037	0	0
Dr John Jones, Staploe Medical Centre	3,129,781	0	113,286	0	0
Dr Richard Withers, Yaxley Group Practice	1,990,346	0	91,157	7,290	0
Dr Arnold Fertig, Nuffield Road Medical Centre	1,920,394	0	100,141	0	0
Robert Kinnersley, NED, Cambridgeshire & Peterborough NHS FT	51,279,000	88,000	313,000	94,000	0
Andrew Vowles - Cambridge University Hospitals NHS FT	203,341,000	380,000	7,174,000	358,000	170,123
Colin Coulson Thomas, Peterborough & Stamford NHS FT	31,649,000	0	291,000	0	0
Rebecca Stephens, CCG Lay Member, Cambridgeshire & Peterborough NHS FT	51,279,000	88,000	313,000	94,000	0
Rebecca Stephens, CCG Lay Member, Peterborough & Stamford NHS FT	31,649,000	0	291,000	0	0
	379,628,389	556,000	8,758,743	553,290	170,123

Prior Year comparators:

	Payments to	Receipts from	Amounts owed	Amounts due from	Amts due Provided

	Related Party	Related Party	to Related Party at year end	Related Party at year end	as Doubtful Debts at year end
	£	£	£	£	£
Dr Simon Hambling, Doddington Medical Centre	1,111,594	0	29,292	0	0
Dr David Roberts, Great Staughton Surgery	834,575	0	19,031	0	0
Dr David Irwin, Mayfield Surgery, Buckden	1,414,285	0	49,585	0	0
Dr John Jones, Staploe Medical Centre	3,281,717	0	117,656	0	0
Dr Peter Godbehere, North Brink Practice	3,811,133	0	145,667	0	0
Dr Pauline Brimblecombe, Newnham Walk Surgery	1,176,051	0	59,660	0	0
Dr Caroline Lea-Cox, Trumpington Street Practice	1,185,212	0	31,107	0	0
Robert Kinnersley, NED, Cambridge & Peterborough NHS FT	55,459,000	609,000	746,000	23,000	0
Andrew Vowles - Cambridge University Hospitals NHS FT	192,627,000	862,000	6,331,000	332,000	0
	260,900,567	1,471,000	7,528,998	355,000	0

The Department of Health is regarded as a related party. During the year Cambridgeshire Primary Care Trust 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 of England Strategic Health Authority	82,000	5,719,000	25,000	147,000	0
NHS Business Services Authority	0	0	0	0	0
NHS Litigation Authority	62,000	0	0	0	0
Hinchingbrooke Health Care NHS Trust	85,020,000	42,000	5,360,000	12,000	0
Cambridgeshire and Peterborough NHS Foundation Trust	51,279,000	88,000	313,000	94,000	0
Cambridge University Hospitals NHS Foundation Trust	203,341,000	380,000	7,174,000	358,000	170,123
Cambridgeshire Community Services NHS Trust	73,190,000	2,654,000	1,739,000	539,000	0
Bedford Hospitals NHS Trust	904,000	0	113,000	0	0
Peterborough Primary Care Trust	53,000	1,065,000	244,000	1,997,000	0
Bedfordshire Primary Care Trust	87,000	49,000	9,000	6,000	0
Suffolk Primary Care Trust	42,000	43,000	12,000	5,000	0
Norfolk Primary Care Trust	68,000	92,000	55,000	0	0

East of England Ambulance NHS Trust	18,074,000	0	172,000	0	0
Queen Elizabeth Hospital, King's Lynn NHS FT	26,130,000	0	302,000	0	0
Papworth Hospitals NHS Foundation Trust	12,027,000	0	163,000	544,000	0
Peterborough & Stamford Hospitals NHS Foundation Trust	31,649,000	0	291,000	0	0
South East Essex Primary Care Trust	68,663,000	33,000	45,000	2,078,000	0
Norfolk and Suffolk NHS Foundation Trust	236,000	0	21,000	0	0
West Suffolk Hospitals NHS Foundation Trust	3,868,000	0	0	36,000	0

Prior Year comparators

East of England Strategic Health Authority	154,000	6,247,000	4,000	110,000	0
NHS Business Services Authority	0	0	0	0	0
NHS Litigation Authority	54,000	0	46,000	0	0
Hinchingbrooke Health Care NHS Trust	90,540,000	10,000	1,179,000	7,000	0
Cambridgeshire and Peterborough NHS Foundation Trust	55,459,000	609,000	746,000	23,000	0
Cambridge University Hospitals NHS Foundation Trust	192,627,000	862,000	6,331,000	332,000	0
Cambridgeshire Community Services NHS Trust	89,117,000	3,459,000	876,000	309,000	0
Bedford Hospitals NHS Trust	801,000	0	36,000	0	0
Peterborough Primary Care Trust	70,000	606,000	8,000	306,000	0
Bedfordshire Primary Care Trust	168,000	86,000	0	8,000	0
Suffolk Primary Care Trust	851,000	68,000	0	8,000	0
Norfolk Primary Care Trust	114,000	129,000	26,000	52,000	0
East of England Ambulance NHS Trust	17,552,000	0	381,000	0	0
Queen Elizabeth Hospital, King's Lynn NHS FT	25,248,000	0	202,000	0	0
Papworth Hospitals NHS Foundation Trust	10,251,000	0	847,000	0	0
Peterborough & Stamford Hospitals NHS Foundation Trust	31,024,000	0	277,000	0	0
South East Essex Primary Care Trust	64,736,000	85,000	830,000	3,000	0
Norfolk and Suffolk NHS Foundation Trust	136,000	0	3,000	0	0
West Suffolk Hospitals NHS Trust	1,993,000	0	0	0	0
West Suffolk Hospitals NHS Foundation Trust (w.e.f. 01/12/11)	1,025,000	0	536,000	0	0

In addition, the Primary Care Trust has had a significant number of material transactions with other Government Departments and other central and local Government bodies (see note 15). Most of these transactions have been with Cambridgeshire County Council in respect of joint enterprises and lead

commissioning arrangements, but there are also a number of transactions with District Councils, with whom the Trust works closely through the Local Strategic Partnership. This also includes amounts provided as doubtful debts (see note 17.3). In addition the PCT has paid Cambridgeshire County Council £310,000 in respect of the LGPS (2011/12 £311,000) (see Note 7.4.2).

For 2011-12 and 2012-13, in accordance with the directed accounting policy from the Secretary of State, the PCT does not consolidate the NHS charitable funds for which it is the corporate trustee. The PCT has had no transactions with its charitable funds, which are managed by Cambridgeshire & Peterborough NHS Foundation Trust.

33 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	165,701	6
Total losses	165,701	6
Total special payments	0	0
Total losses and special payments	165,701	6

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	0	0
		1
Special payments - PCT management costs	120,000	
Losses in respect of the provision of family practitioner services	0	0
Special payments in respect of the provision of family practitioner services	0	0
Total losses	0	0
Total special payments	120,000	1
Total losses and special payments	120,000	1

Details of cases individually over £250,000

There were no cases over £250,000.

34 Third party assets

The PCT held £0 cash and cash equivalents at 31 March 2013 on behalf of patients (£0 at 31 March 2012).

35 Events after the end of the reporting period

Per Note 1, under the provisions of The Health and Social Care Act 2012 (Commencement No.4.Transitional, Savings and Transitory Provisions) Order 2013, Cambridgeshire PCT was dissolved on 1st April 2013. The PCT's functions, assets and liabilities transferred to successor bodies as at 1st April 2013.

The commissioning of healthcare for Cambridgeshire and Peterborough patients, that was carried out by Cambridgeshire PCT in 2012-13 are to be carried out by the following successor organisations for 2013-14:

Service	Successor organisation
General Acute	Cambridgeshire and Peterborough Clinical Commissioning Group
Community Services	Cambridgeshire and Peterborough Clinical Commissioning Group
Mental Health	Cambridgeshire and Peterborough Clinical Commissioning Group
Learning Disability services	Cambridgeshire and Peterborough Clinical Commissioning Group
Ambulance Services	Cambridgeshire and Peterborough Clinical Commissioning Group
Public Health Services	Cambridgeshire County Council
Sexual Health	Cambridgeshire County Council
Specialised Commissioning	NHS England
Primary Care Services	NHS England

The balance sheet entries for Cambridgeshire PCT will transfer to the following organisations:

Asset/Liability	Successor organisation
Non-current assets - IT related	Cambridgeshire and Peterborough Clinical Commissioning Group
Non-current assets - other	NHS Property Company Ltd & Cambridgeshire Community Services
Local Government Pension Scheme Deferred Liabilities	Department of Health
Cash	Department of Health
Provisions relating to former staff	Department of Health
Provisions relating to transferred services	Cambridgeshire and Peterborough Clinical Commissioning Group
Short term debtors and creditors	Department of Health - (who it is expected will devolve responsibility to the appropriate receiving bodies.)
Revaluation reserve	NHS Property Company Ltd & Cambridgeshire Community Services
General Fund	The appropriate receiving body

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.

As disclosed in the Annual Governance Statement, the auditors have identified matters to report in forming their conclusion on the PCT's arrangements for securing economy, efficiency and effectiveness in the use of resources. The auditors' conclusion concerns the two criteria specified by the Audit Commission as to whether the PCT has proper arrangements for securing financial resilience and for challenging how it secures economy, efficiency and effectiveness. The ownership and robustness of the detailed QIPP plans together with the reporting processes now in place will be taken forward by the Cambridgeshire and Peterborough Clinical Commissioning Group for the purpose of achieving the cost savings targets identified for 2013/14.

Taking into account the matter set out above, to the best of my knowledge and belief, I have properly discharged the above responsibilities, as designated Signing Officer and through experience in my role as Accountable Officer until 31 March 2013.

Signed  .Designated Signing Officer

Name: **Andrew Reed**

Date **7 June 2013**

STATEMENT OF RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

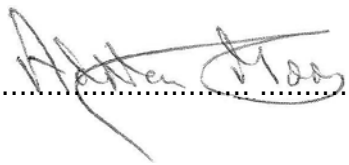
Primary Care Trusts as NHS bodies are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the primary care trust and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

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.
- ensure that the PCT kept proper accounting records which disclosed with reasonable accuracy at any time the financial position of the primary care trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State.
- have taken reasonable steps for the prevention and detection of fraud and other irregularities.

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

By order of the Permanent Secretary.

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

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

REMUNERATION REPORT

Membership of Remuneration Committee

Name	Position
Robert Kynnersley (NED)	Chairman
Glen Clark	Non-Executive Director
Peter Southwick	Non-Executive Director (to August 2012)
Colin Coulson-Thomas	Non-Executive Director (Rem. Committee from August 2012)
Malcolm Burch	Non-Executive Director

Policy on the remuneration of senior managers

Remuneration payments made to the Non-Executive directors and Professional Executive Committee members are set nationally by the Secretary of State. The remuneration for Officer Directors is set by the Remuneration Committee, having regard to comparative salary data and the labour market. No remuneration was waived by members and no compensation was paid for loss of office. No payments were made to co-opted members and no payments were made for golden hellos.

Where individual national review bodies govern salaries, then the national rates of increase have been applied. Where national review bodies do not cover staff, then increases have been in line with the percentage notified by the NHS Chief Executive and approved by the Remuneration Committee. For 2012/13 this was 0.0% (2011/12 0.00%). Any increases above that limit have been on the basis of increased responsibilities or promotion.

Policy on Performance Conditions

The PCT's Joint Remuneration Committee set standards in conjunction with the Chief Executive, who has held regular appraisals and 1:1 supervision sessions with the individuals concerned. The Chair sets individual targets for the Chief Executive based on the performance of the PCT in relation to national and local targets set out in the PCT service plans. The Remuneration Committee

takes the financial circumstances of the organisation into consideration in making pay awards, as well as Advance letters advice from the Department of Health. All uplifts were discussed with and decided by the Chair and Non Executives at the Remuneration Committee, which is supported by a Human Resource (HR) professional. Middle managers receive their targets through cascade of organisational objectives with advice and support from HR. The annual cost of living uplift is decided by the Remuneration Committee.

Policy on duration of contracts, notice periods and termination payments

Senior manager contracts are subject to 3 - 6 months' contractual notice due to the time it takes to replace a senior manager. Termination payments are in accordance with NHS policy and negotiated with trades unions. Contracts, where possible, are permanent except for project work, due to the legislation giving fixed term contracts similar employment rights. During times of change the organisation resorts to fixed term contracts and secondments, but this is becoming increasingly regulated.

	Service Contracts					
	Name	**Position**	**Date of Contract**	**Unexpired term (if applicable)**	**Early termination terms**	
*	Dr Christine MacLeod	Medical Director	1-Jun-02	N/A	N/A	
	Liz Robin	Director of Public Health	30-May-02	N/A	N/A	
*	Andy Vowles	Director of Strategy & Delivery	2-Sep-09	N/A	N/A	
*	Jessica Bawden	Director of Communications & Public Engagement	4-Jun-07	N/A	N/A	
*	Alan Mack	Director of Corporate Development & Performance	29-Mar-10	N/A	N/A	
	Tim Woods	CCG Chief Finance Officer	1-Sep-12	N/A	N/A	
	Victoria Corbishley	CCG Director of Performance & Delivery	1-Sep-12	N/A	N/A	
	Harper Brown	CCG Director of Commissioning & Contracting	1-Sep-12	N/A	N/A	
	Dr Neil Modha	CCG Chief Clinical Officer	1-Jun-12	N/A	N/A	
*	Joint appointments to NHS Cambridgeshire & NHS Peterborough.					

Remuneration Report (audited information)										
			2012-13				2011-12			
Name	Title	Period	Salary (bands of £5,000)	% of total remuneration	Other Remuneration (bands of £5,000)	Benefits in kind (Rounded to the nearest £00)	Salary (bands of £5,000)	% of total remuneration	Other Remuneration (bands of £5,000)	Benefits in kind (Rounded to the nearest £00)
			£000		£000	£00	£000		£000	£00
Non-Executive Directors										
*Maureen Donnelly	PCT Cluster Chair from 01/12/11, CCG Lay Chair w.e.f. 01.07.12		30-35	87%			30-35	83%		
*John Barratt	Non-Executive Director, PCT Cluster Chair w.e.f.01.07.12		15-20	50%			10-15	83%		
Malcolm Burch	Non-Executive Director		0-5	50%			00-05	17%		
*Glen Clark	Non-Executive Director, CCG Lay Member w.e.f. 01.08.12		5-10	50%			05-10	83%		
Colin Coulson-Thomas	Non-Executive Director		0-5	50%			00-05	17%		
*Robert Kynnersley	Non-Executive Director		0-5	50%			05-10	83%	5-10	
*Peter Southwick	Non-Executive Director, CCG Lay Member 01.08.12 - 30.11.12	to 30.11.12	0-5	50%			05-10	83%		
*Sally Williams	Non-Executive Director		0-5	50%			05-10	83%		
*Edward Libbey	Audit Committee Chair	w.e.f. 01.07.12	0-5	50%						
*Rebecca Stephens	CCG Lay Member	w.e.f. 01.08.12	0-5	50%						
*Alex Plant	Non-Executive Director	to June 11	0	0%			00-05	100%		
Officer Members/Directors										

*Sushil Jathanna	Chief Executive	to 30.09.12	55-60	50%	*****60-65		70-75	50%		
**Sheila Bremner	Chief Executive	w.e.f. 01.10.12	n/a							
*John Leslie	Director of Finance & QIPP	to 31.01.13	50-55	60%	***75-80		65-70	60%		
**Adrian Marr	Director of Finance	w.e.f. 01.02.13	n/a							
*Alan Mack	Director of Corporate Development & Performance, Deputy Chief Executive w.e.f. 01.10.13		70-75	60%	***125-130		65-70	60%		
Dr Liz Robin	Director of Public Health		100-105	100%			100-105	100%		
Andy Vowles	Director of Strategy & Delivery, CCG Chief Operating Officer w.e.f. 24.10.12		125-130	100%			100-105	100%		
*Jessica Bawden	Director of Communications & Public Engagement, Director of Corporate Affairs w.e.f. 21.12.13		45-50	60%			45-50	60%		
*Dr Christine MacLeod	Medical Director		85-90	60%			45-50	60%	70-75	
*Jill Houghton	Director of Nursing & Quality (w.e.f. 01.02.12), CCG Director w.e.f. 01.07.12.		70-75	60%		1	15-20	74%		
*Mandy Renton	Executive Nurse & Director of Clinical Redesign & Service Improvements	w.e.f. 28.09.09 - 24.10.11	0				30-35	60%		
*Barbara Stuttle	Interim Director of Nursing & Quality	24.10.11 - 31.01.12	0				25-30	74%		
Anna Gillard	Director of Acute Commissioning		80-85	100%	***165- 170		80-85	100%		

Members of the Shadow CCG Board										
Dr Simon Hambling	GP Commissioning Senate, CCG Shadow Accountable Officer to 30.05.12	to 30.05.12	0-5	100%	10-15		05-10	100%		
Dr Neil Modha	CCG Chief Clinical Officer	w.e.f 01.06.12	65-70	100%						
Tim Woods	CCG Chief Finance Officer	w.e.f. 01.09.12	55-60	100%						
Victoria Corbishley	CCG Director of Performance & Delivery	w.e.f. 01.09.12	60-65	100%						
Harper Brown	CCG Director of Commissioning & Contracting	w.e.f. 01.09.12	60-65	100%						
Dr Mike Caskey	CCG Governing Body GP Member		0							
Dr Geraldine Linehan	GP Commissioning Senate, CCG Governing Body GP Member		5 -10	100%	70-75		05-10	100%		
Dr Richard Withers	CCG Governing Body GP Member		5 -10	100%	25-30					
Dr John Jones	GP Commissioning Senate, CCG Governing Body GP Member		5 -10	100%	5 -10		05-10	100%		
Dr David Roberts	GP Commissioning Senate, CCG Governing Body GP Member		5 -10	100%	60-65		05-10	100%		
Dr David Irwin	GP Commissioning Senate, CCG Governing Body GP Member		5 -10	100%	25-30		05-10	100%		
Dr Arnold Fertig	CCG Governing Body GP Member		5 -10	100%	60-65					
Dr Andrew Wordsworth	CCG Governing Body GP Member	to November 2012	0	100%						
Dr Christopher Scrace	CCG Governing Body Member	w.e.f. 01.12.12	5-10	100%						

Dr Peter Godbehere	GP Commissioning Senate		0				05-10	100%		
Dr Pauline Brimblecombe	GP Commissioning Senate		0				05-10	100%		
Dr Caroline Lea-Cox	GP Commissioning Senate		0				05-10	100%		
* the above directors became joint appointments to both NHS Cambridgeshire & NHS Peterborough on creation of the PCT Cluster Board on 24/10/11. Full details of their remuneration can be found below. A recharge is made for the services provided by these directors.										
Non-Executive Directors										
*Maureen Donnelly	PCT Cluster Chair from 01/12/11, CCG Lay Chair w.e.f. 01.07.12		35-40				35-40			
*John Barratt	Non-Executive Director, PCT Cluster Chair w.e.f.01.07.12		30-35				10-15			
Malcolm Burch	Non-Executive Director		0				00-05			
*Glen Clark	Non-Executive Director, CCG Lay Member w.e.f. 01.08.12		10-15				05-10			
Colin Coulson-Thomas	Non-Executive Director		0				00-05			
*Robert Kynnersley	Non-Executive Director		5-10				05-10		5-10	
*Peter Southwick	Non-Executive Director, CCG Lay Member 01.08.12 - 30.11.12	to 30.11.12	5-10				05-10			
*Sally Williams	Non-Executive Director		5-10				05-10			
*Edward Libbey	Audit Committee Chair	w.e.f. 01.07.12	5-10							
*Rebecca Stephens	CCG Lay Member	w.e.f. 01.08.12	5-10							
*Alex Plant	Non-Executive Director	to June 11	0				00-05			
Officer Members/Directors										
*Sushil Jathanna	Chief Executive	to 30.09.12	110-115		*****60-65		140-145			
**Sheila Bremner	Chief Executive	w.e.f. 01.10.12	n/a							

*John Leslie	Director of Finance & QIPP	to 31.01.13	85-90		***75-80		105-110			
**Adrian Marr	Director of Finance	w.e.f. 01.02.13	n/a							
*Alan Mack	Director of Corporate Development & Performance, Deputy Chief Executive w.e.f. 01.10.13		120-125		***125-130		110-115			
Dr Liz Robin	Director of Public Health		100-105				100-105			
Andy Vowles	Director of Strategy & Delivery, CCG Chief Operating Officer w.e.f. 24.10.12		125-130				100-105			
*Jessica Bawden	Director of Communications & Public Engagement, Director of Corporate Affairs w.e.f. 21.12.13		75-80				75-80			
*Dr Christine MacLeod	Medical Director		140-145				75-80		70-75	
*Jill Houghton	Director of Nursing & Quality (w.e.f. 01.02.12), CCG Director w.e.f. 01.07.12.		115-120			1	20-25			
*Mandy Renton	Executive Nurse & Director of Clinical Redesign & Service Improvements	w.e.f. 28.09.09 - 24.10.11	0				50-55			
*Barbara Stuttle	Interim Director of Nursing & Quality	24.10.11 - 31.01.12	0				35-40			
Anna Gillard	Director of Acute Commissioning		80-85		***165-170		80-85			
Members of the Shadow CCG Board										
Dr Simon Hambling	GP Commissioning Senate, CCG Shadow Accountable Officer to 30.05.12	to 30.05.12	0-5		****10-15		05-10			

Dr Neil Modha	CCG Chief Clinical Officer	w.e.f 01.06.12	70-75							
Tim Woods	CCG Chief Finance Officer	w.e.f. 01.09.12	55-60							
Victoria Corbishley	CCG Director of Performance & Delivery	w.e.f. 01.09.12	60-65							
Harper Brown	CCG Director of Commissioning & Contracting	w.e.f. 01.09.12	60-65							
Dr Mike Caskey	CCG Governing Body GP Member		0							
Dr Geraldine Linehan	GP Commissioning Senate, CCG Governing Body GP Member		5 -10		****70-75		05-10			
Dr Richard Withers	CCG Governing Body GP Member		5 -10		****25-30					
Dr John Jones	GP Commissioning Senate, CCG Governing Body GP Member		5 -10		****5 -10		05-10			
Dr David Roberts	GP Commissioning Senate, CCG Governing Body GP Member		5 -10		****60-65		05-10			
Dr David Irwin	GP Commissioning Senate, CCG Governing Body GP Member		5 -10		****25-30		05-10			
Dr Arnold Fertig	CCG Governing Body GP Member		5 -10		****60-65					
Dr Andrew Wordsworth	CCG Governing Body GP Member	to November 2012	0							
Dr Christopher Scrace	CCG Governing Body Member	w.e.f. 01.12.12	5-10							
Dr Peter Godbehere	GP Commissioning Senate		0				05-10			
Dr Pauline Brimblecombe	GP Commissioning Senate		0				05-10			
Dr Caroline Lea-Cox	GP Commissioning Senate		0				05-10			

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

The banded remuneration of the highest paid director in NHS Cambridgeshire in the financial year 2012-13 was £125k to £130k (2011-12, £100k to £105k). This was 3.73 times (2011-12, 3.00 times) the median remuneration of the workforce, which was £34,189 (2011-12, £34,189). Remuneration ranged from £2179 to £130,000 (2010-11 £3,626 to £138,571).

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

In 2012/13, nine employees (2011/12 no employees) received remuneration in excess of the highest director, resulting from severance packages paid in addition to salary payments.

The Shadow CCG Board was created in 2012/13, so there is no comparative with 2011/12. Some GPs on the CCG Board were also members in 2011/12 of the GP Commissioning Senate, which had Board decision making status.

** Sheila Bremner & Adrian Marr, in their roles within the Local Area Office of the NHS Commissioning Board, were confirmed in director roles for Cambridgeshire & Peterborough PCT Cluster.

In accordance with national guidance the salary costs of the Local Area Office staff have continued to be met in full by their employer, rather than accounted for in part by Cambridgeshire PCT, so there are no values disclosed in the remuneration report.

*** Other Remuneration refers to exit packages, see Accounts note 7.3

**** Other remuneration for GPs on the shadow CCG Board represents meetings attended other than CCG Board meetings.

***** This represents the maximum value of the exit package, which has yet to be determined.

Remuneration Report - Pension entitlements (audited information)

Name and title	Real increase in pension at age 60 (bands of £2,500) £000	Lump sum at age 60 related to real increase in pension (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2013 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31-Mar 2013 £000	Cash Equivalent Transfer Value at 31 March 2012 £000	Real increase in Cash Equivalent Transfer Value £000	Pension Accrued 31 March 2012 (restated) *	Lump Sum 31 March 2012 (restated) *	CETV 31 March 2012	Pension Accrued 31 March 2013	Lump Sum 31 March 2013	CETV 31/03/ 2013
*Sushil Jathanna, Chief Executive (to 30.09.12)	0-2.5	- 2.5 - 5	25 -30	60 - 65	695	621	42	27,086.73	64,667.19	620,695.93	29,044.09	64,667.19	695,291.63
**Sheila Bremner, Chief Executive, w.e.f. 01.10.12	n/a	n/a	n/a	n/a	n/a	n/a	n/a						
**Adrian Marr, Director of Finance, w.e.f. 01.02.13	n/a	n/a	n/a	n/a	n/a	n/a	n/a						
John Leslie, Director of Finance to 30.01.13	0-2.5	0-2.5	15 -20	50 -55	292	265	13	15,991.39	47,974.18	265,161.62	17,114.63	51,343.89	291,758.61
*Dr Christine MacLeod, Medical Director	- 0 - 2.5	- 2.5 - 5	60 -65	180 - 185	1,321	1,247	9	59282.38	177847.14	1247449.06	60,886.49	182,659.47	1,320,818.23
Dr Liz Robin, Director of Public Health	0-2.5	0-2.5	20- 25	65 - 70	432	397	15	21,604.32	64,812.96	396,971.89	22,875.93	68,627.79	432,362.24
*Alan Mack, Director of Corporate Development & Performance (w.e.f. 29.03.10)	-2.5 - 5	-7.5 - 10	50 -55	160 -165	1,205	1,168	-23	53,350.67	160,052.00	1,167,671.63	53,505.34	160,516.03	1,205,407.69
Jessica Bawden, Director of Communications & Public Engagement, Director of Corporate	0-2.5	0-2.5	5 - 10	15 - 20	83	67	12	4,543.04	13,629.12	67,282.42	5,436.52	16,309.56	82,825.38

Affairs w.e.f. 21.12.12													
***Mandy Renton, Executive Nurse & Director of Clinical Redesign & Service Improvements (w.e.f. 28.09.09 - 24.10.11)	n/a	n/a	n/a	n/a	0	0	0						
Andy Vowles, Director of Strategy & Delivery, CCG Chief Operating Officer w.e.f. 24.10.11	0-2.5	0-2.5	20 -25	60 - 65	320	293	12	20,240.20	60,720.59	292,617.94	21,527.70	64,583.09	320,060.22
Anna Gillard, Director of Contracting (18.10.10 - 24.10.11)	- 0 - 2.5	- 0 - 2.5	20 -25	70 - 75	396	368	9	22339.77	67,019.31	368,316.38	23,375.59	70,126.77	396,415.18
* Jill Houghton, Director of Nursing & Quality (w.e.f. 01.02.12), CCG Director w.e.f. 01.07.12.	-7.5 - 10	-20 - 22.5	35 -40	85 -90	706	790	-126	43,001.51	101,268.00	790,218.94	37,499.15	85,128.00	705,524.81
Tim Woods, CCG Chief Finance Officer, w.e.f. 01.09.12	0-2.5	0-2.5	45 - 50	135 - 140	897	825	29	43,423.65	130,270.94	825,184.19	45,816.78	137,450.34	896,683.55
****Victoria Corbishley, CCG Director of Performance & Delivery, w.e.f. 01.09.12	n/a	0	5 -10	0	51	0	51				5,811.18	0.00	50,942.27
Harper Brown, CCG Director of Commissioning & Contracting, w.e.f. 01.09.12	0-2.5	0-2.5	20 -25	70 - 75	548	498	24	23,317.49	69,952.47	498,213.63	24,888.95	74,666.86	547,623.67

* Values for real increase in pension and lump sum are negative because director's pensionable pay is less than in 2011/12.
** Sheila Bremner & Adrian Marr, in their roles within the Local Area Office of the NHS Commissioning Board, were confirmed in director roles for Cambridgeshire & Peterborough PCT Cluster.
In accordance with national guidance the salary costs of the Local Area Office staff have continued to be met in full by their employer, rather than accounted for in part by Cambridgeshire PCT, so there are no pension values disclosed in the remuneration report.

*** Mandy Renton, included for comparatives but values not applicable because she left on 24.10.11
*****Victoria Corbishley. The real increase in pension cannot be calculated as she is new to the pension scheme. Lump Sum values are zero as she is member of the 2008 scheme which does not provide a lump sum.

Cash Equivalent Transfer Values

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

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

Real Increase in CETV

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

Independent Auditors' Report to the officer responsible for preparing the accounts of Cambridgeshire Primary Care Trust

We have audited the financial statements of Cambridgeshire Primary Care Trust ("the PCT") for the year ended 31 March 2013 which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is the accounting policies directed by the Secretary of State for Health with the consent of the Treasury as relevant to the National Health Service in England set out therein.

Respective responsibilities of the officer responsible for preparing the accounts and auditors

As explained more fully in the Directors' Responsibilities Statement of set out on page 122 of the officer responsible for preparing the accounts is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view in accordance with accounting policies directed by the Secretary of State, with the consent of the Treasury, as being relevant to the National Health Service in England. Our responsibility is to audit and express an opinion on the financial statements in accordance with Part II of the Audit Commission Act 1998, the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission and International Standards on Auditing (ISAs) (UK and Ireland).Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the officer responsible for preparing the accounts of Cambridgeshire Primary Care Trust in accordance with Part II of the Audit Commission Act 1998 as set out in paragraph 45 of the Statement of Responsibilities of Auditors and of Audited Bodies (Local NHS Bodies) published by the Audit Commission in March 2010 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

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 and Accounts 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 state of the PCT's affairs as at 31 March 2013 and of its net operating costs for the year then ended; and

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

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion

- the part of the Remuneration Report to be audited has been properly prepared in accordance with the requirements directed by the Secretary of State with the consent of the Treasury as being relevant to the National Health Service in England;

- 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; and

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

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Code of Audit Practice issued by the Audit Commission requires us to report to you if:

- in our opinion, the Governance Statement does not comply with the Department of Health's requirements set out in "2012/13 Governance Statements – Guidance " issued on 31 January 2013 or is misleading or inconsistent with information of which we are aware from our audit; or

- we refer a matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful

expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or

- we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

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

Respective responsibilities of the PCT and auditors

The PCT is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

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 to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

We report if significant matters have come to our attention which prevent us from concluding that the PCT has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the PCT's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the review of the arrangements for securing economy, efficiency and effectiveness in the use of resources

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

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

- our review of the Governance Statement;

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

- our locally determined risk-based work on the PCT's governance arrangements for the demise of the PCT and review of the achievement of the PCT's savings plans and in year reporting mechanisms.

As a result, we have concluded that there are the following matters to report:

- In 2012/13 the PCT has underperformed in regards to achieving savings targets and has been reliant on the use of non-recurrent savings to support the achievement of breakeven. The underperformance of savings targets has been a consistent theme over the past three years.
- Savings plans have not been fit for purpose and supported by robust delivery plans and have not been consistently and effectively monitored throughout the financial year.

Certificate

We certify that we have completed the audit of the financial statements of Cambridgeshire Primary Care Trust in accordance with the requirements of Part II of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Clive Everest, Engagement Lead

For and on behalf of PricewaterhouseCoopers LLP

Appointed Auditors

Cambridge

Date: 9 June 2013

The maintenance and integrity of the Cambridgeshire Primary Care Trust website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.

Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.