Department of Health

NHS

County Durham Primary Care Trust

2012-13 Annual Report and Accounts

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County Durham Primary Care Trust

2012-13 Annual Report

NHS
County Durham

Annual Report

Including Operating and Financial Review 2012/13

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Contents

1. About County Durham PCT

County Durham PCT was formed on 1st October 2006 following the formal amalgamation of five primary care trusts (PCTs) into a single PCT across County Durham. We became one of the first PCTs nationally to become a commissioning only organisation, working with and on behalf of Darlington PCT to commission healthcare for 600,000 residents living in County Durham and Darlington.

It served a diverse community that included both disadvantaged and affluent areas, and rural communities.

The populations of County Durham and Darlington experience high levels of health inequalities which include high rates of heart disease and cancer. Smoking remains the cause of lower life expectancy and high disease rates. Obesity also continues to pose a major public health challenge and risk to future health, wellbeing and life expectancy.

County Durham PCT worked to deliver the best possible care for our local population by developing services that best met the needs of their local communities.

The PCT worked closely with their providers of healthcare and health services; these included GPs, dentists, pharmacists and optometrists, County Durham and Darlington NHS Foundation Trust, Tees Esk and Wear Valley NHS Foundation Trust and North East Ambulance Service NHS Foundation Trust. They also worked closely with Durham County Council, Darlington Borough Council and the community and voluntary sector in County Durham and Darlington.

This annual report and financial accounts is the last to be published by County Durham PCT. For future information for NHS commissioning information for County Durham post April 1 2013, please go to:

www.durhamdaleseasingtonsedgefieldccg.nhs.uk/
www.northdurhamccg.nhs.uk/

or seek information from the Durham, Darlington and Tees Area Team of the NHS Commissioning Board.

For information on public health, visit www.durham.gov.uk

2. Welcome to our annual report for 2012/13

Welcome to the final County Durham Primary Care Trust 2012/13 annual report. This incorporates the operating and financial review for the period 1 April 2012 to 31 March 2013. Details on budgets and financial management can be found in the financial accounts.

During this year the PCT continued to deliver all their statutory duties through a period of intense transition and change for the NHS.

Following the publication of the national NHS White Paper and the Health and Social Care Bill 2011, they focused on ensuring that appropriate clinical leadership was in place across County Durham and Darlington as they moved to support GP colleagues as clinical commissioners of the future.

This also signalled a fundamental shift for NHS commissioning with the abolition of PCTs, the establishment of clinical commissioning groups (CCGs) and the transfer of our public health improvement responsibilities to local authorities, from 1 April 2013.

The Health and Social Care Bill 2011 which became law in April 2012 set out plans to transfer responsibility for commissioning the majority of health services from primary care trusts to groups of primary care clinicians. Under this legislation, local authorities will also play a leading part in the health system, ensuring effective local patient and public 'voice,' and overseeing public health improvement functions.

During 2012/13 the PCT continued their preparations to put this legislation into place by April 2013 and worked with local partners looking at how new health arrangements would fit together.

With Darlington PCT they worked closely with the three local clinical commissioning groups (CCGs), NHS Durham Dales, Easington and Sedgefield CCG, NHS North Durham CCG and NHS Darlington CCG to support them in taking on their new responsibilities and more recently worked with the North of England Commissioning Support Unit (NECS), which now provides support services for the CCGs.

County Durham PCT also worked closely with Durham County Council and Darlington Borough Council to ensure a smooth transfer of responsibilities for public health and with the emerging Durham, Darlington and Tees Area Team of the NHS Commissioning Board in relation to other functions that will transfer from the PCTs.

Commissioning support services developed their plans and proposals for supporting clinical commissioning groups and other NHS 'customers'.

As the PCT's financial management has been robust they achieved a balanced position on 31 March 2013 which ensured that CCGs would start from a strong financial position.

The PCT also worked with their partners in the development of the new shadow Health and Wellbeing Board in County Durham which prepared to lead across health, social care and public health, and of the local health consumer 'champion' organisation HealthWatch has been in place since April 2013. In particular they worked closely with Durham County Council on transition plans as they prepared to take the lead for public health.

The PCT would like to thank all their staff, past and more recent, for their commitment to the delivery of improved health and health services for their population. They were particularly proud of the way staff continued to deliver during what has been an extensive period of change and uncertainty, and wished them well for their future in a range of new organisations which will benefit from their commitment and expertise.

As the PCT approached the end of their existence, they were proud of what they had achieved over the past twelve years as primary care organisations in County Durham. They left behind a secure financial position for the future and an infrastructure that continues to support the delivery of improved primary care services.

County Durham PCT delivered real achievements throughout the life of the PCTs and continued to do during 2012/13 by working with their key partners to meet their health and wellbeing challenges. The local community and voluntary sector have played a major role, together with patients and the public, in shaping future services that have genuinely benefited local residents.

Cameron Ward
Director (Durham, Darlington and Tees)
NHS England

3. Managing transition towards the new NHS system

As 2013/14 marks the first full year of the new system, significant progress was made during 2012/13 in determining which new NHS organisations would take on the range of PCT functions.

Clinical Commissioning Groups

The PCT worked with Darlington PCT to support their three clinical commissioning groups to ensure they were in a good position to take on their new commissioning responsibilities and to be formally established as NHS statutory bodies.

The CCG configuration is:

- **North Durham** – covering Durham, Chester-le-Street and Derwentside;
- **Durham Dales, Easington and Sedgefield** - working together as localities; and
- **Darlington.**

Applications for CCGs' authorisation were submitted in autumn 2012 followed by panel visits which took place during late 2012 to explore their readiness to take on their new responsibilities. A key aspect of this process included independent consideration of key policies and documents produced by the CCGs.

Each CCG developed a five year 'clear and credible plan' to demonstrate accountability by explaining how public money is invested and how priorities are set. These plans were part of the authorisation process which provided ongoing assurance to National Commissioning Board and were shared with stakeholders to inform future discussions around the CCGs' commissioning intentions for 2013/14.

A further element of this authorisation was a 360°stakeholder survey where key partners were identified and asked to take part in a survey, allowing the future NHS Commissioning Board to assess whether the relationships the CCG had forged during transition with partners was likely to provide sufficient basis for effective commissioning. During the year all three CCGs undertook activity to seek the public's views on health commissioning intentions and how health services should be shaped for the future.

By February 2013, all three CCGs received official notification of their authorisation from the NHS Commissioning Board.

The CCGs continued to be overseen by a subcommittee of the NHS County Durham and Darlington cluster board until April 2013.

North of England Commissioning Support (NECS)

Commissioning support units (CSUs) were developed across the county to support the emerging roles, responsibilities and statutory duties of CCGs. They now provide support to CCGs in the key areas that drive successful clinical commissioning – strategic planning, service design and change, contract and performance management and business support services.

During 2012/13 commissioning support units began preparations for their authorisation which took place from autumn 2012 onwards. All CSUs were required to pass the NHS Commissioning Board's assurance process in order be awarded a 'licence to operate'.

The commissioning support services needed to demonstrate that they were financially viable, and could meet customers' needs and provide value for money.

The North East commissioning support unit - now North of England Commissioning Support (NECS) worked both locally and regionally to develop their service prospectus and to support the CCGs in developing their commissioning plans.

At 31st March 2013 the NECS passed two of three authorisation stages and was judged as financially viable and fit for purpose.

The local commissioning support service in County Durham and Darlington was part of NECS with shadow arrangements in place to support CCGs. The services continued to work with local CCGs to understand their needs through 'relationship managers'.

A final business plan was submitted at the end of August 2012 and received a recommendation at the end of October 2012 for hosting by the NHS CB from April 2013 and a licence to provide commissioning support.

Positive feedback was received from the NHS CB Business Development Unit during the process of continuous assessment which ran until the end of March 2013. NECS achieved the highest cumulative score and was ranked number one commissioning support unit in the country.

By 31st March 2013 NECS had developed an operating model for a customer focused local service and agreed service 'lines' and specifications with input from CCGs. This involved reviewing and standardising processes where possible to ensure customers benefit from consistent and more cost efficient services, and developing a flexible workforce equipped to meet the varied requirements of each individual CCG.

NECS also secured contracts to support NHS Cumbria CCG as well as providing at scale services to clinical commissioning groups and CSUs across the North East, Cumbria, West Yorkshire and North Yorkshire and Humber.

Communicating with staff

Most PCT staff have now transferred to either one of the CCGs, North of England Commissioning Support (NECS), local authority Public Health teams or the NHS Commissioning Board.

This was an unsettling period for commissioning staff. During the year significant efforts were made to ensure staff were kept informed about changes happening including staff meetings, regular staff bulletins and updates.

As the PCT recognised that their staff networked closely with peers and colleagues in other parts of the region's NHS organisations, they co-ordinated key announcements with other PCT clusters in the region to ensure, where possible, all staff received information at the same time and on a fair and equal basis.

Consultation on the structures and job descriptions for NECS and the CCGs took place with staff and staffside representatives and they were encouraged to feedback any comments. A series of workshops were held by both NECS and the CCGs which staff were supported to attend.

From September 2012 onwards more clarity was gained over new receiving NHS organisations 'staffing structures and local staff engagement took place giving colleagues the opportunity to feedback on local CCG and commissioning support structures. Some changes were made as a result of this engagement and this process also helped staff understand how the new organisations would work in partnership in the future.

A national HR transition process and timeframe was published and a North East partnership board established with staff side, union representatives and management to help support a smooth process and staff scrutiny over the matching of staff to jobs, recruitment and transfer where appropriate to new bodies. This was in addition to our ongoing engagement with the NHS County Durham and Darlington staff side.

Area Teams

Regional directors worked with PCT and SHA clusters, emerging CCG leaders and local government partners to plan the geographies of the of area teams (ATs) within each region.

They are being referred to as ATs to reflect the number of office bases for local staff. In the North East and Cumbria are two of these teams as set out below:

Area Team	Current PCT Cluster
Cumbria, Northumberland & Tyne and Wear	Cumbria North of Tyne South of Tyne and Wear
Durham, Darlington and Tees	County Durham and Darlington Tees

It was agreed that the two area teams across the North East would continue to maintain a single commissioning structure for primary care which was hosted by Durham, Darlington and Tees area team.

Cumbria, Northumberland, Tyne & Wear host the specialised services commissioning team who commission low volume but high cost NHS services for the North East and Cumbria.

All ATs have the same core functions around:

- CCG development and assurance;
- Emergency planning, resilience and response;
- Quality and safety;
- Partnerships; and
- Configuration and system oversight.

All ATs have taken on the direct commissioning responsibilities for GP services, dental services, pharmacy and certain aspects of optical services.

Public health

From April 2013 the integrated public health team was disaggregated and staff transferred to Durham County Council and Darlington Borough Council.

Both local authorities established public health transition groups and worked closely with County Durham PCT and Darlington PCT to ensure the transfer was as smooth as possible. There was on-going dialogue with providers of public health services to keep them apprised of changes and potential implications

Shadow working arrangements were established with both local authorities during 2012/13. Durham County Council established a public health “receiver” group to ensure that the council was prepared to take on the new responsibilities.

A new joint health and wellbeing strategy (JHWS) was developed for County Durham.

Durham County Council has taken on the lead from the NHS for some public health functions, co-ordinating efforts to protect health and ensure health services promote health and reduce health inequalities. A variety of public health services transferred to the local authority such as tobacco control, alcohol and substance misuse, obesity and community nutrition initiatives, sexual health services and health checks.

The Director of Public Health was a joint appointment between County Durham PCT and Durham County Council, and took a lead role in the joint transition work.

Work was on-going nationally to finalise public health budgets and local authorities were notified of their respective ring-fenced grant allocations for 2013/14 by the end of 2012.

Public Health England (PHE) has set up 16 ‘centres’ around England as part of its structure. They provide local leadership and presence for health protection, health improvement and health promotion. PHE sought alignment with local authority boundaries, NHS Commissioning Board local area teams and local resilience forums.

Health and Wellbeing Board (HWBB) and Joint Health and Wellbeing (HWB) Strategy

The HWBB in Durham County Council was formalised from April 2013, although it previously existed in shadow form. Through this, Durham County Council promotes the joining up of local services, social care and health improvement through a single integrated programme across health and social care.

The County Durham Shadow HWB held a consultation event on in June 2012 on proposed strategic objectives for the Joint HWB Strategy. Joint strategic needs assessments (JSNAs) and joint health and wellbeing strategies were in place by October 2012 to inform the first CCG commissioning plans for 2013/14.

A regional transition programme was established involving all NHS North East organisations, local authority partners, shadow CCGs, as well as staff and patient representatives to ensure robust arrangements were in place as the changes were implemented. This programme provided oversight of the development of HWBBs across the North East.

Scrutiny and 'voice'

Health overview and scrutiny functions are directly undertaken by local authorities. Durham County Council also has formal scrutiny powers that cover all NHS-funded services.

The local health consumer 'champion' organisation – HealthWatch – was in place from April 2013 in County Durham. HealthWatch gives people the opportunity to share their views and concerns about their local health and social care services.

National Commissioning Board (NCB) / NHS England

From June 2011, the NCB was established as a Special Health Authority. The NCB has overall responsibility for a budget of £80bn, of which it will allocate £60bn directly to GP commissioners. It directly commissions a range of services including primary care and specialised services and have a key role in improving broader public health outcomes.

The NCB became fully operational on 1 April 2013, when it took on its complete legal responsibilities for managing the new NHS commissioning system and is now known as NHS England.

North East teams which are be part of NHS England include offender health, specialist commissioning, veterans' health, children (0-5), North East Primary Care Services Agency and clinical networks / senates. These teams were individually hosted by PCT clusters until NHS England became operational. County Durham PCT and Darlington PCT hosted offender health.

4. Communicating, engaging and listening

A priority during this year has continued to be communicating and managing relationships with stakeholders including the public, service users and carers, staff, clinicians and partners as the PCT moved into the final stages of transition.

During 2012/13 the PCT delivered a range of support to the clinical commissioning groups (CCGs) to ensure they were well placed to communicate and engage with the local communities they now serve and worked with them to develop their communications and engagement strategies in preparation for authorisation.

During a period of extensive NHS transition and change nationally and locally, County Durham PCT continued to work with stakeholders to build understanding and engagement around all aspects of the transition.

The PCT also needed to raise wider public awareness of the changing health landscape and developing health systems, and what this would mean for them. The three CCGs

raised their profiles with the public as new commissioning organisations and encouraged public and patient involvement.

To help build this awareness, the PCT launched a monthly supplement in April 2012 which aimed to give a range of information about current developments in health and social care. Copies of this supplement are at:

http://www.thenorthernecho.co.uk/news/health/focusonhealth/

Patient Advice and Liaison Service (PALS)

PALS at County Durham PCT and Darlington PCT closed on 31 March 2013. This was as a result of the abolition of the PCT with effect from that date, as part of the changes to the NHS.

The PCT PALS team provided advice and support to patients, relatives and the public regarding queries and concerns about local NHS services, particularly in relation to primary care services.

For anyone contacting PALS at the PCT after this date, a recorded message is in place directing callers to alternative sources of support regarding queries, concerns, comments and compliments.

Beyond 31 March 2013, PALS within local NHS provider organisations continue to offer advice and support about NHS trust services. Information about the PALS services in local NHS trusts is available via the PCT's website – www.cdd.nhs.uk – until September 2013.

PALS dealt with 2,227 queries from patients, carers and members of the public during 2012/13 for the County Durham and Darlington cluster.

5. Governance

Cluster Board

The NHS County Durham and Darlington cluster board oversaw and accounted for delivery throughout 2012/13 and supported the development of the new NHS system. These governance arrangements were in place until April 2013.

The cluster board was the vehicle through which the boards for County Durham PCT and Darlington PCT continued to deliver their statutory business. Lady Ann Calman was the Chair of this committee and Ken Greenfield was the Vice Chair. The cluster board oversaw the four new sub committees of the three shadow CCGs (SCCGs) and the shadow commissioning support unit (SCSU).

These sub-committees consisted of an aligned interim director and a NED who chaired the subcommittee. These sub-committees, working alongside local GPs, enabled delegation of a range of PCT cluster board responsibilities to the SCCGs.

* The SCCGs were no longer in shadow form from 1 August 2102. At this point the NEDS who were sub-committee chairs became link NEDs.

County Durham PCT kept its own individual board as a statutory function, and delegated all other business to the cluster board; formerly the joint board. The statutory board met annually to approve its annual report and accounts.

NHS County Durham and Darlington Cluster Board members 1 April 2012 – 31 March 2013	
Lady Ann Calman	Chair
Ken Greenfield	Vice Chair / Durham Dales, Easington and Sedgefield SCCG sub committee Chair / Link NED from 1 August 2012*
Non Executive Directors	
Malcolm Cook	Non Executive Director / SCSU sub-committee Chair
Annie Dolphin	Non Executive Director / North Durham SCCG sub committee Chair / Link NED from 1 August 2012*
John Flook	Non Executive Director / Darlington SCCG sub committee Chair / Link NED from 1 August 2012* / Joint Audit and Risk Chair
Jenny Flynn	Non Executive Director
Bunny Forsyth	Non Executive Director (until 31 October 2012)
Keith Tallintire	Non Executive Director
Chief Executive and Voting Directors	
Yasmin Chaudhry	Joint Chief Executive
Pat Taylor	Joint Director of Finance
Anna Lynch	Director of Public Health, County Durham
Miriam Davidson	Director of Public Health, Darlington
Mike Guy	Medical Director
Pat Keane	Joint Deputy Chief Executive
June Tulley	Director of Commissioning Development and Transition
In attendance (non voting)	
Debbie Edwards	Nurse and Clinical Quality Advisor
Mike Taylor	Shadow CCG Representative North Durham
Stewart Findlay	Shadow CCG Representative Durham Dales, Easington and Sedgefield
Neil O'Brien	Shadow CCG Representative North Durham
Martin Phillips	Shadow CCG Representative Darlington

Cluster Management Executive

The cluster management executive (CME), chaired by the Chief Executive, oversaw all maintenance and delivery of the PCT cluster, the SCCGs and the SCSU throughout 2012/13.

County Durham PCT Statutory Board

The role of the County Durham PCT statutory board was to provide local health leadership and appropriate governance to set standards, establish strategy, determine priorities and review health outcomes. The County Durham PCT statutory board met once during 2012/13 for the annual general meeting.

During 2012/13 the statutory board consisted of the Chair, Chief Executive, seven NEDs and three voting directors.

County Durham PCT Statutory Board Members 2012/13	
Lady Ann Calman	Chair
Non Executive Directors	
Malcolm Cook	Non Executive Director
Annie Dolphin	Non Executive Director
Keith Tallintire	Non Executive Director
John Flook	Non Executive Director / Audit and Risk Committee Chair
Jenny Flynn	Non Executive Director / Chair of Charitable Funds Committee
Bunny Forsyth	Non Executive Director (until 31 October 2012)
Ken Greenfield	Non Executive Director
Chief Executive and Voting Directors	
Yasmin Chaudhry	Joint Chief Executive (joint with NHS Darlington)
Pat Keane	Joint Deputy Chief Executive (joint with NHS Darlington)
Anna Lynch	Director of Public Health, County Durham
Pat Taylor	Joint Director of Finance (joint with NHS Darlington)
Non Voting Directors	
Mike Guy	Medical Director
Mike Taylor	Director of Corporate Affairs
June Tulley	Director of Commissioning Development and Transition
In attendance	
Debbie Edwards	Nurse and Clinical Quality Advisor

6. Our people

Equality and Diversity

The equality delivery system set out County Durham PCT's approach to promoting equality, diversity and human rights for the local population and County Durham PCT staff. The NHS County Durham and Darlington Equality and Diversity Annual Report and equality delivery system stated key priorities for the year.

The PCT worked to ensure that all its HR processes, including the way it recruits staff, were fair and transparent. All Job descriptions and person specifications were in accordance with Equal Opportunities, equity and fairness and all advertisements indicated that NHS County Durham and Darlington was working towards Equal Opportunities. These processes were set out in the Equal Opportunities Policy

The PCT cluster was a two tick (√√) organisation demonstrating a positive attitude towards job applications from disabled people.

Our staff

County Durham PCT employed 367 staff with a full time equivalent (FTE) of 324.60 at March 31 2013. The PCT's gender profile was 71% female and 29% male as at 31 March 2013.

Sickness absence

The table below provides staff sickness absence data for the 12 months to 31 December 2012, showing the total number of FTE staff days lost to sickness absence and the total number of FTE years available, based on the total number of FTE staff members within the PCT. This equates to an average number of days' sickness per FTE member of staff of 5.7 for the 12 months to 31 December 2012:

	2012 Number	2011 Number
Total number of FTE days lost to sickness absence	1,896	2,527
Total staff years	333	380
Average number of days' sickness absence per FTE	5.7	6.7

7. Performance, quality and safety

The quality and safety of care was assured through formal arrangements to routinely monitor clinical quality and safety measures. In addition to quality assurance, there was an increasing emphasis on quality and safety improvement and on patient outcomes.

Performance

Reducing waiting

The PCT's commitment was to at least maintain 90% of admitted and 95% of non-admitted patient pathways being completed within the maximum duration of 18 weeks. Performance was maintained above those levels during 2012/13 and the latest known position as at 31 March 2013 was that there were zero patients waiting over 52 weeks for County Durham PCT.

Healthcare associated infection (HCAI)

Reports were routinely provided to every board meeting outlining progress against the HCAI targets.

- *Clostridium difficile*

The performance position at end of March 2013 (validated data) for County Durham and Darlington NHS Foundation Trust was above the trajectory and has exceeded the maximum for the year. County Durham PCT remained above the year to date trajectory since September 2012 and exceeded the maximum for the year at the end of January 2013.

Choice / Choose and book

The Department of Health (DH) set a national expectation during the roll out of the national programme that 90% of first outpatient bookings should be made via Choose and Book C&B.

Utilisation in March 2013 was 84% for County Durham PCT, compared to 78% for NHS North East and 52% nationally.

Cancer

There are several waiting time targets with regard to receiving cancer treatments. These include a target of 31 days from diagnosis to first treatment and a target of 62 days from urgent GP referral to first treatment.

The cumulative performance for County Durham PCT at the end of March 2013 was above the 85% target at 86.6%.

Health visitors

The PCT Cluster target for 2012/13 was confirmed as 151wte and performance at the end of March 2013 was 156.6 wte.

Complaints

NHS County Durham and Darlington received and handled complaints on behalf of County Durham PCT and Darlington PCT.

In accordance with the NHS complaints regulations the complainants have the choice of complaining direct to the commissioner rather than provider of the service. County Durham PCT then chose to handle and investigate the complaint or pass it to the service provider.

Number of complaints received

During the period from 1 April 2012 to 31 March 2013, there were a total of 208 complaints received across the County Durham and Darlington PCT Cluster. Of these:

26 related to PCT functions/services; 19 were formally investigated and a response sent from the Chief Executive, 3 were withdrawn, 3 passed to CHC appeals process and 1 was outside NHS complaints procedure on the grounds of being out of time.

182 related to NHS providers and were passed to the relevant organisation to handle with the complainants' consent.

Principles of Remedy

In all aspects of their activity, County Durham PCT adhered to the 'principles of remedy' published by the Parliamentary and Health Service Ombudsman in October 2007. Incident and risk procedures ensured that any serious incidents were reported, and lessons learned and applied.

Information Governance and Security

Information governance ensures necessary safeguards for and appropriate use of patient and personal information. Performance was measured using the self-assessment information governance toolkit, which is submitted annually. County Durham PCT achieved the minimum standard of level 2 or above across each of the 36 requirements against the Connecting for Health (CfH) Information Governance Toolkit (version 9).

Emergency Preparedness

County Durham PCT had a major incident plan that was fully compliant with the *NHS Emergency Planning Guidance 2005* and the *Civil Contingencies Act 2004*. The PCT had statutory responsibilities to work with partner agencies to identify risks, warn and inform, exercise and produce business continuity plans.

The PCT contributed to multi agency planning through active participation in the local resilience forum as well as multiagency exercises across a range of scenarios.

8. Our estate and sustainability

In order to deliver a high quality service, the PCT ensured all premises were accessible, well maintained, functional and safe. This work was managed by the estates and facilities team. To achieve this level of service, 2012/13 saw investment in both new and existing buildings.

Two schemes saw completion in 2012:

Pelton - a multi-occupier development including general practices, library, pharmacy and PCT space.

- A number of refurbishment schemes, including those which support the transition to new NHS organisations have been undertaken, have ensured improvements in the quality of the patient environment, energy efficiency and statutory obligations of the organisation.

- St John's Square - a substantial primary care centre to serve the North of the Easington locality. This centre will accommodate two general practices, a pharmacy, and a wide range of outpatient activities and primary care services including the unscheduled care service, x-ray, physiotherapy and talking therapies.

All new building schemes led by the estates and facilities management team adhered to increasingly strict environmental and energy saving requirements.

During 2012/13 the team continued to streamline the estate that County Durham PCT either owned, leased or rented with a view to all staff being based in fewer buildings. This has had a significant impact on energy consumption and business travel.

The PCT also continued to deliver their environmental sustainability strategy.

9. How available resources were used

Operating and financial review

Overview

During the year the PCT worked hard to secure high quality services, making every effort to ensure they used resources economically and with effectiveness and efficiency. The annual accounts demonstrate that once again the PCT was successful in achieving their key statutory and administrative financial duties during the financial year ended 31 March 2013, which reflects the strong financial management within the organisation.

This was the final year of County Durham PCT, ending on 31 March 2013. This was a unique and extremely challenging year for everyone and it was therefore very pleasing to see the achievement of all financial targets once more.

Objectives and performance for the year

Once control totals for the year were agreed with the strategic health authority the PCT's successful management of financial risks and robust financial management ensured that there was no deviation during the year in respect of year end forecasts.

The PCT's successful results in 2012/13 are set out in the table below with further detail included in note 3 of the full annual accounts published alongside this annual report.

Headline results	Target Met?
Revenue surplus of £1,004k against a revenue resource limit of £1,035m	√
Maintain capital spending within overall resource limit (capital resource limit)	√
Ensure cash spending is within the cash limit set	√

Other financial targets and disclosures

In addition to the above statutory duties PCTs have similar responsibilities to other NHS organisations to record performance against the Department of Health's better payment practice code published by the DH and to measure running costs according to definitions provided by the DH.

Compliance with better payment practice code

The PCT was an approved signatory to the prompt payments code. All NHS organisations are required to make payments to their creditors within their contract terms or within 30 days where no terms have been agreed. The target is to pay all valid invoices within this timescale, and performance is monitored during the year.

Improvements continued to be made compared to previous years although the PCT fell a little short of the target of 100%. Details of the performance against the code can be found in note 8.1 of the accompanying annual accounts.

Although this was disappointing, performance must be considered in the context of reduced staff numbers and significant organisational change associated with the closure of the PCT.

Running Costs

Note 5.2 of the annual accounts provides further detail in respect of running costs of the PCT.

Pensions

Details of the accounting for pension liabilities can be found in the accounting policies and pension costs notes in the full set of the PCT accounts (notes 1.12 and 7.4 respectively). Further details of directors' pension benefits can be found on page 30 of this document.

Audit and Risk Committee

A joint audit and risk committee operating across both County Durham PCT and Darlington PCT was in place throughout 2012/13.

The role of chair of the joint audit and risk committee was undertaken by Keith Tallintire up to June 2012 at which point John Flook was appointed as the chair.

Other members of the joint audit and risk committee were:

- Malcolm Cook, Non Executive Director
- Annie Dolphin, Non Executive Director
- Jenny Flynn, Non Executive Director
- Bunny Forsyth, Non Executive Director (until 4 November 2012)
- Ken Greenfield, Non Executive Director
- Keith Tallintire, Non Executive Director

External auditors

Following a procurement process undertaken by the Audit Commission, Mazars LLP were appointed as auditors to the PCT for 2012/13.

The cost of audit services can be found in note 5.1 of the PCTs annual accounts.

The auditors took an annual work plan to the joint audit and risk committee for approval. This confirmed that the audit team are independent of the PCT and also would include any details of non-audit work if applicable. When considering whether the level of non-audit work is appropriate the PCT would consider the composition of the team (and whether any audit team members are involved) and the level of fees.

Directors disclosure of information to Auditors

The statement of directors' responsibilities in respect of the accounts can be found in Appendix 2.

As far as the directors are aware there is no relevant audit information of which the PCT's auditors are unaware and each director has taken all the steps that they ought to have taken as directors, in order to make themselves aware of any relevant audit information and to establish that the PCT's auditors are aware of that information.

Summary

The PCT had an extremely challenging agenda to deliver in 2012/13 as it continued to focus upon securing value for money and improving the health of its population within available resources, whilst also supporting the reform of the health system contained within the Health and Social Care Bill, including the development of emerging CCGs.

It is pleasing to be able to report that this agenda has been successfully delivered and the PCT leaves a stable financial foundation on which to continue the transition to the new NHS commissioning architecture from 1 April.

A copy of the full set of County Durham PCT's annual accounts for 2012/2013 is published alongside this annual report. The financial statements have been prepared in accordance with the *2012/13 Financial Reporting Manual* (FReM) issued by HM Treasury.

Remuneration Report

Remuneration and terms of service committee:
The remuneration and terms of service committee was established to advise the board about pay, other benefits and terms of employment for the Chief Executive and other senior staff. The committee was made up as follows:

Lady Ann Calman	PCT Chair and Chair of Remuneration and Terms of Service Committee
Annie Dolphin OBE	Non-Executive Director
Jenny Flynn MBE	Non-Executive Director
Keith Tallintire	Non-Executive Director
Malcolm Cook	Non-Executive Director
John Flook	Non-Executive Director
Ken Greenfield	Non-Executive Director
Bunny Forsyth	Non-Executive Director (until 4 November 2012)

The policy of the remuneration and terms of service committee on the remuneration of senior managers is to adopt DH guidance and Whitley Council agreements on all aspects of senior managers' pay. There were no variations to this policy within the financial year 2012/2013. Similarly, there were no significant awards made to past senior managers.

The remuneration for senior managers for the financial year was determined in accordance with national policy.

County Durham PCT Senior Officers 2012/13 Declarations of Interests:

Name	Title	Declaration detail
A Calman	Chair	Corporate Trustee of County Durham & Darlington Primary Care Trusts Charitable Fund.
Y Chaudhry	Chief Executive	Corporate Trustee of County Durham & Darlington Primary Care Trusts Charitable Fund; Director of Health Innovation Education Clusters (HIEC) North East.
M Cook	Non Executive Director	Corporate Trustee of County Durham & Darlington Primary Care Trusts Charitable Fund; Appointed Governor Tees Esk & Wear Valley NHS Foundation Trust.
A Dolphin	Non Executive Director	Corporate Trustee of County Durham & Darlington Primary Care Trusts Charitable Fund; Teesdale Area Action Partnership (TAP) forum member.
D Edwards	Board Nurse / Clinical Quality Lead	Corporate Trustee of County Durham & Darlington Primary Care Trusts Charitable Fund.
S Findlay	Chief Clinical Officer Designate – DDES CCG	Chair, Durham Dales Clinical Group; Chair, Durham Dales Executive Board; Chair, Durham Dales Stakeholder Group;

		GP, Bishopgate Medical centre and at present involved in running the Durham Dales PMS Practice and Evenwood Surgery; Acted in an advisory capacity to the pharmaceutical industry. Drug companies worked for include: Astra Zeneca, GSK, MSD, Schering Plough, Boehringer Ingleheim, Sanofi-Aventis, Sanofi-Pasteur, Otsuka Pfizer, Jannsen Cilag; LMC member; NHS Alliance lead for clinical commissioning in the North East; NHS alliance lead for cardiovascular disease; Bishopgate also provides a GP clinical tutor and appraisal lead within the Durham Dales area (Dr Bowron); Bishopgate Medical Centre also provide occupational health for Cummins (Serco), Health Sure (Serco), Health Management, Norwich Union, Sunlight Services, Healthcare connexions, OCCHEA, Connought Compliances, Nexus, TMD Friction; Corporate Trustee of County Durham & Darlington Primary Care Trusts Charitable Fund.
J Flook	Non Executive Director	Senior Non-Executive Director, NHS Professionals Ltd; Governor, Hummersknott School and Language College; Member of the General Pharmaceutical Council; Independent Member of the Governance, Audit & Risk Committee of Sport England; Corporate Trustee of County Durham & Darlington Primary Care Trusts Charitable Fund.
J Flynn	Non Executive Director	Corporate Trustee of County Durham & Darlington Primary Care Trusts Charitable Fund; Director and Company Secretary of Tow Law Community Association; Trustee of Durham Rural Community Council.
R Forsyth	Non Executive Director	Regional Clinical Director North East, Castlebeck (independent sector healthcare provider); Corporate Trustee of County Durham & Darlington Primary Care Trusts Charitable Fund.
K Greenfield	Vice Chair / Non Executive Director	Chair of GP School Northern Deanery; Corporate Trustee of County Durham & Darlington Primary Care Trusts Charitable Fund.
M Guy	Medical Director	Spouse is an independent member of Northumbria Police Authority; Spouse is a Non Executive Director of Northumbria Probation Trust; Medical Director for NHS North of Tyne; Corporate Trustee of County Durham & Darlington Primary Care Trusts Charitable Fund.
P Keane	Deputy Chief Executive	Corporate Trustee of County Durham & Darlington Primary Care Trusts Charitable Fund
A Lynch	Director of Public Health	Corporate Trustee of County Durham & Darlington Primary Care Trusts Charitable Fund; Chair of East Durham Domestic Abuse Forum; Trustee East Durham Trust.

N O'Brien	Chief Clinical Officer Designate – North Durham CCG	Corporate Trustee of County Durham & Darlington Primary Care Trusts Charitable Fund; GP partner at Cestria, which also provides intermediate level services in ENT, Dermatology, Minor Surgery and Palpitations.
K Tallintire	Non Executive Director	Corporate Trustee of County Durham & Darlington Primary Care Trusts Charitable Fund; Director of: Derwentside Homes Ltd; Prince Bishops Homes Ltd; Prince Bishops Community Bank; Derwentside Enterprise Agency; Lanchester Community Investment Company; Social Housing Enterprise Durham Ltd; KT Financial Services Ltd; Spouse partner, Aileen Tallintire Solicitors.
M Taylor	Interim Chief Operating Officer - North Durham CCG	Corporate Trustee of County Durham & Darlington Primary Care Trusts Charitable Fund.
P Taylor	Director of Finance	Corporate Trustee of County Durham & Darlington Primary Care Trusts Charitable Fund; PCT Governor of Newcastle upon Tyne Hospitals NHS Foundation Trust.
J Tulley	Director of Commissioning Development	Corporate Trustee of County Durham & Darlington Primary Care Trusts Charitable Fund.

County Durham Primary Care Trust Senior Officers Salaries & Allowances 2012/13:

Name	Title	2012/13			2011/12		
		Salary (Bands of £5000) £000	Other Remuneration (Bands of £5000) £000	Benefits in kind (Rounded to the nearest £00) £00	Salary (Bands of £5000) £000	Other Remuneration (Bands of £5000) £000	Benefits in kind (Rounded to the nearest £00) £00
Y Chaudhry	Chief Executive	80 - 85	330 - 335		80 - 85	0 - 5	
P Taylor	Director of Finance	55 - 60	260 - 265	71	55 - 60		72
P Keane	Deputy Chief Executive	55 - 60	220 - 225	74	55 - 60		75
A Lynch	Director of Public Health	100 - 105		26	100 - 105		25
M Guy	Medical Director	40 - 45			40 - 45		
J Tulley	Director of Commissioning Development	85 - 90	10 - 15	55	85 - 90		81
D Edwards	Board Nurse / Clinical Quality Lead	85 - 90	175 - 180		80 - 85		
M Taylor	Interim Chief Operating Officer – North Durham CCG (until 30 October 2012)	55 - 60		34	95 - 100		42
N O'Brien	Chief Clinical Officer Designate – North Durham CCG (from 1 November 2012)	35 - 40					
S Findlay	Chief Clinical Officer Designate – DDES CCG (from 1 April 2012)	160 - 165					
A Hume	Interim Director for CSU (until 31 March 2012)				100 - 105		107
D Gallagher	Interim Chief Operating Officer – DDES SCCG (until 31 March 2012)				100 - 105		56
A Calman	Chair	35 - 40			35 - 40		
M Cook	Non Executive Director	15 - 20			5 - 10		
A Dolphin	Non Executive Director	20 - 25			5 - 10		
J Flook	Non Executive Director (from 21 July 2011)						
J Flynn	Non Executive Director	10 - 15			5 - 10		
R Forsyth	Non Executive Director (from 1 December 2011 until 4 November 2012)						
K Greenfield	Non Executive Director (from 1 December 2011)						
K Tallintire	Non Executive Director	10 - 15			10 - 15		

Notes:

The following senior officers were Joint posts shared with Darlington PCT, amounts disclosed above are the total costs apportioned and recharged to the PCT. As these were joint posts, total costs were apportioned on a 50:50 basis between County Durham PCT and Darlington PCT. The full value of remuneration earned by each individual for their roles with both County Durham PCT and Darlington PCT are shown below:

Name	Title	2012/13			2011/12		
		Salary (Bands of £5000) £000	Other Remuneration (Bands of £5000) £000	Benefits in kind (Rounded to the nearest £00) £00	Salary (Bands of £5000) £000	Other Remuneration (Bands of £5000) £000	Benefits in kind (Rounded to the nearest £00) £00
Y Chaudhry	Chief Executive	160 - 165	330 - 335		160 - 165	5 - 10	
P Taylor	Director of Finance	115 - 120	260 - 265	71	115 - 120		72
P Keane	Deputy Chief Executive	110 - 115	220 - 225	74	110 - 115		75

The following Senior Officers became joint posts with Darlington PCT during 2011/12. It is not considered practical to apportion their costs between both PCTs and on the basis of materiality, the full costs for these individuals have been charged to County Durham PCT, both in 2011/12 and 2012/13 which is reflected in the amounts disclosed above.

A Calman	Chair	Joint post with Darlington PCT from 1 December 2011
M Cook	Non Executive Director	Joint post with Darlington PCT from 21 July 2011
A Dolphin	Non Executive Director	Joint post with Darlington PCT from 21 July 2011
J Flynn	Non Executive Director	Joint post with Darlington PCT from 1 December 2011
K Tallintire	Non Executive Director	Joint post with Darlington PCT from 21 July 2011

The following individuals were previously senior officers of Darlington PCT only but became joint posts with County Durham PCT during 2011/12. It is not considered practical to apportion their costs between both PCTs and on the basis of materiality, the full costs for these individuals have been charged to Darlington PCT, hence no costs are included in the amounts disclosed above. The total value of remuneration charged to Darlington PCT in both 2011/12 and 2012/13 in respect of these individuals is included in the table below:

Name	Title	2012/13			2011/12		
		Salary (Bands of £5000) £000	Other Remuneration (Bands of £5000) £000	Benefits in kind (Rounded to the nearest £00) £00	Salary (Bands of £5000) £000	Other Remuneration (Bands of £5000) £000	Benefits in kind (Rounded to the nearest £00) £00
J Flook	Non Executive Director (from 21 July 2011)	15 - 20			10 - 15		
R Forsyth	Non Executive Director (from 1 December 2011 until 4 November 2012)	5 - 10			5 - 10		
K Greenfield	Non Executive Director (from 1 December 2011)	30 - 35			30 - 35		

The following senior officers were made redundant on 31 March 2013 following the closure of the PCT and the related redundancy settlements are reflected in the 2012/13 other remuneration figures above:

Y Chaudhry	Chief Executive
P Taylor	Director of Finance
P Keane	Deputy Chief Executive
D Edwards	Board Nurse / Clinical Quality Lead

The full redundancy settlement for all joint posts shared with Darlington PCT has been reflected in County Durham PCT as the employing organisation.

The following Senior Officer agreed a voluntary redundancy arrangement in 2010/11, which was reflected in the 2010/11 Remuneration Report, but only left the organisation on 31 March 2013. The additional redundancy cost in excess of the amount previously recognised in 2010/11 is included in the 2012/13 other remuneration figures above.

J Tulley Director of Commissioning Development

Pay Multiples:

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

The banded remuneration of the highest paid director in County Durham PCT in the financial year 2012/13 was £160 – 165k (2011/12: £110 - 115k). This was 5.3 times (2011/12: 3.5 times) the median remuneration of the workforce, which was £30,460 (2011/12: £32,573).

In 2012/13, no (2011/12: seven) employees received a full time equivalent remuneration in excess of the highest paid director. Full time equivalent remuneration for employees ranged from £7,822 to £186,020 (2011/12: £8,085 to £172,720).

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include employer pension contributions and the cash equivalent transfer value of pensions. Severance payments have been excluded from the calculation of the highest paid director's total remuneration.

	2012/13	**2011/12**
Band of Highest Paid Director's Total Remuneration (£'000)	160 – 165	110 – 115
Median Total Remuneration (£)	30,460	32,573
Ratio	5.3	3.5

The increase in the highest paid director's total remuneration in 2012/13 reflects the appointment of an individual into a new post relating to the Durham Dales, Easington and Sedgefield clinical commissioning group with effect from 1 April 2012.

County Durham Primary Care Trust Senior Officers Pension Benefits 2012/13:

Name and Title	Real increase / (reduction) in pension at age 60 (bands of £2500)	Real increase / (reduction) in Pension Lump Sum at aged 60 (bands of £2500)	Total accrued pension at age 60 at 31 March 2013 (bands of £5000)	Lump Sum at aged 60 related to accrued pension at 31 March 2013 (bands of £5000)	Cash Equivalent Transfer Value at 31 March 2012	Cash Equivalent Transfer Value at 31 March 2013	Real increase in cash equivalent transfer value
	£000	£000	£000	£000	£000	£000	£000
Y Chaudhry Chief Executive	(0 - 2.5)	(2.5 - 5.0)	70 - 75	215 - 220	1,416	1,426	10
P Taylor Director of Finance	(0 - 2.5)	(0 - 2.5)	35 - 40	115 - 120	719	731	12
P Keane Deputy Chief Executive	(0 - 2.5)	(2.5 - 5.0)	50 - 55	160 - 165	1,150	1,154	4
A Lynch Director of Public Health	0 - 2.5	0 - 2.5	20 - 25	65 - 70	539	0	(539)
J Tulley Director of Commissioning Development	0 - 2.5	0 - 2.5	30 - 35	90 - 95	639	663	24
D Edwards Board Nurse / Clinical Quality Lead	0 - 2.5	2.5 - 5.0	30 - 35	100 - 105	561	595	34
M Taylor Interim Chief Operating Officer – North Durham CCG	0 - 2.5	0 - 2.5	25 - 30	85 - 90	609	627	18
S Findlay Chief Clinical Officer (Designate) – DDES CCG	0 - 2.5	2.5 - 5.0	80 - 85	240 – 245	1,704	1,785	81
N O'Brien Chief Clinical Officer (Designate) – North Durham CCG	2.5 – 5.0	7.5 – 10.0	25 - 30	75 - 80	306	352	46

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 benefit accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV 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 Cash Equivalent Transfer Values

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.

Performance

Continuation of employment, under the Chief Executive and Directors' contracts of employment, is subject to satisfactory performance. Performance in post and progress in achieving set objectives is reviewed annually. There were no individual performance review payments made to the Chief Executive or Directors during the year and there are no plans to make such payments in future years outwith the *Very Senior Management Pay Framework*. This is in accordance with standard NHS terms and conditions of service and guidance issued by the DH.

Contracts of employment in relation to the Chief Executive, directors and senior managers are permanent in nature and subject to six months notice of termination by either party. Termination payments are limited to those laid down in statute and those provided for within NHS terms and conditions of service and under the *NHS Pension Scheme Regulations* for those who are members of the scheme.

County Durham Primary Care Trust Exit Packages

Details of the exit packages agreed by the PCT during the year can be found in note 7.3 of the PCT's annual accounts.

Review of Tax Arrangements of Public Sector Appointees

In accordance with the Treasury published PES (2012)17 *Annual Reporting Guidance 2012/13*, the PCT is required to disclose information about "off-payroll engagements".

There were no off payroll engagements at a cost of over £58,200 per annum that were in place as of 31 January 2012, nor were there any new off-payroll engagements between 23 August 2012 and 31 March 2013 for more than £220 per day and more than six months.

APPENDIX 1

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

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

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

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

Signed.....Designated Signing Officer

Name Cameron Ward

Date 07 June 2013

APPENDIX 2

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.

07 June 2013 Date.....Signing Officer

07 June 2013 Date .....Finance Signing Officer

APPENDIX 3

Annual Governance Statement 2012/2013

Annual Governance Statement 2012/2013

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1	County Durham

1.1 County Durham Primary Care Trust 5ND

2	Scope of responsibility

The Statutory Board was accountable for internal control. The Accountable Officer and Chief Executive of this Board had responsibility for maintaining a sound system of internal control that supported the achievement of the organisation's policies, aims and objectives. The Statutory Board also had responsibility for safeguarding the public funds and the organisation's assets for which they were responsible as set out in the Accountable Officer Memorandum.

The Accountable Officer and Chief Executive was accountable to the Statutory Board and exercised their responsibilities for internal control through:

- the setting of a risk management strategy with the Statutory Board. This provided a framework and direction within which internal controls were exercised and developed,
- the cluster board (CB) was delegated powers from the statutory board, which includes being responsible for ensuring that high standards of integrated governance and personal behaviour were maintained in the conduct of the business of the whole organisation,
- chairing the Cluster Management Executive (CME) and the Transition Management Executive (TME), which reported to the CB, and managed day to day activity,
- the scrutiny role of the Joint Audit and Risk Committee (JARC), which reported to the Statutory Board and
- the independent assurance given by internal and external audit, which reported to the JARC.

In addition to accountability to the Statutory Board, the Accountable Officer and Chief Executive was also accountable to the Department of Health for the effectiveness of the system of internal control. This accountability was exercised through NHS North of England. NHS North of England undertakes performance management of the system of internal control duly advised by internal auditors.

At the end of January 2013, as part of the reforms specified in the *Health and Social Care Act 2012,* the Chief Executive of the PCT, Yasmin Chaudhry, passed responsibility as accountable officer to me, as Area Team Director - Durham, Darlington and Tees at NHS Commissioning Board (now NHS England), whilst retaining her position as Chief Executive of the PCT.

During the year, the Chief Executive of the PCT attended monthly meetings with the SHA Chief Executive and other primary care organisation chief executives within the SHA area. She was also a member of the Chief Officers Group which comprises the senior leaders of public sector partners in County Durham, who work together to improve health and health gain, amongst other things, of the County Durham population.

3	The Governance framework of the organisation

The Health and Social Care Act 2012 established and made provision for the setting up of the National Health Service Commissioning Board and Clinical Commissioning Groups whose responsibility it will be to develop, manage and evaluate processes for the commissioning of health care for the population of the United Kingdom. The Act is the culmination of the proposals outlined in *Equity and Excellence: Liberating the NHS (July 2010)*, and provides specific direction on the abolition of Strategic Heath Authorities (SHAs) and Primary Care Trusts (PCTs). The timeline for the completion of this change was set at 2013, with both SHAs and PCTs being disestablished in April 2013. The Act also makes provision for the transfer of public health commissioning and associated functions into the local authorities with which the PCTs were co-terminous. As a proactive NHS organisation we felt it was timely to review our governance arrangements in light of the emerging transition environment.

As a statutory body, the PCT's functions, powers and duties were set out in legislation. In order that the statutory organisation continued to carry out its statutory obligations whilst in transition to the new commissioning arrangements, a review of the PCT's Standing Orders, Standing Financial Instructions and Reservation and Delegation of Powers was undertaken to ensure currency and accuracy. The cluster management executive (CME) became the transition management executive (TME) in June 2012 in order to have a more detailed focus on phase 1 of the transition process. The TME reverted to being the CME in September 2012. Figure 1 (below) shows the structure of the board committees.

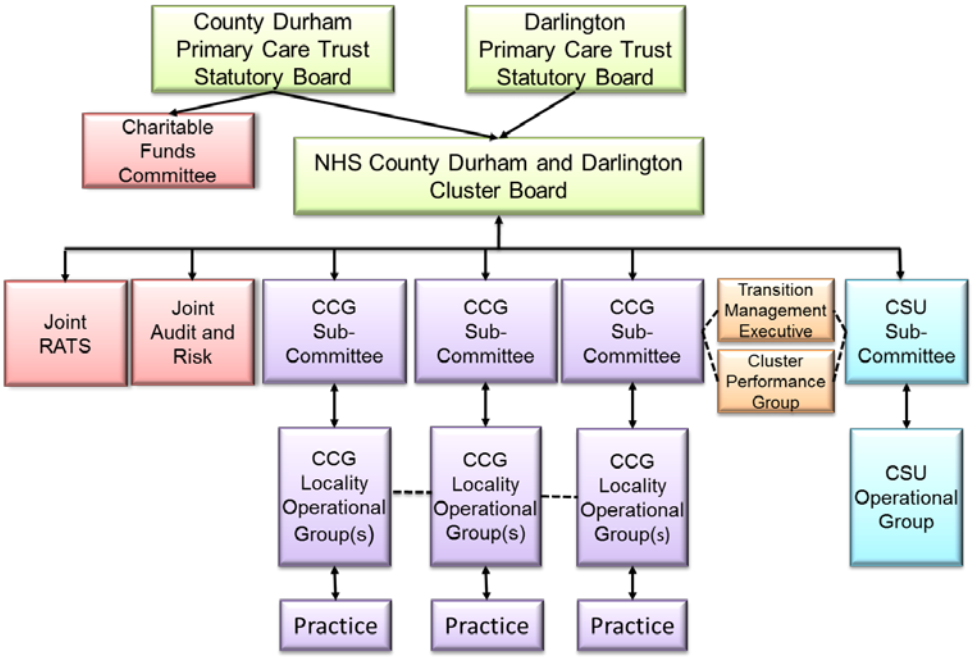


Figure 1.

Across this comprehensive range of board committees/groups within the organisation, a

variety of opportunities and challenges were reviewed and escalated drawing together position statements and providing evidence on governance, risk management and control providing a coherent and consistent reporting mechanism. Board committees and sub-committees worked to a standard agenda - Strategy, Delivery and Transition.

The three CCG sub-committees were established to deliver specific, delegated commissioning functions of the PCTs.

The CSU sub-committee oversaw the development and delivery of an affordable and viable commissioning support service. The principle purpose of this sub-committee was to deliver functions that were delegated to it in relation to commissioning support.

The TME was established to support the CB in acting as a transition vehicle as outlined in the shared operating model for PCT clusters to:

- oversee and account for delivery; and
- support the development of the new system.

The Cluster Performance Group was established as a sub group of the TME, to oversee the performance management of the PCT cluster transition environment.

The Joint Audit and Risk committee (JARC) oversaw all elements of governance, risk management and internal control. The committee reviewed the strategic processes and systems of governance (including quality and patient safety), risk management and internal control across each statutory PCT activity, supporting achievement of the corporate objectives. It was also responsible for ensuring that appropriate systems and processes were in place to maintain the accuracy and quality of the annual accounts in preparation for final sign-off in June 2013. An audit sub committee of the Department of Health's own Audit and Risk Committee has now been established, made up of former PCT non-executive directors, in order to review the annual accounts, along with this governance statement, prior to signing by the Accountable Officer. This audit sub committee will provide an assurance mechanism to the Accountable Officer of the NHS on the quality of the annual accounts, annual report and governance statement of the PCT.

The Remuneration and Terms of Service (RATS) Committee and Charitable Funds Committee terms of reference were amended to reflect changes in creating the CB.

The Governance Risk and Assurance Group (GRAG) was an operational group that supported the governance, risk and assurance agenda, acting in accordance with Connecting for Health's Information Governance Toolkit requirements and to comply with the Statement of Compliance. As an integral part of the governance agenda, the group also supported and drove the broader Information Governance issues and provided the TME with the assurance that effective Information Governance best practice mechanisms were in place within the organisation.

In order to meet the reform timescale set out in the Act, a number of work streams were established to manage the transition of commissioning functions from the PCTs to the new

statutory commissioning bodies. The work streams addressed:

- Corporate and Human Resources;
- Workforce Development;
- Provider Development and Outcome and Quality;
- Health and Wellbeing and Public Health; and
- Commissioning Development

Governance of the work streams has been through the provision of assurance to the CME/TME and CB on progress, with each work stream having its own detailed risk management process. All serious (red) risks were also recorded on the corporate risk register.

Working to the guidance set out in *Handover and Closedown Guidance -Transfer documentation: identifying legal title in assets and liabilities and completing transfer documentation (2012)* and *Handover and Closedown Guidance - Transfer of Intellectual Property Rights and related Assets (2012)* published by the DH, a detailed draft transfer scheme document has been developed which will inform the DH legal team in their development of the final transfer schemes for sender and receiver organisations. The development of this documentation has been reviewed by the PCT's solicitors to ensure compliance with the DH guidelines.

The work programme of the Board has involved a full refresh of the vision and strategy for the PCT, encapsulated in the ISOP and the balanced revenue and capital budgets set for the year. The Board has monitored performance against all operating framework targets and statutory duties, agreeing action as needed throughout the year. They have received reports from management and all sub-committees in support of this work. The board has led significant work on the changes needed to the governance and assurance framework to support the delivery of the transition to the new system. A key piece of work involved leading the consultation on proposed changes to stroke services within County Durham and Darlington NHS Foundation Trust (CDDFT).

Attendance records are kept for the Board and all its sub-committees. These are available for review, and confirm that throughout the year there has been good attendance at all meetings.

4	**Risk assessment**

4.1 Risk management assessment is an integral part of good management practice and to be most effective must become part of the organisation's culture. The statutory board was therefore committed to ensuring that risk management formed an integral part of corporate philosophy, practices and business plans rather than being viewed or practiced as a separate programme, and that responsibility for implementation was accepted at all levels of the organisation.

The risk management strategy and operational policy described how risks were identified and

evaluated in a structured way. A risk grading matrix was used to quantify identified risks within all directorates and commissioning activities. Key risks were identified, consistent criteria are used to evaluate risks and ownership of risk was identified at a level with sufficient authority to assign appropriate resources to implement control measures. There was a definition of the acceptable level of exposure in relation to risk. Action plans were developed with clear timescales in relation to the risks identified.

A key corporate risk in year related to the maintenance of "grip" throughout the period of transition. In addition new corporate risks were addressed by the Board including:

- Management of poor performers by NEPSCA.
- Contract stocktake exercise.
- Retrospective assessment of eligibility for NHS Continuing Healthcare and reimbursement of costs.
- Achievement of breast feeding 6-8 weeks targets for 2011/12 and 2012/2013 for County Durham.
- Performance monitoring of NHS Health Checks programme.
- School nursing contract with CDDFT.
- Funds available for 2012/13 County Durham Alcohol Service.
- Stabilisation of Public Health contracts.
- Achievement of national priority indicators for cancer urgent referral to treatment waiting times.
- EMIS GP Clinical System; Concerns regarding the Web upgrade in relation to system functionality and readiness/fitness for use.
- Target for Category A 8 min response for urgent ambulance by the North East Ambulance Service (NEAS).
- Acute Oncology in CDDFT.

A series of review meetings were held involving PCT cluster risk leads, to determine future accountable organisations for each risk. This information was then shared with CCG risk leads, who agreed which risks should be transferred to their individual registers. All risks have been transferred to either NHS North Durham CCG, or NHS Durham Dales, Easington and Sedgefield CCG.

Other accountable organisations including Public Health England and Durham County Council had not agreed arrangements for the transfer of risks at 31 March 2013, however mechanisms were in place to achieve this as part of the final PCT transition work. All risks have continued to be managed appropriately by the PCT until 31 March 2013.

4.2 There has been a continuous focus on implementing the information risk management and assurance framework. There was an Information Risk Policy, which formally linked to the risk management arrangements and assigned information assets to asset owners, who 'owned' and provided assurance to the senior information risk officer (SIRO) on the security and use of those assets. Training was provided to the SIRO and the information asset owners to ensure they were fully aware of their responsibilities and were competent to identify and assess information governance risks. The action plan to reduce the risks arising from the use of patient identifiable data by secondary users in accordance with Department of Health guidance and the Data Protection Act (1988) was implemented.

We had one serious incident involving a breach of patient confidentiality reported during 2012/13 as per organisational policy. The incident was recorded as a level 1 IG serious incident and a full investigation was carried out employing root cause analysis methodology. There were no patient care problems identified. The findings were fully reviewed, a robust action plan developed and the lessons learned were shared across the organisation.

County Durham PCT used the *Department of Health Information Governance Tool Kit* to review the risk and control framework for information and data. Internal awareness campaigns were held to ensure that all staff were aware of their individual and departmental responsibilities for protecting data, both in electronic and paper format. A review of information governance policies was undertaken to ensure current guidance is available to support staff in their role of protecting information. The information risk and data security framework and associated policies were assessed against the requirements of the IG Tool Kit and found to be compliant and met the requirements for 2012/13 in accordance with the *NHS Annual Operating Framework*.

By 31 March 2013 NHS County Durham and Darlington (NHSCDD) published with NHS Connecting for Health an Information Governance Toolkit (IGT) achieving full level two compliance scoring 82%. By achieving compliance with the IG toolkit NHSCDD was able to measure compliance against the law and central guidance and to ensure information was handled correctly and protected from unauthorised access, loss, damage and destruction. Our ultimate aim was to demonstrate that the organisation could be trusted to maintain the confidentiality and security of personal information. This in-turn increased public confidence that 'the NHS' and its partners can be trusted with personal data.

5	**Risk and control framework**

The risk management policy and strategy contributed to the overall vision and strategic aims of the organisation and supported organisational assurance. The risk management policy was an integrated process by which the organisation systematically applied procedures to the task of identifying and assessing risk, and then planning and implementing risk responses. The risk management strategy set out the management and committee structure as well as responsibilities for risk management and patient safety.

A corporate risk register was the repository for all identified risks facing the organisation. It provided a means to quantify, prioritise and manage risks. The risk register comprised:

- strategic risks derived from corporate objectives within the assurance framework,
- risks related to key performance targets, clinical and patient safety issues, commissioning of services, highlighted at the CME/TME or by directorates,
- risks related to organisational change,
- a director assigned as owner of each corporate risk with responsibility for review, escalation and on-going management,

- actions arising from reviews by external and internal audit,
- actions arising from assessments by external bodies e.g. Care Quality Commission,
- health and safety risks and action plans.

The Governance, Risk and Assurance Group (GRAG) and CME/TME reviewed the corporate risk register on a regular basis which included the regrading of risk and progress against actions.

The JARC reviewed the strategic processes and systems of governance (including quality and patient safety), risk management and internal control across the whole of each organisation's activity that supported the achievement of the corporate objectives.

In particular, the JARC reviewed the adequacy of:

- the strategic process for risk, control and governance and related disclosure statements, e.g. the Annual Governance Statement and declarations of compliance, together with any accompanying head of internal audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the CB or statutory board and the accountable officer,
- the underlying assurance processes that indicated the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements,
- the organisation's strategic policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements,
- the corporate risk register and systems and processes for the management of strategic risk,
- the policies and procedures related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Protect, the Counter Fraud Service,
- the emerging audit and risk arrangements being proposed by the CCGs to ensure they meet the requirements for authorisation by March 2013.

In carrying out this work the JARC utilised primarily the work of internal audit, external audit and other assurance functions, but was not limited to these audit functions. Reports and assurances, as appropriate to the over-arching systems of governance, risk management and internal control, were obtained from CME/TME functions together with indicators of their effectiveness. This work and that of the audit and assurance functions that reported to it are evidenced through the use of an effective assurance and risk framework.

The JARC ensured that there was an effective internal audit function that met mandatory NHS Internal Audit Standards and provided appropriate independent assurance to the JARC, Joint Chief Executive, the CB and statutory board. The JARC reviewed the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation. These included, but were not limited to, any reviews by Department of Health arms-length bodies or regulators (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

6	Review of the effectiveness of risk management and internal control

6.1 The risk management framework and processes were applied to business planning, the annual operational plan, project plans, performance framework and commissioning arrangements. This approach ensured that risk management was embedded within key activities and integrated into everyday practice. A simple demonstration of this is the requirement for all board, sub-committee and management executive papers to include a clear indication that the paper's impact has been considered against an agreed list of issues, that include legal duties, delivery of the strategic objectives and national policy requirements.

Under the risk management process, overseen by the JARC, issues were regularly reported to the GRAG, CME/TME and CB. The risk management arrangements and processes were applied to the on-going self-assessment against the requirements of external assessments. In addition, to ensure effective leadership, director objectives were mapped to the organisation's strategic objectives.

A number of sub-groups supported the delivery of the CME/TME delegated responsibilities. These also supported cross functional-working and engagement with clinicians, clinical commissioners and staff.

The CME/TME had responsibility to oversee the effective management and implementation of all risk management processes. The Joint Director of Finance had delegated responsibility to lead the implementation of risk management and was the board level SIRO.

A number of specialists provided risk management advice and guidance to the organisation in addition to continuous testing and reporting on the main financial and IM&T systems by internal audit.

The CB was committed to the ethos that responsibility for the implementation of risk management was accepted at all levels of the organisation. The provision of appropriate training was central to the achievement of successful risk management. A mandatory risk management training programme was in place for staff relevant to their area of work or professional role within the organisation. This included an induction process for new employees. Guidance on the implementation of the risk management strategy and processes was provided to heads of department and managers.

6.2 Performance and assurance in the transition environment - The PCT Cluster Performance and Assurance Framework supported the reporting relationships and escalation routes connected with the performance and assurance framework during the year and set out the arrangements for the PCT to oversee and account for delivering its legal, financial and performance responsibilities as described in the shared operating model for PCT clusters (DH, July 2011); and the NHS Operating Framework for England for 2012/13 (DH, November 2011). The framework outlined the themes from the shared operating model and the operating framework and was agreed by the accountable leads for ensuring delivery with agreed reporting arrangements. The majority of reports were delivered by the Commissioning

Support Unit (CSU).

The PCT cluster held the CSU's portfolio leads and director to account for the functions they undertook to deliver the outcomes aligned to the themes in the framework. Where the CSU undertook functions on behalf of CCGs, as their customers, it was the CCGs who owned any risks associated with delivery.

6.3 Cluster governance and risk management of the ISOP 2011/12 – 2014/15. The NHSCDD ISOP had an agreed governance route as part of the sign off process with on-going monitoring of individual areas within the plan being overseen by the Cluster Oversight Group (COG). The COG had delegated duties and was therefore responsible for the risk management of implementation plans for all relevant areas.

The organisation encouraged a transparent culture through compliance with the Freedom of Information Act (2000) and had a publication scheme. An annual general meeting was held in public and minutes of meetings of the CB are available on request by the public and through the website.

6.4 The system of internal control was 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 was based on an on-going process designed to:

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

The system of internal control was in place in CDPCT for the year ended 31 March 2013 and up to the date of approval of the annual report and accounts. I have received a Head of Internal Audit opinion with significant assurance in respect of the system of internal control.

7	Significant issues

In 2012/13 CDPCT failed to achieve 2 key operational targets, Clostridium Difficile cases and Category A Ambulance response times.

7.1 Clostridium Difficile

Our position at 31 March 2013 was 177 cases against a trajectory of 154. The PCT's performance against this key national target was reported each month at CME/TME and CB. Concern was expressed part way through the year on the deliverability of this target, and as a result it was escalated internally, in line with our performance framework. The PCT worked with partner trusts to review every case, employing root cause analysis. Action plans were monitored through the clinical quality and infection control routes. This matter was escalated

by the North East SHA at regular performance review meetings. Every effort continues to be made to minimise the number of cases.

7.2 Category A Ambulance response times

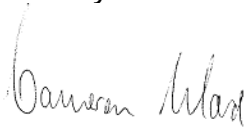
Our position at the end of March 2013 was 65.63% responses within 8 minutes against a local target of 71%. Ambulance performance was reported and discussed each month at the CME/TME and CB. We escalated performance issues through the host commissioning PCT, which resulted in us working directly with our ambulance providers. The Board and CCGs were fully briefed on the impact of our rural geography in County Durham and we continued to explore alternatives to support an appropriate safe, effective and timely response to emergency calls. This issue was escalated by the North East SHA at our regular performance review meetings.

7.3 Summary

There are no other significant issues to report.

8	**Accountable Officer: Cameron Ward**

Organisation: County Durham PCT

Signed: 

Date: 07 June 2013

Department of Health

NHS

County Durham Primary Care Trust

2012-13 Accounts

Published to gov.uk, in PDF format only.

www.gov.uk/dh

County Durham Primary Care Trust

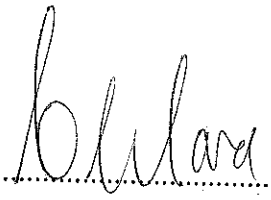
2012-13 Accounts

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

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

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

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

Signed.....  .....Designated Signing Officer

Name: Cameron Ward

Date: 7 June 2013

INDEPENDENT AUDITORS' REPORT TO THE ACCOUNTABLE OFFICER FOR COUNTY DURHAM PRIMARY CARE TRUST

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

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

- the table of salaries and allowances of senior managers and related narrative notes;
- the table of pension benefits of senior managers and related narrative notes; and
- the table of pay multiples and related narrative notes.

This report is made solely to the Accountable Officer for County Durham PCT in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

Respective responsibilities of the Signing Officer and Finance Signing Officer, and auditors

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

Scope of the audit of the financial statements

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

In addition, we are required to obtain evidence sufficient to give reasonable assurance that the expenditure and income reported in the financial statements have

been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of County Durham PCT as at 31 March 2013 and of its net operating costs for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters

In our opinion:

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

Matters on which we report by exception

We report to you if:

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

We have nothing to report in these respects

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

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

We have undertaken our audit in accordance with the Code of Audit Practice, 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 PCT; and
- our locally determined risk-based work on transition.

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

Certificate

We certify that we have completed the audit of the accounts of County Durham PCT in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Signed:  Date: 7 June 2013

Cameron Waddell CPFA, Engagement Lead, for and on behalf of Mazars LLP
Chartered Accountants
Rivergreen Centre, Aykley Heads, Durham, DH1 5TS

STATEMENT OF COMPREHENSIVE NET EXPENDITURE FOR THE YEAR ENDED 31 March 2013

	NOTE	2012/13 £000	2011/12 £000
Administration Costs and Programme Expenditure			
Gross employee benefits	7.1	18,186	16,265
Other costs	5.1	1,047,369	1,032,040
Income	4	(32,027)	(41,841)
Net operating costs before interest		**1,033,528**	**1,006,464**
Investment income	9	(120)	(34)
Other (Gains) / Losses	10	0	0
Finance costs	11	103	2,307
Net operating costs for the financial year		**1,033,511**	**1,008,737**
Of which:			
Administration Costs			
Gross employee benefits	7.1	13,861	13,552
Other costs	5.1	11,400	14,214
Income	4	(3,625)	(5,456)
Net administration costs before interest		**21,636**	**22,310**
Investment income	9	(120)	(34)
Other (Gains) / Losses	10	0	0
Finance costs	11	1	0
Net administration costs for the financial year		**21,517**	**22,276**
Programme Expenditure			
Gross employee benefits	7.1	4,325	2,713
Other costs	5.1	1,035,969	1,017,826
Income	4	(28,402)	(36,385)
Net programme expenditure before interest		**1,011,892**	**984,154**
Investment income	9	0	0
Other (Gains) / Losses	10	0	0
Finance costs	11	102	2,307
Net programme expenditure for the financial year		**1,011,994**	**986,461**
Other Comprehensive Net Expenditure			
Impairments and reversals charged to the revaluation reserve		409	371
Net gain on revaluation of property, plant & equipment		(26)	(80)
Total comprehensive net expenditure for the year		**1,033,894**	**1,009,028**

The notes on pages 5 to 40 form part of this account.

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	12	59,910	51,861
Intangible assets	13	271	258
Other financial assets	19	423	423
Total non-current assets		**60,604**	**52,542**
Current assets:			
Trade and other receivables	17	9,707	22,925
Cash and cash equivalents	20	2	8
Total current assets		**9,709**	**22,933**
Non-current assets held for sale	21	0	0
Total current assets		**9,709**	**22,933**
Total assets		**70,313**	**75,475**
Current liabilities			
Trade and other payables	22	(52,120)	(59,548)
Provisions	25	(9,863)	(4,351)
Borrowings	23	(3,322)	(2,612)
Total current liabilities		**(65,305)**	**(66,511)**
Non-current assets plus/less net current assets/liabilities		**5,008**	**8,964**
Non-current liabilities			
Borrowings	23	(32,072)	(26,830)
Total non-current liabilities		**(32,072)**	**(26,830)**
Total Assets Employed:		**(27,064)**	**(17,866)**
Financed by taxpayers' equity:			
General fund		(32,479)	(23,721)
Revaluation reserve		5,415	5,855
Total taxpayers' equity		**(27,064)**	**(17,866)**

The notes on pages 5 to 40 form part of this account.

The financial statements on pages 1 to 40 were approved by the Audit sub-committee of the Department of Health Audit and Risk Committee on 7 June 2013 and signed on its behalf by

Accountable Officer:  Date: 7 June 2013

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY
For the year ended 31 March 2013

	General fund	Revaluation reserve	Total reserves
	£000	£000	£000
Balance at 1 April 2012	(23,721)	5,855	**(17,866)**
Changes in taxpayers' equity for 2012/13:			
Net operating cost for the year	(1,033,511)	0	**(1,033,511)**
Net gain on revaluation of property, plant, equipment	0	26	**26**
Impairments and reversals	0	(409)	**(409)**
Transfers between reserves	57	(57)	**0**
Total recognised income and expense for 2012/13	**(1,033,454)**	**(440)**	**(1,033,894)**
Net Parliamentary funding	1,024,696	0	**1,024,696**
Balance at 31 March 2013	**(32,479)**	**5,415**	**(27,064)**

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY
For the year ended 31 March 2012

	General fund	Revaluation reserve	Total reserves
	£000	£000	£000
Balance at 1 April 2011	(19,956)	6,724	**(13,232)**
Changes in taxpayers' equity for 2011/12:			
Net operating cost for the year	(1,008,737)	0	**(1,008,737)**
Net gain on revaluation of property, plant, equipment	0	80	**80**
Impairments and reversals	0	(371)	**(371)**
Transfers between reserves	578	(578)	**0**
Total recognised income and expense for 2011/12	**(1,008,159)**	**(869)**	**(1,009,028)**
Net Parliamentary funding	1,004,394	0	**1,004,394**
Balance at 31 March 2012	**(23,721)**	**5,855**	**(17,866)**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2013

	2012/13 £000	2011/12 £000
Cash flows from operating activities		
Net Operating Cost Before Interest	(1,033,528)	(1,006,464)
Depreciation and Amortisation	2,547	2,497
Impairments and Reversals	1,021	1,013
Interest Paid	(103)	(2,307)
Decrease in Trade and Other Receivables	13,218	1,896
(Decrease)/Increase in Trade and Other Payables	(7,973)	1,758
Provisions Utilised	(1,085)	(2,544)
Non-cash movements in Provisions	6,597	2,041
Net cash outflow from operating activities	**(1,019,306)**	**(1,002,110)**
Cash flows from investing activities		
Interest Received	120	34
Payments for Property, Plant and Equipment	(1,919)	(2,163)
Payments for Intangible Assets	(105)	(217)
Proceeds of disposal of assets held for sale (PPE)	0	298
Proceeds of disposal of assets held for sale (Intangible)	0	150
Net cash outflow from investing activities	**(1,904)**	**(1,898)**
Net cash outflow before financing	**(1,021,210)**	**(1,004,008)**
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	(3,492)	(388)
Net Parliamentary Funding	1,024,696	1,004,394
Net cash inflow from financing activities	**1,021,204**	**1,004,006**
Net decrease in cash and cash equivalents	**(6)**	**(2)**
Cash and cash equivalents (and bank overdraft) at beginning of the period	8	10
Cash and cash equivalents (and bank overdraft) at year end	**2**	**8**

1. Accounting policies

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

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

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

Under the provisions of *The Health and Social Care Act 2012 (Commencement No. 4. Transitional, Savings and Transitory Provisions) Order 2013*, County Durham PCT was dissolved on 1 April 2013. The PCT's functions, assets and liabilities transferred to other public sector entities as outlined in Note 31 *Events after the Reporting Period*. Where reconfigurations of this nature take place within the public sector, Government accounting requires that the activities concerned are to be considered as continuing operations, and so the closing entity prepares accounts on a "going concern" basis.

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

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 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 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 are considered to be:

- determining whether an arrangement meets the definition of a service concession within the scope of IFRIC 12;
- determining whether a substantial transfer of risks and rewards has occurred in relation to leased assets; and
- determining the carrying value of property, plant and equipment and whether there is an impairment in value.

Key sources of estimation uncertainty

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 are considered to relate to the assumptions applied in the valuation and estimated remaining useful life of property, plant and equipment, as well as the apportionment and recharge of shared management costs and overheads between the PCT and Darlington PCT, over which joint management arrangements exist.

Where such critical judgements and estimates have been made, they have been detailed in the relevant accounting policy below or in the relevant notes to the accounts as appropriate.

1. Accounting policies (continued)

1.2 Revenue and Funding

The main source of funding for the PCT is allocations (Parliamentary Funding) from the Department of Health within an approved cash limit, which is credited to the General Fund of the PCT. 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 PCT. 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 income has been received for a specific activity to be delivered in the following financial year, that income will be deferred.

1.3 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.

1.4 Administration and Programme Costs

HM 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.

1.5 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 a 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.

1. Accounting policies (continued)

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

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

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

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

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

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

1. Accounting policies (continued)

1.6 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 asset 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.

1.7 Depreciation, amortisation and impairments

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

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

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

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit 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 HM Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.

AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1. Accounting policies (continued)

1.8 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 on the revaluation reserve is transferred to retained earnings.

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

1.9 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.

1.10 Losses and Special Payments

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

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

1.11 Clinical Negligence Costs

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

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 25.

1. Accounting policies (continued)

1.12 Employee benefits

Short-term employee benefits

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

Retirement benefit costs

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

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

1.13 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.

1.14 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.

1.15 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.

1.16 Contingencies

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

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

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

1. Accounting policies (continued)

1.17 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 of 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.

1.18 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 and the time value of money is significant, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of up to 2.2% (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 ongoing activities of the entity.

1. Accounting policies (continued)

1.19 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

Available for sale financial assets

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

Loans and receivables

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

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques using discounted cash flow analysis.

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 the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1. Accounting policies (continued)

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

Financial liabilities are initially recognised at fair value.

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

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

1.20 Private Finance Initiative (PFI) and NHS Local Improvement Finance Trust (LIFT) transactions

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

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:
a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

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

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

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

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

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

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

1. Accounting policies (continued)

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

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

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

Assets contributed by the PCT to the operator for use in the scheme
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the PCT's Statement of Financial Position.

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

1.21 Accounting standards that have been issued but have not yet been adopted

Neither the Treasury FReM nor the Department of Health's Manual for Accounts 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 PCT accounts in 2012/13, were they applied in that year:

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

2. Operating segments

The PCT has considered the definition of an operating segment contained within IFRS 8 in determining its operating segments, in particular considering the internal reporting to the PCT's Board, considered to be the 'chief operating decision maker' of the PCT, which was used for the purpose of resource allocation and assessment of performance. On this basis, two separate operating segments have been identified, being lead commissioning and other commissioning.

All activity performed by the PCT related to its role as a commissioner of healthcare for its relevant population. This includes the purchasing of services from other providers of healthcare, including the provision of hospital care, General Practitioner services, cost of drugs and non NHS care (i.e. day-to-day running costs).

During 2011/12 and 2012/13 the PCT also had certain lead commissioning arrangements under which a North East team, hosted by the PCT, was responsible for the commissioning of Offender Health services across the North East. Due to the different nature of the PCT's lead commissioning arrangements and the relative size of total income and expenditure relating to lead commissioning, which is accounted for on a gross basis, this has been identified as a separate reportable operating segment.

An analysis of the income and expenditure relating to each segment is included below. Net assets are not reported separately for each segment to the PCT's Board.

Expenditure from transactions with County Durham and Darlington NHS Foundation Trust amount to more than 10% of total gross operating costs, in either the current or prior year, as follows:

	2012/13 £000	**2011/12 £000**
County Durham and Darlington NHS Foundation Trust	348,528	342,405

	Lead Commissioning		**Other Commissioning**		**Total**	
	2012/13 £000	**2011/12 £000**	**2012/13 £000**	**2011/12 £000**	**2012/13 £000**	**2011/12 £000**
Gross operating costs	21,959	20,466	1,043,596	1,027,839	1,065,555	1,048,305
Miscellaneous income	(1,223)	(7,958)	(30,804)	(33,883)	(32,027)	(41,841)
Net operating costs before interest	**20,736**	**12,508**	**1,012,792**	**993,956**	**1,033,528**	**1,006,464**
Investment revenue	0	0	(120)	(34)	(120)	(34)
Other (gains) / losses	0	0	0	0	0	0
Finance costs	0	0	103	2,307	103	2,307
Net operating costs for the financial year	**20,736**	**12,508**	**1,012,775**	**996,229**	**1,033,511**	**1,008,737**

3. Financial Performance Targets

3.1 Revenue Resource Limit

	2012/13 £000	2011/12 £000
The PCT's performance for the year ended 31 March 2013 is as follows:		
Net Operating Cost for the Financial Year	1,033,511	1,008,737
Revenue Resource Limit	1,034,515	1,009,745
Underspend Against Revenue Resource Limit (RRL)	**1,004**	**1,008**

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	12,119	1,854
Charge to Capital Resource Limit	12,013	1,835
Underspend Against Capital Resource Limit (CRL)	**106**	**19**

3.3 Underspend against cash limit

	2012/13 £000	2011/12 £000
Total Charge to Cash Limit	1,024,696	1,004,394
Cash Limit	1,029,096	1,004,394
Underspend Against Cash Limit	**4,400**	**0**

3.4 Reconciliation of Cash Drawings to Parliamentary Funding

	2012/13 £000	2011/12 £000
Total cash received from the Department of Health (Gross)	894,909	876,064
Less: Trade Income from the Department of Health	(25)	(30)
Plus: movement in Department of Health receivables	25	30
Sub total: net advances	**894,909**	**876,064**
Plus: cost of Dentistry Schemes (central charge to cash limits)	20,740	19,058
Plus: drugs reimbursement (central charge to cash limits)	109,047	109,272
Parliamentary Funding credited to General Fund	**1,024,696**	**1,004,394**

4. Miscellaneous revenue

	2012/13 Admin £000	2012/13 Programme £000	2012/13 Total £000	2011/12 Total £000
Dental Charge income from Contractor-Led GDS & PDS	0	5,870	5,870	5,791
Prescription Charge income	0	6,445	6,445	6,207
Strategic Health Authorities	13	1,170	1,183	1,316
NHS Foundation Trusts	275	6,717	6,992	9,353
Primary Care Trusts - Other	3,097	1,562	4,659	5,036
Primary Care Trusts - Lead Commissioning	0	719	719	7,389
Department of Health - Other	0	25	25	0
Recoveries in respect of employee benefits	230	56	286	234
Local Authorities	0	1,267	1,267	1,659
Education, Training and Research	0	3,328	3,328	3,424
Charitable and Other Contributions to Expenditure	0	19	19	0
Rental Income from Operating Leases	0	933	933	1,082
Other Income	10	291	301	350
Total miscellaneous income	**3,625**	**28,402**	**32,027**	**41,841**

5. Operating Costs

5.1 Analysis of operating costs:

	2012/13 Admin £000	2012/13 Programme £000	2012/13 Total £000	2011/12 Total £000
Goods and Services from Other PCTs				
Healthcare	0	69,642	69,642	53,686
Non-Healthcare	2,858	813	3,671	2,929
Total	**2,858**	**70,455**	**73,313**	**56,615**
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	0	1,397	1,397	15,539
Goods and services (other, excl Trusts, FT and PCT))	81	562	643	3,340
Total	**81**	**1,959**	**2,040**	**18,879**
Goods and Services from Foundation Trusts	1,029	605,058	606,087	597,366
Purchase of Healthcare from Non-NHS bodies	0	102,957	102,957	98,277
Expenditure on Drugs Action Teams	0	11,183	11,183	11,688
Contractor Led GDS & PDS (excluding employee benefits)	0	26,951	26,951	24,996
Chair, Non-executive Directors & PEC remuneration	112	0	112	84
Executive committee members costs	482	0	482	323
Consultancy Services	998	315	1,313	660
Prescribing Costs	0	90,915	90,915	92,858
G/PMS, APMS and PCTMS (excluding employee benefits)	0	78,637	78,637	76,252
Pharmaceutical Services	0	1,318	1,318	1,372
New Pharmacy Contract	0	27,316	27,316	26,774
General Ophthalmic Services	0	4,809	4,809	4,953
Supplies and Services - Clinical	9	2,764	2,773	2,540
Supplies and Services - General	52	192	244	416
Establishment	2,080	571	2,651	2,967
Premises	2,056	6,697	8,753	7,680
Impairments & Reversals of Property, plant and equipment	0	1,021	1,021	1,013
Depreciation	1,033	1,422	2,455	2,438
Amortisation	92	0	92	59
Impairment of Receivables	(160)	0	(160)	563
Audit Fees	156	0	156	258
Other Auditors Remuneration	43	0	43	62
Clinical Negligence Costs	138	0	138	50
Education and Training	109	714	823	1,154
Other	232	715	947	1,743
Total Operating costs charged to Statement of Comprehensive Net Expenditure	**11,400**	**1,035,969**	**1,047,369**	**1,032,040**
Employee Benefits (excluding capitalised costs)				
PCT Officer Board Members	987	0	987	1,068
Other Employee Benefits	12,874	4,325	17,199	15,197
Total Employee Benefits charged to SOCNE	**13,861**	**4,325**	**18,186**	**16,265**
Total Operating Costs	**25,261**	**1,040,294**	**1,065,555**	**1,048,305**

5.2 Running Costs

	Commissioning Services	Public Health	Total
PCT Running Costs 2012/13			
Running costs (£000s)	18,547	3,104	**21,651**
Weighted population (number in units) *	608,503	608,503	**608,503**
Running costs per head of population (£ per head)	**30.48**	**5.10**	**35.58**
PCT Running Costs 2011/12			
Running costs (£000s)	19,029	2,720	**21,749**
Weighted population (number in units)	608,503	608,503	**608,503**
Running costs per head of population (£ per head)	**31.27**	**4.47**	**35.74**

* 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.

As a result, 2011/12 weighted populations have been used to calculate the Running Costs per head of population in 2012/13.

5.3 Analysis of operating expenditure by expenditure classification

	2012/13 £000	2011/12 £000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	78,637	76,252
Prescribing costs	90,915	92,858
Contractor led GDS & PDS	26,951	24,996
General Ophthalmic Services	4,809	4,953
Pharmaceutical services	1,318	1,372
New Pharmacy Contract	27,316	26,774
Total Primary Healthcare purchased	**229,946**	**227,205**
Purchase of Secondary Healthcare		
Learning Difficulties	21,567	21,238
Mental Illness	99,171	100,837
Maternity	20,496	20,417
General and Acute	412,911	411,773
Accident and emergency	11,452	11,090
Community Health Services	113,037	107,695
Other Contractual	98,057	83,318
Total Secondary Healthcare Purchased	**776,691**	**756,368**
Total Healthcare Purchased by PCT	**1,006,637**	**983,573**
Included above:		
Healthcare from NHS FTs included above	602,312	593,043

6. Operating Leases

The PCT has entered into a number of operating lease arrangements, the majority of which relate to the lease of properties and leased cars, none of which are individually significant. Specific lease terms vary by individual arrangement but are based upon standard practice for the type of arrangement involved.

The PCT has also entered into certain financial arrangements involving the use of GP premises. Under IAS 17 'Leases', SIC 27 'Evaluating the substance of transactions involving the legal form of a lease' and IFRIC 4 'Determining whether an arrangement contains a lease', the PCT has determined that these arrangements contain operating leases which must be recognised accordingly. The financial value recognised as an expense in the Statement of Comprehensive Net Expenditure for 2012/13 is £5,752k (2011/12: £5,032k), however as there is no defined term in the arrangements, it is not possible to analyse these over financial years and as a result no amounts are included in the payable section of the table below in respect of these arrangements.

6.1 PCT as lessee

	2012/13 Total £000	2011/12 Total £000
Payments recognised as an expense		
Minimum lease payments	6,850	6,813
Contingent rents	64	323
Sub-lease payments	0	0
Total	**6,914**	**7,136**

	2012/13 Buildings £000	2012/13 Other £000	2012/13 Total £000	2011/12 Total £000
Payable:				
No later than one year	935	112	1,047	1,046
Between one and five years	3,376	104	3,480	3,385
After five years	7,586	0	7,586	7,018
Total	**11,897**	**216**	**12,113**	**11,449**

6.2 PCT as lessor

The PCT has entered into certain leasing arrangements involving the occupation of PCT properties by third parties under operating lease arrangements which are reviewed on an annual basis.

	2012/13 £000	2011/12 £000
Recognised as income		
Rents	933	1,082
Contingent rents	0	0
Total	**933**	**1,082**
Receivable:		
No later than one year	250	277
Between one and five years	618	865
After five years	0	0
Total	**868**	**1,142**

7. Employee benefits and staff numbers

7.1 Employee benefits

	Total			Permanently employed			Other		
	Total £000	**Admin £000**	**Programme £000**	**Total £000**	**Admin £000**	**Programme £000**	**Total £000**	**Admin £000**	**Programme £000**
Employee Benefits 2012/13 - gross expenditure									
Salaries and wages	14,470	11,866	2,604	12,969	10,611	2,358	1,501	1,255	246
Social security costs	1,055	864	191	1,055	864	191	0	0	0
Employer contributions to NHS Pensions scheme	1,590	1,302	288	1,590	1,302	288	0	0	0
Termination benefits	1,242	0	1,242	1,242	0	1,242	0	0	0
Total employee benefits	**18,357**	**14,032**	**4,325**	**16,856**	**12,777**	**4,079**	**1,501**	**1,255**	**246**
Less recoveries in respect of employee benefits	(286)	(230)	(56)	(286)	(230)	(56)	0	0	0
Total - Net Employee Benefits including capitalised costs	**18,071**	**13,802**	**4,269**	**16,570**	**12,547**	**4,023**	**1,501**	**1,255**	**246**
Employee costs capitalised	171	171	0	0	0	0	171	171	0
Gross Employee Benefits excluding capitalised costs	**18,186**	**13,861**	**4,325**	**16,856**	**12,777**	**4,079**	**1,330**	**1,084**	**246**
Recoveries in respect of employee benefits 2012/13									
Salaries and wages	237	190	47	237	190	47	0	0	0
Social Security costs	20	16	4	20	16	4	0	0	0
Employer Contributions to NHS BSA - Pensions Division	29	24	5	29	24	5	0	0	0
Total recoveries in respect of employee benefits	**286**	**230**	**56**	**286**	**230**	**56**	**0**	**0**	**0**

Employee Benefits - 2011/12:	**Total £000**	**Permanently employed £000**	**Other £000**
Employee Benefits 2011/12 - gross expenditure			
Salaries and wages	13,523	12,953	570
Social security costs	1,011	1,011	0
Employer Contributions to NHS BSA - Pensions Division	1,632	1,632	0
Termination benefits	99	99	0
Total gross employee benefits	**16,265**	**15,695**	**570**
Less recoveries in respect of employee benefits	(234)	(234)	0
Total - Net Employee Benefits including capitalised costs	**16,031**	**15,461**	**570**

No employee benefits were capitalised during 2011/12.

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	4	4	0	3	3	0
Administration and estates	338	284	54	304	283	21
Nursing, midwifery and health visiting staff	32	32	0	41	41	0
Scientific, therapeutic and technical staff	10	10	0	12	12	0
TOTAL	**384**	**330**	**54**	**360**	**339**	**21**

Numbers of staff above (wte) whose costs have been capitalised: 6 (2011/12: none).

The number of staff who retired early due to ill-health during the year was 1 (2011/12: 1), with total additional pensions liabilities accrued in the year of £81,800 (2011/12: £65,744).

7.3 Exit Packages

	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	0	**1**	0	4	**4**
£10,001-£25,000	2	0	**2**	0	2	**2**
£25,001-£50,000	1	0	**1**	0	0	**0**
£50,001-£100,000	2	0	**2**	0	0	**0**
£100,001 - £150,000	0	0	**0**	0	0	**0**
£150,001 - £200,000	1	0	**1**	0	0	**0**
>£200,000	3	0	**3**	0	0	**0**
Total number of exit packages by type	**10**	**0**	**10**	**0**	**6**	**6**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Total resource cost	1,221	0	**1,221**	0	56	**56**

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

This disclosure reports the number and value of exit packages agreed during the financial year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

7.4 Pension costs

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

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

a) Accounting valuation

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

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

b) Full actuarial (funding) valuation

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

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

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

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

c) Scheme provisions

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

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

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

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

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

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

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

8. Better Payment Practice Code

8.1 Measure of compliance

	2012/13 Number	2012/13 £000	2011/12 Number	2011/12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	41,191	139,944	41,061	133,330
Total Non-NHS Trade Invoices Paid Within Target	39,681	136,152	38,270	127,287
Percentage of Non-NHS Trade Invoices Paid Within Target	**96.33%**	**97.29%**	**93.20%**	**95.47%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	4,427	682,394	4,614	683,290
Total NHS Trade Invoices Paid Within Target	4,355	680,668	4,454	676,301
Percentage of NHS Trade Invoices Paid Within Target	**98.37%**	**99.75%**	**96.53%**	**98.98%**

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	1	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	**1**	**0**

9. Investment Income

	2012/13 Admin £000	2012/13 Programme £000	2012/13 Total £000	2011/12 Total £000
Interest Income				
LIFT: loan interest receivable	120	0	120	34
Total investment income	**120**	**0**	**120**	**34**

10. Other Gains and Losses

There were no other gains or losses in 2012/13 (2011/12: £nil).

11. Finance Costs

	2012/13 Admin £000	2012/13 Programme £000	2012/13 Total £000	2011/12 Total £000
Interest				
Interest on obligations under finance leases	0	16	16	9
Interest on obligations under PFI contracts:				
- main finance cost	0	956	956	971
- contingent finance cost	0	326	326	269
Interest on obligations under LIFT contracts:				
- main finance cost	0	(1,285)	(1,285)	987
- contingent finance cost	0	89	89	71
Interest on late payment of commercial debt	1	0	1	0
Total	**1**	**102**	**103**	**2,307**

12. Property, plant and equipment

2012/13	Land	Buildings excluding dwellings	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000
Cost or valuation:						
At 1 April 2012	7,441	44,296	2,864	8,826	1,789	**65,216**
Additions Purchased	0	9,765	260	1,831	52	**11,908**
Disposals other than for sale	0	(170)	(1,124)	(6,854)	(235)	**(8,383)**
Upward revaluation/positive indexation	0	26	0	0	0	**26**
Impairments/negative indexation	(42)	(367)	0	0	0	**(409)**
Reversal of Impairments	0	0	0	0	0	**0**
At 31 March 2013	**7,399**	**53,550**	**2,000**	**3,803**	**1,606**	**68,358**
Depreciation						
At 1 April 2012	107	2,628	1,981	7,517	1,122	**13,355**
Disposals other than for sale	0	(170)	(1,124)	(6,854)	(235)	**(8,383)**
Upward revaluation/positive indexation	0	0	0	0	0	**0**
Impairments	0	1,041	0	0	0	**1,041**
Reversal of Impairments	0	(20)	0	0	0	**(20)**
Charged During the Year	0	1,474	314	520	147	**2,455**
At 31 March 2013	**107**	**4,953**	**1,171**	**1,183**	**1,034**	**8,448**
Net book value at 31 March 2013	**7,292**	**48,597**	**829**	**2,620**	**572**	**59,910**
Net book value at 31 March 2013 comprises:						
Purchased	7,292	48,597	829	2,620	572	**59,910**
Total at 31 March 2013	**7,292**	**48,597**	**829**	**2,620**	**572**	**59,910**
Asset financing:						
Owned	7,292	17,804	603	2,620	572	**28,891**
Held on finance lease	0	0	226	0	0	**226**
On-SOFP PFI contracts	0	30,793	0	0	0	**30,793**
Total	**7,292**	**48,597**	**829**	**2,620**	**572**	**59,910**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Plant & machinery	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	4,204	1,543	103	0	5	**5,855**
Movements	(42)	(341)	(52)	0	(5)	**(440)**
At 31 March 2013	**4,162**	**1,202**	**51**	**0**	**0**	**5,415**

12. Property, plant and equipment (continued)

2011/12	Land	Buildings excluding dwellings	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000
Cost or valuation:						
At 1 April 2011	7,778	43,718	2,736	8,121	1,575	**63,928**
Additions Purchased	0	617	334	901	214	**2,066**
Reclassifications as Held for Sale	(85)	0	(206)	(196)	0	**(487)**
Upward revaluation/positive indexation	60	20	0	0	0	**80**
Impairments/negative indexation	(312)	(59)	0	0	0	**(371)**
At 31 March 2012	**7,441**	**44,296**	**2,864**	**8,826**	**1,789**	**65,216**
Depreciation						
At 1 April 2011	75	280	1,811	7,031	896	**10,093**
Reclassifications as Held for Sale	0	0	(95)	(94)	0	**(189)**
Impairments	32	1,310	0	0	0	**1,342**
Reversal of Impairments	0	(329)	0	0	0	**(329)**
Charged During the Year	0	1,367	265	580	226	**2,438**
At 31 March 2012	**107**	**2,628**	**1,981**	**7,517**	**1,122**	**13,355**
Net book value at 31 March 2012	**7,334**	**41,668**	**883**	**1,309**	**667**	**51,861**
Net book value at 31 March 2012 comprises:						
Purchased	7,334	41,668	883	1,309	667	**51,861**
Total at 31 March 2012	**7,334**	**41,668**	**883**	**1,309**	**667**	**51,861**
Asset financing:						
Owned	7,334	18,897	585	1,309	667	**28,792**
Held on finance lease	0	0	298	0	0	**298**
On-SOFP PFI contracts	0	22,771	0	0	0	**22,771**
Total	**7,334**	**41,668**	**883**	**1,309**	**667**	**51,861**

12. Property, plant and equipment (continued)

Professional valuations are carried out by the District Valuers of HM Revenue and Customs. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury. Full asset valuations were undertaken by the District Valuers in 2009 as at a valuation date of 31 March 2009.

The valuations have been carried out primarily on the basis of Depreciated Replacement Cost for specialised operational property and Existing Use Value for non-specialised operational property.

In line with HM Treasury guidance, the revaluation of specialised operational property at Depreciated Replacement Cost on 31 March 2009 was based on "modern equivalent assets" rather than the "like for like" replacement basis used in the previous valuation. The value of land for existing use purposes is assessed to Existing Use Value.

In respect of non-operational properties, including surplus land, the valuations have been carried out at Open Market Value. Additional alternative Open Market Value figures have only been supplied for operational assets scheduled for imminent closure and subsequent disposal.

To supplement the full asset valuation undertaken as at 31 March 2009, the District Valuers have performed a further review of all properties as at 31 March 2013, using valuation methodologies consistent with those applied in the detailed March 2009 valuation. The results of this review have been reflected in these accounts.

12.1 Economic Lives of Property, Plant & Equipment

Property, Plant and Equipment	Min Life Years	Max Life Years
Buildings excl. dwellings	0	70
Plant & machinery	0	9
Information technology	0	5
Furniture & fittings	0	10

The economic lives of property, plant and equipment, together with residual values, are continually reviewed. There have been no significant changes to either economic lives or residual values during the year.

13. Intangible non-current assets

2012/13	Software purchased £000	Total £000
Cost or valuation:		
At 1 April 2012	595	**595**
Additions - purchased	105	**105**
Disposals other than for sale	(353)	**(353)**
At 31 March 2013	**347**	**347**
Amortisation		
At 1 April 2012	337	**337**
Disposals other than for sale	(353)	**(353)**
Charged during the year	92	**92**
At 31 March 2013	**76**	**76**
NBV at 31 March 2013	**271**	**271**
Net book value at 31 March 2013 comprises:		
Purchased	271	**271**
Total at 31 March 2013	**271**	**271**

2011/12	Software purchased £000	Total £000
Cost or valuation:		
At 1 April 2011	566	**566**
Additions - purchased	217	**217**
Reclassified as held for sale	(188)	**(188)**
At 31 March 2012	**595**	**595**
Amortisation		
At 1 April 2011	316	**316**
Reclassified as held for sale	(38)	**(38)**
Charged during the year	59	**59**
At 31 March 2012	**337**	**337**
NBV at 31 March 2012	**258**	**258**
Net book value at 31 March 2012 comprises:		
Purchased	258	**258**
Total at 31 March 2012	**258**	**258**

13.1 Economic Lives of Intangible Assets

Intangible assets	Min Life Years	Max Life Years
Software licences	0	5

No intangible assets have been assessed as having indefinite useful lives.
There have been no significant changes to useful lives during the year.

13.2 Revaluation reserve balance for intangible assets

There was no revaluation reserve balance for intangible assets in either 2012/13 or 2011/12.

14. Analysis of impairments and reversals

	2012/13 Admin £000	2012/13 Programme £000	2012/13 Total £000	2011/12 Total £000
Property, Plant and Equipment impairments and reversals taken to SoCNE:				
Loss or damage resulting from normal operations	0	0	0	651
Total charged to Departmental Expenditure Limit (DEL)	**0**	**0**	**0**	**651**
Impairments due to changes in market price	0	1,021	1,021	362
Total charged to Annually Managed Expenditure (AME)	**0**	**1,021**	**1,021**	**362**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve:				
Changes in market price	0	409	409	371
Total impairments for Property, Plant and Equipment charged to reserves	**0**	**409**	**409**	**371**
Total Impairments of Property, Plant and Equipment	**0**	**1,430**	**1,430**	**1,384**
Total Impairments charged to Revaluation Reserve	0	409	409	371
Total Impairments charged to SoCNE - DEL	0	0	0	651
Total Impairments charged to SoCNE - AME	0	1,021	1,021	362
Overall Total Impairments	**0**	**1,430**	**1,430**	**1,384**
Of which:				
Impairment on revaluation to "modern equivalent asset" basis	0	1,450	**1,450**	**1,252**

No material impairment loss was recognised or reversed in the period for any individual asset.

The impairments charged during the year reflect the results of a review of the valuation of all properties as at 31 March 2013 performed by the District Valuers.

15. Commitments

There are no contracted capital commitments or non-cancellable contracts entered into by the PCT at 31 March 2013 which are not otherwise included in these financial statements.

At 31 March 2012, the PCT had entered into a PFI contract for the provision of a new primary care centre at St John's Square in Seaham, which was still under construction and as a result the related capital and financial commitments were not recognised in the financial statements. The primary care centre become operational in June 2012 and hence all related commitments are included in the financial statements at 31 March 2013. Further details of this contract can be found in note 27. There were no other contracted capital commitments or non-cancellable contracts entered into by the PCT at 31 March 2012 which were not otherwise included in the financial statements.

16. Intra-Government and other balances

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with other Central Government Bodies	2,172	0	1,090	0
Balances with Local Authorities	278	0	965	0
Balances with NHS Trusts and Foundation Trusts	6,252	0	10,132	0
Balances with bodies external to government	1,005	0	39,933	0
At 31 March 2013	**9,707**	**0**	**52,120**	**0**
Prior period:				
Balances with other Central Government Bodies	1,560	0	906	0
Balances with Local Authorities	635	0	3,475	0
Balances with NHS Trusts and Foundation Trusts	18,622	0	15,505	0
Balances with bodies external to government	2,108	0	39,662	0
At 31 March 2012	**22,925**	**0**	**59,548**	**0**

17. Trade and other receivables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
NHS receivables - revenue	7,585	11,113	0	0
NHS prepayments and accrued income	188	8,500	0	0
Non-NHS receivables - revenue	1,218	1,259	0	0
Non-NHS prepayments and accrued income	732	2,140	0	0
Provision for the impairment of receivables	(528)	(691)	0	0
VAT	512	569	0	0
Other receivables	0	35	0	0
Total	**9,707**	**22,925**	**0**	**0**
Total current and non current	**9,707**	**22,925**		

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.

17.1 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	5,384	1,049
By three to six months	22	366
By more than six months	0	11
Total	**5,406**	**1,426**

17.2 Provision for impairment of receivables

	2012/13 £000	2011/12 £000
Balance at 1 April	(691)	(129)
Amount written off during the year	3	1
(Increase)/decrease in receivables impaired	160	(563)
Balance at 31 March	**(528)**	**(691)**

The PCT has reviewed all receivables to determine whether an impairment in value is required. In determining the recoverability of a receivable, the PCT considers any change in the credit quality of the receivable from the date credit was initially granted up to the reporting date. The overall level of credit risk is considered to be relatively low due to the proportion of the customer base which is comprised of NHS bodies and other central and local government bodies.

18. NHS LIFT investments

	Loan £000	Share capital £000	Total £000
Balance at 1 April 2011, 1 April 2012 and 31 March 2013	**419**	**4**	**423**

19. Other financial assets

	Non-current	
	31 March 2013 £000	31 March 2012 £000
Available for sale financial assets carried at fair value	423	423
Total	**423**	**423**

20. Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Balance at 1 April	8	10
Net change in year	(6)	(2)
Balance at 31 March	**2**	**8**
Made up of		
Cash with Government Banking Service	2	1
Commercial banks	0	7
Cash and cash equivalents as in statement of financial position	**2**	**8**
Cash and cash equivalents as in statement of cash flows	**2**	**8**

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

21. Non-current assets held for sale

	Land	Plant and Machinery	Information Technology	Intangible Assets	Total
	£000	£000	£000	£000	£000
Balance at 1 April 2012 and 31 March 2013	**0**	**0**	**0**	**0**	**0**
Balance at 1 April 2011	0	0	0	0	**0**
Plus assets classified as held for sale in the year	85	111	102	150	**448**
Less assets sold in the year	(85)	(111)	(102)	(150)	**(448)**
Balance at 31 March 2012	**0**	**0**	**0**	**0**	**0**

During 2011/12 an agreement was reached to sell land at Pelton as part of the development of a new clinic. The land was valued at £85k and was sold for that value.

In addition certain items of plant and machinery, information technology assets and intangible assets with a total net book value of £363k were sold at that value in 2011/12.

22. 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	642	105	0	0
NHS payables - capital	0	14	0	0
NHS accruals and deferred income	10,580	16,292	0	0
Family Health Services (FHS) payables	20,946	22,425	0	0
Non-NHS payables - revenue	1,465	3,079	0	0
Non-NHS payables - capital	666	107	0	0
Non-NHS accruals and deferred income	17,801	17,526	0	0
Other	20	0	0	0
Total	**52,120**	**59,548**	**0**	**0**
Total payables (current and non-current)	**52,120**	**59,548**		

Other payables include £nil (2011/12: £nil) in respect of payments due in future years under arrangements to buy out the liability for early retirements over 5 instalments; and £nil in respect of outstanding pensions contributions at 31 March 2013 (31 March 2012: £nil).

23. Borrowings

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
PFI liabilities:				
Main liability	1,489	1,499	15,811	16,568
LIFT liabilities:				
Main liability	1,741	1,021	16,152	10,076
Finance lease liabilities	92	92	109	186
Total	**3,322**	**2,612**	**32,072**	**26,830**
Total borrowings (current and non-current)	**35,394**	**29,442**		

Borrowings/Loans - Payment of Principal Falling Due in:	DH £000	Other £000	Total £000
0 - 1 Years	0	3,301	3,301
1 - 2 Years	0	3,241	3,241
2 - 5 Years	0	9,153	9,153
Over 5 Years	0	19,699	19,699
Total at 31 March 2013	**0**	**35,394**	**35,394**

This disclosure is included for the first time in 2012/13 and prior year comparatives are not presented.

24. Finance lease obligations

The PCT has entered into five finance lease arrangements for diagnostic equipment, none of which are significant.

Amounts payable under finance leases	Minimum lease payments		Present value of minimum lease payments	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
Within one year	92	92	92	92
Between one and five years	177	269	109	186
Less future finance charges	(68)	(83)	0	0
Present value of minimum lease payments	**201**	**278**	**201**	**278**
Included in:				
Current borrowings			92	92
Non-current borrowings			109	186
			201	**278**

25. Provisions

	Total £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Continuing Care £000s	Other £000s	Redundancy £000s
Balance at 1 April 2012	**4,351**	18	182	2,691	1,182	278
Arising During the Year	**6,743**	0	6	6,669	0	68
Utilised During the Year	**(1,085)**	(18)	(171)	(123)	(496)	(277)
Reversed Unused	**(146)**	0	(2)	(113)	(31)	0
Balance as at 31 March 2013	**9,863**	**0**	**15**	**9,124**	**655**	**69**
Expected Timing of Cash Flows:						
No Later than One Year	**9,863**	0	15	9,124	655	69

Pensions relating to other staff

This represents amounts due to NHS Trusts reimbursing them for future year cash payments to the Pensions Agency in respect of pensions paid to other staff of the NHS Trust, all of which have been settled in the year.

Legal Claims

This represents sums due to NHS Trusts reimbursing them for future year cash payments in respect of employer liability claims.

Continuing Care

This represents estimated amounts due in respect of Continuing Care restitution cases, for which the timing and amounts of annual payments is uncertain.

Other

This largely represents a provision for expected costs in respect of the removal and replacement of PIP implants.

Redundancy

The opening provision represents amounts due to PCT employees who agreed to a voluntary redundancy arrangement in a previous year and left the PCT during 2013/14. The closing provision relates to an additional compulsory redundancy agreed during 2013/14, the costs of which are expected to be paid during 2013/14.

£42k is included in the provisions of the NHS Litigation Authority at 31 March 2013 in respect of clinical negligence liabilities of the PCT (31 March 2012: £11k).

26. Contingencies

There were no contingent assets or liabilities at 31 March 2013 (31 March 2012: £nil).

27. PFI and NHS LIFT Schemes

27.1 PFI and NHS LIFT schemes off-Statement of Financial Position

There are no PFI or NHS LIFT schemes off-Statement of Financial Position.

27.2 PFI and NHS LIFT schemes on-Statement of Financial Position

The PCT has two operational PFI schemes, Sedgefield Community Hospital and Stanley Primary Care Centre, and two NHS LIFT schemes, Richardson Community Hospital and Seaham Primary Care Centre. Under IFRIC 12 each of these are treated as assets of the PCT, the substance of the contracts is that the PCT has a finance lease and payments comprise two elements - imputed finance lease charges and service charges.

The Sedgefield Community Hospital PFI scheme is for the provision of a 42 bedded hospital, providing elderly care beds, elderly mental health beds, day care facilities, out patient facilities and extended x-ray facilities in Sedgefield. The contract commenced in 2001 from which time the operator has been required to make the project assets available to the PCT for use as hospital accommodation, for which the PCT pays a monthly 'unitary charge'. The annual unitary charge due to the operator will vary each year according to changes in the Retail Prices Index. The operator will be required to make the assets available to the PCT or relevant successor body until the contract ends in July 2031. At this point, the operator's rights and responsibilities shall cease and the assets will be transferred to the relevant successor body to the PCT.

The Stanley Primary Care Centre PFI scheme is for the provision of a new integrated primary care centre facility to replace the previous health centre in Stanley and enable the provision of primary care services appropriate for the 21st century, including additional facilities such as x-rays/diagnostics and a minor operations suite. Construction on the new facility commenced in June 2008 and the centre was operational in September 2009, from which time the operator has been required to make the project assets available to the PCT for use as a primary care centre facility, for which the PCT pays a monthly 'unitary charge'. The annual unitary charge due to the operator will vary each year according to changes in the Retail Prices Index. The operator will be required to make the assets available to the PCT or relevant successor body until the end of the fixed contract term of 30 years, at which point the operator's rights and responsibilities shall cease and the assets will be transferred to the relevant successor body to the PCT.

The Richardson Community Hospital LIFT scheme involved the creation of a hospital providing access to a whole range of services from out-patients and rehabilitation to therapy services and palliative care, as part of the Government's LIFT programme, funding through Care Partnerships 25 Ltd. Construction of the Hospital was completed in March 2007, following which the operator has been required to make the project assets available to the PCT for use as community hospital accommodation, for which the PCT pays a monthly charge ('Lease Plus Payments'). The annual Lease Plus Payments due to the operator will vary each year according to changes in the Retail Prices Index. The operator will be required to make the assets available until May 2035, at which point the PCT or relevant successor body will have an option to purchase the residual interest in the assets at their open market value.

There have been no changes in either the Sedgefield PFI, Stanley PFI or Richardson LIFT scheme arrangements during the period.

The Seaham Primary Care Centre PFI scheme is for the provision of a new integrated primary care centre facility in Seaham, alongside a multi-purpose centre built by Durham County Council. The centre aims to improve the quality of local health facilities by providing access to a range of services including urgent care, therapy services, x-ray and range of visiting outpatient services. There will also be access to community mental health and rehabilitation facilities. Two general practices will be operating from the site.

Construction on the scheme was completed in 2011/12 and the primary care centre became operational on 14 May 2012, from which time the operator is required to make the project assets available to the PCT for use as a primary care centre facility, for which the PCT will pay a monthly 'unitary charge'. The annual unitary charge due to the operator will vary each year according to changes in the Retail Prices Index. The operator will be required to make the assets available to the PCT or relevant successor body until the end of the fixed contract term of 25 years, at which point the operator's rights and responsibilities shall cease and the assets will be transferred to the relevant successor body to the PCT.

27.3 Additional information in respect of PFI contracts

Total imputed finance lease obligations for on-Statement of Financial Position PFI contracts due:

	31 March 2013 £000	31 March 2012 £000
Not later than one year	1,489	1,499
Later than one year, not later than five years	5,549	5,692
Later than five years	21,875	23,220
Sub total	**28,913**	**30,411**
Less: interest element	(11,612)	(12,344)
Total	**17,301**	**18,067**

The total charged in the year to expenditure in respect of the service element of on-statement of financial position PFI contracts was £367k (2011/12: £357k).

The PCT is committed to the following annual charges in respect of the service element of on-statement of financial position PFI contracts:

	31 March 2013 £000	31 March 2012 £000
Amounts due:		
Not later than one year	376	367
Later than one year, not later than five years	1,599	1,560
Later than five years	8,128	8,543
Total	**10,103**	**10,470**

27.4 Additional information in respect of NHS LIFT contracts

Total imputed finance lease obligations for on-Statement of Financial Position NHS LIFT contracts due:

	31 March 2013 £000	31 March 2012 £000
Not later than one year	1,741	1,021
Later than one year, not later than five years	6,716	4,325
Later than five years	29,810	22,373
Sub total	**38,267**	**27,719**
Less: interest element	(20,374)	(16,622)
Total	**17,893**	**11,097**

The total charged in the year to expenditure in respect of the service element of on-statement of financial position LIFT contracts was £579k (2011/12: £359k).

The PCT is committed to the following annual charges in respect of the service element of on-statement of financial position LIFT contracts:

	31 March 2013 £000	31 March 2012 £000
Amounts due:		
Not later than one year	596	397
Later than one year, not later than five years	2,784	1,839
Later than five years	18,476	13,824
Total	**21,856**	**16,060**

27.5 Impact of IFRS treatment	2012/13 Admin £000	2012/13 Programme £000	2012/13 Total £000	2011/12 Total £000
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g LIFT/PFI)				
Depreciation charges	0	717	717	566
Interest Expense	0	86	86	2,298
Impairment charge - AME	0	633	633	(228)
Other Expenditure	0	946	946	716
Revenue Receivable from subleasing	0	0	0	(597)
Total IFRS Expenditure (IFRIC12)	**0**	**2,382**	**2,382**	**2,755**
Revenue consequences of LIFT/PFI schemes under UK GAAP / ESA95 (net of any sublease income)	0	(4,592)	(4,592)	(2,828)
Net IFRS change (IFRIC12)	**0**	**(2,210)**	**(2,210)**	**(73)**
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12				
Capital expenditure in year			9,444	0
UK GAAP capital expenditure in year (Reversionary Interest)			249	241

28. 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, together with PFI and LIFT contracts which are summarised in note 27, and the PCT is therefore exposed to little credit, liquidity or market list.

Currency risk

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

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

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

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

28.1 Financial Assets

	Loans and receivables £000	Available for sale £000	Total £000
Receivables - NHS	7,773	0	**7,773**
Receivables - non-NHS	1,202	0	**1,202**
Cash at bank and in hand	2	0	**2**
Other financial assets	211	423	**634**
Total at 31 March 2013	**9,188**	**423**	**9,611**
Receivables - NHS	11,113	0	**11,113**
Receivables - non-NHS	1,172	0	**1,172**
Cash at bank and in hand	8	0	**8**
Other financial assets	21	423	**444**
Total at 31 March 2012	**12,314**	**423**	**12,737**

28.2 Financial Liabilities

	Other £000	Total £000
NHS payables	642	**642**
Non-NHS payables	23,077	**23,077**
PFI & finance lease obligations	35,394	**35,394**
Other financial liabilities	38,264	**38,264**
Total at 31 March 2013	**97,377**	**97,377**
NHS payables	119	**119**
Non-NHS payables	25,611	**25,611**
PFI & finance lease obligations	29,442	**29,442**
Other financial liabilities	38,169	**38,169**
Total at 31 March 2012	**93,341**	**93,341**

29. Related party transactions

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

During the year County Durham PCT has undertaken material transactions with Darlington PCT, over which joint management arrangements exist, including a Cluster Board which governs both County Durham PCT and Darlington PCT, as well as with the following Board Members or members of the key management staff or parties related to them:

Name	Title	Related Party	Payments to Related Party £	Receipts from Related Party £	Amounts owed to Related Party 31/03/13 £	Amounts due from Related Party 31/03/13 £
All members of key management staff		Darlington PCT	860,958	3,607,431	496,328	1,135,151
P Taylor	Director of Finance	PCT Governor of Newcastle upon Tyne Hospitals NHS Foundation Trust	27,834,847		475,280	
A Lynch	Director of Public Health	East Durham Trust	274,931		26,175	
M Guy	Medical Director	Northumberland Care Trust	36,343		9,400	
		North Tyneside PCT	69,098,776		60,546	
		Newcastle PCT	89,781	320,308	19,274	116,497
		Northumbria Police Authority	609			
N O'Brien	Chief Clinical Officer - North Durham CCG	Cestria Health Centre	508,127		637	
S Findlay	Chief Clinical Officer - DDES CCG	Bishopgate Medical Centre	308,356		450	
		Evenwood Surgery	8,211		20	
		NHS Alliance	770			
		Serco Limited	112,616			
J Flynn	Non Executive Director	Tow Law Community Association	10,734			
		Durham Rural Community Council	52,200			
M Cook	Non Executive Director	Governor of Tees Esk and Wear Valley NHS Foundation Trust	84,044,881	33,340	30,968	
R Forsyth	Non Executive Director	Castlebeck	760,120			

The Department of Health is regarded as a related party. During both the current and prior year, County Durham PCT has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are:

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

In addition, the PCT has had a number of material transactions with other government departments and other central and local government bodies in both the current and prior year. Most of these transactions have been with Durham County Council, together with other local authorities.

The PCT has also made payments to and received monies from the County Durham & Darlington PCTs Charitable Fund of which County Durham PCT is the Corporate Trustee.

29. Related party transactions (continued)

2011/12 Prior Year Comparators

During 2011/12 County Durham PCT undertook material transactions with Darlington PCT, over which joint management arrangements exist, including a Cluster Board which governs both County Durham PCT and Darlington PCT, as well as with the following Board Members or members of the key management staff or parties related to them:

Name	Title	Related Party	Payments to Related Party £	Receipts from Related Party £	Amounts owed to Related Party 31/03/12 £	Amounts due from Related Party 31/03/12 £
All members of key management staff		Darlington PCT	274,230	4,480,725	11,232	570,996
P Taylor	Director of Finance	PCT Governor of Newcastle upon Tyne Hospitals NHS Foundation Trust	34,342,926		667,296	
D Gallagher	Interim Chief Operating Officer - DDES SCCG	Durham and Tees Community Ventures Ltd	2,476,946		26,709	
		PCT Governor of County Durham and Darlington NHS Foundation Trust	342,405,561	8,554,298	7,217,587	17,265,189
A Lynch	Director of Public Health	East Durham Trust	8,726			
M Guy	Medical Director	Northumberland Care Trust	3,454	2,533,462	3,454	5,350
		North Tyneside PCT	52,983,396	5,350	212,753	5,350
		Newcastle PCT	118,079	155,774	67,581	55,821
J Flynn	Non Executive Director	Tow Law Community Association	8,587			
M Cook	Non Executive Director	Governor of Tees Esk and Wear Valley NHS Foundation Trust	83,936,551	211,622		890,296
K Greenfield	Non Executive Director	GP School Northern Deanery		500		
R Forsyth	Non Executive Director	Castlebeck	574,932			

30. Losses and special payments

The total number of losses cases in 2012/13 was 4, all relating to PCT management costs, involving a total loss of £3,199 (2011/12: 10 cases and £46,481).

No special payments were made in 2012/13. The total number of special payments made in 2011/12 was 2, with a total value of £7,998.

There were no cases which were individually in excess of £250,000.

31. Events after the reporting period

The main functions carried out by County Durham Primary Care Trust in 2012/13 are to be carried out in 2013/14 by a number of public sector bodies, including the Durham Dales, Easington and Sedgefield (DDES) clinical commissioning group, North Durham clinical commissioning group, NHS England, Durham County Council and Public Health England.

Detailed guidance on the services to be commissioned by each organisation has been published separately by the NHS Commissioning Board (now NHS England), but in general the clinical commissioning groups will be responsible for commissioning the majority of health services for their patients which were previously commissioned by the PCT with the exception of:

- certain specialised services, public health services and primary care services commissioned directly by NHS England;
- health improvement services commissioned by Durham County Council; and
- health protection and promotion services provided by PHE.

Certain items of property, plant and equipment have also transferred to NHS Property Services and other entities including clinical commissioning groups, on 1 April 2013. These were considered operational at the year-end and so have not been impaired in the PCTs accounts. It is for the successor body to consider whether, in 2013/14, it is necessary to review these for impairment.

The remaining assets and liabilities of the PCT at 31 March 2013 are to be transferred to the receiver body with relevant future commissioning responsibilities with effect from 1 April 2013, including the Department of Health, clinical commissioning groups, NHS England and NHS Property Services.

County Durham NHS
Primary Care Trust

Annual Governance Statement 2012/2013

Annual Governance Statement 2012/2013

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1	County Durham

1.1 County Durham Primary Care Trust 5ND

2	Scope of responsibility

The Statutory Board was accountable for internal control. The Accountable Officer and Chief Executive of this Board had responsibility for maintaining a sound system of internal control that supported the achievement of the organisation's policies, aims and objectives. The Statutory Board also had responsibility for safeguarding the public funds and the organisation's assets for which they were responsible as set out in the Accountable Officer Memorandum.

The Accountable Officer and Chief Executive was accountable to the Statutory Board and exercised their responsibilities for internal control through:

- the setting of a risk management strategy with the Statutory Board. This provided a framework and direction within which internal controls were exercised and developed,
- the cluster board (CB) was delegated powers from the statutory board, which includes being responsible for ensuring that high standards of integrated governance and personal behaviour were maintained in the conduct of the business of the whole organisation,
- chairing the Cluster Management Executive (CME) and the Transition Management Executive (TME), which reported to the CB, and managed day to day activity,
- the scrutiny role of the Joint Audit and Risk Committee (JARC), which reported to the Statutory Board and
- the independent assurance given by internal and external audit, which reported to the JARC.

In addition to accountability to the Statutory Board, the Accountable Officer and Chief Executive was also accountable to the Department of Health for the effectiveness of the system of internal control. This accountability was exercised through NHS North of England. NHS North of England undertakes performance management of the system of internal control duly advised by internal auditors.

At the end of January 2013, as part of the reforms specified in the *Health and Social Care Act 2012,* the Chief Executive of the PCT, Yasmin Chaudhry, passed responsibility as accountable officer to me, as Area Team Director - Durham, Darlington and Tees at NHS Commissioning Board (now NHS England), whilst retaining her position as Chief Executive of the PCT.

During the year, the Chief Executive of the PCT attended monthly meetings with the SHA Chief Executive and other primary care organisation chief executives within the SHA area. She was also a member of the Chief Officers Group which comprises the senior leaders of public sector partners in County Durham, who work together to improve health and health gain, amongst other things, of the County Durham population.

3 The Governance framework of the organisation

The Health and Social Care Act 2012 established and made provision for the setting up of the National Health Service Commissioning Board and Clinical Commissioning Groups whose responsibility it will be to develop, manage and evaluate processes for the commissioning of health care for the population of the United Kingdom. The Act is the culmination of the proposals outlined in *Equity and Excellence: Liberating the NHS (July 2010)*, and provides specific direction on the abolition of Strategic Heath Authorities (SHAs) and Primary Care Trusts (PCTs). The timeline for the completion of this change was set at 2013, with both SHAs and PCTs being disestablished in April 2013. The Act also makes provision for the transfer of public health commissioning and associated functions into the local authorities with which the PCTs were co-terminous. As a proactive NHS organisation we felt it was timely to review our governance arrangements in light of the emerging transition environment.

As a statutory body, the PCT's functions, powers and duties were set out in legislation. In order that the statutory organisation continued to carry out its statutory obligations whilst in transition to the new commissioning arrangements, a review of the PCT's Standing Orders, Standing Financial Instructions and Reservation and Delegation of Powers was undertaken to ensure currency and accuracy. The cluster management executive (CME) became the transition management executive (TME) in June 2012 in order to have a more detailed focus on phase 1 of the transition process. The TME reverted to being the CME in September 2012. Figure 1 (below) shows the structure of the board committees.

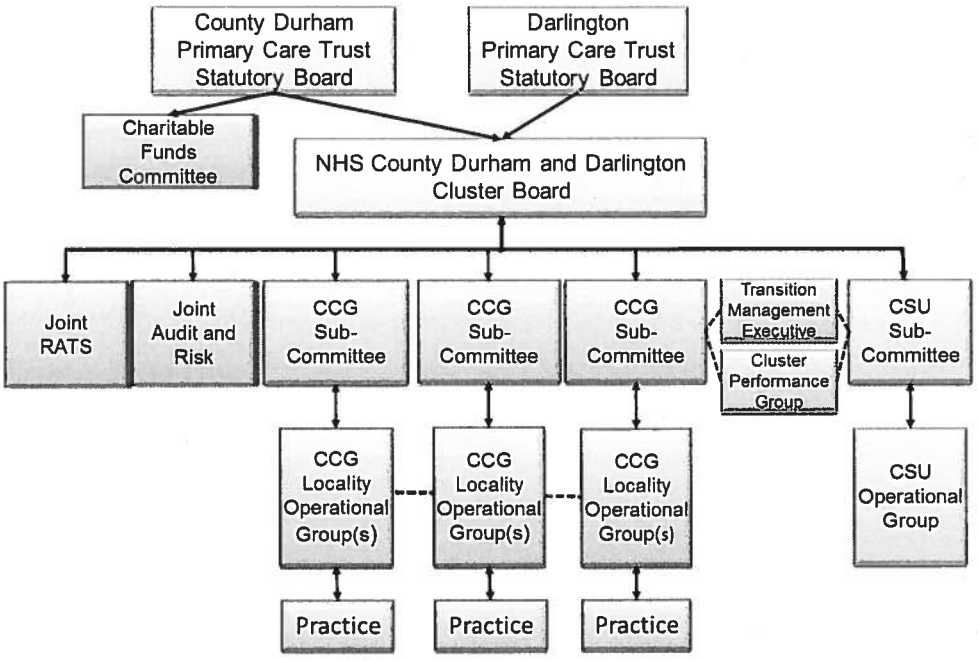


Figure 1.

Across this comprehensive range of board committees/groups within the organisation, a variety of opportunities and challenges were reviewed and escalated drawing together position statements and providing evidence on governance, risk management and control providing a coherent and consistent reporting mechanism. Board committees and sub-committees worked to a standard agenda - Strategy, Delivery and Transition.

The three CCG sub-committees were established to deliver specific, delegated commissioning functions of the PCTs.

The CSU sub-committee oversaw the development and delivery of an affordable and viable commissioning support service. The principle purpose of this sub-committee was to deliver functions that were delegated to it in relation to commissioning support.

The TME was established to support the CB in acting as a transition vehicle as outlined in the shared operating model for PCT clusters to:

- oversee and account for delivery; and
- support the development of the new system.

The Cluster Performance Group was established as a sub group of the TME, to oversee the performance management of the PCT cluster transition environment.

The Joint Audit and Risk committee (JARC) oversaw all elements of governance, risk management and internal control. The committee reviewed the strategic processes and systems of governance (including quality and patient safety), risk management and internal control across each statutory PCT activity, supporting achievement of the corporate objectives. It was also responsible for ensuring that appropriate systems and processes were in place to maintain the accuracy and quality of the annual accounts in preparation for final sign-off in June 2013. An audit sub committee of the Department of Health's own Audit and Risk Committee has now been established, made up of former PCT non-executive directors, in order to review the annual accounts, along with this governance statement, prior to signing by the Accountable Officer. This audit sub committee will provide an assurance mechanism to the Accountable Officer of the NHS on the quality of the annual accounts, annual report and governance statement of the PCT.

The Remuneration and Terms of Service (RATS) Committee and Charitable Funds Committee terms of reference were amended to reflect changes in creating the CB.

The Governance Risk and Assurance Group (GRAG) was an operational group that supported the governance, risk and assurance agenda, acting in accordance with Connecting for Health's Information Governance Toolkit requirements and to comply with the Statement of Compliance. As an integral part of the governance agenda, the group also supported and drove the broader Information Governance issues and provided the TME with the assurance that effective Information Governance best practice mechanisms were in place within the organisation.

In order to meet the reform timescale set out in the Act, a number of work streams were established to manage the transition of commissioning functions from the PCTs to the new statutory commissioning bodies. The work streams addressed:

- Corporate and Human Resources;
- Workforce Development;
- Provider Development and Outcome and Quality;
- Health and Wellbeing and Public Health; and
- Commissioning Development

Governance of the work streams has been through the provision of assurance to the CME/TME and CB on progress, with each work stream having its own detailed risk management process. All serious (red) risks were also recorded on the corporate risk register.

Working to the guidance set out in *Handover and Closedown Guidance -Transfer documentation: identifying legal title in assets and liabilities and completing transfer documentation (2012)* and *Handover and Closedown Guidance - Transfer of Intellectual Property Rights and related Assets (2012)* published by the DH, a detailed draft transfer scheme document has been developed which will inform the DH legal team in their development of the final transfer schemes for sender and receiver organisations. The development of this documentation has been reviewed by the PCT's solicitors to ensure compliance with the DH guidelines.

The work programme of the Board has involved a full refresh of the vision and strategy for the PCT, encapsulated in the ISOP and the balanced revenue and capital budgets set for the year. The Board has monitored performance against all operating framework targets and statutory duties, agreeing action as needed throughout the year. They have received reports from management and all sub-committees in support of this work. The board has led significant work on the changes needed to the governance and assurance framework to support the delivery of the transition to the new system. A key piece of work involved leading the consultation on proposed changes to stroke services within County Durham and Darlington NHS Foundation Trust (CDDFT).

Attendance records are kept for the Board and all its sub-committees. These are available for review, and confirm that throughout the year there has been good attendance at all meetings.

4	Risk assessment

4.1 Risk management assessment is an integral part of good management practice and to be most effective must become part of the organisation's culture. The statutory board was therefore committed to ensuring that risk management formed an integral part of corporate philosophy, practices and business plans rather than being viewed or practiced as a separate programme, and that responsibility for implementation was accepted at all levels of the organisation.

The risk management strategy and operational policy described how risks were identified and evaluated in a structured way. A risk grading matrix was used to quantify identified risks within all directorates and commissioning activities. Key risks were identified, consistent criteria are used to evaluate risks and ownership of risk was identified at a level with sufficient authority to assign appropriate resources to implement control measures. There was a definition of the acceptable level of exposure in relation to risk. Action plans were developed with clear timescales in relation to the risks identified.

A key corporate risk in year related to the maintenance of "grip" throughout the period of transition. In addition new corporate risks were addressed by the Board including:

- Management of poor performers by NEPSCA.
- Contract stocktake exercise.
- Retrospective assessment of eligibility for NHS Continuing Healthcare and reimbursement of costs.

- Achievement of breast feeding 6-8 weeks targets for 2011/12 and 2012/2013 for County Durham.
- Performance monitoring of NHS Health Checks programme.
- School nursing contract with CDDFT.
- Funds available for 2012/13 County Durham Alcohol Service.
- Stabilisation of Public Health contracts.
- Achievement of national priority indicators for cancer urgent referral to treatment waiting times.
- EMIS GP Clinical System; Concerns regarding the Web upgrade in relation to system functionality and readiness/fitness for use.
- Target for Category A 8 min response for urgent ambulance by the North East Ambulance Service (NEAS).
- Acute Oncology in CDDFT.

A series of review meetings were held involving PCT cluster risk leads, to determine future accountable organisations for each risk. This information was then shared with CCG risk leads, who agreed which risks should be transferred to their individual registers. All risks have been transferred to either NHS North Durham CCG, or NHS Durham Dales, Easington and Sedgefield CCG.

Other accountable organisations including Public Health England and Durham County Council had not agreed arrangements for the transfer of risks at 31 March 2013, however mechanisms were in place to achieve this as part of the final PCT transition work. All risks have continued to be managed appropriately by the PCT until 31 March 2013.

4.2 There has been a continuous focus on implementing the information risk management and assurance framework. There was an Information Risk Policy, which formally linked to the risk management arrangements and assigned information assets to asset owners, who 'owned' and provided assurance to the senior information risk officer (SIRO) on the security and use of those assets. Training was provided to the SIRO and the information asset owners to ensure they were fully aware of their responsibilities and were competent to identify and assess information governance risks. The action plan to reduce the risks arising from the use of patient identifiable data by secondary users in accordance with Department of Health guidance and the Data Protection Act (1988) was implemented.

We had one serious incident involving a breach of patient confidentiality reported during 2012/13 as per organisational policy. The incident was recorded as a level 1 IG serious incident and a full investigation was carried out employing root cause analysis methodology. There were no patient care problems identified. The findings were fully reviewed, a robust action plan developed and the lessons learned were shared across the organisation.

County Durham PCT used the *Department of Health Information Governance Tool Kit* to review the risk and control framework for information and data. Internal awareness campaigns were held to ensure that all staff were aware of their individual and departmental responsibilities for protecting data, both in electronic and paper format. A review of information governance policies was undertaken to ensure current guidance is available to support staff in their role of protecting information. The information risk and data security framework and associated policies were assessed against the requirements of the IG Tool Kit and found to be compliant and met the requirements for 2012/13 in accordance with the *NHS Annual Operating Framework*.

By 31 March 2013 NHS County Durham and Darlington (NHSCDD) published with NHS Connecting for Health an Information Governance Toolkit (IGT) achieving full level two compliance scoring 82%. By achieving compliance with the IG toolkit NHSCDD was able to measure compliance against the law and central guidance and to ensure information was handled correctly and protected from unauthorised access, loss, damage and destruction. Our ultimate aim was to demonstrate that the organisation could be trusted to maintain the confidentiality and security of personal information. This in-turn increased public confidence that 'the NHS' and its partners can be trusted with personal data.

5	Risk and control framework

The risk management policy and strategy contributed to the overall vision and strategic aims of the organisation and supported organisational assurance. The risk management policy was an integrated process by which the organisation systematically applied procedures to the task of identifying and assessing risk, and then planning and implementing risk responses. The risk management strategy set out the management and committee structure as well as responsibilities for risk management and patient safety.

A corporate risk register was the repository for all identified risks facing the organisation. It provided a means to quantify, prioritise and manage risks. The risk register comprised:

- strategic risks derived from corporate objectives within the assurance framework,
- risks related to key performance targets, clinical and patient safety issues, commissioning of services, highlighted at the CME/TME or by directorates,
- risks related to organisational change,
- a director assigned as owner of each corporate risk with responsibility for review, escalation and on-going management,
- actions arising from reviews by external and internal audit,
- actions arising from assessments by external bodies e.g. Care Quality Commission,
- health and safety risks and action plans.

The Governance, Risk and Assurance Group (GRAG) and CME/TME reviewed the corporate risk register on a regular basis which included the regrading of risk and progress against actions.

The JARC reviewed the strategic processes and systems of governance (including quality and patient safety), risk management and internal control across the whole of each organisation's activity that supported the achievement of the corporate objectives.

In particular, the JARC reviewed the adequacy of:

- the strategic process for risk, control and governance and related disclosure statements, e.g. the Annual Governance Statement and declarations of compliance, together with any accompanying head of internal audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the CB or statutory board and the accountable officer,

- the underlying assurance processes that indicated the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements,
- the organisation's strategic policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements,
- the corporate risk register and systems and processes for the management of strategic risk,
- the policies and procedures related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Protect, the Counter Fraud Service,
- the emerging audit and risk arrangements being proposed by the CCGs to ensure they meet the requirements for authorisation by March 2013.

In carrying out this work the JARC utilised primarily the work of internal audit, external audit and other assurance functions, but was not limited to these audit functions. Reports and assurances, as appropriate to the over-arching systems of governance, risk management and internal control, were obtained from CME/TME functions together with indicators of their effectiveness. This work and that of the audit and assurance functions that reported to it are evidenced through the use of an effective assurance and risk framework.

The JARC ensured that there was an effective internal audit function that met mandatory NHS Internal Audit Standards and provided appropriate independent assurance to the JARC, Joint Chief Executive, the CB and statutory board. The JARC reviewed the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation. These included, but were not limited to, any reviews by Department of Health arms-length bodies or regulators (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

6	Review of the effectiveness of risk management and internal control

6.1 The risk management framework and processes were applied to business planning, the annual operational plan, project plans, performance framework and commissioning arrangements. This approach ensured that risk management was embedded within key activities and integrated into everyday practice. A simple demonstration of this is the requirement for all board, sub-committee and management executive papers to include a clear indication that the paper's impact has been considered against an agreed list of issues, that include legal duties, delivery of the strategic objectives and national policy requirements.

Under the risk management process, overseen by the JARC, issues were regularly reported to the GRAG, CME/TME and CB. The risk management arrangements and processes were applied to the on-going self-assessment against the requirements of external assessments. In addition, to ensure effective leadership, director objectives were mapped to the organisation's strategic objectives.

A number of sub-groups supported the delivery of the CME/TME delegated responsibilities. These also supported cross functional-working and engagement with clinicians, clinical commissioners and staff.

The CME/TME had responsibility to oversee the effective management and implementation of

all risk management processes. The Joint Director of Finance had delegated responsibility to lead the implementation of risk management and was the board level SIRO.

A number of specialists provided risk management advice and guidance to the organisation in addition to continuous testing and reporting on the main financial and IM&T systems by internal audit.

The CB was committed to the ethos that responsibility for the implementation of risk management was accepted at all levels of the organisation. The provision of appropriate training was central to the achievement of successful risk management. A mandatory risk management training programme was in place for staff relevant to their area of work or professional role within the organisation. This included an induction process for new employees. Guidance on the implementation of the risk management strategy and processes was provided to heads of department and managers.

6.2 Performance and assurance in the transition environment - The PCT Cluster Performance and Assurance Framework supported the reporting relationships and escalation routes connected with the performance and assurance framework during the year and set out the arrangements for the PCT to oversee and account for delivering its legal, financial and performance responsibilities as described in the shared operating model for PCT clusters (DH, July 2011); and the NHS Operating Framework for England for 2012/13 (DH, November 2011). The framework outlined the themes from the shared operating model and the operating framework and was agreed by the accountable leads for ensuring delivery with agreed reporting arrangements. The majority of reports were delivered by the Commissioning Support Unit (CSU).

The PCT cluster held the CSU's portfolio leads and director to account for the functions they undertook to deliver the outcomes aligned to the themes in the framework. Where the CSU undertook functions on behalf of CCGs, as their customers, it was the CCGs who owned any risks associated with delivery.

6.3 Cluster governance and risk management of the ISOP 2011/12 – 2014/15. The NHSCDD ISOP had an agreed governance route as part of the sign off process with on-going monitoring of individual areas within the plan being overseen by the Cluster Oversight Group (COG). The COG had delegated duties and was therefore responsible for the risk management of implementation plans for all relevant areas.

The organisation encouraged a transparent culture through compliance with the Freedom of Information Act (2000) and had a publication scheme. An annual general meeting was held in public and minutes of meetings of the CB are available on request by the public and through the website.

6.4 The system of internal control was 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 was based on an on-going process designed to:

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

The system of internal control was in place in CDPCT for the year ended 31 March 2013 and up to the date of approval of the annual report and accounts. I have received a Head of Internal Audit opinion with significant assurance in respect of the system of internal control.

7	Significant issues

In 2012/13 CDPCT failed to achieve 2 key operational targets, Clostridium Difficile cases and Category A Ambulance response times.

7.1 Clostridium Difficile

Our position at 31 March 2013 was 177 cases against a trajectory of 154. The PCT's performance against this key national target was reported each month at CME/TME and CB. Concern was expressed part way through the year on the deliverability of this target, and as a result it was escalated internally, in line with our performance framework. The PCT worked with partner trusts to review every case, employing root cause analysis. Action plans were monitored through the clinical quality and infection control routes. This matter was escalated by the North East SHA at regular performance review meetings. Every effort continues to be made to minimise the number of cases.

7.2 Category A Ambulance response times

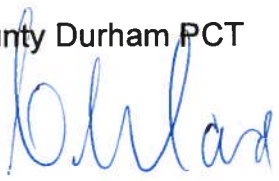
Our position at the end of March 2013 was 65.63% responses within 8 minutes against a local target of 71%. Ambulance performance was reported and discussed each month at the CME/TME and CB. We escalated performance issues through the host commissioning PCT, which resulted in us working directly with our ambulance providers. The Board and CCGs were fully briefed on the impact of our rural geography in County Durham and we continued to explore alternatives to support an appropriate safe, effective and timely response to emergency calls. This issue was escalated by the North East SHA at our regular performance review meetings.

7.3 Summary

There are no other significant issues to report.

8	Accountable Officer: Cameron Ward

Organisation: County Durham PCT

Signed: 

Date: 7.6.13