Department of Health

NHS

Cumbria Teaching Primary Care Trust

2012-13 Annual Report and Accounts

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Cumbria Teaching Primary Care Trust

2012-13 Annual Report

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Annual Report 2012/13

About this report

All NHS organisations are required to publish an annual report and financial statements at the end of each financial year.

This report provides a brief overview of the work of NHS Cumbria, also known as Cumbria Teaching Primary Care Trust (PCT), between 1 April 2012 and March 2013.

Following the passing of the Health and Social Care Bill through parliament, a number of new organisations are being developed to support commissioning. As part of these changes primary care trusts were abolished on 31st March 2013.

The report is in two parts. The first part is a short, illustrated round up of NHS Cumbria during the year 2012/13, including commentary on events which shaped our business and priorities. The report also includes information on Cumbria Clinical Commissioning Group, (NHS Cumbria's main successor organisation), and the transition into clinical commissioning.

The second part of this report is published separately and is a summary of the organisation's financial statements for the financial year 2012/13. The full financial accounts will be made available at www.cumbria.nhs.uk.

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Message from the Chief Executive

2012/13, the year of transition

2012/13 is the year of transition for the NHS.

It is the year that will see the closedown of primary care trusts and strategic health authorities, as Clinical Commissioning Groups are established and authorised to carry out the majority of local commissioning activities.

In Cumbria over the past few years, we have worked hard with our GP colleagues to ensure that more services, and the decisions made about them, are closer to home. Throughout the transition process, partners across the NHS and social care have been working together to develop new health organisations that will continue the work that we have begun.

During the lifetime of NHS Cumbria, we have developed commissioning and services in Cumbria to ensure that more people receive the right treatment in the right place at the right time, closer to where they live.

Clinicians have been the key drivers in developing improved quality of care and a greater voice for patients who are now more involved than ever before about decisions that affect their care and treatment.

Cumbria's communities have always been our county's greatest strength and it is this strength that Cumbria Clinical Commissioning Group will continue to harness as the NHS in Cumbria continues to rise to the challenges that we may face in the future.

As we come to the end of the financial year 2012/13, and the closedown of Cumbria Teaching Primary Care Trust, I wish all NHS colleagues and partners, Cumbria Clinical Commissioning Group and communities in Cumbria the very best for the future.

Regards
Sue Page
Chief Executive

A message from Cumbria Clinical Commissioning Group

Nine times of ten, when someone comes into contact with the NHS it is through their GP. GPs are the ones who prescribe the drugs, admit the emergencies, and refer people to hospital specialists.

GPs can help hospital clinicians to make sure services work for patients. It makes sense that they should be responsible for commissioning the care their patients receive. In Cumbria over the last six years, GPs have been getting the responsibility they need to make this happen, and following the authorisation of the Cumbria Clinical Commissioning Group we are now responsible for commissioning and as a statutory organisation with effect from 1 April 2013.

Following the assessment and authorisation process, Cumbria Clinical Commissioning Group was formally authorised in March 2013.

Cumbria Clinical Commissioning Group has developed a robust quality approach to our new commissioning arrangements. During the last year, as an emerging CCG, we have been developing alternative approaches to contracting, as well as continuing to support improvements.

Over the coming years we will be working to support integrated working between primary care, community and acute providers and placing quality at the heart of everything we do.

Hugh Reeve
GP Clinical Chair, Cumbria Clinical Commissioning Group

1. About NHS Cumbria

NHS Cumbria is the county's primary care trust (PCT). As a primary care trust, NHS Cumbria is the lead organisation for health in Cumbria, and decides where and how Cumbria's health budget should be spent. This is called commissioning health services, by deciding what health services should be available and where they should be delivered.

The organisation was created in 2006 following the merger of the smaller primary care trust's which covered Cumbria. The full, legal title of NHS Cumbria is 'Cumbria Teaching Primary Care Trust'.

NHS Cumbria is the biggest primary care trust in the North West region, and serves a population of around 500,000 over an area covering 2,600 square miles.

In addition to commissioning a wide range of health services, NHS Cumbria is also responsible for ensuring that people across the county have access to primary care services – these are the services you would normally access when you first have a health problem and include 82 GP surgeries, 89 NHS dental practices, 107 pharmacies and 77 opticians.

NHS Cumbria does not directly manage acute hospitals, which are independent trusts, but commissions services from North Cumbria University Hospitals NHS Trust, which manages the Cumberland Infirmary in Carlisle and West Cumberland Hospital in Whitehaven, and University Hospitals of Morecambe Bay NHS Foundation Trust, which manages Furness General Hospital in Barrow-in-Furness, Westmorland General Hospital in Kendal, Ulverston Community Health Centre and the Royal Lancaster Infirmary. Services are also commissioned from North West Ambulance Service NHS Trust which provides ambulance services in Cumbria, and Cumbria Partnership NHS Foundation Trust which provides mental health, learning disability, drug and alcohol services (until April 2012), condition management services, acquired brain injury services and community health services.

Cumbria Partnership NHS Foundation Trust also manages all of the nine community hospitals in Cumbria at Alston, Brampton, Cockermouth, Keswick, Maryport, Millom, Penrith, Wigton and Workington as well as step-up/step-down units at Reiver House - Carlisle, Copeland Unit - West Cumberland Hospital, Langdale Unit - Westmorland General Hospital and Abbey View - Furness General Hospital. These units provide care for patients who need more treatment than they can receive at home, but who don't need to be in hospital.

From April 2013, Cumbria Clinical Commissioning Group will take over the role of commissioning most local health services from NHS Cumbria following the passing of the Health and Social Care Bill 2012. Cumbria Clinical Commissioning Group is made up of lead GPs who each support a locality executive (each serving Carlisle, Eden, Allerdale, Copeland, South Lakeland and Furness).

The 82 GP practices in Cumbria (and Bentham in North Yorkshire) are represented on these groups as the CCGs member practices. Each executive is responsible for commissioning hospital, nursing and other health services for people in their area; helping to provide more health services, and decisions taken about them, closer to where people live.

1.1 Vision, aims and objectives

Objective: To improve the health and wellbeing of the residents of the county.

Vision: To improve the health and wellbeing of all people in Cumbria and help them to stay active, independent and in control for as long as possible.

Aims:

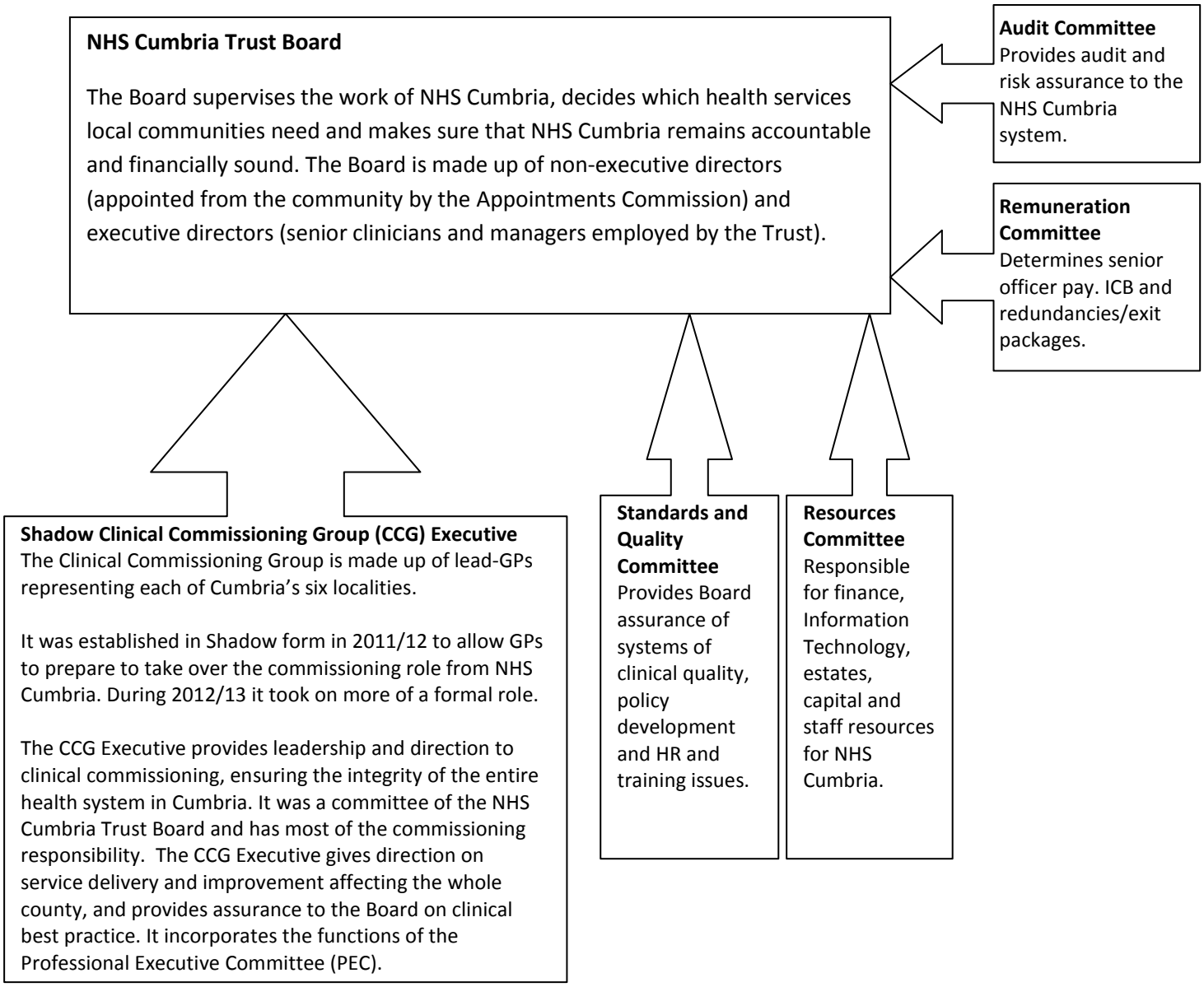
- Better Health: Improve health and reduce health inequalities
- Better Life: Improve independent living and self management of care
- Better Care: Improve the way we deliver care and increase ownership and engagement

Quality of healthcare

NHS Cumbria's five corporate quality objectives:

- **Commission for quality**. To ensure all commissioning strategies and service specifications have clear quality outcomes.
- **Improving quality.** To lead advances in the quality of care in NHS Cumbria based on a continually refreshed framework for quality improvement.
- **Making an impact.** To make a demonstrable impact on the quality and safety of patient care and treatment linking with patient safety, governance and risk systems in providers but as commissioners be able to measure impact on populations and groups of service users and patients
- **Sharing the knowledge.** To contribute to the advancement of knowledge and understanding of quality improvement.
- **Working effectively and productively.** To ensure the NHS in Cumbria delivers its functions effectively and efficiently.

1.2 Decision-making structure



1.3 Who's who

Ian Gordon – Chair (to February 2013)
Mary Dowling - Chair (from February 2013
Sue Page - Chief Executive
Dr Hugh Reeve – Cumbria Clinical Commissioning Group Chair

Executive and other Directors
John Ashton - Director of Public Health
Michael Bewick - Medical Director
Ross Forbes - Director of Corporate Affairs
Sue Page - Chief Executive
Nigel Maguire – Chief Operating Officer
Charles Welbourn – acting Director of Finance

Johanna Reilly - Locality Commissioning (on Secondment from July 2012)
Mark Graham - Communications
Moira Angel - Nursing
Rosalind Fallon - Performance

Non Executive Directors
Allan Buckley
Bob McCulloch
Ian Gordon - Chair (to February 2013)
Keith Little
Mary Dowling - Chair (from February 2013)
Peter Nuttall
Shirley Reveley

Cumbria Clinical Commissioning Group
Nigel Maguire – Chief Executive
Hugh Reeve – Chair of Cumbria CCG
Charles Welbourn - Director of Resources
Anthony Gardner – Network Director South Lakeland and Furness
Caroline Rea – Network Director Allerdale and Copeland
Ellie Roddick – Network Director Carlisle and Eden

The six Lead GPs on the Shadow Cumbria Clinical Commissioning Group Executive are:
Rachel Preston – Eden GP Commissioning Lead (Cameron Munro held the role to April 2012)
David Rogers - Copeland GP Commissioning Lead / Deputy Medical Director
Fayyaz Chaudhri – Allerdale GP Commissioning Lead
Geoff Jolliffe – Furness GP Commissioning Lead
Alistair McKenzie - South Lakeland GP Commissioning Lead
Colin Patterson Interim Carlisle GP Commissioning Lead (Peter Weaving held the role from April 2012 to December 2012).

2. Organisational Change

During 2012/13 colleagues at NHS Cumbria were supported through the NHS Transition and the matching, pooling and recruitment process into roles in new receiver organisations. These receiver organisations have developed as part of reforms to the NHS that are outlined in *Liberating the NHS* and the Health and Social Care Act 2012.

Cumbria's Clinical Commissioning Group (CCG) was established in shadow form during 2011/12 and went through an authorisation process that saw the CCG authorised in December 2012 with one condition and fully authorised in March 2013.

Alongside the authorisation of the Cumbria CCG, several other new organisations were developed prior to the abolition of primary care trusts and strategic health authorities in April 2013:

NHS Commissioning Board (NCB)
Cumbria CCG will be supported by a new body, the NHS Commissioning Board. The Board will authorise clinical commissioning groups, allocate resources, and commission certain services, such as primary care. A Local Area Team of the NCB will span Cumbria, Northumberland, Tyne and Wear.

North of England Commissioning Support Service (NECS)
Back-office support services will be delivered by the North of England Commissioning Support Service. Around 30 commissioning support services have been created nationally to support CCGs, they are hosted by the National Commissioning Board (NCB) until 2016 when they are expected to become independent bodies.

Public Health
Action to protect and promote the health of the population will be led nationally by a new public health service, Public Health England - an agency of the Department of Health. At a local level, Cumbria County Council will take the lead role for public health in the county, with public health colleagues formally transferring to the council on 1st April 2013.

Close working relationships between the NHS Cumbria and the Local Authority has facilitated speedy development of the Health and Wellbeing Board to become an effective local system leader across health, social care and public health, and will ensure smooth transition of the public health function to Cumbria County Council.

Since 2011/12, when Cumbria Clinical Commissioning Group were established in shadow form, the CCG has developed their vision, aims and objectives, policies and processes, governing body and membership to ensure effective transition to the new commissioning architecture.

Cumbria has a strong Clinical Commissioning Group with good clinical leadership and involvement of member practices.

3. Review of the year

2012/13 has been a year of transition, as new organisations were developed and NHS Cumbria prepared to devolve responsibilities to new receiver organisations within the new NHS architecture.

Supporting the transition to ensure the delivery of high-quality services, based on clinical decision making and integrated care for patients and service users, has been the focus of the year for NHS Cumbria.

April

NHS Cumbria hosts national conference on using IT to share information

NHS Cumbria has been gradually introducing a local 'shared record' system across the county to help improve patient care. This is through creating a secure electronic record which summarises important patient information. This is can then be shared between GPs and different health services with an individual's permission.

Health professionals, doctors and NHS managers from across the country visited Cumbria to learn more about Cumbria's experiences and share best practice to help organisations who may also be looking to establish an effective and secure way to share important patient information.

May

Cumbrian GPs launch campaign to hear patients' views

GPs across Cumbria are keen to prove that they are 'Listening to Cumbria' and hear people's views and experiences of local NHS services. In May, 'Listening to Cumbria' was launched by Cumbria Clinical Commissioning Group (CCG) to gather views from the people of Cumbria on the good and bad points of their local health services.

A series of roadshow events were held around the county, with views gathered used to inform future decisions on health services. Cumbria CCG is using the 'Listening to Cumbria' as a platform for future patient engagement.

June

First Community Cancer Champions for Carlisle

Catching cancer early is important. Community Cancer Champions is a joint project involving NHS Cumbria Carlisle Locality, Macmillan Cancer Support and Carlisle City Council which aims to recruit and use volunteers to help deliver messages within their communities around cancer awareness and early cancer symptoms.

The champions work with people in their own neighbourhoods or with the groups that they already attend such as; gardening, or bingo to help raise awareness of the signs and symptoms of cancer. As the scheme develops it will roll out to other areas of Cumbria.

July

More people referred for lung cancer checks following Cumbrian Cough Cough campaign

Feedback from the Department of Health showed that during Cumbria's lung cancer campaign called Cough Cough more people were also referred for urgent two week cancer tests than the year before and, as a result after these tests, there was a 61 per cent increase in people subsequently diagnosed with lung cancer.

The Cumbria Cough Cough campaign aimed to raise people's awareness of the early signs and symptoms of lung cancer and the importance of an early diagnosis. Following the success of the last round of the campaign there will be another round of public awareness raising planned to begin in September 2012.

August

Major investment in Cumbria's community hospitals and medical facilities

The final phase of a three year, £7.6 million investment in Cumbria's community hospitals, health centres and clinics began in August.

The NHS Cumbria project to bring all community hospitals up to CQC standards, also includes refurbishing the occupational therapy and physiotherapy unit at West Cumberland Hospital and complete redesign and fit out of two dental facilities in Kendal and Alston.

September

Free 'health MoTs' for Cumbrians

People aged 40-74 in Cumbria began being invited for a free health check at their GP practice in September as part of a national campaign.

Those invited were offered screening for heart disease, stroke, diabetes and kidney disease. Together, these four conditions are the largest cause of death in Cumbria.

Doctors believe the assessments, which will be available to those not already diagnosed with one of the four conditions, will save lives and cut the number of people in Cumbria affected by these illnesses.

October

Cumbria's GPs prioritise plans to reduce the hundreds who die prematurely in Cumbria

Currently around 745 people a year in Cumbria die prematurely from cancer under the age of 75, and Cumbria's lead GPs want to reduce this number.

Reducing premature cancer deaths and a further reduction in the number of people who die aged under 75 from circulatory disease is just one of the key priorities which Cumbria's new lead commissioning GPs have laid out.

As part of the NHS transition, Cumbria Clinical Commissioning Group published its key priorities in October. They include:

- Improving care to respond to the challenges of an ageing population
- Improving the health of children and young people and the quality and integration of care services
- Improving mental wellbeing and reducing alcohol misuse
- Reducing health inequalities and premature mortality from cancer and cardiovascular disease

November

Improvements to Cumbria's mental health services for children and young people

More nurses, more consultant psychiatrists and extended opening hours, are just some of the improvements planned for children and young people's mental health services in Cumbria following an independent countywide review.

Cumbria CCG and Cumbria Partnership NHS Foundation Trust jointly commissioned an independent review of Child and Adolescent Mental Health Services (CAMHS) in Cumbria amidst a rise in demand for its services and changing and improved clinical guidance.

In November, a joint implementation plan was agreed by Cumbria CCG and Cumbria Partnership NHS Foundation Trust, who run the CAMHS service in Cumbria, to make improvements to the service.

December

Cumbria's GPs get the nod to become an NHS Commissioning Organisation

In December, NHS Cumbria Clinical Commissioning Group was authorised by the NHS National Commissioning Board to become a standalone Statutory NHS Organisation. This means that Cumbria CCG is deemed able to handle Cumbria's local commissioning budget and make clear decisions about how services will be designed and where they should be delivered.

The new GP led clinical commissioning system will focus on delivering improved clinical outcomes, patient safety, quality, innovation, public participation and patient experience that will bring real benefits to patients and the public.

From April 2013, as part of the government health reforms, primary care trusts will no longer exist.

January

Local NHS services join together to look at the future of healthcare across Morecambe Bay

Patients, members of the public and groups across North Lancashire and South Cumbria will this year have the opportunity to share their views on the future of local health services.

In January, local NHS organisations including University Hospitals of Morecambe Bay NHS Foundation Trust, NHS Cumbria Clinical Commissioning Group and Lancashire North Clinical Commissioning Group all agreed to work together to develop a strategy for how hospital services linking to wider health services in the community and primary care will work in the future around the Morecambe Bay area, and began an engagement process with the local community.

February

Report finds more can be done on stillbirths and infant mortality

Stillbirths and infant mortality in Cumbria are declining but more can be done to reduce rates further according to a report published in February by NHS Cumbria.

The report, one of the most detailed of its kind, finds that perinatal deaths in Cumbria have been consistently falling over the last five years and are below the regional and national average.

Despite the low numbers, the report says more can be done to reduce rates further through better clinical care and tackling lifestyle issues, such as smoking and obesity. The full report can be found at www.cumbria.nhs.uk.

March

NHS Cumbria closedown

NHS Cumbria, the county's primary care trust, will close on 31 March 2013, and its responsibilities will transfer to a range of new and existing organisations.

The change is part of the government's health reforms contained the Health and Social Care Act 2012 which will also see the end of strategic health authorities.

An interactive diagram of the new health and social care system from 1 April 2013 is available at healthandcare.dh.gov.uk/system.

4. How we have performed

The NHS priorities and direction for 2012/13 were set out in the NHS Operating Framework. This NHS Operating Framework sets out the planning, performance and financial requirements for NHS organisations in 2012/13 and the basis on which the PCT is held to account.

The NHS reforms set out a clear strategic vision around transforming service delivery so that it is focused on better outcomes for patients with real decisions increasingly being taken by patients and their GPs and services being held to account by them. This has been the basis for the development of engagement mechanisms that will be used by Cumbria CCG.

Delivery of high-quality services, based on clinical decision making and integrated care for patients and service users, will provide a strong platform for future years.

To improve services for patients, there were four key themes for all NHS organisations during 2012/13, as detailed in the NHS Operating Framework:

- putting patients at the centre of decision making in preparing for an outcomes approach to service delivery, whilst improving dignity and service to patients and meeting essential standards of care;
- completion of the last year of transition to the new system, building the capacity of emerging clinical commissioning groups (CCGs) and supporting the establishment of Health and Wellbeing Boards so that they become key drivers of improvement across the NHS;
- increasing the pace on delivery of the quality, innovation, productivity and prevention (QIPP) challenge; and
- maintaining a strong grip on service and financial performance, including ensuring that the NHS Constitution right to treatment within 18 weeks is met.

We are externally assessed and benchmarked against other organisations through a number of routes, including the Strategic Health Authority and through peer review. Assessment is based on a set of National Performance Measures. NHS Cumbria continues to build on the performance in previous years and has demonstrated improvement against a number of performance standards in 2012/13.

Maintaining and Improving Quality

During the 2012-13 contracting round, which commenced January 2012, Cumbria CCG agreed with North Cumbria University Hospital NHS Trust (NCUHT), University Hospitals of Morecambe Bay NHS Foundation Trust (UHMB) and Cumbria Partnership NHS Foundation Trust (CPFT) trajectories for achieving KPIs. However by the end of 2011-12 the CCG and PCT Cluster recognised that performance was likely to deteriorate until new leadership arrangements were established at both Acute trusts which would lead to any period of sustained improvement. This was reported to NHS North at the Year End Review in May 2012, the Quarterly Review in August 2012 and the Mid Year Review in December 2012.

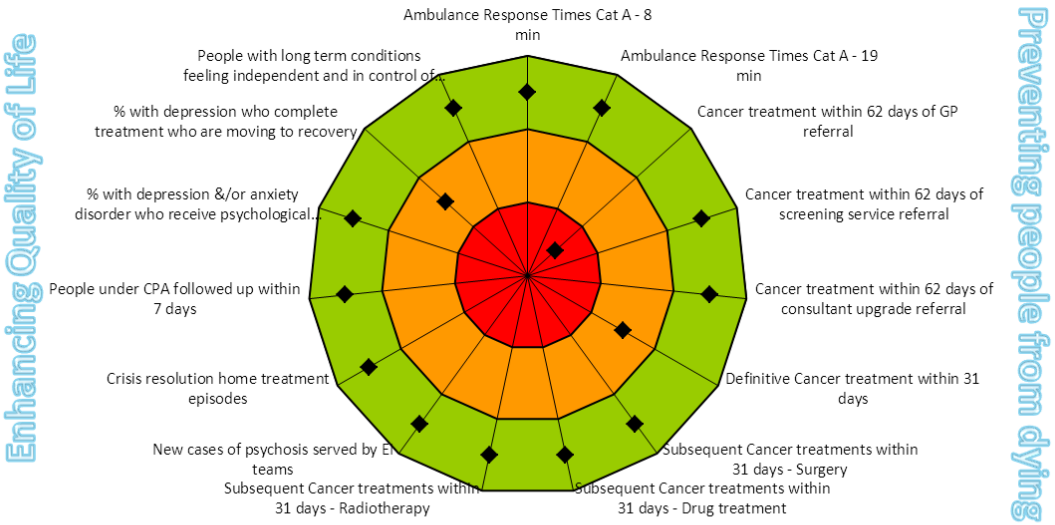
Whilst both trusts demonstrated some improvement in year against some of the KPIs predicted, deterioration was well underway by late quarter 2 and continued throughout the winter as both trusts experienced operational pressures. The PCT Cluster and Cumbria CCG worked with both trusts throughout the year to rebase plans however the revised plans were not achieved and maximum penalties were applied to each trust contract where performance was not achieved.

With CPFT the Cluster and CCG agreed a joint action plan to address deficiencies in children's services, notably child and adolescent mental health services, identified through the review process.

In summary the PCT Cluster underperformed against the Referral to Treatment (RTT), Accident & Emergency (A&E), Healthcare Associated Infections (HCAI) and Stroke indicators.

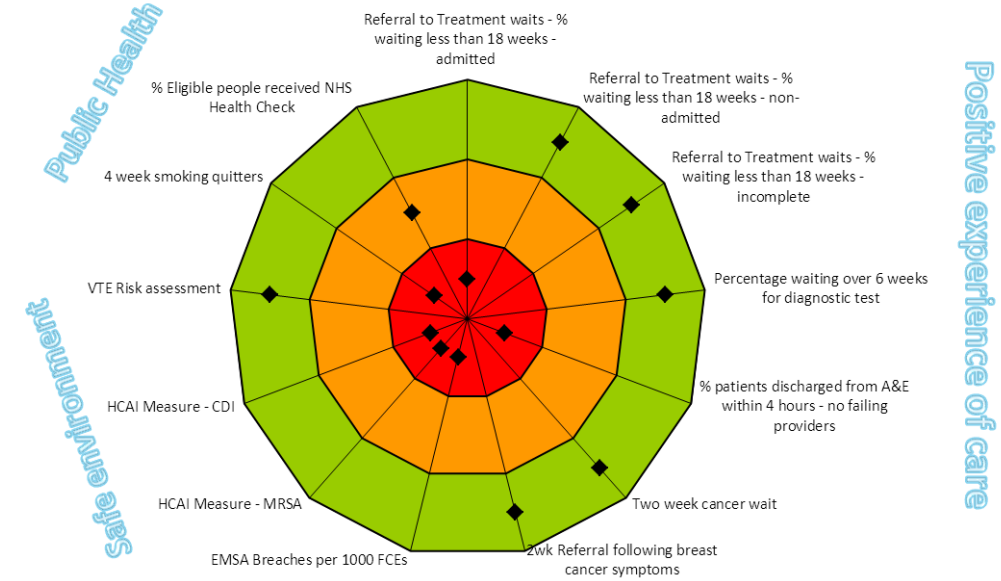
The PCT Cluster also underperformed against Mixed Sex Accommodation (MSA), Diagnostics, Smoking Cessation and the recovery rate performance indicator of Improving Access to Psychological Therapies (IAPT).

National Performance Measures 2012-13
Quality
- Preventing people from dying
- Enhancing quality of life for people with LTC
Predicted Performance (at May 2013)



Green = Achieving Target Amber = Underachieving against Target Red = Failing against Target

National Performance Measures 2012-13
Quality
- Ensuring that people have a positive experience of care
- Treating & caring for people in a safe environment
- Public Health
2012-13 Predicted Performance (at May 2013)



Green = Achieving Target Amber = Underachieving against Target Red = Failing against Target

In 2012/13 NHS Cumbria is predicted to achieve the year-end targets in eighteen of the 27 Quality measures. NHS Cumbria has always worked to improve the quality of the services it commissions on behalf of the population. Detailed reviews have been carried out and action plans have been implemented with local acute providers to improve standards in the failing quality measures across Cumbria.

4.1 Environmental performance

As one of the world's largest organisations, the NHS has an important role to play in reducing carbon emissions. Taking sustainability and carbon emissions seriously is an integral part of providing a high quality health service and through this money can be saved that can be reinvested directly into patient care.

Throughout the past year, NHS Cumbria has continued to review and introduce additional energy saving devices where practical.

To further reduce the organisations carbon footprint, where appropriate, staff are provided with home working facilities as well as access to video and teleconferencing facilities. Taking this approach minimises the need for travel. In addition our lease car company provide driver incentives to encourage staff to choose environmentally friendly vehicles.

5. Governance

5.1 Risk Management

NHS Cumbria is committed to commissioning health services of the highest quality and safety, where risks to the care of patients, staff and visitors are minimised.

The governance strategy for the organisation supports and embeds the principles of risk management at all levels and functions of the organisation. The overall aim of the strategy is to ensure that all risks associated with the business of the primary care trust are managed appropriately and minimised to the lowest possible level at every available opportunity. The governance arrangements are reviewed on a regular basis.

The Risk Assessment Policy describes the systems in place for identification, management and monitoring of risk in both commissioning and provider services in order to effectively manage risk associated with the business of the Trust. It includes risk assessment guidance on control measures and tools to complete and effectively manage risk assessments.

NHS Cumbria operates a Risk Register which is populated through the identification and evaluation of risks from a number of sources both internal and external. Examples of the sources of risk include national enquiries and standards, high level primary care trust objectives, business plans, health and safety, clinical service change, risk assessment, incident reviews, complaints, claims and self-assessments. In the context of the NHS in 2012/13 particular attention has been given to risks associated with transition.

NHS Cumbria's established risk grading system is used to evaluate risk and calculate the risk grading by considering the likelihood that the hazard may cause harm and the potential consequences. NHS Cumbria utilises a Risk and Assurance Framework, as a way of linking business objectives to key risks and identifying areas for further action (gaps in assurance or control). This is the basis for completing the Statement of Internal Control.

The Risk and Assurance Framework is set against the key strategic objectives for the primary care trust. The framework considers each of these objectives in relation to the risk presented, the control measures in place to minimise the risks, the mechanisms for providing assurance, the effectiveness of

control measures and outstanding issues in relation to both control and assurance provided. The framework also links explicitly to the NHS Cumbria Corporate Risk Register to ensure that risks affecting the delivery of objectives are managed effectively. The Risk and Assurance Framework for the organisation has been approved and reviewed by the Audit Committee to provide the Trust Board with assurance that progress is being made to address gaps in assurance and/or control. The Audit Committee approves updates to the framework every six months.

Providing a safe environment at NHS Cumbria is the responsibility of all members of staff and is a particular focus as more services are delivered closer to home.

The Principles of our approach to risk are:-

i. That risk assessment and management is owned by those who can take appropriate action to reduce the risk through mitigation plans
ii. That roles, responsibilities and reporting mechanisms are clear
iii. That risk management is embedded into planning and development
iv. That performance management of risk mitigation action plans is in place

The application of risk assessment and successful risk management ensures the Trust fulfils its function as a public body within legislative requirements, and enables services to remain safe and effective for all.

5.2 Clinical governance

Care Quality Commission Regulations

Clinical governance is the system through which NHS Cumbria are accountable for continuously improving the quality of services, safeguarding high standards of care and providing an environment in which clinical excellence will flourish.

From April 2010, a new registration framework was introduced under the Health and Social Care Act 2008. Under this system, health and adult social care providers (including the NHS) are required to register with the Care Quality Commission under a coherent framework that aligns the regulation of health and adult social care, across public and independent sectors. This also demonstrates to service users, carers and local communities that services are achieving the essential standards of quality and safety. These regulations are based around patient experience and outcomes rather than just systems, policies and procedures, and help ensure that we are listening to our patients and implementing robust systems which enable high quality services and outcomes for the people who use our services. Further information is available on the Care Quality Commission website at www.cqc.org.uk.

Whilst NHS Cumbria is not required to be registered with the Care Quality Commission, we do have a duty to work both proactively and reactively with the Regulators. This includes sharing intelligence regarding health and social care providers. NHS Cumbria has a system wide role, working with Regulators, the independent sector, partners in social care and other healthcare providers to ensure the immediate safety for service users where Regulators have identified areas of serious concern regarding quality and safety.

NHS Cumbria adheres to the concept that quality care can only be successfully developed and implemented through strong clinical leadership and public involvement. The development of the Cumbria Clinical Commissioning Group arrangements during 2011/12 further advances our commitment to ensuring strong clinical leadership and engagement in the commissioning for quality and contracting processes.

Serious Untoward Incidents

NHS Cumbria, as commissioner, has been working closely with providers over the last three years to take a systematic approach to developing a robust monitoring, review and reporting system for Serious Untoward Incidents (SUIs) and near misses. NHS Cumbria has a high level serious untoward

incident group that meets to monitor this process and take action if required. It invites representatives from all service providers to discuss their mitigating actions and to share practice changes resulting from learning from serious untoward incidents. This has led to improvements in the reporting of incidents, and more consistent handling of reviews. NHS Cumbria ensures that action plans are developed that address key learning points, mitigating against reoccurrence and ensuring that these plans are followed through to completion. This has allowed lessons learnt to be used to improve the future commissioning of safe, high quality health services. NHS Cumbria also closely monitors and applies the system above to other serious untoward incidents including issues in relation to Adult and Child Safeguarding. Neela Shabde, as Medical Director (Children), supports the development of Safeguarding policy and processes, working with other NHS trusts and partners across Cumbria.

As commissioners, NHS Cumbria continues to champion effective clinical governance across the health economy making the best use of the intelligence available across the system on matters of quality and safety in commissioning and contracting arrangements.

Infection Control
The prevention and control of infection is a top priority across Cumbria. Health care associated infections have been tackled successfully in recent years with the number of reports of patients suffering MRSA bacteraemia falling from 37 cases in 2007/08 to 14 cases in 2009/10, 10 in 2010/11 and 9 in both 2011/12 and 2012/13. Similarly the number of patients suffering Clostridium difficile associated diarrhoea has fallen from 787 cases reported in 2007/08 to 457 reports in 2009/10, 245 in 2010/11, 231 in 2011/12 and 220 in 2012/13.

Mandatory training to promote good practice and ensure continuing downward trends in rates of infection is provided to NHS staff across Cumbria by Trust Infection Prevention Teams. NHS Cumbria Infection Prevention Nurses have been working with both Cumbria Care Sector Alliance and Cumbria Care, providing support to private and voluntary care provider organisations on infection prevention and control measures.

Audit and regular feedback continue to be used to provide assurance that the issue of health care associated infection is being addressed and infection prevention and control measures applied correctly and consistently.

Communications and public awareness campaigns on reducing the spread of infection including antibiotic awareness are launched throughout the year.

Campaigns focus on hand hygiene for health care staff, patients, visitors and the community, as well as self-care advice to reduce infections spreading and the importance of vaccination to limit the spread of illnesses such as flu.

5.3 Disclosure of serious untoward incidents
No serious untoward incidents involving personal data were reported to the Information Commissioner's Office in 2012/13 as they did not meet the required criteria for reporting as stipulated in the Chief Executive of the NHS – Information Governance Assurance Programme Letter (20 May 2009).

5.4 Ensuring safety of personal information
During 2012/13, safeguarding personal information has remained a high priority for NHS Cumbria.

UK and European laws demand that personal information is protected and legal action can be taken against either individual members of staff or the organisation (or both) if protection is not in place. In addition, regulatory bodies, including the Information Commissioner, exist to make sure we look after information properly and these bodies can impose fines or, in the worst case, could even order the NHS to stop handling people's information.

The way in which the NHS handles information is called information governance (IG) which ensures that all personal information is dealt with legally, securely and effectively to help deliver the best possible care.

NHS organisations are assessed against a set of 41 requirements known as the "IG Toolkit". NHS Cumbria maintains a satisfactory score for the toolkit assessment.

Ultimate responsibility for information governance in NHS Cumbria rests with the Board. The Board has ensured:

- Information governance is explicitly referenced within the organisation's statement of internal controls.
- Ross Forbes was the Board level Senior Information Risk Owner (SIRO). The SIRO leads our approach to information risk ensuring it is effective in terms of resource, commitment and execution and that the Board is adequately briefed on safety mechanisms and processes.
- A Board level Caldicott Guardian, Dr John Ashton, is in place. Caldicott Guardians are senior staff in the NHS and social services appointed to protect patient information.
- Appropriate information governance training is mandatory for all users of personal data and for all those in key roles.
- The annual information governance assessment, via the Information Governance Toolkit is complete for 2012/13
- Details of serious untoward incidents involving actual or potential loss of personal data or breach of confidentiality are published in annual reports and reported to the NPSA and the Information Commissioner.
- The Information Governance Group and NHS Cumbria Business Group provided assurance to the IG processes and sign off improvement plans against each sequence number in the IG toolkit.

Expertise from the Information Governance Manager and Information Security Manager are in place through a Service Level Agreement with Cumbria Partnership Foundation Trust.
There have been concerted efforts to remind staff of the need to ensure the safety of personal data and the requirement for all staff to demonstrate an appropriate level of knowledge through on-line IG training and face to face training workshops.

5.5 Your right to access information
NHS Cumbria respects the rights of individuals to have as much information as possible about their diagnosis, treatment and/or employment and ensures that the Data Protection Act 1998 is fully implemented. The DPA 98 gives every living person or their authorised representative, the right to apply for access to their health and/or employment records irrespective of when the records were compiled. This is called a Subject Access Request.

Without detracting from the need to record what is in the best interest of patients/clients, all health professionals are advised to compile records on the assumption that they will be accessible to patients.

The Freedom of Information Act 2000 gives the right to all individuals to request access to information held by the Trust. The aim of the Act is to create a climate of openness in the public services and amongst other things, to inform people how public authorities make their operational decisions and how public money is used. Requests should be made to the Freedom of Information Administrator at Trust Headquarters.

In some cases, however, information may not be provided; this is where an exemption applies. An example of this is where the required information contains personal information (this will continue to be covered by the conditions of the Data Protection Act 1998). Another is where the requested

information is available by other means – if it is on our website or Publication Scheme, so you may need to check there first before putting in a request for information.

In some circumstances a fee may be payable for Subject Access Requests or FOI requests where the costs to gather the requested information exceeds designated limits. If that is the case a fees notice will be issued. NHS Cumbria has complied with Treasury's guidance on setting charges for information.

5.6 Information Technology
Healthcare professionals rely on good communication with their patients - and with each other – in order to provide the best quality care.

Shared records have been introduced at GP surgeries and community health services across Cumbria to improve communication between health professionals. With patient consent, limited information from a patient's medical record is collated on a secure remote access system and can be accessed and shared between health services more safely and effectively.

This means the most accurate and up-to-date information on a patient's health such as such as medication, allergies and on-going treatment is stored in one place and can be remotely accessed and updated by health staff involved in a patients care.

This supports consultations and reduces administration costs and travel time needed to update records at health centres and doctors' surgeries.

During 2012/13, the patient population of Cumbria was also informed about plans to launch the national Summary Care Record in Cumbria and given the opportunity to opt out. Summary Care Records will be enabled in Cumbria after April 2013.

6. Compliments, comments and complaints

NHS Cumbria aims to improve the health and wellbeing of people in Cumbria by ensuring that service users receive the highest possible standards of health care. Your experiences and views, good and bad, help us to understand what we are getting right and where we could do better. We use your feedback to help us to learn and continually improve our services.

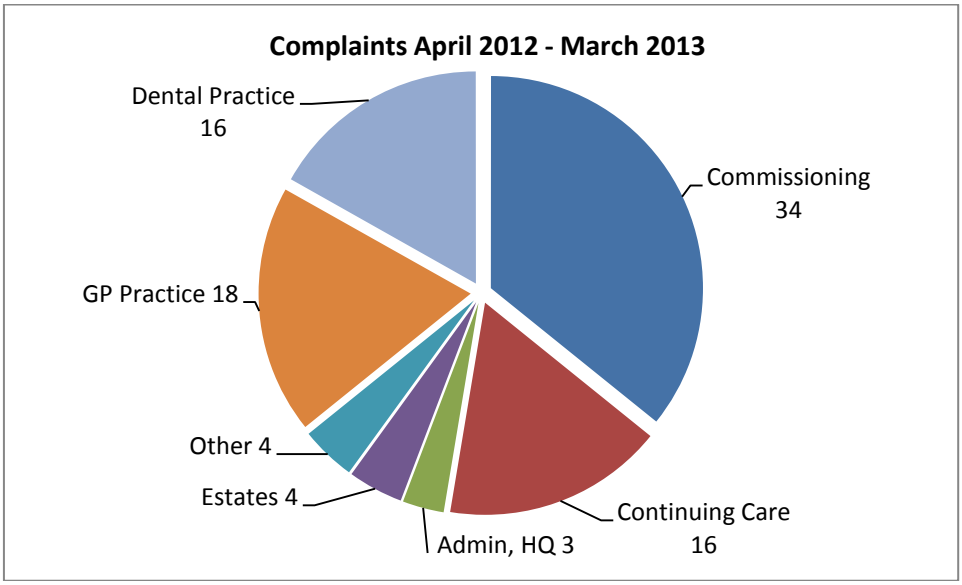
We take all complaints and concerns very seriously and endeavour to respond quickly if you feel dissatisfied with some aspect of your care or the services you have received from NHS Cumbria.

We seek to ensure that we use your concerns and complaints as a way of improving our services. We do this by reflecting the Health Service Ombudsman's Principles of Remedy.

In particular we work to constantly ensure that we are open and accountable and that we act fairly and proportionally, putting right things that go wrong and seeking to learn from our mistakes.

All healthcare providers must provide a complaint service within the requirements of Complaint Regulations 2009. Often the problem can be resolved quickly and easily with those directly involved with the issues – this is called local resolution. Local resolution can also provide you with a more formal process if necessary. Complaints about GPs, dentists, pharmacists or opticians should be directed to the service's manager in the first instance and, following the closedown of NHS Cumbria, to NHS England.

Number of Complaints received from April 2012 – March 2013 regarding services NHS Cumbria provided, commissioned and contracted (figures do not include complaints that have been made directly to GP or Dental Practices, pharmacies or the prison service).



Category	Total
Access To Appointments	7
Access To Premises/facilities	3
Appointment Delay	2
Attitude - Clinical Staff	2
Attitude - Admin Staff	3
Breach Confidentiality Staff	1
Communication - GP Practice	1
Complaints Handling	3
Consent	1
Cost Of Treatment	4
Delay In Diagnosis	2
Delay In Treatment	2
Failure To Follow Procedures	1
Funding	40
Nursing Care	1
Outcome Of Treatment	12
PCT Commissioning	3
Prescribing	4
Problems With GP Referral	1
Access To CAMHS Service	1
Missing Records	1
Grand Total	95

During 2012/13, NHS Cumbria's Patient Advice and Liaison Service (PALs) listened and responded to patient concerns, answered patient and public questions, signposted to other support services and helped to improve services by listening to what matters to you.

For more information on the NHS Cumbria complaints and resolution process and PALS, visit www.cumbria.nhs.uk/YourSay/ComplaintsComments.

7. Emergency Preparedness

NHS bodies play a key role in planning for and responding to emergencies. This is stated in the Civil Contingencies Act 2004.

NHS Cumbria is designated under the Act as a Category 1 responder, requiring us to have robust multi-agency mechanisms in place to ensure an effective response to incidents and put in place emergency plans and business continuity arrangements.

For NHS Cumbria, responsibility includes independent health services including GPs, Dentists, Pharmacists and Opticians. Independent contractors, especially GP surgeries, play a vital role in an emergency response, yet are not classed as 'Category 1' responders and therefore have no legal requirement to plan for an emergency.

Provider organisations are responsible for their own services and emergency preparedness, however NHS Cumbria plays a key role in the response if a Major Incident is declared that involves any provider organisation. This includes provision for a 24 hour emergency response.

NHS Cumbria leads the strategic NHS response at the request of the Strategic Health Authority, and represents all NHS Trusts within Cumbria at the Local Resilience Forum and at the multi-agency Strategic Coordinating Group.

NHS Cumbria, through their Major Incident Team, will direct partners as to how services are to be deployed in response to declared Major Incidents by coordinating and monitoring the local NHS response in Cumbria, including the response of Cumbria NHS Trusts, the Ambulance Service, Out of Hours, the National Blood Service and NHS Direct. This includes advising (and providing strategic direction to) all local NHS organisations in the county to make major decisions including implementing their major incident plans, evacuating, closing, and standing down major incident plans. Subject to the immediacy of the decisions, this will normally be in consultation with NHS North of England.

In Cumbria our highest area of risk is assessed as being from pandemic influenza, followed by flooding and technical failure of the electricity network.

In order to ensure that we are fully prepared to respond appropriately to any incident, emergency planning also involves training and exercising to simulate an emergency situation, enabling us to test our emergency plans, systems and procedures and rehearse key staff roles.

NHS Cumbria has participated in several multiagency major exercises during 2012/13 with partner agencies to prepare for an event. Staff have also received training in Supporting People in Emergencies and have undertaken the training in recovery from a nuclear incident.

All on call staff have received training in the use of the National Resilience Extranet, the national emergency communications system that enables responders to have access to key information up to and including restricted level documents for multi-agency working, communication and response.

NHS Cumbria had a Major Incident Plan that was fully compliant with the requirements of the NHS Emergency Planning Guidance 2005 and all associated guidance.

Business Continuity
Business continuity is a process that helps ensure that if a disruption occurs, key functions will be managed so that the organisation can continue to provide a viable service.

Business continuity processes are most often implemented during periods of adverse weather, when resources such as staffing are diverted to priority areas such as at-risk and vulnerable patients.

All departments within NHS Cumbria have a responsibility to conduct a Business Impact Analysis (BIA) and then to develop a functional business continuity plan to ensure services are maintained and prioritised during periods of high demand or during a major or unusual incident.

Support and the role of the public
Part of the role of NHS Cumbria during a major or unusual incident is to provide information to the public. This is done through media announcements, providing support literature or commissioning increased support services.

Our experience in Cumbria has shown us the invaluable contribution of ordinary citizens in sustaining each other – particularly through support after the acute phase of an incident and while moving into recovery.

By becoming more resilient, our community can complement the work of local emergency services and reduce the impact of an emergency.

To emphasis the role members of the public can play in responding to emergencies, the 2012 Annual Public Health Report includes a personal resilience guide with practical information on how to prepare for an emergency and basic first aid advice.

8. Our employees

8.1 Communicating with our employees
NHS Cumbria strives to maintain open and two way communications with our employees to ensure our staff feel informed, engaged and involved, and to ensure NHS Cumbria benefits from our employees' extensive experience and knowledge. Employees are also vital communicators with the wider public and patients, helping deliver health messages.

The spread of staff across the county means that we have developed corporate communication tools which involve face-to-face, digital and print-based communication approaches. This complements the more direct involvement and engagement of staff in operational and service planning issues affecting their own services.
As part of our continuing drive to improve communication with staff and support staff through the NHS transition, in the last year we have:

- Continued to deliver staff and GP e-newsletters - 'Cumbria Roundup' and 'GP Roundup' - featuring a summary of corporate messages to reduce corporate email traffic.
- Continued to deliver the Team Briefing system. This is a monthly cascade of corporate information and decisions which is delivered face to face by managers to their teams. Team Brief also provides an opportunity for employees to ask questions and feed comments back to the Senior Management Team. Previous Team Brief staff feedback and questions are shared with staff each month.
- Developed the staff intranet site to support internal communication. Particularly a section on 'Changes in the NHS' that gave full information on the transition and HR processes.
- Continued to run Management Team meetings in order to ensure directorate leads have the opportunity to contribute to forward planning and to be briefed about important corporate issues.
- Delivered a series of chief executive and locality roadshows to update staff on changes to the NHS and Public Health systems and the development of the Cumbria Clinical Commissioning Group, offering an opportunity to ask questions and learn more about the developments.

- Developed 'Transition News', a time limited newsletter that gave updates, question and answers and messages from the Chief Executive on the transition process.
- Continued to offer AskSue, a mechanism for staff members to email the Chief Executive and get a prompt and direct response to questions or comments.

8.2 Policy relating to disabled employees
Disabled people are assured of full and fair consideration for all vacancies for which they offer themselves as suitable candidates, with every effort made to meet any special requirements, particularly in relation to access and mobility.

Where possible, modifications to workplaces are made to provide access and, therefore, job opportunities for disabled people. Every effort is made to continue the employment of people who become disabled via the provision of additional facilities, job redesign and the provision of appropriate.

8.3 Data on sickness absences
During 2012/13, NHS Cumbria's annual absence level was on average 3.7 days lost per employee.

NHS Cumbria's overall absence target is 4%. Overall absence during 2012/13 was 1.79%.

8.4 Workforce
NHS Cumbria has a clear commitment to quality. We recognise that only by working together across organisational boundaries will we find a solution that will produce the necessary productivity gains and improvements in health outcomes.

We are committed to creating a workforce with the skills to meet the demands of modern day healthcare in Cumbria, and have been supporting receiver organisations to recognise and plan for this while retaining the skills and experience of our current workforce as they move into new roles and organisation.

Learning and Development
NHS Cumbria recognises the important contribution a confident and competent workforce makes to the delivery of high quality and safe healthcare.

Working in partnership with managers, staff and their representatives, as well as the leaders of developing receiver organisations, a profile of the skill mix and the competencies of the current and future workforce needed has been undertaken.

NHS Cumbria has a suite of development programmes and training opportunities designed to transform leadership and performance through clinicians and staff at every level of our organisation, these will be developed and mirrored in receiver organisations.

Through appraisals and development reviews, NHS Cumbria has worked to support and develop the workforce through appropriate training and development opportunities to increase the skills and capacity of the workforce and enable more services to be delivered closer to home.

8.5 The trades unions
Throughout the year, Trades Unions from partner PCT clusters have supported the primary care trust through the HR transition process.

8.6 Policy on equal opportunities
Equality is of fundamental importance to the way NHS Cumbria conducts itself, as a provider and commissioner of services as well as an employer. We believe everyone, regardless of their background, has an equal right to health and employment, free from any form of prejudice.

We are firmly committed to tackling discrimination, promoting equality of opportunity and having a workforce which reflects the make-up of the population it serves.

NHS Cumbria has a Single Equality Scheme, Health for All, which demonstrates our commitment to equality and diversity.

Training ensures managers and staff understand the importance of equality and diversity and link this to all areas of business, service and policy development.

The communities that NHS Cumbria serves are diverse and have differing health needs. We aim to ensure that we deliver a range of services which meet the needs of all these communities in an appropriate manner and that are accessible to all. This may require providing an interpreter or translator services.

Inequalities in people's experience of health still presents significant challenges in Cumbria, with people in the most affluent areas living up to 20 years longer than those in more deprived circumstances. NHS Cumbria is committed to reducing inequality in the health of our population. This, as well as a commitment to equal access, is a commitment in the Strategic Plan and has featured heavily in development of the successor organisation, Cumbria Clinical Commissioning Group.

In order to tackle inequality and target resources efficiently, all NHS Cumbria services and schemes are required to carry out an Equality Impact Assessment (EIA). EIAs help NHS Cumbria to better understand the different needs of the communities we serve and provide a useful framework to identify any potential barriers and ensure an equitable service.

9. Financial review

9.1 Review of the Year and On-going Financial Strategy

NHS Cumbria has a number of key measures of financial performance and the results are summarised below.

Financial Target	FINAL POSITION	OUTCOME
NHS Cumbria's operating costs should not exceed the revenue resource limit (i.e. "break-even" position)	£6,021,000 surplus	Achieved
PCT operate within the agreed cash limit of £936,732,000	£936,732,000	Achieved
Operate within the notified capital resource limit of £3,402,000	£3,401,000	Achieved

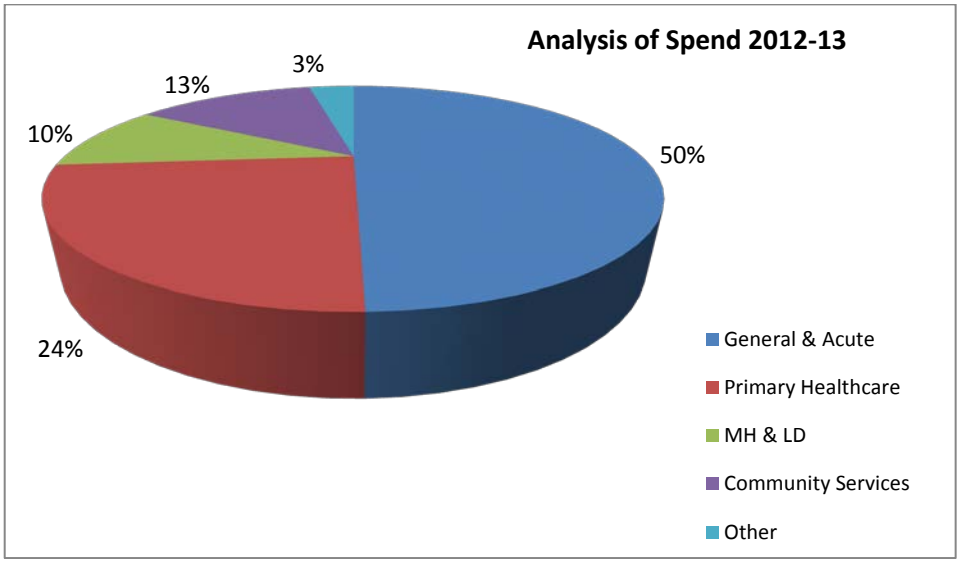
All PCTs have a statutory duty to maintain spending within their resource limits (that is within total budget) which is referred to as operating financial balance for the year. NHS Cumbria has reported a financial surplus for the year of £6,021m following a surplus of £4.195m for 2011/12.

As a consequences of the Government's Health and Social Care Bill, passed in March 2012, the PCT was abolished as at 31 March 2013. To help ensure PCTs discharge their duties and support the creation of GP Consortia, PCTs were grouped into 'clusters'. Due to rurality and demography, Cumbria Teaching PCT was designated a stand alone cluster. Following its establishment in shadow form during 2011/12, Cumbria's Clinical Commissioning Group (CCG) was formally authorised in March 2013 to assume full responsibility for commissioning local health services in the county from 1 April 2013.

In line with the national requirements for transition and closedown the PCT undertook extensive processes of due diligence to confirm that all properties, assets and liabilities were identified, mapped to the function to which they related and then identified for transfer (by means of the Transfer Schemes) to the relevant receiver organisation(s).

9.2 How we spent your money

NHS Cumbria spent a total of £944 million on health services for their population of which £929 million was funded from Department of Health allocations with a further £21 million of income received from areas such as prescription charges and patient contributions for dental care. The chart below summarises the key areas of investment.



- "General & Acute" covers services provided in the secondary care (hospital) sector including maternity and accident and emergency services and out of county acute spend.
- "Primary Healthcare" includes payments to GPs, pharmacists and dentists providing services to the NHS and the cost of GP prescribing.
- "MH&LD" comprises services commissioned on behalf of patients with mental health and learning disabilities. NHS Cumbria operates a "pooled fund" arrangement with Cumbria County Council to commission Learning Disability services for the residents of the county.
- "Community Services" includes services previously delivered by NHS Cumbria's own provider arm.

Capital Expenditure

During 2012/13 we are pleased to report net capital investment amounting to £3.4 million in improving the infrastructure used to support provision of healthcare in Cumbria. This money was allocated to projects using a risk based approach on the basis of in-year reviews of the estate. Work included: refurbishment of Copeland unit at West Cumberland Hospital, new minor operation and injury unit and x-ray facility at Keswick Hospital, as well as refurbishments and remedial works at Penrith Hospital, Brampton Hospital, Maryport and Wigton Hospital. We invested over £540k in new information technology

There is more detailed information on our finances in the summary financial information included in this report.

9.3 Summary financial position

The following financial statements are extracts from the Annual Accounts of Cumbria Teaching PCT for the year 2012/13. I certify that these extracts are consistent with the statutory accounts prepared by NHS Cumbria, on which an unqualified opinion has been issued. The accounts have been prepared under section 98 (2) of the National Health Service Act 1977 (as amended by section 24 (2), schedule 2 of the National Health Service and Community Care Act 1990) in the form which the Secretary of State has, with the approval of the Treasury, directed.

These summary financial statements may not contain sufficient information for a full understanding of NHS Cumbria's financial position and performance. The full accounts are available, separately, by written application to the Chief Finance Officer, NHS Cumbria Clinical Commissioning Group, Lonsdale Unit, Penrith Hospital, Bridge Lane, Penrith, CA11 8HX.

This report also contains a Member's Remuneration Report.

John Lawlor
Area Director, Cumbria, Northumberland, Tyne & Wear Area Team, NHS England – North

4 June 2013

9.4 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.

John Lawlor
Area Director, Cumbria, Northumberland, Tyne & Wear Area Team, NHS England – North

4 June 2013

9.5 INDEPENDENT AUDITOR'S REPORT TO THE DEPARTMENT OF HEALTH'S ACCOUNTING OFFICER OF CUMBRIA TEACHING PCT

We have examined the summary financial statement for the year ended 31 March 2013 which comprises the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity and the Statement of Cash Flows.

This report is made solely to the accountable officer of Cumbria Teaching 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. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust's accountable officer and the Trust as a body, for our audit work, for this report, or for opinions we have formed.

Respective responsibilities of signing officer and auditor

The signing officer is responsible for preparing the Annual Report.

Our responsibility is to report to you our opinion on the consistency of the summary financial statement within the Annual Report with the statutory financial statements.

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

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

Opinion
In our opinion the summary financial statement is consistent with the statutory financial statements of the Cumbria Teaching PCT for the year ended 31 March 2013.

Grant Thornton UK LLP

Grant Thornton UK LLP
4 Hardman Square
Spinningfields
Manchester
M3 3EB

4 June 2013

9.6 Annual Governance Statement

The PCT Board was responsible for ensuring that there was a sound system of governance incorporating the system for internal control. As Chief Executive, Sue Page was the Accountable Officer from 1 April 2012 to 28 March 2013. As such she was accountable for maintaining a sound system of governance incorporating the system of internal control that supported the achievement of the organisation’s policies, aims and objectives and responsibility for safeguarding the public funds and the organisation’s assets.

Sue Page has confirmed that, to the best of her knowledge and belief, she properly discharged the responsibilities set out in her letter of appointment in accordance with the NHS Operating Framework and NHS Mandate, and in discharging these responsibilities had been mindful to do so in a manner that prepared for the safe transition to new statutory arrangements from 1 April 2013.

On the 28 March 2013, following a resolution by the PCT Board, John Lawlor took over responsibility as Accountable Officer for the completion and signing off of the PCT's accounts.

The Board agreed an integrated governance framework to ensure that robust commissioning arrangements were in place to ensure provision of quality of care.

The NHS Cumbria approach focused strongly on patient experience, choice, and user and public involvement at all levels. The PCT developed integrated arrangements for commissioning, provider services and primary care at locality level, whilst ensuring that World Class Commissioning standards are upheld.

The focus of the Board's committees was on governance, performance and monitoring of progress. This provided the framework for identifying the totality of the risks facing the organisation and provided assurances that risks were being properly managed.

The full Annual Governance Statement is shown on page (iii) to (ix) of the accounts.

9.7 Notes Supporting Summary Financial Statements

Capital Structure

NHS Cumbria is fully funded by Taxpayers' Equity with the details outlined on the Statement of Financial Position at 31 March 2013 (shown on page 30). NHS Cumbria manages cash in accordance with the procedures outlined in Department of Health guidance.

Significant Accounting Policies

The accounting policies of NHS Cumbria are shown in note 1 to the accounts. This includes the accounting for pension costs in accordance with the national arrangements for the NHS Pensions Scheme.

Income Generation

NHS Cumbria did not perform any significant income generation activities outside core NHS activities.

Value for Money

In establishing a comprehensive financial strategy NHS Cumbria has considered the potential to provide services in a setting outside the acute hospital environment, with clear benefits in terms of both patient access and cost. This has been demonstrated by the underlying hospital activity trends in 2012/13 where Cumbria has the lowest overall rate of admissions in either the North West or North East of England. Similarly, NHS Cumbria takes a proactive approach in supporting cost effective prescribing by GPs in the county, who continue to demonstrate the most efficient prescribing in the North West of England. In addition, the PCT has further developed its work in conjunction with Cumbria Partnership FT to provide access to services in Cumbria for patients with complex mental health needs this reducing the reliance on expensive specialised services. The PCT has also used Audit Commission benchmarking tools on elective referrals to secondary care to identify further opportunities to reduce costs and improve clinical outcomes.

NHS Cumbria's Resources Committee has a remit to scrutinise financial performance and ensure that value for money is considered when evaluating new investments.

Better Payment Practice Code

The Better Payment Practice Campaign has published a code which requires subscribers to

- Agree payment terms at the outset of a deal and stick to them;
- Explain your payment procedures to suppliers;
- Pay bills in accordance with any contract agreed with the supplier or as required by law; and
- Tell suppliers without delay when an invoice is contested, and settle disputes quickly.

NHS Cumbria is a signatory to this code.

NHS Cumbria is required to pay 95% of invoices (by number and value) within 30 days and the combined results for NHS and non-NHS suppliers are shown below. The full breakdown is shown in note 8 of the accounts.

Better Payment Practice Performance	Target	Actual	2011/12
Number of Invoices	95%	99%	96%
Value of Invoices	95%	100%	99%

NHS Cumbria achieved both targets in 2012/13.

Private Finance Initiative

The only use of the private finance initiative by NHS Cumbria is for Workington Community Hospital that opened in 2005.

Running Costs

	2012/13	2011/12
Running costs - Commissioning Services (£000s)	17,362	15,601
Running costs - Public Health (£000s)	1,247	981
Running costs - Total (£000s)	18,609	16,582
Weighted population (number in units)	526,281	526,281
Running Costs per weighted head of population (£ per head)	£35.36	£31.51

Asset Values and Fixed Assets

In the opinion of NHS Cumbria there are no material differences between the carrying amount and market value of land and buildings on the balance sheet.

Related Party Transactions

Information on related party transactions is shown at note 27 to the accounts.

Post Balance Sheet Events

As a consequences of the Government's Health and Social Care Bill, passed in March 2012, the PCT was abolished as at 31st March 2013. To help ensure PCTs discharge their duties and support the creation of GP Consortia, PCTs were grouped into 'clusters'. Due to rurality and demography, Cumbria Teaching PCT was designated a stand alone cluster. Following its establishment in shadow form during 2011/12, Cumbria's Clinical Commissioning Group (CCG) was formally authorised in March 2013 to assume full responsibility for commissioning local health services in the county from April 2013.

In line with the national requirements for transition and closedown the PCT undertook extensive processes of due diligence to confirm that all properties, assets and liabilities were identified, mapped to the function to which they related and then identified for transfer (by means of the Transfer Schemes) to the relevant receiver organisation(s).

Directors' Responsibilities Regarding The Auditor

All the Directors carried out their responsibilities to make the External Auditor aware of any relevant audit information. They are not cognisant of any such data of which the External Auditor is unaware.

STATEMENT OF COMPREHENSIVE NET EXPENDITURE FOR THE PERIOD ENDED 31 MARCH 2013

Statement of Comprehensive Net Expenditure	2012/13 £000	2011/12 £000
Administration Costs and Programme Expenditure		
Gross Employee Benefits	14,243	13,546
Other Costs	929,595	904,504
Income	(20,864)	(19,020)
PCT Net Operating Costs Before Interest	**922,974**	**899,030**
Finance Costs	724	738
Net Operating Costs for the financial year	**923,698**	**899,768**
Of which:		
Administration Costs		
Gross employee benefits	11,235	10,203
Other costs	9,746	8,675
Income	(3,006)	(3,034)
Net administration costs before interest	**17,975**	**15,844**
Finance Costs	634	738
Net administration costs for the financial year	**18,609**	**16,582**
Programme Expenditure		
Gross employee benefits	3,008	3,343
Other costs	919,849	895,829
Income	(17,858)	(15,986)
Net Programme Expenditure before interest	**904,999**	**883,186**
Finance Costs	90	-
Net Programme Expenditure for the financial year	**905,089**	**833,186**
Other Comprehensive Net Expenditure		
Impairments put to the Revaluation Reserve	700	-
Total Comprehensive Net Expenditure for the year	**924,398**	**899,768**

STATEMENT OF FINANCIAL POSITION AT 31 MARCH 2013

	31 March 2013	31 March 2012
	£000	£000
Non-current assets:		
Property, plant and equipment	47,376	49,357
Intangible assets	55	84
Other Financial Assets	380	426
Trade and other receivables		
Total non-current assets	**47,811**	**49,867**
Current assets:		
Trade and other receivables	11,105	11,659
Cash	-	1
Total current assets	**11,105**	**11,660**
Non-current assets held for sale	824	110
Total non-current assets	**11,929**	**11,770**
Total assets	**59,740**	**61,637**
Current liabilities		
Trade and other payables	(44,079)	(63,639)
Provisions	(10,818)	(3,531)
Borrowings	(175)	(160)
Total current liabilities	**(55,072)**	**(67,330)**
Non-current assets plus/less net current assets/liabilities	**4,668**	**(5,693)**
Non-current liabilities		
Trade and other payables	-	(1,558)
Provisions	(2,327)	(2,567)
Borrowings	(6,475)	(6,650)
Total non-current liabilities	**(8,802)**	**(10,775)**
Total Assets Employed:	**(4,134)**	**(16,468)**
FINANCED BY:		
TAXPAYERS' EQUITY		
General fund	(12,758)	(25,792)
Revaluation reserve	8,624	9,324
Total Taxpayers' Equity:	**(4,134)**	**(16,468)**

STATEMENT OF CHANGES IN TAXPAYERS EQUITY

	2012/13	2011/12
	£000	£000
Balance 01 April	**(16,468)**	**(22,151)**
Net Operating Cost for the Year	(923,698)	(899,768)
Impairments	(700)	-
Total Recognised Revenue and Expense	**(924,398)**	**(899,768)**
Net Parliamentary Funding	936,732	905,451
Balance at 31 March	**(4,134)**	**(16,468)**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2013

	2012/13	2011/12
	£000	£000
Cash flows from operating activities		
Net operating cost before interest	(922,974)	(899,030)
Depreciation and Amortisation	3,997	2,963
Interest Paid	(634)	(649)
(Increase)/Decrease in Trade and Other Receivables	554	(5,114)
Increase/(Decrease) in Trade and Other Payable	(21,218)	(1,841)
Provisions utilised	(3,257)	(681)
Increase in Provisions	10,214	2,783
Net cash outflow from operating activities	**(933,138)**	**(901,569)**
Cash flows from investing activities		
Payments to purchase property, plant and equipment	(3,552)	(3,740)
Payments to purchase intangible assets	(21)	-
Proceeds of disposal of assets held for sale	318	-
Net cash outflow from investing activities	**(3,255)**	**(3,740)**
Net cash outflow before financing	**(936,573)**	**(905,309)**
Cash flows from financing activities		
Net Parliamentary Funding	936,732	905,451
Capital grants received		
Capital element of payments in respect of on-SoFP PFI	(160)	(146)
Net cash inflow from financing	**936,572**	**905,305**
Net decrease in cash	**(1)**	**(4)**
Cash at the beginning of the financial year	**1**	**5**
Cash at the end of the financial year	**-**	**1**

Financial Performance Targets for the year ended 31 March 2013

Operational Financial Balance

	2012/13	2011/12
	£000	£000
NHS Cumbria's performance is as follows:		
Net operating cost for the financial year	923,698	899,768
Final Revenue Resource Limit for year	929,719	903,963
Underspend against Revenue Resource Limit	6,021	4,195

Capital Resource Limit

NHS Cumbria is required to keep within its Capital Resource Limit

	2012/13	2011/12
	£000	£000
Charge to the Capital Resource Limit	3,402	3,749
Capital Resource Limit	3,401	3,749
Under/(over)spend against Capital Resource Limit	1	-

Under/(Over)spend against cash limit

	2012/13	2011/12
	£000	£000
Charge to the Cash Limit	936,732	905,451
Cash Limit	936,732	905,451
Under/(over)spend against Cash Limit	-	-

Remuneration Report

Name	Title	Start Date	2012-13				2011-12		
			Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Compensation for Loss of Office[13] (rounded to the nearest £100)	Taxable Benefit of Lease Car (rounded to the nearest £100)	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Taxable Benefit of Lease Car (rounded to the nearest £100)
			£000	£000	£	£	£000	£000	£
Executive Directors									
Sue Page	Chief Executive (PCT Cluster)[7]	01-Nov-06	160-165		326,400	5,200	160-165		5,100
Alan Horne	*Chief Operating Officer*[1]								
John Ashton	Director of Public Health[2]	01-Jan-07	205-210		103,000	4,200	200-205		5,600
Nigel Maguire	Director of Market Development[3]	06-Oct-06	120-125			3,700	70-75		2,600
Anthony Gardner	Acting Director of Planning[4]	01-Feb-11					65-70		
Mike Bewick	Medical Director (PCT Cluster)[7]	09-Jul-07	185-190				190-195		3,500
Irving Cobden	Medical Director[5]	01-Sep-07					20-25		100
John Critchley	Director of Resources[6] (PCT Cluster)[7]	23-Apr-07			397,300		85-90		3,700
Charles Welbourn	Acting Director of Finance[6] (PCT Cluster)[7]	01-Sep-11	110-115			6,300	60-65		2,900
Ross Forbes	Director of Corporate Affairs	01-Jan-07	85-90		58,000	3,000	115-120		7,000
Johanna Reilly	Interim Director of Commissioning Development (PCT Cluster)[7]	01-May-11	25-30			1,000	95-100		2,300
Moira Angel	Interim Director of Nursing (PCT Cluster)[7]	01-May-11	90-95			5,300	75-80		
Rosalind Fallon	Interim Acting Director of Performance (PCT Cluster)[7]	01-Oct-11	105-110		212,400	3,700	50-55		2,800
Mark Graham	Interim Director of Communications (PCT Cluster)[7]	01-Oct-11	70-75			100	35-40		200
Non Executive Directors									
Mike Taylor	Chairperson[8]	01-Apr-10					15-20		
Ian Gordon	Interim Chair[8]	06-Oct-11	30-35				20-25		
Mary Dowling	Interim Chair[8]	01-Mar-07	10-15				5-10		
Allan Buckley	Non Executive Director	01-Mar-07	5-10				5-10		
Peter Nuttall	Non Executive Director	01-Mar-07	5-10				5-10		
Keith Little	Non Executive Director	01-Mar-07	10-15				10-15		
Shirley Reveley	Non Executive Director	01-Mar-07	5-10				5-10		
Bob McCulloch	Non Executive Director	01-Oct-06	5-10				5-10		
GP Locality Leads									
David Rogers	GP Commissioning Lead / Deputy Medical Director	01-Sep-07	60-65	20-25			55-60	30-35	
Geoff Jolliffe	GP Commissioning Lead	01-Sep-07	60-65	20-25			60-65	10-15	
Cameron Munro	GP Commissioning Lead[9]	01-Apr-10	0-5				30-35		
Rachel Preston	GP Commissioning Lead[9]	01-May-12	45-50						
Peter Weaving	GP Commissioning Lead[10]	01-Sep-07	30-35	25-30			85-90	5-10	
Colin Patterson	GP Commissioning Lead[10]	01-Sep-11	50-55	20-25					
Hugh Reeve	GP Commissioning Lead[11]	01-Nov-07	20-25	65-70			85-90		
Alistair MacKenzie	GP Commissioning Lead[11]	14-May-07	30-35	5-10					

[1] On secondment from 30 June 2007. Mr Horne left the PCT on 30 September 2011.

[2] The Director of Public Health, fully funded by the PCT, is a joint post with Cumbria County Council. Salary includes a nationally funded merit award.

[3] Nigel Maguire was seconded to Cumbria Partnership NHS FT 1 April to 31 August 2011 to oversee the transfer of Community Services.

[4] Anthony Gardner ceased to act as an Executive director 14 November 2011.

[5] Irving Cobden retired on 30 June 2011.

[6] John Critchley was seconded to Central Lancashire PCT from 5 December 2011. Charles Welbourn is acting Director of Finance from 1 September 2011

[7] Provisional appointments were made to the new PCT Cluster during 2011/12 and 2012/13.

[8] Mike Taylor left the PCT 5 October 2011 ; Ian Gordon, Non-Executive director, was interim Chair 6 October 2011 to 30th January 2013. Mary Dowling was appointed interim Chair wef 1st February 2013.

[9] Cameron Munro left 29th April 2012 and Rachel Preston took over the GP lead role for Eden Locality 1st May 2012.

[10] Peter Weaving left and Colin Patterson took over the GP lead role for Carlisle Locality in Dec 2012.

[11] Hugh Reeve relinquished his GP lead role for South Lakes Locality to Alisatir MacKenzie wef July 2012.

[12] Johanna Reilly was seconded to Salford PCT from July 2012.

[13] These payments were either to the individual or additional payments to the NHS Pension Fund.

The content of this Table has been audited by our external auditor.

The chair and non-executive directors are members of the Remuneration and Terms of Reference Committee. Amendments to directors'' remuneration and terms and conditions are considered and approved by the Remuneration and Terms of Service Committee.

Clear performance objectives are agreed with directors. These are shared with the Remuneration and Terms of Service Committee and are regularly monitored.

All the directors' contracts are open. Any notice periods are in line with national policy and any redundancy and other departure costs have been paid in accordance with the provisions of Cumbria PCT voluntary redundancy scheme or standard NHS redundancy terms.

Pensions Details

Name	Title	Real increase / (decrease) in pension at age 60 (bands of £2,500)	Real increase / (decrease) in pension lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2013 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2012	Real increase / (decrease) in Cash Equivalent Transfer Value
		£000	£000	£000	£000	£000	£000	£000
Sue Page	Chief Executive	0-2.5	0-2.5	60-65	190-195	1,282	1,207	45
Nigel Maguire	Director of Market Development	0-2.5	0-2.5	50-55	150-155	891	838	32
John Critchley	Director of Resources	0-2.5	0-2.5	45-50	140-145	907	854	32
Ross Forbes	Director of Corporate Affairs	0-2.5	2.5-5.0	5-10	25-30	188	154	31
John Ashton	Director of Public Health[1]	-	-	-	-	0	269	(276)
Mike Bewick	Medical Director	5.0-7.5	15.0-17.5	60-65	190-195	1,366	1,179	158
Charles Welbourn	Acting Director of Resources	0-2.5	5.0-7.5	25-30	85-90	476	391	44
Johanna Reilly	Interim Director of Locality Commissioning (PCT	0-2.5	0-2.5	20-25	70-75	435	400	23
Moira Angel	Interim Director of Nursing (PCT Cluster)	2.5-5.0	10.0-12.5	40-45	120-125	827	710	91
Rosalind Fallon	Interim Acting Director of Performance (PCT Cluster)	0-2.5	2.5-5.0	35-40	115-120	789	718	26
Mark Graham	Interim Director of Communications (PCT Cluster)	0-2.5	-	10-15	-	104	83	10

[1] John Ashton left the NHS Pension Scheme at the end of February 2012.

The PCT made no contributions to private pension schemes on behalf of Directors.

The content of this Table has been audited by our external auditor.

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

Cash Equivalent Transfer Values

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

Real Increase in CETV
This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.
Self employed GPs who are members of the Professional Executive Committee (PEC) may have pension entitlements. However, the proportion of those entitlements that relates to their membership of the PEC is not significant compared to the proportion that relates to their work as practitioners independent of the Primary Care Trust. It is therefore not appropriate to disclose the pension entitlements.

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 NHS Cumbria was £212.5k (2011/12, £212.5k). This was 5.8 times (2011/12, 6.4 times) the median remuneration of the workforce, which was £36k (2011/12, £33k).

During 2012/13 no employees received remuneration in excess of the highest paid director (2011/12, none). The lowest remuneration was £15k (2011/12, £14k).

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.

As part of the reorganisation of the NHS architecture and the authorisation of the Cumbria CCG, there was in an increase in staff numbers in the year which resulted in an increase in the median and lowest earnings.

Reporting of other compensation schemes - exit packages

Exit package cost band (including any special payment element)	Sub code	*Number of compulsory redundancies	*Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages
		WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	NUMBERS ONLY	£s
Less than £10,000	**100**	2	18,923			2	18,923
£10,000 - £25,000	**110**			1	22,379	1	22,379
£25,001 - £50,000	**120**	2	71,396			2	71,396
£50,001 - £100,000	**130**	1	58,005	4	274,146	5	332,151
£100,001 - £150,000	**140**			2	237,310	2	237,310
£150,001 - £200,000	**150**			3	484,860	3	484,860
>£200,000	**160**	2	538,823	1	397,277	3	936,100
Total	**170**	**7**	**687,147**	**11**	**1,415,972**	**18**	**2,103,119**

9.8 Audit arrangements

Grant Thornton UK LLP was the appointed external auditor for NHS Cumbria for 2012/13:

Grant Thornton UK LLP
4 Hardman Square
Spinningfields
Manchester
M3 3EB

Grant Thornton provided external audit services for NHS Cumbria at a cost of £138,252k and undertook further work for NHS Cumbria (commissioned at a national level) at a cost of £25,200k.

The Audit Committee maintained a close scrutiny of NHS Cumbria's internal control systems, through the reports received from Internal Audit, and through regular access to the records of the work of other Board Committees. The Committee received no reports which might lead to doubt that the

provisions of the Statement of Internal Control are not effectively in place. The Directors who served on the Audit Committee for NHS Cumbria during 2012/13 were as follows:

K Little (Chair) R McCulloch S Reveley

9.9 Directors' other interests

Executive and other Directors

Charles Welbourn
Wife is an investment accountant at Cumbria County Council
Wife is a member on the Executive Committee of Carlisle MENCAP

John Ashton
£1 shareholder in Liverpool Housing Trust
Trustee of Carlisle Youth Zone
Trustee of National Museum Liverpool
Wife is Director of Public Health for Central Lancashire PCT
Son is Public Health Consultant with Knowsley PCT

Michael Bewick
Board member eLIFT Cumbria – resigned 2013

Nigel Maguire
Nil

Ross Forbes
Nil

Sue Page
Nil

Anthony Gardner
Wife is Chair of Bolton Exchange, a community initiative in Eden, which may receive minor funding from NHS Cumbria

Johanna Reilly
Nil

Mark Graham
Nil

Moira Angel
External Examiner at the University of Chichester

Neela Shabde
Nil

Rosalind Fallon
Nil

Non Executive Directors

Allan Buckley
Lay member of Cumbria Local Safeguarding Children's Board

Bob McCulloch
Trustee - South Lakes Society for the Blind
Member of South Cumbria Low Vision Group
Director of SLSB Enterprises Ltd

Ian Gordon - Chair (to February 2013)
Member of Cumbria Partnership NHS Foundation Trust

Keith Little
Elected member of Cumbria County Council
Trustee of Allerdale Citizens' Advice Bureau

Mary Dowling - Chair (from February 2013)
Director and Chairman of South Lakes Housing
HR Consultant to North Lancashire Teaching PCT
Non Legal Member Employment Tribunals
Lay Member NHS North Western Deanery
Lay Member Advisory Committee Excellence Awards (North West) - resigned September 2012
Member of University Hospitals Morecambe Bay
Member of Cumbria Partnership NHS Foundation Trust

Peter Nuttall
Nil

Shirley Reveley
Emeritus Professor at the Open University
Visiting Professor, University of Cumbria
Public Governor for Cumbria Partnership Foundation Trust
Member of the University of Cumbria International Centre for Health Improvement Steering Group

<u>Cumbria Clinical Commissioning Group</u>
Cameron Munro
GP at Appleby Medical Practice

David Rogers
GP and Director of Cleator Moor Healthcare Ltd

Fayyaz Chaudhri
GP Partner at Maryport Group Practice

Geoff Jolliffe
GP at Risedale Surgery and for Cumbria Health On Call and Abbey View Step-Up Step Down Unit.

Helen Jervis
GP Partner at Temple Sowerby Medical Practice

Hugh Reeve
GP Partner at Nutwood Surgery

Peter Weaving
GP at Brampton Medical Practice

Rachel Preston
GP at Lakes Medical Practice

Alistair Mackenzie
GP at James Cochrane Practice
Director at Castleheads Ltd

Colin Patterson
GP at Brunswick House Medical Group

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Contact
NHS Cumbria Clinical Commissioning Group
Lonsdale Unit
Penrith Hospital
Bridge Lane
Penrith
CA11 8HX

Tel: 01768 245317

Email: enquiries@cumbriaccg.nhs.uk

Department of Health

NHS

Cumbria Teaching Primary Care Trust

2012-13 Accounts

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Cumbria Teaching Primary Care Trust

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Cumbria Teaching PCT

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FOREWORD TO THE ACCOUNTS

CUMBRIA TEACHING PRIMARY CARE TRUST

These accounts, for the twelve months ended 31 March 2013, have been prepared by Cumbria Teaching Primary Care Trust. They have been prepared under section 98 (2) of the National Health Service Act 1977 (as amended by section 24 (2), schedule 2 of the National Health Service and Community Care Act 1990) in the form which the Secretary of State has, with the approval of the Treasury, directed.

These accounts show (note 3.1, page 14) the PCT has reported a surplus for the year of £6,021k, following a surplus of £4,195k for 2011/12, equating to less than 1% of the notified revenue resource limit of £929,719k. The PCT has managed its cash balance within the agreed cash limit and capital spending within the notified capital resource limit.

The PCT has considered the valuation of properties in the light of the uncertainties in the current market. There have been no material changes to properties in the last year, in particular, there have been no changes as a result of management action, changes in condition or unforeseen obsolescence. Property price indices show little significant movement over the year. The PCT has therefore decided that it is appropriate not to revalue or apply indices to property values in the current year.

To help ensure PCTs discharge their duties and support the creation of GP Consortia, PCTs were grouped into 'clusters'. Due to rurality and demography, Cumbria Teaching PCT was designated a stand alone cluster. As a consequences of the Government's Health and Social Care Act 2012, the PCT is abolished as at 31 March 2013. Following its establishment in shadow form during 2011/12, Cumbria's Clinical Commissioning Group (CCG) was formally authorised in March 2013 to assume responsibility for commissioning local health services in the county for which it will be accountable for from 1 April 2013.

In line with the national requirements for transition and closedown the PCT undertook extensive processes of due diligence to confirm that all staff, properties, assets and liabilities were identified, mapped to the function to which they related, and then identified for transfer (by means of the Transfer Schemes) to the relevant receiver organisation(s).

As a consequence of the Health and Social Care Act 2012, Cumbria Teaching PCT was dissolved on 31 March 2013 and its functions transferred to various new or existing public sector entities. The Secretary of State has directed that, where Parliamentary funding continues to be voted to permit the relevant services to be carried out elsewhere in the public sector, this is normally sufficient evidence of going concern. As a result the Board of Cumbria Teaching PCT prepared these financial statements on a going concern basis.

Robert Cornall
Area Finance Director, Cumbria, Northumberland, Tyne & Wear Area Team, NHS England – North

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 set out in my letter of appointment as an Accountable Officer.

Signed ..... Designated Signing Officer

Name: John Lawlor
Area Director, Cumbria, Northumberland, Tyne & Wear Area Team, NHS England – North

Date 4th June 2013

STATEMENT OF RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

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

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

Signing Officer ..... Date 4th June 2013

Name: John Lawlor
Area Director, Cumbria, Northumberland, Tyne & Wear Area Team, NHS England – North

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

Name: Robert Cornall
Area Finance Director, Cumbria, Northumberland, Tyne & Wear Area Team, NHS England – North

ANNUAL GOVERNANCE STATEMENT

A. SCOPE OF RESPONSIBILITY

Cumbria Teaching Primary Care Trust (PCT) was responsible, in 2012/13, for improving the health and health care of the people of Cumbria by ensuring that the resources available to the NHS are used effectively to commission high quality health care that meets the needs of people in the county in line with local circumstances and national policy.

The PCT Board was responsible for ensuring that there was a sound system of governance incorporating the system for internal control. The system of internal control is a significant part of the governance framework and is designed to manage risk to a reasonable level. It cannot eliminate all risk of failure and can therefore only provide reasonable and not absolute assurance, of effectiveness. As Chief Executive, Sue Page was the Accountable Officer from 1 April 2012 to 28 March 2013. As such she was accountable for maintaining a sound system of governance incorporating the system of internal control that supported the achievement of the organisation's policies, aims and objectives and responsibility for safeguarding the public funds and the organisation's assets. As set out in the Accountable Officer Memorandum issued by the Department of Health, the Accountable Officer is personally responsible for:

- Ensuring effective management systems are in place to safeguard public funds and assets and assist in the implementation of corporate governance.
- Ensuring value for money is achieved from the resources available to the Primary Care Trust.
- Ensuring that the expenditure and income of the Primary Care Trust has been applied to the purposes intended by Parliament and confirm to the authorities which govern them.
- Ensuring effective and sound financial management systems are in place; and that 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 including the net operating cost, recognised gains and losses and cash flows for the year 2012-13.

Sue Page has confirmed that, to the best of her knowledge and belief, she properly discharged the responsibilities set out in her letter of appointment in accordance with the NHS Operating Framework and NHS Mandate, and in discharging these responsibilities had been mindful to do so in a manner that prepared for the safe transition to new statutory arrangements from 1 April 2013.

On the 28 March 2013, following a resolution by the PCT Board, I took over responsibility as Accountable Officer for the completion and signing off of the PCT's accounts.

All the property, assets and liabilities of the PCT transferred to the receiver organisations on 1 April 2013 under transfer schemes approved by the Secretary of State.

B. THE GOVERNANCE FRAMEWORK OF THE ORGANISATION

1. Trust Board and Committee Structure

The PCT Board - was responsible for setting the vision and strategy of the organisation and for the approval of the assurance arrangements relating to its operation. The Board had a structure of committees and operational groups that provided it with the necessary assurance. As part of its commitment to safety and quality, the Board took an active role in monitoring NHS provider performance in respect of serious untoward incidents.

The Board had an agreed governance framework and robust commissioning arrangements were in place to ensure provision of quality of care. The Board's strategic approach of developing health and health care around individuals and their communities gave it a focus on local, clinically led decision making reflecting patient experience, choice, and user and public involvement. In September 2011 the Board formally established the Interim Clinical Commissioning Group Executive, as a committee of the Board, consolidating locality management and with substantial delegated commissioning responsibilities and budgets.

The Interim Clinical Commissioning Group Executive - this group was established as a committee of the PCT Board. An Accountability Agreement set out the terms of delegated commissioning responsibility for the Committee and was refreshed in April 2012. As such it was accountable for most aspects of the current commissioning process and it undertook many of the functions of a Professional Executive Committee, advising the Board on strategic clinical matters. It is this Group that also led the development of the Clinical Commissioning Group and the preparation for its successful authorisation within the new arrangements.

1. Trust Board and Committee Structure (continued)

The Audit Committee - this committee reviews reports from Internal Audit/External Audit as well as considering reports on risk management and other assurance matters. Through its scrutiny and reports, the Audit Committee enables the Board to have confidence in its control systems. It provides an important voice when the Board considers the effectiveness of the systems of internal control and its implications. The Committee has a key role in the monitoring of risk and assurance within the organisation and routinely reports to the PCT Board to ensure that the Board is fully briefed on the risk issues. Members of the Committee are: Three Non Executive Directors who are supported by the Director of Finance and external and internal audit leads (the latter also acting as the Counter Fraud Specialist for the PCT). From 1 April 2013, 3 Non Executive Directors have formed an audit sub-committee of the NHS Audit Committee in order to approve the final accounts.

The Remuneration & Terms of Service Committee - this committee advised on the determination of the appropriate salaries and conditions of the Chief Executive and Directors discharging its functions in accordance with legal and NHS requirements, principles of probity and the requirements of good corporate governance, including termination of the employment of employees on the grounds of redundancy. It comprised the Chair and Non-Executive Directors of the PCT Board.

The Standards and Quality Committee - In order to ensure that quality lies at the centre of the Commissioning process and is also at the heart of the Board's agenda, the former Standards and Quality Committee was disbanded at its request, with the Interim Executive of the Clinical Commissioning Group taking direct oversight of quality in the contracting and contract monitoring processes and the Board dedicating a significant part of its routine agenda to quality matters.

Resources Committee – this committee operated under formal delegated authority from the PCT Board, scrutinising and reviewing the systems in place associated with financial management, estates, information technology and infrastructure, human resources and organisational development. The Committee also reviewed business cases for service change to ensure that there was no conflict of interest.

Charitable Funds Committee - this Committee had formal delegated authority to discharge the PCT's responsibilities as a corporate Trustee for one charity registered with the Charity Commission. However, this is a separate legal entity in its own right and does not actually form part of the PCT, and the governance arrangements are incorporated in a separate report and accounts. At the Board Meeting on the 20 March 2013 a formal resolution was agreed under which the Charitable Fund would be dissolved and transferred to Cumbria Partnership Foundation Trust effective 1 April 2013.

The Senior Management Team - The PCT Chief Executive & Directors and the Chair of the interim Clinical Commissioning Group met as a senior management team to address the management functions of the PCT. This was particularly important during the transition to the new NHS architecture to ensure a co-ordinated and consistent approach to change and also ensure effective management controls continued to be in place. The arrangements for the working of the Senior Management Team were developed throughout the year to reflect the progress towards the modelling of the new arrangements for the NHS, whilst maintaining the single current accountability of the PCT.

In the light of developing progress toward the implementation of the Health and Social Care Act, the former Transition and Business Groups were closed. **A PCT Closedown Group** was formed to manage the programmes of transition and closedown, reporting to the Senior Management Team and Board.

All of the above were involved in the identification and management of risk and contributed to the organisation's corporate risk register.

2. Corporate Governance

In line with the Corporate Governance Code, the PCT had up to 8 Non Executive Directors and Chair all appointed by the NHS Appointments commission. The Chair, Ian Gordon was appointed to another NHS Organisation effective from 1 February 2013. Mary Dowling became Acting Chair from 1 February 2013 to 31 March 2013. The Executive Director vacancy created by the secondment of the Director of Resources, was covered in year by the Acting Director of Finance and the Acting Director of Performance.

PCT Board Meetings were held regularly. The Board meetings were held in public, with public notification and papers available in advance. The business of each meeting was defined by the agenda, agreed by the Chair and published one week ahead of the meetings. Papers were issued to Board Members in advance of the meetings and they were published on the PCT website. Minutes and the action plans arising from PCT Board meetings were also published.

The PCT Board and Resources Committee received performance and finance & quality reports on a regular basis.

2. Corporate Governance (continued)

Part II business (for which press and public are excluded) was kept to a minimum. The only regular item was the consideration of Serious Untoward Incidents. During 2012-13 Part II business also covered any necessarily confidential items in regard to PCT closedown.

During 2012-13 the PCT Board monitored areas of risk associated with both the achievement of PCT's objectives and the management of the transition/closedown of the PCT through detailed reports presented by Executive Directors at the PCT Board Meetings. Areas of work included the developing Clinical Commissioning Group arrangements and transfer/closedown of the PCT's functions; continuing progress of the implementation of the Closer to Home strategies; quality assurance (in particular in regard to the 3 main provider Trusts); major and serious untoward incidents; Care Quality Commission and other external reports; QIPP priorities and Public Health issues.

3. Board Performance & Effectiveness

The Corporate Handover Document, approved by the Board at its meeting on 20 March 2013, documents in detail the PCT's strategic aims and objectives, achievements and use of resources. It is a comprehensive record of the strategic approach and action of the Board and clearly identifies outstanding issues and not yet completed tasks. As a part of the Document, a Quality Handover Document was prepared in line with the guidance of the National Quality Board. This documents the underlying and operational quality concerns in the health system in Cumbria. It provides a clear basis for the identification of the mitigation actions required across the transition into the new organisations for reducing risk and improving quality. The two handover Documents provide evidence of what the PCT has achieved/delivered and what remains to be addressed/resolved in meeting the ongoing challenges in Cumbria. They have formed a core part of the handover process from the PCT as a "sender" to the new receiving organisations in order to maintain business continuity. They have also been placed in the public domain, as part of the public record of the action of the Board and PCT.

During 2012-13 the PCT has been required to model new ways of working within the new architecture of the NHS whilst maintaining the formal governance and organisational structures. This involved maintaining a focus on delivery in 2012-13 as well as developing the new organisations and the arrangements to support them. It also required some dual working, allowing the new arrangements to start operating but within the existing formal and statutory structures and accountabilities. The Cumbria approach was already predicated on local clinically led decision making within the policy framework/objectives of the Board. During 2012-13 it was necessary to give increasing space for the interim CCG to establish itself and to model its future autonomous functioning. This was managed by the CCG Chief Officer Designate being a member of the Senior Management Team and by the Chair Designate of the CCG providing detailed reports to each meeting of the PCT Board.

Non Executive Directors have taken special interest/responsibilities within the Corporate Board for Resources and Business process, Quality and HR, Children and Public Engagement, Nursing and Audit and Safeguarding. In addition they each aligned themselves with one of the 6 Cumbria localities and acted as informal contacts to locality teams. The intention was to enable Non Executive Directors individually, and collectively, to have roles and focus outside the board meeting agenda and these arrangements supported a more dynamic way of ensuring the Non Executive Directors were equipped to provide the challenge and scrutiny required within their roles as members of the PCT Board during the transition process.

The PCT Chair met regularly with the Non Executive Directors to ensure clear communication and to review their areas of action and contribution.

The Chair met routinely and regularly with the Chief Executive and the Medical Director (and other directors/senior managers as necessary). Again this ensured two way communication and information exchange and influence outside of the formal meeting structure.

In assessing its own effectiveness the PCT Board confirms:-

PCT Board Strengths

- Clear strategic vision
- Explicit commitment to the county of Cumbria and the individuals and communities within it
- Shared commitment to development of local, clinically led decision making
- Evidence of a pattern of internal challenge and robust exchange of views
- A shared determination to make a difference and overcome some of the long term barriers to delivery of good health in Cumbria
- Strong management lead with strong connection into clinical community

3. Board Performance & Effectiveness (continued)

PCT Board Vulnerabilities

- Complex context given the two health economies (North and South Cumbria) and significant local variations
- Fast moving context, grappling with complex historical issues
- Risk of financial issues predominating because of financial pressures
- Serious Concerns in the 3 main NHS Provider Organisations in Cumbria as set out in section 4 below
- The difficulty in achieving the traction necessary to deliver the performance and quality improvements in the provider trusts and across the health/social care system

PCT Board Success and positive outcomes

- Support of the Clinical Commissioning Group to achieve authorisation
- Empowering and supporting a strong group of clinical leaders for local system change and quality improvement
- Continuing to oversee the delivery of positive service change based on integrated pathways of care reflecting patient need and resulting in reduction of unscheduled demand on acute hospitals, against the national trend
- Development of a strong focus on system failures and or untoward incidents in terms of driving performance management and learning
- A good level of confidence in the reporting of the management of PCT resources to the Trust Board, in a difficult and complex financial context. The Non Executive Directors have felt fully informed and involved with "no surprises".

PCT Performance

- The PCT was monitored, audited or inspected by various external agencies including the Strategic Health Authority, external audit & Care Quality Commission

4. NHS Operating Framework National Priorities 2012/13

Maintaining and Improving Quality

During the 2012-13 contracting round, which commenced January 2012, Cumbria CCG agreed with North Cumbria University Hospital NHS Trust (NCUHT), University Hospitals of Morecambe Bay NHS Foundation Trust (UHMB) and Cumbria Partnership NHS Foundation Trust (CPFT) trajectories for achieving KPIs. However by the end of 2011-12 the CCG and PCT Cluster recognised that performance was likely to deteriorate until new leadership arrangements were established at both Acute trusts which would lead to any period of sustained improvement. This was reported to NHS North at the Year End Review in May 2012, the Quarterly Review in August 2012 and the Mid Year Review in December 2012.

Whilst both trusts demonstrated some improvement in year against some of the KPIs predicted, deterioration was well underway by late quarter 2 and continued throughout the winter as both trusts experienced operational pressures. The PCT Cluster and Cumbria CCG worked with both trusts throughout the year to rebase plans however the revised plans were not achieved and maximum penalties were applied to each trust contract where performance was not achieved.

With CPFT the Cluster and CCG agreed a joint action plan to address deficiencies in children's services, notably child and adolescent mental health services, identified through the review process.

In summary the PCT Cluster underperformed against the Referral to Treatment (RTT), Accident & Emergency (A&E), Healthcare Associated Infections (HCAI) and Stroke indicators.

The PCT Cluster also underperformed against Mixed Sex Accommodation (MSA), Diagnostics, Smoking Cessation and the recovery rate performance indicator of Improving Access to Psychological Therapies (IAPT).

5. Risk Assessment

The Board's committee structure supported organisational governance assurance, performance management and identification of key risks to the PCT's business objectives. This provided the framework for identifying the totality of the risks facing the organisation and provided assurances that risks were being properly managed.

Risk management activity is integral to the strategic and operational management of the PCT's activity and it must form a natural part of routine working practices, this activity determines the organisations risk profile. A systematic and consistent process was in place for the identification of risk in order to ensure that all material risks associated with the business of the PCT were managed appropriately and minimised to the lowest possible level at every available opportunity.

In view of the requirement to model new ways of working within the existing structures, the Audit Committee reviewed both the PCT Cluster Risk and Assurance Framework and that developed within the Cumbria CCG, the latter having particular relevance to many of the operational and commissioning risks that fell within the responsibility of the PCT.

5. Risk Assessment (continued)

The integrated risk and assurance framework was populated through the identification and evaluation of risks from a number of sources both internal and external to the organisation. In the context of the NHS in 2012/13 particular attention continued to be given to risks associated with transition.

The PCT's established risk grading system was used to evaluate risk evaluating likelihood and consequence. The Risk Register recorded the risk assessment grade. Risks which attract a score of 15 or above (maximum 25) are regarded as high risk and are managed at a corporate level by regular review. Risks with a score of less than 15 are managed locally by the operational managers for each area under the relevant Director's guidance (directorate risk register). The PCT Board and its committees reviewed the Risk and Assurance Framework on a periodic basis. New risks identified during 2012-13 included:

- Risk of loss of focus and momentum in delivery as a result of the transition process.
- Risk to patient safety associated with quality and safety failings and loss of public confidence in University Hospitals Morecambe Bay NHS Foundation Trust (UHMB). The consequences of the major incident and a further major incident at UHMB and increasing evidence of concern (notably mortality) at North Cumbria University Hospitals NHS Trust (NCUH).
- Risk to the delivery of health benefits associated with a failure to secure and sustain clinical engagement and organisational support through agreed clinical strategy and clinical pathways.
- Risk of failure of the new commissioning arrangements to ensure safe services and effective use of available resources.
- Focus on quality risks associated with 3 main NHS providers

6. The Risk and Control Framework

Operational and financial risk was inherent within all aspects of the PCT's activities including: taking decision on the future strategies; the determination of Commissioning priorities and developing commissioning arrangements; financial management; managing programmes of work associated with transition and undertaking statutory duties as an employer.

The system of internal control was designed to manage risk to a reasonable level; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control was based on an ongoing process designed to:

- identify, prioritise and mitigate 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 the PCT for the year ended 31 March 2013 at which point all assets, liabilities and property transferred to receiving organisations. By agreement with the Area Team [Cumbria, Northumberland, Tyne and Wear Area Team, NHS England – North] the Cumbria CCG finance function prepared the final accounts for the financial year 2012-13, subject to the approval of the Audit Sub committee and final signature by me, as Director of the Cumbria, Northumberland, Tyne and Wear Area Team, NHS England – North.

7. Review of the effectiveness of risk management and internal control

Sue Page, as Accountable Officer, was responsible for the introduction and implementation of the risk management process within the organisation. The PCT Board supported the Chief Executive and Executive Directors with designated responsibilities for risk management within the organisation.

The leadership for corporate governance was delegated to the Executive Nurse co-ordinating the quality, safety and governance activities of the PCT and the Acting Director of Finance co-ordinating the finance and resources activities. However, whilst specific lead responsibilities were delegated, Risk Management remained the responsibility of all within the PCT.

The Audit Committee's terms of reference included the monitoring of corporate governance arrangements and initial approval of the financial statements. Financial monitoring was carried out at budget manager and board level.

During 2012-13 the Chair of the Audit Committee, supported by other Non Executive members of the Committee, maintained oversight on governance arrangements including the risk and assurance framework. The Audit Committee agreed the internal audit programme using a risk based approach. Internal Audit reports were presented to the Audit Committee and compliance with the implementation of recommendations was followed up on audit reviews. Significant risks identified with the non compliance of recommendations for improvement of systems were recorded on the corporate risk register. The Audit Committee received assurance from external auditors on the PCT's accounting systems and value for money assessment and provided the PCT with information on significant risks arising from the conduct of PCT business. Pro-active Counter Fraud arrangements enabled the PCT to agree a settlement to reclaim NHS funds in year from contractor services.

7. Review of the effectiveness of risk management and internal control (continued)

Risk management activity within the PCT considered clinical, financial and operational risks associated with commissioning the major change programme for health services in Cumbria.

The managers and staff received training and guidance to help them in managing risk including: formal policies and procedures, mandatory training and risk awareness training .

In addition, the PCT maintained system wide oversight to support the prevention and management of system wide risks to quality and patient safety. This included co-ordination of intelligence from the quality, contracting and reporting requirements for provider services. Work on the Quality Handover arrangements ensured that key risks identified within the health system were documented and discussed with providers, commissioners and regulators as part of the transition to the new NHS architecture.

The risk and control framework, as set out below, was in place for the full year.

The PCT utilised a Risk and Assurance Framework as a way of linking business objectives to key risks and identifying areas for further action (gaps in assurance or control). This framework informed the Annual Governance Statement.

The Risk and Assurance Framework was set against the key strategic objectives for the PCT. The framework considered each of these objectives in relation to the risk presented, the control measures in place to minimise the risks, the mechanisms for providing assurance, the effectiveness of control measures and outstanding issues in relation to both control and assurance provided. The framework also linked explicitly to the PCT corporate risk register to ensure that risks affecting the delivery of objectives were managed effectively. The Risk and Assurance Framework for the organisation, reflecting Cluster and CCG issues, was approved and reviewed by the Audit Committee to provide assurance that progress is being made to address gaps in assurance and/or control. The Audit Committee approved updates to the framework every 6 months.

As set out in the Corporate Handover Document, the PCT strategy for improving health in Cumbria involved very substantial change with potential impacts on Providers, Partners and Public. The document summarises the progress made and the tasks outstanding. It also sets out some of the intrinsic risks in the change programme. To support the delivery of this ambitious programme the PCT developed joint working with key delivery partners (particularly the Provider Trusts and the County Council). It also sought to build the confidence of the Public by working through local stakeholder groups, the Patients Voice Group and Local Involvement Networks (LINk). The CCG has further developed the Locality Commissioning arrangement in order to ensure that local need is met in ways that are consistent with the PCT strategic objectives in line with the Joint Strategic Needs Assessment (JSNA) and the characteristics protected by the Equality Act.

The PCT had systems in place to ensure that service changes which were subject to the requirements of a consultation process were endorsed by the Cumbria County Council Health and Wellbeing Overview and Scrutiny Committee (OSC). In the South of the County the development of a Clinical Strategy to address particular local challenges was taken forward by the PCT and CCG, with in-built mechanisms for public engagement in the development of the options, prior to proposals being constructed as a basis for formal public consultation. The PCT briefed the full OSC quarterly on relevant developments and policy changes and maintained discussion through the OSC on live issues with local councillors. The PCT Communications Department maintained a regular flow of press releases through the local media - county wide, to keep people aware and informed. Localities each had their own arrangements for local stakeholder engagement, through lay representation and through stakeholder groups.

Information Governance within the PCT was a key component of clinical governance, service planning and performance management. Information Governance covered ALL staff employed by the PCT, private contractors, volunteers and temporary staff. The PCT maintained level 2 compliance during 2012-13 with the IG toolkit however, the PCT acknowledged that this was a high risk area which required focus to maintain and increase compliance during the period of transition to new organisational forms and to support innovative new ways of integrated working across health, social care and the independent sector, which improve outcomes for patients. A formal information security risk assessment and management method was used in high risk areas, to ensure all threats, vulnerabilities and impacts were properly assessed and included in a PCT-wide risk register, and acknowledged in the PCT's Information Governance assurance framework.

In order to manage the information governance risks associated with the transfer and closedown processes a specific project group was formed with external support. A detailed project plan was worked through and second phase will operate in the first quarter of 2013-14 to ensure safe transition.

The Director of Corporate Affairs was appointed as the Senior Information Risk Officer (SIRO). The PCT did not report any information security issues to the Information Commissioner during 2012-13.

7. Review of the effectiveness of risk management and internal control (continued)

In line with the national requirements for transition and closedown the PCT undertook extensive processes of due diligence to confirm that all properties, assets and liabilities were identified, mapped to the function to which they related and then identified for transfer (by means of the Transfer Schemes) to the relevant receiver organisation(s).

The Head of Internal Audit Opinion for the year ended 31 March 2013 confirms significant assurance can be given that there was a generally sound system of internal control in operation. This statement confirms the main issues facing the PCT related to the risks recognised and managed by the PCT in respect of the challenges of managing the transition to Clinical Commissioning arrangements and the National Commissioning Board, the delivery of an affordable clinical strategy and risks to patient safety associated with the safety and viability of commissioned services at University Hospitals Morecambe Bay NHS Foundation Trust and Clinical Safety and viability of some commissioned services at North Cumbria University Hospitals NHS Trust.

Significant Issues to Report:

Significant issues arising in 2012-13 were those relating to the transfer and closedown process as reported to the Board in March 2013 in the Transition and Closedown report and those relating to quality and safety of commissioned services, as set out in the Quality Handover Document approved by the Board in March 2013.

The most significant continuing issues:

These are set out in the Corporate Handover Document which identifies the outstanding strategic issues and the action that is required in order for the local health system to provide sustainable high quality services. The key operational quality risks are identified in the Quality Handover Document. These evidence based documents have been shared with Cumbria CCG, the Cumbria, Northumberland, Tyne & Wear Area Team and the 3 local Provider Trusts as well as the Local Authority and key stakeholders. They are also available as public documents. They ensure that the closure of the PCT and the transfer of its responsibilities, does not result in the loss of knowledge, intelligence or focus in addressing key ongoing risks.

In summary the fundamental risks relate to:

- the sustainability (clinical and financial) of North Cumbria University Hospitals NHS Trust which is going through an acquisition porcess with Northumbria Healthcare NHS Foundation Trust.
- the sustainability of services in the Morecambe bay area as covered by the "Better Care Together" programme.
- delivery of the planned improvements to services for children.

8. Conclusion

My review confirms Cumbria Teaching Primary Care Trust had a generally sound system of internal control to support the achievement of its aim and objectives in the context of the transition to new organisations and the closedown of the PCT .

Accountable Officer : Sue Page, Chief Executive Cumbria Teaching Primary Care Trust 1 April 2012-27 March 2013

John Lawlor, Accountable Officer - 28 March 2013 onwards

Signing Officer ..... Date 4th June 2013

John Lawlor, Area Director, Cumbria, Northumberland, Tyne & Wear Area Team, NHS England – North

INDEPENDENT AUDITOR'S REPORT TO THE DEPARTMENT OF HEALTH'S ACCOUNTING OFFICER OF CUMBRIA TEACHING PRIMARY CARE TRUST

We have audited the financial statements of Cumbria Teaching Primary Care Trust 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 on page 33 of the Annual Report;
- the table of pension benefits of senior managers and related narrative notes on page 34 of the Annual Report; and
- the table of pay multiples and related narrative notes on page 35 of the Annual Report.

This report is made solely to the Department of Health's accounting officer in respect of Cumbria Teaching Primary Care Trust 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. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Department of Health's accountable officer and the Trust as a body, for our audit work, for this report, or for opinions we have formed.

Respective responsibilities of the signing officer, finance signing officer and auditor

As explained more fully in the Statement of Responsibilities, 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 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 Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Trust; 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 Cumbria Primary Care Trust 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
- we refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have a reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

We have nothing to report in these respects.

Other matters on which we are required to conclude

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are also required by the Audit Commission's Code of Audit Practice 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 and, having regard to the guidance issued by the Audit Commission, we have considered the results of the following:

- our review of the annual governance statement; and
- the work of other relevant regulatory bodies or inspectorates, to the extent the results of the work have an impact on our responsibilities; and
- our locally determined risk-based work.

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

Certificate

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

Karen Murray

Karen Murray

Senior Statutory Auditor, for and on behalf of Grant Thornton UK LLP

4 Hardman Square
Spinningfields
Manchester
M3 3EB

4 June 2013

Statement of Comprehensive Net Expenditure for year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure			
Gross employee benefits	7.1	14,243	13,546
Other costs	5.1	929,595	904,504
Income	4	(20,864)	(19,020)
Net operating costs before interest		922,974	899,030
Finance costs	9	724	738
Net operating costs for the financial year		923,698	899,768
Of which:			
Administration Costs			
Gross employee benefits	7.1	11,235	10,203
Other costs	5.1	9,746	8,675
Income	4	(3,006)	(3,034)
Net administration costs before interest		17,975	15,844
Finance costs	9	634	738
Net administration costs for the financial year		18,609	16,582
Programme Expenditure			
Gross employee benefits	7.1	3,008	3,343
Other costs	5.1	919,849	895,829
Income	4	(17,858)	(15,986)
Net programme expenditure before interest		904,999	883,186
Finance costs	9	90	-
Net programme expenditure for the financial year		905,089	883,186

Other Comprehensive Net Expenditure		2012-13 £000	2011-12 £000
Impairments put to the Revaluation Reserve	12	700	-
Total comprehensive net expenditure for the year		924,398	899,768

Statement of Financial Position at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	10	**47,376**	49,357
Intangible assets	11	**55**	84
Other financial assets	17	**380**	426
Total non-current assets		**47,811**	49,867
Current assets:			
Trade and other receivables	15.1	**11,105**	11,659
Cash	18	**-**	1
Total current assets		**11,105**	11,660
Non-current assets held for sale	19	**824**	110
Total current assets		**11,929**	11,770
Total assets		**59,740**	61,637
Current liabilities			
Trade and other payables	20	**(44,079)**	(63,639)
Provisions	22	**(10,818)**	(3,531)
Borrowings	21	**(175)**	(160)
Total current liabilities		**(55,072)**	(67,330)
Non-current assets plus/less net current assets/liabilities		**4,668**	(5,693)
Non-current liabilities			
Trade and other payables	20	**-**	(1,558)
Provisions	22	**(2,327)**	(2,567)
Borrowings	21	**(6,475)**	(6,650)
Total non-current liabilities		**(8,802)**	(10,775)
Total Assets Employed:		**(4,134)**	(16,468)
Financed by taxpayers' equity:			
General fund		**(12,758)**	(25,792)
Revaluation reserve		**8,624**	9,324
Total taxpayers' equity:		**(4,134)**	(16,468)

The notes on pages 5 to 31 form part of this account.

The financial statements on pages 1 to 4 were approved by the Audit Sub-Committee of the Audit and Risk Committee of the Department of Health on 4 June 2013 and signed on its behalf by

John Lawlor
Area Director, Cumbria, Northumberland, Tyne & Wear Area Team, NHS England – North
Accountable Officer Date: 4 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	(25,792)	9,324	**(16,468)**
Changes in taxpayers' equity for 2012-13			
Net operating cost for the year	(923,698)		**(923,698)**
Impairments		(700)	**(700)**
Total recognised income and expense for 2012-13	(923,698)	(700)	**(924,398)**
Net Parliamentary funding	936,732		**936,732**
Balance at 31 March 2013	**(12,758)**	**8,624**	**(4,134)**
Balance at 1 April 2011	(31,475)	9,324	(22,151)
Changes in taxpayers' equity for 2011-12			
Net operating cost for the year	(899,768)		(899,768)
Total recognised income and expense for 2011-12	(899,768)	-	(899,768)
Net Parliamentary funding	905,451		905,451
Balance at 31 March 2012	(25,792)	9,324	(16,468)

Statement of cash flows for the year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Cash flows from operating activities			
Net Operating Cost Before Interest		(922,974)	(899,030)
Depreciation and Amortisation		3,997	2,963
Interest Paid		(634)	(649)
(Increase)/Decrease in Trade and Other Receivables	15	554	(5,114)
Decrease in Trade and Other Payables[1]	20	(21,218)	(1,841)
Provisions Utilised	22	(3,257)	(681)
Increase in Provisions	22	10,214	2,783
Net cash outflow from operating activities		(933,318)	(901,569)
Cash flows from investing activities			
Payments for Property, Plant and Equipment (PPE)[2]		(3,552)	(3,740)
Payments for Intangible Assets		(21)	-
Proceeds of disposal of assets held for sale (PPE)		318	-
Net cash outflow from investing activities		(3,255)	(3,740)
Net cash outflow before financing		(936,573)	(905,309)
Cash flows from financing activities			
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI		(160)	(146)
Net Parliamentary Funding		936,732	905,451
Net cash inflow from financing activities		936,572	905,305
Net decrease in cash		(1)	(4)
Cash at beginning of the period		1	5
Cash at year end		-	1

[1] excludes movement in Capital Payables

[2] includes movements in Capital Payables and LIFT investment

NOTES TO THE ACCOUNTS

1. Accounting policies

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

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

As a consequence of the Health and Social Care Act 2012, Cumbria Teaching PCT was dissolved on 31 March 2013. Its functions will be transferred to various new or existing public sector entities. The Secretary of State has directed that, where Parliamentary funding continues to be voted to permit the relevant services to be carried out elsewhere in the public sector, this is normally sufficient evidence of going concern. As a result these financial statements have been prepared on a going concern basis.

1.1 Accounting Conventions

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

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

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

Critical judgements in applying accounting policies
Management has made no critical judgements, apart from than those involving estimations (see below), in the process of applying the PCT's accounting policies.

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

Indexation of Land and Buildings
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. Between periodic valuations by the District Valuer the PCT considers annually whether price movements warrant adjustment to the carrying value of land and buildings, the last valuation having been carried out in 2009-10. In the current year, the Building Cost Information Service (BCIS) national index has shown a rise of 1.7% which would amount to £768k indexation on the closing land and buildings NBV. The PCT does not regard this to be a material change to the carrying value of the PCT's properties, nor to justify an interim valuation, and thus the PCT considers it appropriate to apply no indexation in the current year.

Depreciation
Fixed assets are depreciated over their estimated useful lives. The useful lives of buildings are reviewed periodically (at least every 5 years) by the District Valuer and were last reviewed in 2009-10.

Impairment of Receivables
Details of the PCT's policy on impairment of receivables are disclosed in note 15.3.

1. Accounting policies (continued)

1.1 Accounting Conventions (continued)

Continuing Healthcare Claims

The Department of Health issued a request that all claims for Continuing Healthcare funding up to the 31 March 2011 were received by the PCT on the 30 September 2012. The PCT has received a number of claims which are at various stages in the review process, the PCT has reviewed their status and made a provision for costs expected based on a calculation of individual cost and likelihood of success disclosed in note 22.

Contingencies

Where the PCT can place a reasonable estimate on a potential future liability, and that liability is reasonably likely to materialise, the PCT makes provision in its accounts for that liability. Where one of these conditions is not met, the PCT discloses details under note 23 "Contingencies".

1.2 Revenue and Funding

The main source of funding for the Primary Care Trust is allocations (Parliamentary Funding) from the Department of Health within an approved cash limit, which is credited to the General Fund of the Primary Care Trust. Parliamentary funding is recognised in the financial period in which the cash is received.

Miscellaneous revenue is income which relates directly to the operating activities of the Primary Care Trust. It principally comprises fees and charges for services provided on a full cost basis to external customers, as well as public repayment work. It includes both income appropriated-in-aid of the Vote and income to the Consolidated Fund which HM Treasury has agreed should be treated as operating income.

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Where revenue has been received for a specific activity to be delivered in the following financial year, that income will be deferred.

1.3 Pooled budgets

The PCT has entered into a pooled budget with Cumbria County Council. Under the arrangement funds are pooled under S75 of the NHS Act 2006 for learning disability, locality and equipment store activities and a memorandum note to the accounts provides details of the joint income and expenditure.

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

1.4 Taxation

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

1.5 Administration and Programme Costs

Treasury has set performance targets in respect of non-frontline expenditure (administration expenditure).

From 2011-12, PCTs therefore analyse and report revenue income and expenditure by "admin and programme"

For PCTs, the Department has defined "admin and programme" in terms of running costs.

The broad definition of running costs includes any cost incurred that is not a direct payment for the provision of healthcare or healthcare related services.

Expense incurred under NHS transition redundancy programmes is however classed as "programme" under Treasury budgetary control arrangements and so is recorded as such in the financial statements.

1.6 Property, Plant & Equipment

Categories

Property, plant and equipment consists of: land, buildings excluding dwellings, assets under construction and payments on account, plant and machinery, transport equipment, information technology and furniture and fittings.

Recognition

Property, plant and equipment is capitalised if:

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

1. Accounting policies (continued)

1.6 Property, Plant & Equipment (continued)

- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

Valuation

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

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

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

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

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

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

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

Subsequent expenditure

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

1.7 Intangible Assets

Recognition

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

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

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

1. Accounting policies (continued)

1.7 Intangible Assets (continued)

Measurement

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

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

1.8 Depreciation, amortisation and impairments

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

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

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

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

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

1.9 Donated assets

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

1.10 Non-current assets held for sale

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

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

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

1. Accounting policies (continued)

1.11 Inventories

Due to the high turnover of consumables and the low value, the Primary Care Trust does not value inventories on the Statement of Financial Position but charges all items directly to the Operating Cost Statement when purchased.

Work-in-progress comprises goods in intermediate stages of production. Partially completed contracts for patient services are not accounted for as work-in-progress.

1.12 Cash

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours.

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

1.13 Losses and Special Payments

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

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

1.14 Clinical Negligence Costs

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

The NHSLA operates a risk pooling scheme under which the PCT pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure in the year that it is due. The total value of clinical negligence provisions carried by the NHSLA on behalf of the PCT is disclosed at Note 22.

1.15 Employee benefits

Short-term employee benefits

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

1.16 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.

1.17 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. Accounting policies (continued)

1.18 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.

1.19 Leases

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

The PCT as lessee

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

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

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

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

The PCT as lessor

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

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

1.20 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.

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)

1.21 Financial Instruments

Financial assets

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

Financial assets are initially recognised at fair value.

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

Financial assets at fair value through profit and loss

The PCT does not hold any financial assets at fair value through profit and loss.

Held to maturity investments

The PCT does not hold any held to maturity investments.

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. The PCT only has LIFT investments as available for sale financial assets. Fair value is the value of the outstanding investment.

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 in accordance with generally accepted pricing models based on 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 of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

Financial liabilities

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

Financial liabilities are initially recognised at fair value.

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

Financial liabilities at fair value through profit and loss

The PCT does not hold any financial liabilities at fair value through profit and loss.

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. Accounting policies (continued)

1.22 Private Finance Initiative (PFI) transactions

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

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

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

a) Services received

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

b) PFI assets, liabilities, and finance costs

The PFI 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 liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the 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.

c) Lifecycle replacement

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

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

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

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

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

Other assets contributed by the PCT to the operator

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

1. Accounting policies (continued)

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

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

IAS 19 (Revised 2011) Employee Benefits
IAS 27 Separate Financial Statements - subject to consultation
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IAS 32 Financial Instruments: Presentation
IFRS 7 Financial Instruments: Disclosures
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

Following its establishment in shadow form during 2011/12, Cumbria's Clinical Commissioning Group (CCG) was formally authorised in March 2013 to assume full responsibility for commissioning local health services in the county from April 2013. As part of the preparation for the CCG taking on this responsibility the PCT Board delegated management of a number of budgets to the shadow CCG under an accountability agreement.

	CCG 2012-13 £000	PCT 2012-13 £000	Total 2012-13 £000
Expenditure	714,981	208,717	923,698
Surplus before interest	(5,696)	(325)	(6,021)
Net Assets:			
Segment net assets	-	(4,134)	(4,134)

- PCT segment owns all the PCT's property.

The segments are those reported to the Chief Operating Decision Maker (CODM), which is the PCT Board.

3. Financial Performance Targets

3.1 Revenue Resource Limit

	2012-13 £000	2011-12 £000
The PCTs' performance for the year ended 31 March 2013 is as follows:		
Total Net Operating Cost for the Financial Year	923,698	899,768
Revenue Resource Limit	929,719	903,963
Underspend Against Revenue Resource Limit (RRL)	6,021	4,195

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	3,402	3,749
Charge to Capital Resource Limit	3,401	3,749
(Over)/Underspend Against Capital Resource Limit (CRL)	1	-

3.3 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	936,732	905,451
Cash Limit	936,732	905,451
Under/(Over)spend Against Cash Limit	-	-

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

	2012-13 £000
Total cash received from DH (Gross)	827,950
Plus: cost of Dentistry Schemes (central charge to cash limits)	19,568
Plus: drugs reimbursement (central charge to cash limits)	89,214
Parliamentary funding credited to General Fund	936,732

4. Miscellaneous Revenue

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Dental Charge income from Contractor-Led GDS & PDS	5,983		5,983	5,749
Prescription Charge income	5,186		5,186	4,862
Strategic Health Authorities	3,174	-	3,174	2,987
NHS Trusts	878	-	878	877
NHS Foundation Trusts	132	-	132	165
Primary Care Trusts - Other	826	-	826	385
Local Authorities	518	-	518	78
Education, Training and Research	365	-	365	310
Rental revenue from operating leases[1]	2,800	2,800	-	2,800
Other revenue	1,002	206	796	807
Total miscellaneous revenue	20,864	3,006	17,858	19,020

[1] With effect of 1st April 2011 the PCT's provider arm was transferred to Cumbria Partnership Foundation NHS Trust (CPFT) and, as part of the Business Transfer Agreement (BTA), services continue to operate out of PCT properties. The rental arrangement has been determined as an operating lease over the term of the BTA.

5. Operating Costs

5.1 Analysis of operating costs:

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
Goods and Services from Other PCTs				
Healthcare[1]	84,443		84,443	66,907
Non-Healthcare	475	212	263	657
Total	84,918	212	84,706	67,564
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts[1]	206,468	996	205,472	202,507
Goods and services (other, excl Trusts, FT and PCT))	-	-	-	4,174
Total	206,468	996	205,472	206,681
Goods and Services from Foundation Trusts[1]	331,814	(1,299)	333,113	326,420
Purchase of Healthcare from Non-NHS bodies	57,593		57,593	59,062
Expenditure on Drugs Action Teams	4,585		4,585	2,169
Non-GMS Services from GPs	5,996	666	5,330	6,342
Contractor Led GDS & PDS (excluding employee benefits)	25,094		25,094	26,016
Salaried Trust-Led PDS & PCT DS (excluding employee benefits)	-		-	302
Chair, Non-executive Directors & PEC remuneration	93	93	-	99
Consultancy Services	2,298	1,367	931	1,141
Prescribing Costs	86,080		86,080	86,298
G/PMS, APMS and PCTMS (excluding employee benefits)	79,532	-	79,532	78,845
Pharmaceutical Services	16,243		16,243	16,621
New Pharmacy Contract	8,847		8,847	9,069
General Ophthalmic Services	4,861		4,861	4,451
Supplies and Services - Clinical	9	3	6	29
Supplies and Services - General	74	74	-	64
Establishment	1,569	1,341	228	1,288
Transport	-	-	-	1
Premises	1,503	1,459	44	1,542
Depreciation	3,947	3,947	-	2,924
Amortisation	50	50	-	39
Impairment of Receivables	(114)	(114)	-	66
Audit Fees	138	138	-	212
Other Auditors Remuneration	-	-	-	38
Clinical Negligence Costs	103	-	103	44
Education and Training	439	432	7	163
Grants for capital purposes	1,575	-	1,575	110
Grants for revenue purposes	4,927	-	4,927	2,771
Other	953	381	572	4,133
Total Operating costs charged to Statement of Comprehensive Net Expenditure	929,595	9,746	919,849	904,504
Employee Benefits (excluding capitalised costs)				
PCT Officer Board Members	1,152	1,152	-	1,456
Other Employee Benefits	13,091	10,083	3,008	12,090
Total Employee Benefits charged to SOCNE	14,243	11,235	3,008	13,546
Total Operating Costs	943,838	20,981	922,857	918,050
Analysis of grants reported in total operating costs				
For capital purposes				
Grants to Fund Capital Projects - Other	1,575	-	1,575	110
Total Capital Grants	1,575	-	1,575	110
Grants to fund revenue expenditure				
To Local Authorities	4,927	-	4,927	2,771
Total Revenue Grants	4,927	-	4,927	2,771
Total Grants	6,502	-	6,502	2,881

[1] First tranche of activity shift (£15mill) in respect of policy change re specialised commissioning from Trusts & FTs to North West Specialised Commissioning (hosted by Western Cheshire PCT). Also 1 Trust and 2 Foundation Trusts received additional/transitional support in year.

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	18,609	17,362	1,247
Weighted population (number in units)*	526,281	526,281	526,281
Running costs per head of population (£ per head)	35	33	2
PCT Running Costs 2011-12			
Running costs (£000s)	16,582	15,601	981
Weighted population (number in units)	526,281	526,281	526,281
Running costs per head of population (£ per head)	32	30	2

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

The increase in running costs results from accelerated depreciation following a review of the PCT's Property Plant and equipment in preparation of transferring to receiving organisations (£1m) and the majority of residual increased costs involved with managing the transition of PCT to receiving organisations. These costs were funded from non-recurring funds specifically identified for the purpose.

5.2 Analysis of operating expenditure by expenditure classification

	2012-13 £000	2011-12 £000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	79,532	78,295
Prescribing costs	86,080	86,290
Contractor led GDS & PDS	25,094	26,016
Trust led GDS & PDS	-	308
General Ophthalmic Services	4,862	4,451
Pharmaceutical services	16,243	16,614
New Pharmacy Contract	8,847	9,069
Non-GMS Services from GPs	5,996	6,205
Other	222	327
Total Primary Healthcare purchased	226,876	227,575
Purchase of Secondary Healthcare		
Learning Difficulties	4,898	8,368
Mental Health	90,161	92,075
Maternity	14,136	14,127
General and Acute	409,381	390,648
Accident and emergency	32,630	28,738
Community Health Services	133,788	127,213
Other Contractual	161	95
Total Secondary Healthcare Purchased	685,155	661,263
Grant Funding		
Grants for capital purposes	1,575	110
Grants for revenue purposes	4,927	2,771
Total Healthcare Purchased by PCT	918,533	891,719
Included above:		
Healthcare from NHS FTs included above	333,113	328,001

6. Operating Leases

The PCT leases a number of properties, which the PCT currently occupies, under non-cancellable leases. The PCT also leases cars typically on 3 year leases. The PCT, as lessee, has determined, based on an evaluation of the terms and conditions of the arrangements, that the lessor retains a significant portion of the risks and rewards of ownership. As such the PCT accounts for them as operating leases.

6.1 PCT as lessee

	Land & Buildings £000	Other £000	2012-13 Total £000	2011-12 £000
Payments recognised as an expense				
Minimum lease payments			733	792
Total			**733**	792
Payable:				
No later than one year	435	173	608	733
Between one and five years	1,090	163	1,253	1,706
After five years	2,034	-	2,034	2,458
Total	**3,559**	**336**	**3,895**	4,897

The PCT has entered into certain financial arrangements involving the use of GP Premises. The PCT has determined that those operating leases must be recognised, but, as there is no defined term in the arrangements entered into, it is not possible to analyse the arrangements over financial years. The financial value included in the Statement of Comprehensive Net Expenditure for 2012-13 is £3,991,865 (£3,760,506 in 2011-12).

Although the PCT will cease to exist with effect of 1st April 2013, its services will continue to be provided by various successor bodies within the public sector.

6.2 PCT as lessor

With effect of 1st April 2011 the PCT's provider arm was transferred to Cumbria Partnership NHS Foundation Trust (CPFT) and is no longer part of the PCT. No assets were transferred to CPFT but services continue to operate out of PCT properties and as part of the Business Transfer Agreement (BTA) CPFT is given a licence to occupy PCT premises. As such the PCT has deemed this arrangement as an operating lease and accounted for them as such over the term of the BTA.

	2012-13 £000	2011-12 £000
Recognised as income		
Rental Revenue	2,800	2,800
Total	**2,800**	2,800
Receivable:		
No later than one year	2,800	2,800
Between one and five years	-	2,800
Total	**2,800**	5,600

7. Employee benefits and staff numbers

7.1 Employee benefits

	2012-13			Permanently employed			Other		
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Employee Benefits - Gross Expenditure									
Salaries and wages	11,480	9,313	2,167	10,472	8,417	2,055	1,008	896	112
Social security costs	990	804	186	988	802	186	2	2	-
Employer Contributions to NHS BSA - Pensions Division	1,376	1,118	258	1,373	1,115	258	3	3	-
Termination benefits	397	-	397	397	-	397	-	-	-
Total employee benefits	14,243	11,235	3,008	13,230	10,334	2,896	1,013	901	112
Recognised as:									
Commissioning employee benefits	14,243			13,230			1,013		

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits - Gross Expenditure			
Salaries and wages	10,991	10,294	697
Social security costs	974	971	3
Employer Contributions to NHS BSA - Pensions Division	1,385	1,381	4
Termination benefits	196	196	-
Total gross employee benefits	13,546	12,842	704
Recognised as:			
Commissioning employee benefits	13,546		

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	11	11	-	11	11	0
Administration and estates	193	167	26	184	164	20
Nursing, midwifery and health visiting staff	27	27	-	21	20	1
Scientific, therapeutic and technical staff	17	17	-	19	19	-
TOTAL	248	222	26	235	214	21

7.3 Staff Sickness absence and ill health retirements

	2012-13 Number	2011-12 Number
Total Days Lost	906	11,065
Total Staff Years	245	1,370
Average working Days Lost	3.70	8.08

	2012-13 Number	2011-12 Number
Number of persons retired early on ill health grounds	1	4
	£000	£000
Total additional pensions liabilities accrued in the year	58	421

7.4 Exit Packages agreed during 2012-13

	2012-13			2011-12		
Exit package cost band (including any special payment element)	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages by cost band Number	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages by cost band Number
Lees than £10,000	2	-	2	-	-	-
£10,001-£25,000	-	1	1	-	-	-
£25,001-£50,000	2	-	2	-	-	-
£50,001-£100,000	1	4	5	-	-	-
£100,001 - £150,000	-	2	2	-	-	-
£150,001 - £200,000	-	3	3	1	-	1
>£200,000	2	1	3	-	-	-
Total number of exit packages by type	7	11	18	1	-	1
	£000	£000	£000	£000	£000	£000
Total cost	687	1,416	2,103	196	-	196

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

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

7.5 Pension costs

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8. Better Payment Practice Code

8.1 Measure of compliance

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	15,919	105,967	19,938	105,323
Total Non-NHS Trade Invoices Paid Within Target	15,759	104,839	19,074	104,342
Percentage of NHS Trade Invoices Paid Within Target	98.99%	98.94%	95.67%	99.07%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	4,080	669,798	4,374	666,148
Total NHS Trade Invoices Paid Within Target	4,030	668,646	4,195	662,510
Percentage of NHS Trade Invoices Paid Within Target	98.77%	99.83%	95.91%	99.45%

The Better Payment Practice Code requires the PCT to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The PCT has achieved the set target to pay 95% of invoices within this requirement.

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

The PCT has not incurred any costs associated with the late payments of commercial debts.

9. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest on obligations under PFI contracts:				
- main finance cost	634	634	-	649
Total interest expense	634	634	-	649
Provisions - unwinding of discount	90		90	89
Total	724	634	90	738

10. Property, plant and equipment

2012-13	Land	Buildings excluding dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:								
At 1 April 2012	6,504	38,863	2,212	5,244	68	6,569	2,058	61,518
Additions Purchased	700	2,450		-	-	549	-	3,699
Reclassifications	-	2,212	(2,212)	-	-	-	-	-
Reclassifications as Held for Sale	(170)	(544)	-	-	-	-	-	(714)
Disposals other than for sale	(305)	(14)	-	-	-	-	-	(319)
Impairments/negative indexation	(700)	-	-	-	-	-	-	(700)
At 31 March 2013	6,029	42,967	-	5,244	68	7,118	2,058	63,484
Depreciation								
At 1 April 2012	-	1,546	-	3,783	61	5,222	1,549	12,161
Charged During the Year	-	2,253		642	7	843	202	3,947
At 31 March 2013	-	3,799	-	4,425	68	6,065	1,751	16,108
Net Book Value at 31 March 2013	6,029	39,168	-	819	-	1,053	307	47,376
Purchased	6,029	38,497	-	796	-	1,053	204	46,579
Donated	-	671	-	23	-	-	103	797
Total at 31 March 2013	6,029	39,168	-	819	-	1,053	307	47,376
Asset financing:								
Owned	6,029	31,740	-	819	-	1,053	307	39,948
On-SOFP PFI contracts	-	7,428	-	-	-	-	-	7,428
Total at 31 March 2013	6,029	39,168	-	819	-	1,053	307	47,376

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2012	1,886	7,251	-	147	-	-	-	9,284
Reclassification as Asset Held for Sale		(156)						(156)
Impairment	-	(700)	-	-	-	-	-	(700)
At 31 March 2013	1,886	6,395	-	147	-	-	-	8,428

2011-12	Land	Buildings excluding dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:								
At 1 April 2011	6,534	36,573	1,658	5,235	68	6,234	2,003	58,305
Additions - purchased	-	2,370	554	9	-	335	55	3,323
Reclassified as held for sale	(30)	(80)	-	-	-	-	-	(110)
At 31 March 2012	6,504	38,863	2,212	5,244	68	6,569	2,058	61,518
Depreciation								
At 1 April 2011	-	-	-	3,393	58	4,379	1,407	9,237
Charged During the Year	-	1,546	-	390	3	843	142	2,924
At 31 March 2012	-	1,546	-	3,783	61	5,222	1,549	12,161
Net Book Value at 31 March 2012	6,504	37,317	2,212	1,461	7	1,347	509	49,357
Purchased	6,504	36,616	2,212	1,426	7	1,347	371	48,483
Donated	-	701	-	35	-	-	138	874
At 31 March 2012	6,504	37,317	2,212	1,461	7	1,347	509	49,357
Asset financing:								
Owned	6,504	29,717	2,212	1,461	7	1,347	509	41,757
On-SOFP PFI contracts	-	7,600	-	-	-	-	-	7,600
At 31 March 2012	6,504	37,317	2,212	1,461	7	1,347	509	49,357

10. Property, plant and equipment (continued)

The estimated useful lives of the PCT's property, plant and equipment are as follows:

	Min Life (Years)	Max Life (Years)
Property, Plant and Equipment		
Buildings exc Dwellings	15	100
Plant & Machinery	5	15
Transport Equipment	7	7
Information Technology	5	5
Furniture and Fittings	7	10

Open Market Value of Assets at balance sheet date	**Land**	**Buildings excl. dwellings**	**Total**
	£000s	**£000s**	**£000s**
Open Market Value at 31 March 2013	-	-	-
Open Market Value at 31 March 2012	22	12	34

Cleator Moor Health Centre was depreciated in 2011-12 to reflect its open market value in anticipation of sale as part of the new health centre LIFT development.

11. Intangible non-current assets

Software purchased	**2012-13 £000**	2011-12 £000
At 1 April	**262**	262
Additions - purchased	**21**	-
At 31 March	**283**	262
Amortisation		
At 1 April	**178**	139
Charged during the year	**50**	39
At 31 March	**228**	178
Net Book Value at 31 March	**55**	84
Net Book Value at 31 March comprises		
Purchased	**55**	84
Total at 31 March	**55**	84

The intangible assets have finite useful lives and are amortised, from the date they are available for use, on a straight line basis over the following estimated useful lives:

	Min Life (Years)	Max Life (Years)
Software licences	3	5

Amortisation periods and methods are reviewed annually and adjusted if appropriate.

There is no revaluation reserve balance for intangible assets.

12. Analysis of impairments recognised in 2012-13

	2012-13 Total £000
Property, Plant and Equipment impairments charged to the revaluation reserve	
Other	700
Total impairments for PPE charged to reserves	**700**
Total Impairments of Property, Plant and Equipment	**700**
Total Impairments charged to Revaluation Reserve	700
Overall Total Impairments	**700**

The impairment is a correction to the brought forward value in relation to ownership of Wigton Hospital.

13. Commitments

13.1 Capital commitments

The PCT has no capital commitments as at 31 March 2013 [31 March 2012 £nil].

13.2 Other financial commitments

The PCT has no financial commitments as at 31 March 2013 [31 March 2012 £nil].

14. Intra-Government and other balances

	Current receivables £000	Non-current receivables £000	Current payables £000	Non-current payables £000
	554	-	842	-
Balances with Local Authorities	8,001	-	819	-
Balances with NHS Trusts and Foundation Trusts	418	-	3,880	-
Balances with bodies external to government	2,132	-	38,538	-
At 31 March 2013	**11,105**	**-**	**44,079**	**-**
prior period:				
Balances with other Central Government Bodies	557	-	7,299	-
Balances with Local Authorities	425	-	5,015	-
Balances with NHS Trusts and Foundation Trusts	1,119	-	7,542	1,558
Balances with bodies external to government	9,558	-	43,783	-
At 31 March 2012	**11,659**	**-**	**63,639**	**1,558**

15.1 Trade and other receivables

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
NHS receivables - revenue	**551**	1,203	**-**	-
NHS prepayments and accrued income	**177**	208	**-**	-
Non-NHS receivables - revenue	**884**	869	**-**	-
Non-NHS prepayments and accrued income	**8,041**	8,608	**-**	-
Provision for the impairment of receivables	**(167)**	(458)	**-**	-
VAT	**528**	244	**-**	-
Other receivables	**1,091**	985	**-**	-
Total	**11,105**	11,659	**-**	-
Total current and non current	**11,105**	11,659		

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.

15.2 Receivables past their due date but not impaired

	31 March 2013	31 March 2012
	£000	£000
By up to three months	**427**	223
By three to six months	**62**	46
By more than six months	**88**	27
Total	**577**	296

15.3 Provision for impairment of receivables

	2012-13	2011-12
	£000	£000
Balance at 1 April 2012	**(458)**	(392)
Amount utilised during the year	**177**	-
Decrease/(increase) in receivables impaired	**114**	(66)
Balance at 31 March 2013	**(167)**	(458)

The PCT evaluates its receivables age analysis on a regular basis for potential doubtful debt. The PCT allows an average debtor's payment period of 30 days after invoice date. It is the PCT's policy to assess receivables for recoverability on an individual basis and to make provision where it is considered necessary. In assessing recoverability the PCT takes into account any indicators of impairment up until the reporting date. The PCT does not hold any collateral over these impaired balances.

16. NHS LIFT investments

	Loan
	£000
Balance at 1 April 2012	426
Loan repayments - adjustment to value	(46)
Balance at 31 March 2013	380
Balance at 1 April 2011	-
Additions	426
Balance at 31 March 2012	426

The PCT received formal approval for a new Community hospital in Cockermouth and a health centre in Cleator Moor in March 2012. The developments are being funded through the PCT's express LIFT Partner, eLIFT Cumbria (of which the PCT is a 20% shareholder). The Cumbria Express LIFT Strategic Partnering Board approved the project on 9 March 2012. Following this decision, along with other shareholders, Cumbria Teaching PCT invested its share of the sub-ordinated debt for the project ahead of financial close in early April.

17. Other financial assets

The only financial assets held by the PCT is the investment in LIFT which has been analysed in note 16.

18. Cash

	31 March 2013	31 March 2012
	£000	£000
Opening balance	1	5
Net change in year	(1)	(4)
Closing balance	-	1
Made up of		
Cash with Government Banking Service	-	1
Cash as in statement of cash flows	-	1

19. Non-current assets held for sale

	Land	Buildings, excl. dwellings	Total
	£000	£000	£000
Balance at 1 April 2012	30	80	110
Plus assets classified as held for sale in the year	170	544	714
Balance at 31 March 2013	200	624	824
Balance at 1 April 2011	-	-	
Plus assets classified as held for sale in the year	30	80	110
Balance at 31 March 2012	30	80	110

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

	£000
At 31 March 2012	40
At 31 March 2013	196

Balance brought forward represents the net book value of a property in Barrow, identified as surplus to requirements in 2011/12. A sale fell through in 2012/13 due to changes in the potential buyer's personal circumstances. The PCT is still actively marketing the building and expects it to be sold within a year.

New classification in the year represents the net book value of a property in Kendal, identified as surplus to requirements from a review of the PCT's property as part of the transition and closedown review of the PCT's assets and liabilities. The Property is currently sold subject to planning and contract.

20. 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	975	11,950	-	1,558
NHS payables - capital	27	-	-	-
NHS accruals and deferred income	3,008	1,432	-	-
Family Health Services (FHS) payables	25,370	26,019	-	-
Non-NHS payables - revenue	5,382	5,978	-	-
Non-NHS payables - capital	247	174	-	-
Non-NHS accruals and deferred income	7,378	16,835	-	-
Social security costs	154	146	-	-
Tax	359	178	-	-
Other	1,179	927	-	-
Total	44,079	63,639	-	1,558
Total payables (current and non-current)	44,079	65,197		
Included above (in Other):				
Outstanding pensions contributions at year end (£000)	199	210		

21. Borrowings

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
PFI liabilities:				
Main liability	175	160	6,475	6,650
Total	175	160	6,475	6,650
Total other liabilities (current and non-current)	6,650	6,810		

Although the PCT will cease to exist with effect of 1st April 2013, its services will continue to be provided by various successor bodies within the public sector.

Borrowings - Payment of Principal Falling Due in:

	31 March 2013 Other £000	31 March 2012 Other £000
0 - 1 Years	175	160
1 - 2 Years	191	175
2 - 5 Years	687	629
Over 5 Years	5,597	5,846
TOTAL	6,650	6,810

22. Provisions

	Total	Comprising: Pensions to Former Directors	Pensions Relating to Other Staff	Legal Claims	Restructuring	Continuing Care	Agenda for Change
	£000	£000	£000	£000	£000	£000	£000
Balance at 1 April 2012	6,098	87	2,807	245	2,750	-	209
Arising During the Year	10,550	2	72	251	950	9,275	-
Utilised During the Year	(3,257)	(12)	(330)	(165)	(2,750)	-	-
Reversed Unused	(336)	-	(51)	(76)	-	-	(209)
Unwinding of Discount	90	3	87	-	-	-	-
Balance at 31 March 2013	13,145	80	2,585	255	950	9,275	-
Expected Timing of Cash Flows:							
No Later than 1 Year	10,818	12	326	255	950	9,275	-
Later than 1 Year and not later than 5 Years	1,299	49	1,250	-	-	-	-
Later than 5 Years	1,028	19	1,009	-	-	-	-
	13,145	80	2,585	255	950	9,275	-

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

	£
As at 31 March 2013	774,214
As at 31 March 2012	549,017

Pension Claims
By definition there is some uncertainty relating to pensions, however, the figures included above are based on independent actuarial assessment of the balance outstanding and the expected timing of cash flows has been made on the assumption that there are no changes to the number of individuals.

Legal Claims
Represents legal claims being handled by the PCT's solicitors and Employers Liability claims being handled by the NHS Litigation Authority under the Risk Pooling Scheme for Trusts (RPST) on behalf of Cumbria Teaching PCT. In addition £4,750 is included in contingent liabilities (2011-12 £5,000).

Restructuring
The PCT has made a provision for costs to be incurred relating to the public consultation on the future of health services in the Morecambe Bay area.

Continuing Care
The PCT has made a provision for costs in respect of the Department of Health requests for retrospective Continuing Healthcare claims. The PCT has received a number of claims which are at various stages in the review process and the provision has been based on a calculation of individual cost and likelihood of success.

Although the PCT will cease to exist with effect of 1st April 2013, its services will continue to be provided by various successor bodies within the public sector.

23. Contingencies

	31 March 2013	1 March 2012
	£000	£000
Contingent liabilities		
Employers liability claims being handled by the NHSLA	(5)	(5)
Net Value of Contingent Liabilities	(5)	(5)

In addition to the above £5,250 (2011-12 £5,000) is included in provisions under legal claims.

The following information is supplied relating to areas where it is not possible to give a reliable cost:

Unreported Incidents
In common with other healthcare providers, it is possible that claims and litigations could arise in the future due to incidents that have already occurred. The future expenditure which may arise from such incidents cannot be determined until such time as claims are made.

24. PFI Scheme

The PCT has one PFI Scheme: Workington Community Hospital which opened in March 2005 under a 25 year agreement. Under IFRIC12 the asset is treated as an asset of the PCT and the substance of the contract is that the PCT has a finance lease and payments comprise two elements - imputed finance lease charges and service charges as detailed below.

	31 March 2013	31 March 2012
	£000	£000
24.1 Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI		
Service element of on SOFP PFI charged to operating expenses in year	347	347
Total	**347**	347
Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI	**£000**	£000
No Later than One Year	347	347
Later than One Year, No Later than Five Years	1,388	1,388
Later than Five Years	4,164	4,511
Total	**5,899**	6,246

It is not expected that any annual payments in future years are to be materially different from those which the Trust is committed to make during the next year.

24.2 Imputed "finance lease" obligations for on SOFP PFI contracts due		
Analysed by when PFI payments are due	£000	£000
No Later than One Year	794	794
Later than One Year, No Later than Five Years	3,175	3,175
Later than Five Years	9,525	10,319
Subtotal	13,494	14,288
Less: Interest Element	(6,844)	(7,478)
Total	**6,650**	6,810

Although the PCT will cease to exist with effect of 1st April 2013, its services will continue to be provided by various successor bodies within the public sector.

25. Impact of IFRS treatment - 2012-13

	Admin Total
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g. PFI)	**£000**
Depreciation charges	231
Interest Expense	634
Other Expenditure	265
Total IFRS Expenditure (IFRIC12)	1,130
Revenue consequences of PFI schemes under UK GAAP	(698)
Net IFRS change (IFRIC12)	432

26. Financial Instruments

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

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

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

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

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

26.1 Financial Assets	NOTE	Loans and receivables £000	Available for sale £000	Total £000
Receivables - NHS	15.1	551		**566**
Receivables - non-NHS[1]	15.1	1,809		**1,824**
Other financial assets	16	-	380	**396**
Total at 31 March 2013		**2,360**	**380**	**2,786**
Receivables - NHS	15.1	784		799
Receivables - non-NHS[1]	15.1	1,396		1,411
Cash at bank and in hand	18	1		19
Other financial assets	16	-	426	442
Total at 31 March 2012		2,181	426	2,607

26.2 Financial Liabilities		Other £000	Total £000
NHS payables	20	975	**995**
Non-NHS payables[2]	20, 22	42,652	**42,652**
PFI & finance lease obligations	21	6,650	**6,671**
Total at 31 March 2013		**50,277**	**50,318**
NHS payables	20	13,088	13,108
Non-NHS payables[2]	20, 22	36,057	36,057
PFI & finance lease obligations	21	6,810	6,831
Total at 31 March 2012		55,955	55,996

[1] excludes prepayments and accrued income and VAT

[2] excludes accruals and deferred income, tax and social security costs creditors. It also excludes provisions relating to pension claims and Employers Liability claims

27. Related party transactions

During the year none of the Department of Health Ministers, Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Cumbria Teaching Primary Care Trust, other than the members and transactions set out below:

2012-13	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
I Gordon, Chair (to February 2013)				
(Member of Cumbria Partnership NHS Foundation Trust)	161,987	2,858	500	187
K Little, Non-Executive Director				
(Member of Cumbria County Council)	24,742	469	819	459
M Dowling, Non-Executive Director / Chair (from February 2013)				
(HR Consultant for North Lancs PCT)	609	68	9	22
(Member of Cumbria Partnership NHS Foundation Trust)	161,987	2,858	500	187
(Member of University Hospitals of Morecambe Bay NHS Foundation Trust)	126,755	79	1,327	-
S Reveley, Non-Executive Director				
(Public Governor of Cumbria Partnership NHS Foundation Trust)	161,987	2,858	500	187
J Ashton, Director of Public Health				
(Wife is Director of Public Health at Central Lancashire PCT)	571	107	25	23
M Bewick, Medical Director				
(Board Member eLift Cumbria)	487	-	-	-
C Welbourn, Acting Director of Finance				
(Wife is Executive committee member at Carlisle Mencap)	104	-	-	-
Dr N McGreevy, Allerdale Locality GP				
(Board member, Ryan Smith Rising Sun Trust)	29	-	-	-

2011-12	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
I Gordon, Non-Executive Director / Chair (from October 2011)				
(Member of Cumbria Partnership NHS Foundation Trust)	157,149	2,860	769	156
K Little, Non-Executive Director				
(Member of Cumbria County Council)	23,105	79	5,015	425
M Dowling, Non-Executive Director				
(HR Consultant for North Lancs PCT)	952	11	212	3
(Member of Cumbria Partnership NHS Foundation Trust)	157,149	2,860	769	156
(Member of University Hospitals of Morecambe Bay NHS Foundation Trust)	121,866	79	2,867	7
S Reveley, Non-Executive Director				
(Public Governor of Cumbria Partnership NHS Foundation Trust)	157,149	2,860	769	156
J Ashton, Director of Public Health				
(Trustee, Carlisle Youth Zone)	150	-	-	-
(Wife is Director of Public Health at Central Lancashire PCT)	491	32	73	6
M Bewick, Medical Director				
(Board Member eLift Cumbria)	1,120	49	18	20
C Welbourn, Acting Director of Finance				
(Wife is Executive committee member at Carlisle Mencap)	81	-	5	-
J Muller, Associate Director of Public Health				
(Shadow/Board member, Carlisle Youth Zone)	150	-	-	-
Dr N McGreevy, Allerdale Locality GP				
(Board member, Ryan Smith Rising Sun Trust)	50	-	-	-

27. Related party transactions (continued)

Transactions are between Cumbria Teaching PCT and the declared organisation, not the individual, and form part of the PCT's normal activities.

The membership of the interim Clinical Commissioning Group includes 6 GP locality leads (GPLL) (6 GPs were members in 2011-12). The GPs are members of practices which have an interest in Cumbria Health on Call which provides out-of-hours primary care services and treatment centres. The PCT made payments amounting to £7.5m in 2012-13 (£7.5m in 2011-12). The transactions between these practices and Cumbria Teaching PCT are shown below:

2012-13	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Maryport Health Services	2,848	2	142	-
Nutwood Surgery [GPLL Apr-June12]	826	32	61	-
James Cochrane Medical Practice [GPLL July12-March13]	2,725	1	175	-
Risedale Surgery	699	-	40	-
Brampton Medical Practice [GPLL Apr-Dec12]	4,236	5	182	-
Brunswick House Medical group [GPLL Dec12-March13]	2,169	-	180	-
Fellview Health Centre	3,715	23	11	-
Appleby Health Centre [GPLL April12]	734	-	52	-
Lakes Medical Practice [GPLL May12-March13]	1,370	13	122	-

2011-12	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Maryport Health Services	2,739	16	276	-
Nutwood Surgery (Dr JE Irwin & Partners)	884	6	69	-
Risedale Surgery (Dr GC Joliffe & Partners)	692	-	37	-
Brampton Medical Practice	3,995	1	221	-
Fellview Health Centre	4,121	22	63	-
Appleby Health Centre	807	-	51	-

The Department of Health is regarded as a related party. During the year Cumbria Teaching Primary Care Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are:

2012-13
Blackpool PCT
Blackpool, Fylde and Wyre NHS Foundation Trust
Central Manchester University Hospitals NHS Foundation Trust
Cumbria Partnership NHS Foundation Trust
Greater Manchester West Mental Health NHS Foundation Trust
Lancashire Teaching Hospitals NHS Foundation Trust
Newcastle Upon Tyne Hospitals NHS Foundation Trust
North Cumbria University Hospitals NHS Trust
Northumbria Healthcare NHS Foundation Trust
South Tees Acute Hospitals NHS Foundation Trust
University Hospitals of Morecambe Bay NHS Foundation Trust
Western Cheshire Primary Care Trust
Wrightington, Wigan & Leigh NHS Foundation Trust

2011-12
Blackpool PCT
Blackpool, Fylde and Wyre NHS Foundation Trust
Central Manchester University Hospitals NHS Foundation Trust
Cumbria Partnership NHS Foundation Trust
Lancashire Teaching Hospitals NHS Foundation Trust
Newcastle Upon Tyne Hospitals NHS Foundation Trust
North Cumbria University Hospitals NHS Trust
Northumberland, Tyne & Wear NHS Foundation Trust
Northumbria Healthcare NHS Foundation Trust
South Tees Acute Hospitals NHS Foundation Trust
University Hospitals of Morecambe Bay NHS Foundation Trust
Western Cheshire Primary Care Trust
Wrightington, Wigan & Leigh NHS Foundation Trust

In addition, the PCT has had a significant number of material transactions with other Government Departments and other central and local Government bodies. Most of these transactions have been with Cumbria County Council.

During 2012-13 no debts due to or from related parties have been written off.

The PCT has also received revenue payments from the NHS Cumbria Charitable Fund. The Board of Cumbria Teaching Primary Care Trust act as Corporate Trustee for the NHS Cumbria Charitable Fund. The resources expended by the NHS Cumbria Charitable fund on charitable activities are all grants payable to the PCT which totalled £152k in 2012-13 (£212k in 2011-12).

28. Losses and special payments

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

	Total Value of Cases £	Total Number of Cases
Losses - PCT management costs	109,415	75
Special payments - PCT management costs	44,249	4
Total losses and special payments	153,664	79

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

	Total Value of Cases £	Total Number of Cases
Losses - PCT management costs	320	1
Special payments - PCT management costs	311,112	4
Total losses and special payments	311,432	5

There were no cases exceeding £250,000 during the current year (2011-12 no cases).

29. Pooled budgets

Cumbria PCT operates 3 pooled funds in partnership with Cumbria County Council (CCC) under section 75 of the Health Act 2006. All 3 funds are hosted by CCC.

The Locality pooled fund consolidates the former Generic Care, Intermediate Care and Prevention pooled funds. 6 District based Health and Social Care Joint Management teams use funds flexibly across these 3 services to develop local services that maintain the independence of (predominantly) older people by helping them to stay at home for longer, preventing admission to hospital and assisting discharge from hospital.

The Integrated Community Equipment Service (ICES) provides a stock management and delivery service for occupational therapy equipment used in the community across health and social care.

The Learning Disability pooled fund jointly commissions services to improve general well-being and life chances of adults with a learning disability.

Financial performance in the year to 31 March 2013 was as follows:

	Locality	ICES	Learning Disability	Total
	£000	£000	£000	£000
Contributions				
- NHS Cumbria	4,124	468	7,918	**12,510**
- CCC	3,789	184	39,776	**43,749**
Total Contributions	7,913	652	47,694	**56,259**
Total Spend	7,871	735	48,094	**56,700**
Variance	**42**	**(83)**	**(400)**	**(441)**
Share of Balances				
- NHS Cumbria	22	(23)	(66)	(67)
- CCC	20	(60)	(334)	(374)

30. Events after the end of the reporting period

As a consequences of the Government's Health and Social Care Act 2012, the PCT was abolished as at 31st March 2013. To help ensure PCTs discharge their duties and support the creation of GP Consortia, PCTs were grouped into 'clusters'. Due to rurality and demography, Cumbria Teaching PCT was designated a stand alone cluster. Following its establishment in shadow form during 2011/12, Cumbria's Clinical Commissioning Group (CCG) was formally authorised in March 2013 to assume full responsibility for commissioning local health services in the county from April 2013.

In line with the national requirements for transition and closedown the PCT undertook extensive processes of due diligence to confirm that all properties, assets and liabilities were identified, mapped to the function to which they related and then identified for transfer (by means of the Transfer Schemes) to the relevant receiver organisation(s).

The Department of Health has made detailed arrangements for the transfer of balances (assets / liabilities / contractual commitments) at their recognised carrying value such that there will be no surplus or deficit arising from this transfer. It is for the successor body to consider whether, in 2013/14, it is necessary to review these for impairment. The PCT has a Transfer Agreement showing the expected destination of these balances but the final details have not yet been confirmed. The Department's arrangements ensure that all assets, liabilities and contractual obligations of the PCT will be transferred to other bodies within the public sector.

2012-13 Annual Accounts of Cumbria Teaching Primary Care Trust

Year ended 31 March 2013

SUMMARISATION SCHEDULES (PCTs) FOR THE CUMBRIA TEACHING PRIMARY CARE TRUST

Summarisation schedules numbered PCT01 to PCT98G plus Freetext are attached.

Finance Signing Officer's Certificate

I certify that the attached summarisation schedules have been compiled from and are in accordance with the financial records maintained by the primary care trust and with the accounting standards and policies for the NHS approved by the Secretary of State.

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

Signing Officer's Certificate

I acknowledge the attached summarisation schedules, which have been prepared and certified by the Finance signing officer, as the summarisation schedules which the primary care trust is required to submit to the Secretary of State

4th June 2013 Date ..... Signing Officer