Cornwall and Isles of Scilly Primary Care Trust

2012-13 Annual Report and Accounts

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Cornwall and Isles of Scilly Primary Care Trust

2012-13 Annual Report

Cornwall and Isles of Scilly

NHS Cornwall and Isles of Scilly Annual Report 2012/13

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2 Forward from our Chief Executive

Welcome to our annual report for 2012/13.

The year was a busy one, with the pace quickening as we reached year-end, ahead of the abolition of the PCT. I'm extremely proud that we have left a lasting legacy of commissioning high quality local healthcare services for the people of Cornwall and the Isles of Scilly, as we handed over to our successor, Kernow Clinical Commissioning Group, on 1 April.

There have been many achievements since the PCT's formation in 2006 – some of which are mentioned in this report – including commissioning services so people could be treated closer to their homes and helping thousands adopt healthier lifestyles.

Significant service improvements have included the new Bodmin Stroke Unit, the introduction of Telehealth monitoring, and improved access to NHS dentistry.

There are also some very visible landmarks such as the new Truro Health Park, Praze Surgery, and the soon-to-be-built Torpoint Health Centre.

I'm confident that KCCG will continue to build on our work, having now taken full control of the commissioning of hospitals, community services, mental health and children's services. The new organisation is made up of such capable and compassionate clinicians and managers – and the platform we leave will be a strong foundation for KCCG to build on to ensure further improvements in the local NHS.

I'm delighted that many of our PCT staff have joined KCCG on this journey and remained in the local healthcare system – their knowledge, experience and passion will continue to benefit local patients.

Change can be daunting, and I'd like to pay tribute to the remarkable staff within the PCT for their professionalism and dedication in 'getting to day job done' to benefit patients, whilst helping to make the transition process from the PCT to the KCCG as seamless as possible.

Whilst major changes to the national and local healthcare systems have been taking place, one overriding constant remains: the NHS must continue to ensure that the patient and their family are at the centre of what we do and we are relentless in our pursuit of high-quality care.

I hope you find this report useful and informative.

With kind regards

Steve Moore
Chief Executive
NHS Cornwall and Isles of Scilly

3 About NHS Cornwall and Isles of Scilly

Until it's abolition on 31/3/13 NHS Cornwall and Isles of Scilly was responsible for making sure health services are in place in the county to meet your needs. These responsibilities have now been taken over by Kernow Clinical Commissioning Group and NHS England.

NHS Cornwall's annual budget was almost £1billion. This money was used to plan and buy healthcare from GP practices, pharmacists, hospitals, community health, mental health and ambulance services.

Our role was to improve the health of the people of Cornwall and the Isles of Scilly and to reduce inequalities in healthcare. We know that in Cornwall and the Isles of Scilly there are a number of issues that have a direct effect on people's health – including employment, diet, lifestyle and income.

We have a population of over 534,000. Our population is characterised by a high average age. More than 26 percent are aged over 65 – 20 percent more than average – and we're getting older. We tend to be more active than the average for England, but 30 percent of our 10-year-olds are overweight. Fuel poverty is considerably higher than elsewhere and the rate of child poverty is significantly higher than for the rest of the South West.

Many of our elderly population live with long-term conditions or disabilities in rural dispersed populations and this means we need to focus attention on enabling them to live as well as possible: keeping them out of hospital wherever we can.

The deprivation in areas in the north, far west and the old clay villages around St Austell means that our work needs to be tailored to meet the higher needs of these communities. In these areas, people die on average five years earlier than in the wealthier areas on the north and south coasts.

In order to improve the health of the population we work closely with Cornwall and Isles of Scilly councils, the voluntary sector, local district councils, hospitals and other local partners to ensure we have the best and most efficient services for local people.

4 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 Cornwall and Isles of Scilly between 1 April 2012 and 31 March 2013.

The report is in two parts: the first section is a short round-up of some of our projects and achievements over the year, as well as information about our performance and commentary on wider events which have shaped our business and priorities.

The second part is the organisation's full financial accounts for 2012/13.

5 A year in the life of NHS Cornwall and Isles of Scilly

April 2012

We pushed patient choice to the top of the agenda, with a campaign promoting the two Referral Management Services that operate in the county. The services – Sentinel (now called TRAC) in Plymouth serving patients from practices in the East and Kernow Health for the rest of the county – help guide patients through their options when their GP refers them for a first outpatient appointment. The aim of the campaign was to encourage patients to know their choices and use them when planning their NHS healthcare. It may be a choice about which hospital they visit and when, or the support they may need if visually or hearing impaired or they require a language interpreter, for example. The campaign also included a survey to capture people's awareness and views of the Kernow Health service. The campaign included posters being put on display in GP and hospital settings and leaflets being handed to patients by their GP upon referral.

Also this month, having said farewell to its longstanding Medical Director Dr John Tilbury, who retired in March, the PCT welcomed his successor Dr Shelagh McCormick to the role. She joined the PCT during a phase of rapid change that will see the PCT cease to exist and the establishment of a new organisation, Kernow Clinical Commissioning Group, which will be responsible for commissioning care for the people of Cornwall and the Isles of Scilly. Shelagh has been a GP for over two decades, the previous ten at the Gunnislake Health Centre in East Cornwall. She also took on John's role as chair of the Professional Executive Committee of the PCT.

May 2012

We promoted the launch of a new online database of local services to help people experiencing poor mental health to find out what help is on their doorstep. The site received 2,000 visits in a month. The database was developed and managed by the mental health charity Pentreath, on behalf of the PCT, to enable people to see what support is available to them from NHS organisations and other third sector and independent service providers and how to access it. It is particularly helpful for those who have recently been diagnosed with a mental health condition. The database forms part of the www.cornwallmentalhealth.com website and offers a new way to access information contained in the mental health directory. It is kept up-to-date by all providers using it to promote their services.

June 2012

The British Heart Foundation (BHF) awarded £100,000 to Cornwall and Isles of Scilly PCT to improve the heart health of some of the county's poorest areas. The investment is part of the BHF's UK-wide Hearty Lives programme to reduce geographical inequalities in heart disease. The health of people in Cornwall is generally better than the England average. However, 19,210 children live in poverty and life expectancy is 5.7 years lower for men and 5.2 years lower for women in the most deprived areas of Cornwall than in the least deprived areas. The Hearty Lives Cornwall project will aim to improve heart health by reducing childhood obesity rates in Cornwall with a specific focus on areas of greatest need. About 18 percent of 10-

year-old children in Cornwall are classified as obese and this rises to an estimated 25% of adults. The Hearty Lives Cornwall team will work with children, families and schools to encourage healthy eating and physical activity. The funding will enable Cornwall and Isles of Scilly to build on the Healthy Schools Initiative to target areas with higher rates of child obesity.

The NHS in Cornwall received national recognition for its work in promoting equality across its services. The county collected one of 10 awards made nationally by the Department of Health for the introduction of the new NHS Equality Delivery System that promotes inclusiveness across NHS organisations. We embraced the team approach to ensuring patients are able to fully access healthcare.

July 2012

Our Board gave the green light to plans for a new health centre in Torpoint by approving the full business case. It was another milestone for the scheme that was promised many years earlier, but had struggled to find a suitable location. The scheme will allow the existing Rame Group Practice surgeries at Antony Road and St James' Road and the Peninsula Community Health Community Clinic in Hooper Street to be housed in one centre at Trevol Business Park. The centre will also house local primary and community healthcare services, ambulance services and a pharmacy.

We picked up another award, this time for excellence in patient care. People with dementia who are at the end of their life can be assured of dignity and respect thanks to a new model of care developed by clinicians in Cornwall. The NHS scheme was the winning entry in the dementia care category of the prestigious Care Integration Awards 2012. The awards were created by the Nursing Times and Health Service Journal to celebrate excellence in patient care. The model of care has been created and provided by Cornwall Partnership NHS Foundation Trust, NHS Cornwall and Isles of Scilly, GPs, the Peninsula Deanery, Royal Cornwall Hospitals Trust and the Alzheimer's Society.

We were awarded £20,000 by the Department of Health to fund local health research. The extra funding was given to us to enable us to help 500 patients participate in non-commercial pilot projects and studies that could later be developed into larger, nationally-funded projects.

August 2012

Our alcohol and sexual health teams were out and about supporting the Boardmasters festival at Newquay to give out advice to young people on sensible drinking and sexual health information. The Health Promotion Service worked in partnership with AddAction, a leading specialist drug and alcohol treatment charity to provide helpful advice to young people on sensible alcohol consumption, sexual health and substance misuse. They issued 'Survival packs' comprising helpful advice on sexual health and alcohol consumption; a waterproof poncho; an anti drink-spiking kit; a bottle of water and condoms (for anyone over 16).

September 2012

This month marked the start of the rollout of new NHS Health Checks for people between the ages of 40 and 74 in Cornwall and the Isles of Scilly. The aim of the checks is to lower the risk of developing preventable diseases – heart disease, stroke, type 2 diabetes and kidney disease. Doctors in north and west Cornwall launched the start of the rollout with a target of offering the free check to an initial 8,000 people before the checks become available countywide from April 2013. The NHS Health Check aims to save lives by supporting people to make lifestyle changes and, if necessary, to start medication early to hopefully prevent the onset of disease. Health Promotion staff supported the national attempt to help people to quit smoking en masse. They supported the St Austell Roadshow to get people signed up ready for the launch of 'Stoptober' on 1 October. The campaign was backed by Cancer Research UK and the British Heart Foundation and was the first mass quit attempt of its kind, encouraging the UK's eight million smokers to stop smoking for 28 days. In 2011, 5,000 people stopped smoking with the help of the Cornwall and Isles of Scilly Stop Smoking Service.

In the latter part of the month, we published the outcome of a review showing that the Serco out of hours service is fundamentally 'safe and effective', but had faced clinical staffing challenges and issues with data handling. An independent clinical review by Dr David Colin-Thomè said that the service is safe and effective, but acknowledged that Serco had faced challenges with clinical staffing and service levels in the recent past. He made a number of recommendations for consideration by the PCT Board.

During the remainder of the year further investigation work, commissioned by the PCT, was independently undertaken with regard to the data handling issue identified at Serco. This concluded that the data recording issues had been resolved satisfactorily. A full review of the Serco out of hours service was conducted by the Public Accounts Committee in April 2013. Comments from this and the overall lessons learnt from the various review undertaken on the service are being taken forward by Kernow Clinical Commissioning Group (KCCG).

We also announced new arrangements to assist residents of the Isles of Scilly in continuing to access health appointments following the ending of the commercial helicopter service operated by British International Helicopters. We worked with the Isles of Scilly Steamship Company – owner of the Skybus and passenger ferry, Scillonian III – to ensure people can still access their health appointments, pregnant women can still travel after 36 weeks and urgent samples and blood can still be transported.

October 2012

There was good news for people in West Cornwall waiting for access to NHS dentistry. We announced that the planned opening of a new surgery in Penzance would create places for thousands of people on our dental waiting list. We signed a contract for the new branch surgery with The Chapel Dental Practice in Camborne, offering places for 2,800 patients.

The vaccination programme to protect pregnant women and their babies from whooping cough began this month. The Government launched a temporary vaccine programme in response to concerns over the sharp rise in number of cases being diagnosed nationally, particularly amongst babies. Pregnant women across Cornwall

and the Isles of Scilly started to receive their letters in late September offering them the vaccination at 28 weeks. The South East and South West were particularly affected by the outbreak. The flu vaccine programme also began in October targeting people who could be at risk of developing complications. GP surgeries began vaccinating people aged 65 or over, pregnant women and younger people with underlying medical conditions such as chest or heart complaints, kidney or liver disease, people with weakened immune systems and diabetes.

Public Health staff teamed up with the new Health and Wellbeing Board to launch a major campaign to try to rid Cornwall and the Isles of Scilly of food fats that can lead to an early death. Called transfats and identified on food labels as ‘hydrogenated fat’, they are hardened oils that clog our arteries and raise cholesterol levels in the blood, which can trigger health conditions such as heart attacks and strokes. The campaign asks local food producers to sign up to a pledge to remove hydrogenated fats and oils from their ingredients. It also asks the public to check ingredients for hydrogenated oils and fats and make an informed decision.

We also launched new groups to support mums with post-natal depression in overcoming low mood. Called Finding Yourself Again, the aim is to help new mums deal with the competing demands of motherhood and help them better understand and manage their feelings more effectively. The free groups are funded by us and run by Outlook South West at Children’s Centres in Penzance, Camborne, Truro, Falmouth, Liskeard and Camelford. Additionally, we created new resources to support first-time parents – produced by parents for parents, the DVD and booklet aims to give them confidence in their first year. Different groups including WILD Young Project (Falmouth) and Brook Young Fathers (St Austell) were engaged with Arts for Health Cornwall in the creation of the resources.

The Health Promotion service collected a ‘Health Promotion and Community Well-Being Organisation and Partnership Award’ from the Royal Society for Public Health (RSPH). The team was recognised for its overall achievement in developing and implementing innovative health promotion and community wellbeing initiatives.

November 2012

We used World AIDS Day to remind young people and adults in Cornwall and the Isles of Scilly to get checked for HIV to be sure of their own health. Late diagnosis can lead to the virus inadvertently being passed on through unprotected sex. Over half of those who tested HIV positive between 2008 and 2010 in the South West were diagnosed late, making the virus much harder to treat and manage.

We issued early encouragement for patients to plan for the festive period by ordering their prescription medications in advance to prevent them having to rely on out-of-hours services. We asked people to order their repeat prescriptions at least a fortnight before Christmas.

December 2012

Obesity is one of the most serious health issues facing society today with one in three children currently overweight or obese in the UK. In Cornwall, 24 percent of reception year children are overweight or obese. As part of our work in tackling the problem, we began offering a free 10 week programme aimed at children aged 7-13 years old who are overweight or obese. The programme is called MEND (Mind,

Exercise, Nutrition, Do it), and focuses on the whole family making changes and is run by the Health Promotion Service. The programme is completely free and runs twice a week for 10 weeks. The sessions run after school and up to 12 families can attend at once.

We issued urgent reminders this month for people to use services wisely during the festive period to ensure teams can focus on those most in need of emergency care. Instead of opting for A&E automatically, we encouraged people to consider if services other than the emergency teams could assist. We also asked people to think twice before visiting loved-ones in hospital if there was any chance they had been exposed to Norovirus. The virus that causes the winter diarrhoea and vomiting bug can spread quickly and easily where people are in close proximity. If it finds its way into hospital and care settings, it can disrupt patient care.

January 2013

The new year began with the announcement of the preferred bidder for a new drug and alcohol treatment service to be rolled out in Cornwall and the Isles of Scilly. The daily service – which includes out-of-hours provision – will increase the number of people able to access treatment and recover from their drink and drug problems, with more help available, closer to home. The service was commissioned by the PCT with partners at Cornwall Council, who form the Drug and Alcohol Action Team (DAAT) Board. It will be delivered by preferred bidder Addaction from one-stop shops at Truro, Newquay, Liskeard, Bodmin, Bude, St Austell, Falmouth, Bodmin and Penzance, as well as through home visits and other local outlets, as required. Practical advice and support for people with drug and alcohol problems includes: preparation for change and relapse prevention classes; more intensive support through daily programmes; education and training opportunities to develop skills and qualifications; and peer mentors who have successfully completed treatment, to provide additional support. There is also more support available for families affected by drink and drug problems.

A new toolkit giving children a fun way to learn about who may help them in an emergency was launched in schools. Aimed at children aged 3-5 years, it allows them to have fun with role play and games designed to help them think about healthcare professionals who can help them if they become sick or injured, and how to keep themselves safe and healthy. The new resource comprises a large plastic box designed to look like an NHS emergency ambulance, five costumes for a nurse, dentist, paramedic, surgeon and doctor, two puppets, emergency toy vehicles, a life-size floor game and two card games on healthy eating and sun safety.

February 2013

A series of four reports were released this month looking into organisational knowledge around the competency of Dr Rob Jones, an obstetrician and gynaecologist who resigned from the Royal Cornwall Hospital after being suspended from clinical duties last year following complaints from patients. The Royal Cornwall Hospitals NHS Trust wrote to more than 1,500 women treated by him.

The reports included an Organisational Learning Review for the Primary Care Trust that stated ‘there is no evidence that any specific concerns identified by RCHT were notified to the PCT from 2007 up to the point when the practitioner retired from

clinical practice'. It also states that there appears to have been no earlier opportunity for the PCT to act in response to concerns identified.

The Trusts have recognised the learning that needs to follow from the reports and measures are being put in place to address issues, particularly around internal reporting and information sharing.

March 2013

Preparations are being made to launch a new freephone number to provide advice on appropriate NHS services to use for minor injuries and illness that require urgent care.

The launch of the 111 service in Cornwall and Isles of Scilly has been delayed. The Cornwall and Isles of Scilly NHS 111 Project team and Clinical Governance Group are reviewing all service delivery plans with NHS Direct the local provider and will only authorise a launch date when it is appropriate and safe to do so.
The number will be available 24 hours a day, 7 days a week, 365 days a year, to respond to people's healthcare needs in Cornwall and the Isles of Scilly when:

- they need medical help fast but it's not a 999 emergency
- they don't know who to call for medical help or don't have a GP to call
- they think you need to go to A&E or another NHS urgent care service
- they require health information or reassurance about what to do next.

Callers to 111 are put through to a team of highly trained call advisers, who are supported by experienced clinicians. They use a clinical assessment system and ask questions to assess callers' needs and determine the most appropriate course of action. The new service provides management information to commissioners about the demand for and use of services – such as which services are currently over or under-utilised, or where service gaps exist – to enable the commissioning of more effective and productive services that are designed to meet people's needs.

During October 2012 the Cooperation and Competition Panel (CCP) was asked to assess whether Cornwall and Isles of Scilly NHS Primary Care Trust had acted inconsistently with the Principles and Rules for Cooperation and Competition. It was alleged that the PCT had failed to act consistently with Principles 1, 2 and 5 in relation to the commissioning of hospital learning disability services and mental healthcare. The provisional findings released in May 2013 indicate that in this specific case the PCT had not breached the principles However, the report notes that the lack of transparency of the PCT's decision-making process may have had wider consequences outside the scope of this report. This issue is being taken forward by Kernow Clinical Commissioning Group (KCCG).

6 Developing Kernow Clinical Commissioning Group

Kernow Clinical Commissioning Group has been authorised as fit for purpose to lead the local NHS in Cornwall and the Isles of Scilly. KCCG went through a rigorous process to ensure that the local NHS is safe in its hands – meeting around 120 conditions – as it prepared to take over many of the existing duties of the current primary care trust from April 2013 and buy health services on behalf of local people. It was assessed by an independent panel of people from other parts of the NHS and this process reaffirmed that KCCG can meet the healthcare needs of local people while maintaining safety, quality and financial balance. Indeed, it was testament to the progress made, that KCCG was among the first wave of clinical commissioning groups to be authorised in the country. Feedback from KCCG's authorisation assessment revealed that the panel were particularly impressed with its vision and ambition, people's commissioning, clinical engagement and partnership working.

Over the past year much has been achieved, with solid foundations put in place for the transformation required in health and social care services across Cornwall and the Isles of Scilly. This has included developing new GP leaders and creating a system that puts clinicians in the driving seat of commissioning. Local GPs have met patients, frontline staff, campaigners, politicians and other stakeholders to develop an understanding of the issues and concerns and to gather ideas that improve services. A strong system of governance has also been put in place so that innovation and creativity can flourish within a safe framework. Excellent progress has also been made in setting up collaborative projects with partners. In the coming months KCCG will be working to find solutions and improve quality and experience throughout the healthcare system, using local knowledge and turning it into population wide-insight that leads to better commissioning decisions. This will help KCCG to deliver its aim to ensure people are treated in the right care setting, with the right support, at the right time.

KCCG visualises a future where fewer local people need to travel to be seen in hospital, because they can get the care they need in a local setting – where they have been helped to live a healthier life and are less likely to suffer ill-health. GPs understand this system – they see their patients travel through it every day. This gives GPs an unrivalled ability to see the blockages and to work with their colleagues across all providers to find solutions that will improve care and experience. But even more than this, KCCG sees a vibrant future for Cornwall and the Isles of Scilly. One that is sustainable socially and economically, built on the passion and entrepreneurialism that exists in the community. A future where the NHS can play a full role in creating a system that ensures people live fulfilling and healthy lives.

The organisation will be led by Dr Colin Philip, who is the Chair, and Managing Director, Joy Youart. The group will comprise 10 localities – a collection of GP practices working together to commission services for the area they serve – across Cornwall and the Isles of Scilly.

7 Performance

NHS Cornwall and Isles of Scilly monitors and manages performance against a range of national and local headline measures to determine the quality, safety and timeliness of services offered to residents and assess the impact of national and local initiatives on the health status of the population. These headline measures are supported by more local indicators with regular reporting on improvement and issues received by the incoming Clinical Commissioning Group.

Key achievements include the following:

- Reduction in waiting times
- Reduction in MRSA rates
- Reduction in teenage pregnancy rates
- Reduction in levels of smoking
- A clear set of strategic priorities with good progress made, for example in relation to stroke, cancer, end of life care and dementia services
- More patients being treated closer to home
- Hosting of a number of national pilots, including one of three national sites to test the use of Telecare and Telehealth for patients with complex health and social care needs in their own homes, and two of 16 national integrated care pilots, focussed on community dementia care and mental health services
- Improvements to a range of primary and community healthcare facilities, including the flagship Truro Health Park
- Consistently strong financial management
- Early implementer of Health and Wellbeing Board
- Delivering the social enterprise, Peninsula Community Health, for adult community health services
- Expansion of Telehealth Services to over 1,200 users over three years with 750 active patients receiving monitoring and positive outcomes for patients benefiting from the trial.

8 Emergency planning

Under the Civil Contingencies Act 2004, NHS Cornwall and Isles of Scilly is a ‘category one’ responder. This means that we must plan for and be ready to respond to a range of incidents which could affect the health of the local population, for example, pandemic flu or heatwave incidents. Most recently, we have been involved in the response to the flooding in mid and west Cornwall. We helped to safeguard the health and wellbeing of the affected communities and provided public health advice during the clean-up phase. We also lead on emergency planning for the local NHS. The Director of Public Health is the designated director for emergency planning, with responsibility for ensuring that the organisation is compliant with all duties in accordance with emergency preparedness guidance. The Director of Public Health is supported by an Emergency Planning Lead.

9 We listen to you

Getting the views and opinions of local people is an essential way of knowing how effectively health services are meeting people's needs. We try to ensure that there are plenty of opportunities for people to have their voice heard, and your experiences and comments are taken into consideration when making decisions about commissioning services.

During the past year, people have got involved by:

- meeting us at public events, such as the Royal Cornwall Show and Respect Festival
- attending one of our 'Closer To You' open public meetings held across Cornwall and the Isles of Scilly (including participating online)
- being a member of Your Health Voice
- taking part in a patient forum or user group that advises us about services for specific health conditions
- engaging with us via Facebook or Twitter
- asking questions via our website
- attending a Board meeting
- joining their GP surgery Patient Participation Group
- being a member of LINk
- taking part in specific engagement exercises, such as the events held in Torpoint relating to the new health centre
- becoming involved in formal consultations.

Looking to the future, the incoming Kernow Clinical Commissioning Group is undertaking a pilot scheme on People's Commissioning which, if successful, will lead to local people having a very direct influence on commissioning services. Further information about this exciting new project will be available on the KCCG website.

10 Sustainability

The health of people in Cornwall and the Isles of Scilly is directly affected by the environment. NHS Cornwall and Isles of Scilly continued in its commitment to operate in an environmentally-responsible manner and satisfactorily discharging its statutory duties. It recognised the requirement to have a robust Environmental Policy in place which shows its commitment to the wider global issues involved. The organisation continued to implement a range of initiatives that contribute to the triple bottom line that is the economy, the environment and the health and wellbeing of the Cornish population.

Significant initiatives included:

- The NHS involvement in Cornwall Together, a collective buying initiative for energy that also helps resource work to counter fuel poverty.

- Work related to the establishment of Cornwall's Local Nature Partnership, working with Local Enterprise and Health and Well Being Board partners to maximise the benefits available in the natural environment.

- Year-on-year, we have also improved our recycling rates as a percentage of overall waste, increased the amount of energy from renewable sources and reduced carbon emissions.

In 2013/14 the NHS in Cornwall will continue to implement energy saving and other sustainable green initiatives in order to meet its targets.

11 Our staff

At the end of March 2012 we employed 312 staff, with 258 whole-time equivalent.

Staff engagement

The PCT has a formal recognition agreement with Trade Unions and has continued to work in partnership during 2012/13.

Ensuring our staff are well informed and able to input into the transition process has been key this year. We have regularly asked staff to complete surveys which has enabled us to offer them the support they've needed throughout transition. In 2012/13 we also ran a formal consultation with staff about the future.

We have continued to communicate with staff through our emailed 'Weekly bulletin' and through team leaders using the monthly newsletter 'Teams InTouch' to brief their staff at team and directorate meetings. Formal staff events have been held for staff and leaders, giving them a chance to get out of the office and learn more about the future.

The Chief Executive of the PCT and receiver organisations have met with staff to share information on developments and discuss concerns. Staff also had the opportunity to run their own groups, looking at the way we work now and what changes they would like in the future.

Health and wellbeing

A range of activities and programmes are in place to promote positive work-life balance and support staff. As a result, the PCT has achieved the Healthy Workplace Silver Award.

Examples include

- access to Occupational Health and counselling services
- range of flexible working practices such as home-working, term-time working
- health promotion
- wellbeing checks.

As the organisation has prepared for 'close-down', specific activities have been provided to support staff during transition including:

- Coping with Change programmes
- careers advice
- pensions advice.

Sickness absence and management

The PCT has a range of mechanisms in place to monitor and report absence. This enables line-managers to pro-actively manage absence and respond to any identified causal trends.

For national reporting purposes, sickness absence is monitored on calendar years, instead of financial years. During 2012, the Primary Care Trust had a sickness absence rate of 3.6%, which is an average of 8.0 sick days, per fulltime member of staff, per year. This is a reduction from annual averages of over 10 days in preceding years.

[Note: Absence rate based on 4,513 days lost and 562 fulltime equivalent staff – figures provided by Health and Social Care Information Centre.]

Training and development

The PCT ensures that all staff are equipped with the key skills and competencies to deliver their work safely, with a range of mandatory training programmes provided via e-learning. Further development opportunities have been provided via the Cornwall Leadership Academy, which focuses on leadership development and a range of core business skills.

Equality and Diversity

As part of our work to implement the NHS Equality Delivery System (EDS) we have engaged staff, patients and carers to grade our performance and identify where improvements can be made. From our grades we set our equality objectives – targets we aim to meet to help reduce inequalities and improve access and experience – and published both our EDS grades and our equality objectives on the Equality and Human Rights pages of our website. In January 2013 we also published our equality information for the previous year.

Disability Two Ticks Symbol and Mindful Employer

We are pleased to have signed up to the Two Ticks Symbol which expresses our commitment to be positive about disability in employment. We are also committed to the Mindful Employer standard, which expresses our intention to support people who have suffered mental illness to become and remain valued members of the organisation.

Staff Data

We routinely monitor our staff data, and use this as one of a number of ways, which includes the EDS, to ensure we support our staff from different protected groups.

12 Meet the Board

Executive Directors:

Steve Moore, Chief Executive
Felicity Owen, Director of Public Health
Carol Williams, Director of Nursing
Dr Shelagh McCormick, Medical Director and PEC Chair
Amanda Fisk, Director of Commissioning Development
Robert Knibbs, Director of Finance and Performance
Bridget Sampson, Director of Primary Care and Medicines Management
Tracey Lee, Director of Transition and Governance

Non-Executive Directors:

Andrew Williamson CBE, Chairman
Julie Stone
Nicholas Ball
Tom Sneddon
Dr Nigel Williams
Paul Wyatt
Jim Gould

13 Financial Information

Financial position of the Primary Care Trust

The Primary Care Trust is a statutory NHS body, established by Parliament and responsible for the local NHS system. Almost all of our funding is allocated to us by the Department of Health, on behalf of the Government. We are given a Revenue Resource Limit, which sets the amount we can spend on day-to-day healthcare locally. This amount is set nationally, but influenced by a ‘fair shares’ formula that applies to all Primary Care Trusts. We aim to spend around 99% of this funding each year, leaving a small surplus in line with good financial practice. Any surplus is not lost to the local area as it gets carried forward to the next year’s funding.

The table below shows how we spent our resources during 2012/13:

Primary Care Trust Spend in 2012/13

	2012/13 £m	2011/12
Royal Cornwall Hospitals NHS Trust	266.7	262.0
Peninsula Community Health - **see note below**	79.3	76.4
Cornwall Partnership Foundation NHS Trust & Mental Health Pooled Fund	68.9	66.4
Plymouth Hospitals NHS Trust	59.0	65.7
Specialist Services and other out-of-county contracts	70.3	50.2
Continuing Healthcare and Funded Nursing Care	54.5	49.3
South Western Ambulance Foundation NHS Trust	21.9	21.3
Duchy Hospital	13.5	10.9
Nothern Devon Healthcare NHS Trust	6.2	6.0
Other Commissioned Care	75.3	75.7
Sub Total	715.6	683.9
Prescribing & Pharmacy	106.9	110.0
Primary Care	81.7	81.3
Dental Care	16.9	17.2
Ophthalmic Care	5.0	5.3
Admin & other budgets	31.9	27.4
Total PCT Expenditure	958.0	925.1
PCT Surplus	8.8	8.6
Total PCT Resources 2012/13	966.8	933.7

The 2011/12 figure for Peninsula Community Health includes the costs of direct provision by the PCT until 30th September 2011 of the services

During the year we were also responsible for many of the local NHS buildings. We are allocated capital funding to allow us to develop these buildings and invest in up-to-date equipment: this funding can only be spent on major items and is subject to a Capital Resource Limit.

Our main capital project for 2012/13 was the continuing re-development work at Stratton Hospital. The unit is now open for use and has provided much better and more efficient facilities for the local population. We are grateful for the support of the local League of Friends in undertaking this development.

As a Government body, most cash is funded to us through the Department of Health. We draw down this cash on a monthly basis in line with our spending plans. The amount of cash we are allowed to draw down in this way is set according to the amounts we are allowed to spend on ‘revenue’ and ‘capital’ (as above) so we should always have enough cash available to meet our commitments. This also means that we are not exposed to any significant risks relating to interest rates or availability of borrowing facilities.

The PCT has a statutory duty to ensure it keeps its capital and revenue spending within limits set by the Department of Health. These limits are known as ‘resource limits’.

• The Revenue Resource Limit covers general day-to-day costs including healthcare expenditure and normal running costs. The PCT met its statutory duty to operate within our Revenue Resource Limit (£967million) and delivered a small underspend of £8.8 million (less than 1% of total funding) in line with our plans. This surplus is not lost to the local NHS, as it is returned to the PCT in the following year.

• The Capital Resource Limit applies to investment in items with a useful life expectancy of more than one year and costing more than £5,000(such as land, buildings and major equipment). The PCT is not allowed to carry forward any unspent capital resource. We met our statutory duty to operate within our Capital Resource Limit of £3.7million, and spent virtually all of the funding available to us. The PCT is also required to operate within a Cash Limit which controls the amount of cash it is allowed to use in each year. The PCT's cash limit for 2012/13 was £961.1m. The PCT operated within this limit and drew down £959.6 m of the available amount.

Future Financial Outlook

The PCT ceased to exist on 31/3/13 and the roles that it undertook have transferred to Kernow Commissioning Group, NHS England, Public Health England and Cornwall Council.

Pension Liabilities

Most of the staff in the Primary Care Trust are members of the NHS Pension Scheme. Details of the scheme and how it is funded are set out in the financial statements. Pension arrangements for senior staff are disclosed in the Remuneration Report.

Better Payments Practice Code

The Better Payments Practice Code requires that all valid invoices should be paid by their due date or within 30 days of receipt, whichever is later. Our performance for 2012/13 is presented below, measured in terms of both the number and value of invoices received, against an NHS target to pay over 95 percent of non-NHS trade creditors in accordance with the Code. NHS organisations are also required to report payment performance with respect to other NHS bodies. The performance against the Better Payment Practice Code has continued to be strong in 2012/13. We continue to review our payment processes to ensure we comply with the Code's aspirations and to continue to further improve performance services to new organisations. There have been no claims of interest or compensation from small businesses under the Late Payment of Commercial Debts (Interest) Act 1998.

Prompt Payments code

NHS Cornwall and Isles of Scilly has signed up to the Prompt Payments Code and this was formally endorsed by our Board in July 2009. Signatories to the Code publicly commit to pay suppliers on time and within the terms and conditions of their agreements. Organisations also commit to providing timely and clear guidance to suppliers when issues arise and to encouraging their own supply chain to sign up to the Code.

Better Payment Practice Code Performance

Better Payment Practice Code

Measure of compliance	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	25,296	255,962	35,018	196,994
Total Non-NHS Trade Invoices Paid Within Target	23,275	247,427	32,998	185,438
Percentage of NHS Trade Invoices Paid Within Target	92.01%	96.67%	94.23%	94.13%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	4,197	520,660	4,093	514,057
Total NHS Trade Invoices Paid Within Target	3,814	518,285	3,636	508,679
Percentage of NHS Trade Invoices Paid Within Target	90.87%	99.54%	88.83%	98.95%

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 name of the external auditor and cost of auditing

The Audit Commission is responsible for appointing the external auditor to NHS Cornwall and Isles of Scilly. From 1 November 2012, Grant Thornton were the appointed external auditors; prior to that date, the Audit Commissioner's own operational audit practice fulfilled the role. The fees paid to external auditors are disclosed below. The fees paid to Grant Thornton covered the cost of the statutory audit and associated services: this included a qualitative assessment of the effectiveness of the Trust's arrangements to secure economy, efficiency and effectiveness in our use of resources.

External Audit Fees (excluding VAT)

Work Area	Fee 2012/2013
Audit Services (Grant Thornton)	£122,232
Other services (Audit Commission)	£22,000
Total fee	**£144,232**

In line with national arrangements, the Primary Care Trust pays the Audit Commission for external audit for the 'Payments by Results' rules in local providers. This work is undertaken by the Audit Commission and reported to both the provider and the Primary Care Trust. The Audit Commission charges the Primary Care Trust £21,000 for this work, as reported in 'other services' above. Also included in 'other services' in £1,000 relating to the costs for participating in national fraud initiative work.

Internal Audit

Internal Audit is an important aspect of our control and assurance systems. We have appointed RSM Tenon as our provider of Internal Audit services. Their programme of work is agreed annually by the Trust's Audit committee, based on a risk assessment of systems and assurances, and kept under regular review to ensure that it can address emerging issues. In 2012/13, the Primary Care Trust spent £112,000 on internal Audit services.

Remuneration report

For the purpose of this report, senior managers are defined as being:

'Those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Trust. This means those who influence the decisions of the organisation as a whole rather than the decisions of individual directorates or departments.'

The figures set out within this report relate to all those individuals who held office as a senior manager of NHS Cornwall and Isles of Scilly during the 2012/13 reporting year. The Chair and Non-Executive Directors of the Primary Care Trust are appointed by the Appointments Commission. Their remuneration and terms of service are set nationally and cannot be varied by the Primary Care Trust.

Remuneration and Terms of Service Committee

NHS Cornwall and the Isles of Scilly has a Remuneration and Terms of Service Committee that oversees the remuneration and terms of service of senior staff. The Terms of Reference of this Committee, which have been approved by the Board, set out its responsibilities and membership. The purpose of the Committee is to decide, on behalf of the Board, the appropriate remuneration for the Chief Executive and, in consultation with the Chief Executive, the appropriate remuneration for other senior managers including:

1. All aspects of salary including any performance-related elements/bonuses;
2. Provisions for other benefits, including pensions and cars; and
3. Arrangements for termination of employment and other contractual terms.

The membership of the Committee consists of the Chair and Non-Executive Directors of the Primary Care Trust and at least three members must be present for formal business to be conducted.

Policy on remuneration of senior managers

The senior managers of the Primary Care Trust are normally permanently appointed employees, contracted in line with the nationally agreed 'Pay Framework for Very Senior Managers (VSMs)'. This framework defines many aspects of the terms of service of VSMs, and provides indicative salary levels. For the purposes of the VSM framework, NHS Cornwall and Isles of Scilly is classified as a Level 4 PCT (based upon its local population). The contractual notice period for VSM contracts within the Primary Care Trust is three months. The Remuneration Committee agrees the specific salary details for senior managers within this framework and also considers the individual performance bonus payments and annual uplifts that are payable in line with the framework, having proper regard to the PCT's circumstances and performance. With regard to the Medical Director post the Remuneration Committee agrees specific salary details giving due consideration to the framework set out in the Consultants Contract (2003). Senior managers have individual objectives to clarify accountability for the delivery of the PCT's strategic objectives and their performance is assessed, individually and corporately, against these objectives. Any proposed performance bonuses are ratified by the Strategic Health Authority in line with the

nationally agreed 'Pay Framework for Very Senior Managers (VSMs)'. In recognition of the current economic climate, executive directors agreed to waive any performance bonus awards earned during 2012/13. In line with national guidance the Remuneration Committee did not approve any salary uplift for VSM contract holders in 2012/13. During the year the Remuneration committee approved the following changes to Director's working arrangements:

Chief Executive/Director of Finance/Director of Nursing/Director of Commissioning Development - Additional PCT Cluster responsibilities for Devon cluster undertaken from 1 October 2012, with 50% of costs being recharged from that point.

Director of Transition and Governance – Seconded to NHS Commissioning Board full time from 1 August 2012 to 29 October 2012.

Full details of these changes are given in the table below.

The Remuneration Committee also reviewed and approved all termination payments made in 2012/13.

Fair Pay in Public Sector

Following the Hutton review on Fair Pay in the Public Sector, reporting bodies are required to disclose the relationship between the remuneration of the highest paid director and the median remuneration of the PCT's workforce. This is disclosed as follows:

	2012/13	2011/12
	£	£
Banding of highest paid director	150,000 -155,000	135,000 - 140,000
Median salary of workforce	27,625	27,091
Multiplier	5.5	5.1

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

Remuneration Tables

The tables below set out the salary and relevant pension details of the most senior managers and the non-executive members of the Board, who had control over the major activities of the Primary Care Trust in 2012/13.
The Director of Transition and Governance was made redundant on the 31/3/2013 and in line with contractual obligations a payment of £167,000 was made. In respect of the remuneration report, only the remuneration table below and the disclosure above relating to fair pay have been subject to external audit as referred to in their independent report.

Salaries and Allowances

			01 April 2012 - 31 March 2013				01 April 2011 - 31 March 2012			
			Salary (bands of £5,000)	Other remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (to the nearest £100)	Salary (bands of £5,000)	Other remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (to the nearest £100)
Executive Directors		Note(s)	£'000	£'000	£'000	£'00	£'000	£'000	£'000	£'00
S Moore	PCT Cluster Chief Executive (from 11 May 2011, previously Acting PCT Chief Executive from 4 January 2010)	4	105-110	-	-	-	135-140	-	-	-
S M McCormick	Medical Director & Chair of PEC (from 1 April 2012)		115-120	-	-	-	-	-	-	-
J Tilbury	Medical Director & Chair of PEC (to 31 March 2012)		-	-	-	-	120-125	-	-	-
R Knibbs	Director of Finance and Performance (from 04 July 2011)	3	80-85	-	-	-	75-80	-	-	-
S Bolitho	Acting Director of Finance (from 28 March 2011 until 03 July 2011)		-	-	-	-	25-30	-	-	-
B Sampson	Director of Primary Care and Medicines Management (from 11 April 2012)		80-85	-	-	-	-	-	-	-
F Owen	Director of Public Health	1	45-50	-	-	-	45-50	-	-	-
C T Williams	Director Of Nursing (from 1 June 2011, previously Director of Service Improvement & Executive Nurse)	2	65-70	-	-	7	90-95	-	-	11
T Lee	Director of Transition and Governance and Deputy Chief Executive (from 26 July 2011, previously Director of Communications & Corporate Governance, and Acting Deputy Chief Executive since 12 July 2010)	5,6	55-60	55-60	-	-	100-105	-	-	-
K Baber	Managing Director, Community Health Services (until 30 September 2011)		-	-	-	-	50-55	-	-	11
A Fisk	Director of Commissioning Development (from 21 July 2011, previously Acting Director of Commissioning and Strategic Development)	2	65-70	-	-	-	90-95	-	-	-
Non-executive Directors										
A G Williamson	Chairman		35-40	-	-	-	35-40	-	-	-
N T Ball	Non-executive Director		10-15	-	-	-	10-15	-	-	-
P R Wyatt	Non-executive Director		5-10	-	-	-	5-10	-	-	-
T Sneddon	Non-executive Director		5-10	-	-	-	5-10	-	-	-
N J Williams	Non-executive Director		5-10	-	-	-	5-10	-	-	-
J Stone	Non-executive Director		5-10	-	-	-	5-10	-	-	-
J Gould	Non-executive Director		5-10	-	-	-	5-10	-	-	-

Note 1: This is a joint appointment with Cornwall Council & the Council of the Isles of Scilly. 50% of the costs are funded by Cornwall Council. Salary banding for 2012-13, before recharges, would have been £95-100,000 (2011-12: £95-100,000)

Note 2: Additional PCT Cluster responsibilities for Devon from 1 October 2012, and 50% of costs recharged from that point. Salary banding for 2012-13, before recharges, would have been £90-95,000.

Note 3: Additional PCT Cluster responsibilities for Devon from 1 October 2012, and 50% of costs recharged from that point. Salary banding for 2012-13, before recharges, would have been £105-110,000.

Note 4: Additional PCT Cluster responsibilities for Devon from 1 October 2012, and 50% of costs recharged from that point. Salary banding for 2012-13, before recharges, would have been £150-155,000.

Note 5: Seconded to NHS Commissioning Board full time from 1 August 2012 to 29 October 2012, and on maternity leave thereafter. Salary costs for the period after 1 August are shown as 'Other remuneration'.

Note 6: This post became redundant at 31 March 2013, as part of the NHS re-structuring. Redundancy pay of £167,000 was paid in relation to this event, in line with contractual entitlement.

Pension Benefits

Directors	Notes	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at aged 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 2012	Cash Equivalent Transfer Value at 31 March 2013	Real Increase in Cash Equivalent Transfer Value	Employer's Contribution to Stakeholder Pension
		£000	£000	£000	£000	£000	£000	£000	£00
Steve Moore	1	0 - 2.5	5 - 7.5	30 - 35	100-105	435	499	41	0
Shelagh McCormick		2.5 - 5	10 - 12.5	20 - 25	60-65	291	375	68	0
Robert Knibbs	1,2	0 - 2.5	2.5 - 5	25 - 30	75-80	533	-	-	0
Bridget Sampson		0 - 2.5	2.5 - 5	10 - 15	40-45	230	274	31	0
Felicity Owen	1	(0 - 2.5)	(0 - 2.5)	35 - 40	115-120	778	826	8	0
Carol Williams	1	0 - 2.5	0 - 2.5	35 - 40	110-115	628	692	32	0
Tracey Lee	1	(0 - 2.5)	(0 - 2.5)	25 - 30	80-85	401	432	9	0
Amanda Fisk	1	0 - 2.5	0 - 2.5	25 - 30	80-85	452	504	28	0

Executive roles and periods of service for the directors are recorded in the Salaries and Allowances table above.
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 members' accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefit accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

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

Real Increase in CETV

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

Notes

1 For comparability, pension benefits shown relate to the total benefits for the individual, without reduction for any proportionate recharges to other bodies. Details of the recharged periods are set out the Salaries and Allowances table
2 Age over 60 at 31 March 2013, so CETV is not relevant.

14 Governance Statement

Scope of responsibility

Primary Care Trusts are accountable to Parliament and the Secretary of State for Health through the Accountable Officer. During 2012, NHS Cornwall and Isles of Scilly has worked as a cluster with Devon in preparation of transition to new commissioning arrangements.

The Accountable Officer and Chief Executive of NHS Cornwall and Isles of Scilly Trust Board have responsibility for maintaining a robust system of internal control that supports the achievement of the organisation's policies, aims and objectives, whilst also safeguarding public funds and the assets of the organisation. In his role, the Accountable Officer has attended meetings of the Shadow Health and Wellbeing Boards for Cornwall and the Isles of Scilly, Overview and Scrutiny Committees, the Professional Executive Committee, the Public Sector Group and the Local Medical Committee.

The Accountable Officer is a member of the Integrated Governance Committee of the Primary Care Trust. The Committee oversees the Primary Care Trust's management of risk issues and has attended the Primary Care Trust's Audit Committee during 2012/13.

Primary Care Trust officers represent the Accountable Officer at a number of forums and committees including the Joint Commissioning Board for Mental Health, Health and Wellbeing Boards, the Joint Executive Committee for Learning disabilities, the Children and Young People's Care Trust Board, the Older People's and Long Term Conditions Partnership Board, The Drug and Alcohol Team Action Board, the Peninsula Cancer Network and the Board of the Local Improvement Finance Trust (LIFT) company, known as Community 1st Cornwall Limited. In addition, the Accountable Officer's accountability to the Trust Board he attends meetings with NHS South and accounts to the Strategic Health Authority (SHA) for the performance of the Primary Care Trust through monthly meetings which he attends with the Director of Finance and Performance and the Director of Commissioning Development along with the Strategic Health Authority's Performance Team.

The Governance Framework of the Organisation

Our governance arrangements cover corporate, clinical, financial, information and research governance and govern the way in which we conduct ourselves as an organisation, setting the right policies and procedures and ensuring that business is conducted in a systematic way with transparency and public accountability at its heart and to ensure that we carry out our duties and responsibilities to the standards expected of us. Governance within the Organisation is ultimately led by the Trust Board. The director of Governance and Transition and the Company Secretary advise the Board on matters of governance. All directors have access to the advice and support of the Company Secretary who is responsible for ensuring compliance with Board procedures. The Trust Board comprises the Chair as well as the executive and non-executive members. Non- executive member appointments were made by the Appointments Commission.

Additional individuals who may be invited to the Trust Board meetings are:

- The Chair of Kernow Clinical Commissioning Group

- A member of the Local Involvement Networks for Cornwall and the Isles of Scilly
- The Director of Adult Social Care.

The Board has delegated specific functions to a number of committees at which appropriate attendance has been secured throughout 2012/13. Non-executive member engagement and participation in all the key committees allows for a fuller understanding of clinical and business issues discussed at Board.

Committees of the Trust Board

The Audit Committee is a non-executive committee of the Board. The Committee was originally established in accordance with the requirements of the Audit Committee Handbook 2005. Audit Committee members have undertaken the self assessment checklist set out in the Audit Committee Handbook to assess the performance of the Committee. This indicated that the Committee was meeting all of the 'must dos' and the vast majority of the 'should dos' and 'could dos'. The Terms of Reference of the Audit Committee detail the delegated powers to enquire into matter of propriety, accountability and regularity. The Audit Committee is chaired by a non-executive director who is a qualified Accountant. There is also another non-executive of the Audit Committee with a significant operational background in accountancy.

The Remuneration and Terms of Service Committee was established in line with the requirements of the Code of Accountability and the Higgs Report. Its membership consists entirely of non-executive directors (with three members forming a quoracy). The purpose of this Committee is to decide, on behalf of the Board, the appropriate remuneration and terms of service for the Chief Executive, and in consultation with the Chief Executive, the appropriate remuneration for other very senior managers including all aspects of salary, provisions for other benefits and arrangements for termination of employment and other contractual issues.

The Integrated Governance Committee keeps an overview of governance arrangements with particular responsibilities for risk management arrangements. An annual review of the Integrated Governance Committee is presented to the Trust Board in the first quarter of the following financial year. Those reporting to the Integrated Governance Committee include the Equality and Human Rights sub-committee, Health and Safety sub-committee, Information Governance sub-committee, Joint Partnership Committee, Cornwall Local Intelligence Network for Controlled Drugs, Dignity in Care Group, User Strategy Group and Safeguarding Children and Adults Executive Board. Minutes of the Professional Executive Committee are reported to the Integrated Governance Committee to ensure that clinical governance remains integrated with other aspects of governance across the organisation. Minutes of the Integrated Governance Committee are reported to the Audit Committee along with any issues the Chair feels warrants audit attention.

The Professional Executive Committee was established in accordance with the 2007 Directions and is chaired by the PCT Medical Director. A review of the roles and responsibilities of the Committee during 2011/12 led to the membership being extended to include members of the Clinical Commissioning Groups who have engaged well with the Committee during 2012/13. The PEC now takes primary

responsibility for clinical governance arrangements across the Trust, and has shaped its agenda accordingly, including receiving regular reports from a Serious Incident Panel, ensuring that the learning from such incidents is disseminated effectively.

Kernow Clinical Commissioning Group has been established in line with the requirements of the 'Liberating the NHS' White Paper as a Committee of the PCT. Regular assurance on the work of this Committee is undertaken through the receipt of minutes at Board meetings and the attendance of Executive Directors at meetings of the Clinical Commissioning Group. The Clinical Commissioning Group was authorised as one of the first wave of CCGs and was established as a legal body on 11 December, 2012. It will take over the commissioning of services for the population of Cornwall and the Isles of Scilly on 1 April 2013.

The Finance and Performance Delivery Committee provides assurance on the overall performance and delivery of the Operating Plan for NHS Cornwall and the Isles of Scilly. This specifically applies to the delivery of national and local targets and the financial control total for the PCT. The appraisal process for business cases being presented to the Finance and Performance Delivery Committee includes prior review by a Technical Group

The Charitable Funds Committee controls, manages and monitors the use of the fund's resources. During the year expenditure exceeded income, in line with the commitment to spend historical funds held within the charity. The Audit Commission issued a 'clean' Independent Examiner's Report on the accounts. The Charitable Funds Committee will cease to exist from 1 April 2013 when the responsibility for the management of charitable funds being transferred to Cornwall Partnership Foundation Trust.

Details of members attendances at meetings is shown in appendix 1.

The Board has assessed its position and reviewed its effectiveness against the main principles of the UK Corporate Governance Code, as detailed below

Leadership

As detailed within the Corporate Governance Code the Board is led by the Chairman, supported by a Vice Chair, and sets the vision, values and strategy of the organisation. The roles of Board members are detailed within the Standing Orders of the organisation which were reviewed and agreed by the Board in March 2012.

Strategic objectives are based on the results of the Joint Strategic Needs Assessment and public consultation and are closely linked to the strategy for Reducing Health Inequalities. The strategic priorities support delivery of the vision for improved health and health outcomes – 'adding life to years and years to life'. The Board collectively challenges its position against agreed strategic objectives through its regular meetings.

The Board has also agreed the commissioning intentions for the forthcoming year which, for 2012/13, were developed in conjunction with Clinical Commissioning Groups. The Board has also overseen continued strong financial performance, despite a challenging economic environment, resulting in the PCT again meeting its control total. The Board has met regularly through 2012/13 with the agenda ordered to reflect items for discussion, decision and information ensuring a balance between strategic and operational issues and allowing sufficient time for

debate through the effective contribution by Executive and Non-Executive members. Agendas and papers are distributed in a timely manner to enable informed consideration before meetings to facilitate appropriate questions and challenge where. Agenda papers and minutes of Board meetings are made available to the public through the organisation's website. The Scheme of Reservation and Delegation sets out items reserved for the decision of the Board only. This includes the regulation and control of the PCT, including the approval of Standing Orders, management of the Board itself and its principal committees; approval of strategy, the Annual Operating Plan and annual budgets, Annual Report and Accounts for both general finance and funds held by the Charitable Trust, appointment of external and internal auditors, management of risk, approval of proposals for the acquisition and disposal of capital assets including land and buildings, and approval of the letting of commercial contracts with a value in excess of £1million following a competitive procurement exercise.

Regular Board Seminar sessions are held as a means of exploring issues in further depth, and providing a learning opportunity for Board members. The first part of the Board seminar includes an opportunity for the Non Executive directors to meet with the Chair, and then the Chair and Chief Executive.

Board members are required to demonstrate adherence to the seven principles of public life (the Nolan Principles), and Declarations of Interest are sought and recorded at each meeting of the Board and other key committees, including the Clinical Commissioning Group.

Effectiveness and Remuneration

During 2012/13 the Board continued to build on its strong position:

- through the establishment of Clinical Commissioning Groups
- leadership of Quality Innovation Productivity and Prevention workstreams delivering significant savings for reinvestment locally through improving quality and efficiency
- refining commissioning intentions, in partnership with the Clinical Commissioning Groups.

The Chair meets regularly with the Non Executive Directors and appraisals/development plans are conducted annually to review objectives for the following year. Annual appraisals, including development plans, for all Executive Directors are completed by the Chief Executive, and reported to the Remuneration and Terms of Service Committee. Executive directors also benefit from strong professional relationships with relevant colleagues within NHS South West.

To ensure effective decision-making the Board commissions external advice and expertise where this can add value.

The Integrated Governance Committee maintains an overview of committee structures, and information flows on behalf of the Board, ensuring that committees regularly review their Terms of Reference. Amendments were made during 2012 to accommodate the establishment of Clinical Commissioning Groups as

Committees of the Board.

To ensure the health community develops to meet the needs of the population, regular Board to Board meetings are held between NHS Cornwall and Isles of Scilly and the provider trusts within Cornwall. Chairs of the various organisations also meet on a regular basis to discuss issues pertinent to the organisations involved, as do Audit Chairs.

As part of the annual operating plan process, meetings are held with partner organisations to ensure that the planning, delivery and monitoring of healthcare is co-ordinated across the local area.

While acknowledging the largely positive internal audit report (November 2012) on programme management arrangements for Quality, Innovation, Productivity and Prevention (QIPP) plans in 2012/13, it is acknowledged that there was a gap in projected savings with no clear plans as to how the savings would be made . The shortfall in savings identified, but not yet delivered, has been covered off through prudent financial planning including through deployment of contingencies and is not expected to affect the control total.

Accountability and Relations with Stakeholders

The Board receives a report at each Board outlining Finance, Performance and Quality delivery, including in relation to key targets as set out in the Annual Operating Framework for 2012/13. Board reports include a focus on areas where performance is not yet at the required standard, with a clear account of the actions being taken to ensure achievement. The Board has overseen improvements in performance throughout the year, including in relation to stroke services, waiting times and treating patients with a fractured neck of femur.

Board meetings are held in public at venues across the PCT area to enhance accountability, with the Chair providing opportunities for members of the public to comment before key decisions are made that may impact on local communities. The Board continues work to increase public attendance at these meetings. An Annual Report, which includes the Annual Accounts, is developed and published on the website of the organisation. A summary version is also produced with input from local patient groups and other stakeholders.

The PCT holds consultations with the public which inform the commissioning of services. The Board continues to ensure that in responding to the needs of the whole population served, it is also responsive to more local issues. Plans have been completed during 2012/13 for new primary care facilities in Torpoint and Stratton Hospital has been completed in 2013/14. The PCT has also continued to deliver patient and public involvement training to commissioning colleagues which has been rolled out to general practice staff. The PCT works with key partners such as Cornwall Council and the voluntary and community sector in developing joint opportunities to undertake engagement work. In addition, the PCT has continued to brief community networks and key community groups about changes in the NHS, and engaged locally about key initiatives such as the hospital redevelopment in Stratton.

The Section 24a report, which is a statutory, public facing, annual report on all consultations carried out with regard to commissioning activities, was very well received by partners and

external stakeholders as a comprehensive data capture of the engagement and consultation work undertaken. The Themes report has fed into the Annual Operating Plan discussions so that the themes raised through involvement and engagement work drives future commissioning decisions. The Trust continues to work positively with both Local Involvement Networks and participate in 6-monthly joint meetings with Council colleagues and Local Involvement Networks (LINks). The PCT's User Strategy Group continues to flourish and members have played a key part in holding the organisation to account for its communications and engagement activity. The Trust also continues to ensure that its engagement work specifically targets those groups with protected characteristics, with much engagement taking place with patients and staff to inform equality objectives and support implementation of the Equality Delivery System across Cornwall and the Isles of Scilly. Staff engagement has also strengthened during 2012/13 recognising the importance of supporting staff through transition.

Remuneration

Remuneration to directors is paid in line with the national Very Senior Manager pay framework, and overseen by the Remuneration and Terms of Service Committee. In recognition of the challenging economic climate, executive directors have waved any performance related payments for 2012/13.

Risk assessment

The Integrated Governance Committee (IGC) is the committee with responsibility for risk management and is comprised of Directors and senior managers from across the organisation, including specialist leads as required. The Integrated Governance Committee reports directly to the Trust Board. The IGC reviews all risks which are exceeding their risk appetite. Reports to each PCT Board are based upon the risk appetite of the organisation, including all risks exceeding the Trust's risk appetite in the two areas of lowest risk tolerance, safety and compliance, along with principal risks (those likely to directly impact on achieving strategic objectives).

The PCT's risk appetite was determined through a Board Seminar in 2010 and with the consideration of the Integrated Governance Committee before ratification by the Board. The Appetite Statement sets out the key categories of risk for the organisation and gives each category an appetite rating indicating what grade of risk is unacceptable. Risks with a grade above that level are said to 'exceed' the agreed risk appetite and are, therefore, reportable to the relevant committees for particular consideration. The risk appetite has been determined as follows:

Risk Category	**Risk Appetite (1 = very low risk appetite and 4 = high risk tolerated)**
Quality	2
Safety	1
Prevention, health improvement and self help	3
Compliance	1
Productivity	3
Reputation	3
Innovation	4
Invest to save	3
Access to services	3

Effective partnership working	3
Performance	2

To facilitate understanding of the risk appetite the organisation has developed the following narrative:

The PCT has a measured approach to risk. We have a zero tolerance for regulatory breaches and risks to patient safety. We will do all that we can to keep risks low in respect of the quality of care provided to patients and delivery against national and local performance targets. We take a cautious approach to reputation management and bringing more care closer to home, balancing the need to promote public confidence and respond to local aspirations with the need to occasionally take unpopular decisions in order to protect the safety and quality of services delivered. We are willing to take moderate risks in relation to our work to improve health and prevent ill health, work with partners and increase productivity. We are willing to take higher risks in order to test new and innovative service delivery, ensuring we have the right safeguards in place to protect patients.

The Assurance Framework for the PCT supports the Board in gaining assurance about the effectiveness of the organisation's system of internal control. The key elements of the Assurance Framework are to identify:

- Principal objectives
- Principal risks to the achievement of those objectives
- Key controls in place to manage those risks
- Assurances on the effectiveness of those controls
- Gaps in control and assurance
- Action plans to address gaps in control and assurance.

The key principal risks and the gaps and actions in place, as at 6 March 2013, to mitigate them are as follows:

Principal risk	Gaps in control and/ or assurance	Action required
Strategic Objective 1: Reducing levels of unplanned teenage pregnancy		
Economic climate has been shown to have an impact on teenage conception rates. There is a risk that we will be unable to sustain our downward trend in under 18 conceptions.	Conception rates always subject to fluctuation and need to be kept under review. Latest ONS data due end February 2013	Review latest ONS data when received and assess if further action required
Strategic Objective 2: Help more children to achieve a healthy weight		
Not achieving an upward trend in the number of children who are a healthy weight	Position re commissioning of Tier 3 services in the future is currently unclear	Liaise with key members of CCG teams to explore development of commissioning model

(not underweight, overweight or obese) in Cornwall and Isles of Scilly		
Strategic Objective 3: Help people who smoke to quit and remain smoke free		
NHS CIOS Board determined 29/1/13 that there is no principal risk against this strategic objective at present	None at present	None at present
Strategic Objective 4: Reduce deaths from cancer by improving prevention, early diagnosis, treatment and long term cancer care for all		
Risk of secondary care's ability to respond to enhanced performance requirements set out in the Cancer Reform Strategy	**None at present**	**None at present**
Strategic Objective 5: Reduce the number and impact of strokes		
Failure to achieve Vital Signs stroke targets due to Community based Stroke Rehab capacity/ Early Supported Discharge (ESD)	None at present	None at present
Strategic Objective 6: Improve mental health and well-being and reduce suicides		
Failure to implement an effective strategy to prevent suicides	None at present	None at present
Strategic Objective 7: Improve care and support for people with dementia and their families		
Insufficient levels of case management, dementia diagnosis and integrated working occurring to ensure continuity of care for all people diagnosed with dementia through diagnosis to end of life by end March 2013	Primary care case management not adopted by Cornwall Partnership Foundation Trust (CFT)	Discussions continue with PCT and CFT performance teams and commissioners
Strategic Objective 8: Support the right of people nearing the end of their life to choose to be cared for in the setting of their choice		
Poor co-ordination of end of life care across providers	End of Life register still not implemented Insufficient assurance held at	**Await results of pilot project and make recommendations for future options for KCCG to consider** **Use EoL pilot results,**

	present	**once broadened into wider OOH care, to monitor success in delivering appropriate EoL care to reflect patient choice**
Strategic Objective 9: Reduce the gap between people with the best health and those with the poorest health by targeting support where it is needed most		
Failure to reduce the gap between those with the best and the poorest health	Delivery of action plans Latest figures show that the difference in life expectancy in women between the least and the most deprived areas has got wider	Monitor delivery of action plans Review latest ONS figures when published (due end December 2012) to assess progress in closing the gap over the long term
Strategic Objective 10: Help people to live longer and raise life expectancy in Cornwall and the Isles of Scilly to match best levels in Europe		
Failure to reduce health inequalities and raise life expectancy	None at present	None at present
Strategic Objective 12: Deliver new and existing targets set by Care Quality Commission or within the NHS CIOS Operating Plan (the 'Minimum Guarantee')		
NHS CIOS is at risk of failing to meet the national HCAI targets for 2012/13	None at present	None at present
Strategic Objective 13: To establish and implement a programme of work, supported by organisational development and enabling strategies, to successfully lead and deliver the Quality, Innovation, Productivity and Prevention (QIPP) agenda across Cornwall and the Isles of Scilly		
Inability of the PCT to successfully implement processes and achieve organisational competencies which deliver the QIPP programme for the PCT	Insufficient detail provided regarding operational plans to reduce follow-ups Some follow up protocols agreed, with others needing further development **Insufficient levels of assurance at present**	RCHT to develop detailed action plans to provide assurance that existing proposals for reductions will deliver change Develop remaining protocols Further monitoring of progress against this risk by KCCG P&D Group to obtain assurance regarding the efficacy of controls
Failure to deliver the required control total due to inability to deliver QIPP commissioner	Insufficient levels of assurance at present	Await finalisation of year-end accounts.

savings		
Risk that Secondary Care clinicians do not support a reduction in follow up rates, leading to no change in culture and behaviour	Some risk stratification protocols still under development Insufficient levels of assurance at present	Complete development of risk stratification protocols for all specialties Review RCHT follow up reduction information and agree prioritised implementation list for future action where gaps in control are identified
Strategic Objective 14: Maintain an effective organisation that continues to secure the delivery of high quality healthcare in Cornwall and the Isles of Scilly whilst working with partners to ensure a smooth and effective transition through NHS re-organisation		
Failure to retain adequate capacity/ capable workforce during transition (to 2013/14) will impact on business continuity and delivery of functions	None at present	None at present
If the cost of retrospective CHC reviews is higher than expected then it will place at risk the delivery of the PCT's financial control total for 2012/13, leading to impacts on reputation, performance and compliance	Insufficient capacity to carry out Needs Portrayals The likely cost of retrospective reviews is anticipated to be significantly higher that the DH anticipated. It has been mooted that a dedicated funding pot may be put in place to meet some of the financial risks with this policy implementation	Develop business case to address capacity once number of cases requiring a Needs Portrayal is known. Work closely with the SHA and finance teams to clarify funding options that may be proposed and assess possible impact on KCCG. Ensure Senior Management Team is kept appraised on any developments

The PCT has established a robust control environment to ensure that data/information is managed appropriately and securely. The PCT employs a dedicated Head of Information Governance who completes and implements the annual Information Governance Toolkit self-assessment against which the organisation has self-assessed as achieving the required Level 2. Within the PCT the Information Governance sub Committee (IGSC) meets at least bi-monthly and reports to the Integrated Governance Committee. The IGSC considers the information governance risk register (an extract of the overarching risk register) at each meeting. As well as driving the agenda on compliance with the information governance toolkit, information governance incidents are considered by the sub-Committee. Membership of the IGSC is drawn from across the PCT as well as specialist technical staff from Cornwall Information Technology Services (CITS). A trained Caldicott Guardian, the Nurse Executive, supports this work particularly to assure appropriate safeguards for personal information are in place and adhered to.

The PCT has allocated responsibility of Senior Information Risk Owner to the Director of Finance.

A serious untoward incident procedure for the reporting of data or information losses is in place and CITS maintains an incident log which captures any issues about the electronic management of information, especially relating to data security and access. Incidents relating to the PCT are reported to the IGSC together with the actions taken to avoid a recurrence.

One lapse of data security was reported in 2012/13 A letter and supporting documentation, outlining a specification of needs for a specific client was sent to 92 care suppliers with the aim of securing specialist care for the client. Inadvertently the specification issued, included the client's NHS number, initials of the client (potentially identifying her from a small cohort) and the husband's full name. Further sensitivity is associated with this incident as the client is currently subject to a complex legal process.

This incident happened in November 2012, and was reported to the SHA but not the ICO, as it was only rated as a Level 2 IG incident.

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

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

The PCT updates its Risk Management Strategy annually for ratification by the Board. This was done in December 2012.

The risk register for the PCT is updated on a monthly basis. The register is approved at the Integrated Governance Committee with onward reporting to Board. These arrangements, along with training and awareness for key staff, have embedded risk management as a regular, ongoing activity, owned and embedded within all directorates.

The Cluster Director of Transition and Governance is the designated Director for Risk Management for the PCT, with responsibility for day-to-day management delegated to the Corporate Risk Manager. The Director is also responsible for health, safety, fire and security. Health, safety, risk and fire training are included within the mandatory training programme.

The Cluster Director of Nursing provides the executive lead on clinical governance risks for NHS Cornwall and Isles of Scilly.

The Director of Public Health is the designated director for emergency planning, with

responsibility for ensuring that the organisation is compliant with all duties in accordance with emergency preparedness and the Civil Contingencies Act 2004. The Director of Public Health is supported by an Emergency Planning Lead.

Risk management is promoted by the PCT as the responsibility of all staff and a section to this effect is included within staff job descriptions. Staff are positively encouraged to report risk and contribute to the overall risk register.

Risk management issues are discussed by a variety of staff through the Integrated Governance Committee, the Professional Executive Committee, the Information Governance and Health and Safety sub-committees and the Transition Steering Group. A Headquarters Health and Safety locality group meets regularly to discuss local concerns which can then be escalated, through reporting mechanisms, to the Health and Safety sub-committee.

All papers to the Board and committees in the PCT have frontispieces which include the requirement to link the report to relevant strategic objectives and highlight any impacts on areas such as workforce, finance, equality and diversity and environment. Processes are in place to discuss the management of partnership risk, the outcomes of which are discussed through the internal committee structures. The PCT co-ordinates a partnership risk register on behalf of key public sector organisations, which is reported to the Integrated Governance Committee within the PCT. The PCT also meets with key providers on a regular basis to consider the content of the organisations' assurance frameworks and corporate risk registers to jointly identify and manage risks that are common to the organisations involved and those risks held by one organisation that might also impinge on one or more of the other local organisations.

The PCT is compliant with all aspects of the governance arrangements for cluster PCTs.

During 2012/13, the PCT managed and implemented a Transition Programme to deliver the safe and effective transfer of statutory duties to the appropriate receiving organisations and to oversee key transition workstreams in the interim. The overall responsibility of the programme has been to ensure:

- Sufficient capability and capacity within the organisation to deliver statutory responsibilities during the transition process
- Effective communication within the organisation and externally during the transition process
- Effective transfer of functions into the appropriate receiving organisations
- Appropriate receiving organisations are suitably prepared to receive the new statutory functions, including authorisation of the CCG
- Effective closedown of the PCT.

The Transition Programme developed and maintained its own risk register. Below is an example of a risk that appeared on the Transition Risk Register

The Integrated Governance Committee has been the Committee with responsibility for overseeing the transition programme and regular reports on delivery and progress are provided to the Board.

As part of ensuring the overall aims of the transition programme are delivered, as set out above, there will be a focus on ensuring that PCT property and other fixed assets, are effectively monitored and controlled to ensure a smooth transition to successor organisations. This will address recent internal audit recommendations.

The overall transition programme will continue to be subject to internal audit during 2012/13. The last report which was presented to the Audit Committee in January 2013 reported the following:

> "We are satisfied that the PCT has ensured that it has managed the transition process effectively, with the Board kept aware of development and challenges to the process. The project plan and resultant programme management approach developed by the PCT have proved to be sound and have continued to be followed operationally to date. Kernow Clinical Commissioning Group obtained Authorisation in Wave 1 and a number of other areas are ready for transfer to receiver organisations."

Arrangements in place for the discharge of statutory functions and check for legal compliance.

The PCT retained a firm of lawyers to provide advice on the development of strategy, policy and procedures implemented across the organisation. Legal advice was also sought on demand in response to activities of the Trust to ensure compliance with appropriate legislation. Regular review of these governance tools along with the Standing Orders, Scheme of Delegation and Standing Financial Instructions provided a structured approach to ensure compliance.

In addition to the general responsibility held by Executives, a number of lead officers employed by the Trust also had a responsibility for ensuring compliance with legislation. This included the Company Secretary, Head of Information Governance, Health & Safety Officer, Controlled Drugs Accountable Officer and Local Security Management Specialist, all of whom had access either to legal advice and/or their own professional support mechanisms.

Other sources of intelligence that alerted the PCT to legislative change included briefings received in bulletins from the Department of Health, Internal Audit and the Trust's lawyers. The frontispieces for all board and committee papers included consideration of any legal issues relating to the paper being presented.

The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements were in place and assurance was provided through the Assurance Framework and supporting committees and reporting structures. The Assurance Framework set out the assurances and controls to ensure the PCT maintained a high level focus on national requirements throughout the year.

Overview of the governance framework established for the accounts scrutiny and sign off process.

In line with the Department of Health's letter dated 17th December 2012 (gateway reference 18561) the PCT has set up arrangements to scrutinise and sign off the accounts for 2012/13. This includes the secondment of the Signing officer and Finance signing officer to the Department of Health and the appointment of non-executive Directors to the audit committee.

Review of the effectiveness of risk management and internal control

In formulating the assurance framework for 2012/13, the PCT's Board confirmed its strategic objectives and continued to use the framework to ensure that the Board received adequate assurance on the effective operation of controls to manage the risks to the organisation achieving its principal objectives, including:

- Monthly integrated financial, performance and quality monitoring and reporting including in relation to progress against QIPP delivery
- Progress reports on the Transition Programme, including arrangements for public health and the progress of Kernow Clinical Commissioning Group
- An update on progress in delivering the inequalities strategy
- Updates on progress in infection prevention and control
- An update on Communications and Engagement
- An update on the development of a Health and Well-being Strategy.

A web-based integrated database (iRisk) for the risk register and assurance framework is used across the PCT. It is reviewed by managers, and approved by directors, on a monthly basis. The assurance framework is formally reviewed and updated at least bi-monthly. Executive Directors take responsibility for particular strategic objectives and the executive team collectively review the assurance framework as a whole on a monthly basis, through reports to the Finance, Performance and Delivery Committee on the risk and assurance RAG rating of strategic objectives. This enables the executive team to identify areas where further scrutiny or action may be required. In this way, the assurance framework helps to drive the Board agenda.

Management of the assurance framework is overseen by the Integrated Governance Committee at each of its quarterly meetings, and the framework is also scrutinised by the Audit Committee. The whole assurance framework is seen by the Audit Committee twice a year. In addition, the Audit Committee operates a planned timetable of more detailed scrutiny of individual elements of the assurance framework. Executive Directors are invited to the Audit Committee on a rolling programme to discuss their individual sections of the assurance framework. This ensures that every element of the framework is the subject of very detailed scrutiny at least once per year. The Board monitors the assurance framework at least twice a year and receives an update on the principal risks contained within it at each of its monthly reviews of the corporate risk register. All Board and Committee papers

include reference to the strategic objective(s) and aspect(s) of the assurance framework to which they pertain, together with an indication as to whether or not the paper provides positive or negative assurance or highlights any gaps.
Assurance Framework arrangements have received a positive internal audit report for 2012/13.

The committee structure continues to provide a structured governance framework for the conduct of business and decision making, with clear reporting lines and accountability. In order to review the effectiveness of the system of internal control, assurances have been received from the work conducted by the external auditors who provide an opinion on the true and fair view of the accounts and value for money achieved and confirms that the accounts are prepared under the principles and in a format directed by the Secretary of State. The review is also informed by the Head of Internal Audit opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of Internal Audit's work. The arrangements for internal audit comply with those described in the NHS Internal Audit Manual. The Head of Internal Audit's opinion is set out as follows:

Based on the work undertaken in 2012/13, significant assurance can be given that there is a sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently in all areas reviewed.

Cornwall & Isles of Scilly Primary Care Trust

Appendix 1

Board Member attendance

		2012														2013					
Name	**Title**	**April**		**June**		**July**		**Sep**		**Oct**		**Nov**		**Dec**		**Jan**		**Feb**		**Mar**	
		BRD	Rem Com	BRD	Rem Com	BRD	Rem Com	BRD	Rem Com	BRD	Rem Com	BRD	Rem Com	BRD	Rem Com	BRD	Rem Com	BRD	Rem Com	BRD	Rem Com
Andrew Williamson	**Chair**	✓		A	✓	✓		✓			✓	✓	✓		✓	✓			✓	✓	✓
Steve Moore	Chief Executive	✓		✓	A	✓		✓			✓	✓	✓		✓	✓			✓	✓	✓
Nick Ball	**Non-Executive Director**	✓		✓	✓	✓		A			✓	✓	✓		A	✓			✓	✓	
Amanda Fisk	Director of Commissioning Development	✓		✓		✓		✓				A				✓				✓	
Jim Gould	**Non-Executive Director**	A		✓	✓	A		A			✓	A	✓		✓	✓			✓	✓	
Tracey Lee	Director of Communications & Governance	✓		✓	✓	✓															
Robert Knibbs	Director of Finance	✓		✓		A		✓				✓				✓				✓	
Felicity Owen	Director of Public Health	A		A		A		A				A				✓				✓	
Bridget Sampson	Director of Primary Care and Medicines Management	✓		A		✓		✓				✓				✓				✓	
Tom Sneddon	**Non-Executive Director**	A		✓	A	A		A			A	A	✓		A	A			✓	✓	✓
Julie Stone	**Non-Executive Director**	✓		✓	✓	✓		A			A	✓	✓		A	✓			A	✓	✓
Shelagh McCormick	Medical Director	✓		✓		✓		✓				✓				✓				✓	
Carol Williams	Director of Nursing	✓		A		✓		✓				✓				✓				✓	
Nigel Williams	**Non-Executive Director**	✓		✓	✓	✓		✓			✓	A	✓		✓	✓			✓	✓	✓
Paul Wyatt	**Non-Executive Director**	✓		✓	✓	✓		✓			✓	✓	✓		✓	✓			✓	✓	✓

✓	In attendance	BRD	Board Meetings
A	Apologised	Rem Com	Remuneration and Terms of Service Committee

(green) Non-Executive Director
(blue) Not usually an attendee

Accountable Officer: Steve Moore

Organisation: NHS Cornwall & Isles of Scilly

Steve Moore

Date 23rd May 2013

Cornwall and Isles of Scilly Primary Care Trust

2012-13 Accounts

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Cornwall and Isles of Scilly Primary Care Trust

2012-13 Accounts

2012-13 Annual Accounts of Cornwall and Isles of Scilly Primary Care Trust

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, and from the assurances provided by the Accountable Officer until 31 March 2013, I am assured that the responsibilities have been properly discharged.

nb: sign and date in any colour ink except black

Signed Designated Signing Officer

Name: A Fisk

Date

2012-13 Annual Accounts of Cornwall and Isles of Scilly Primary Care Trust

STATEMENT OF RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

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

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

- make judgements and estimates which are reasonable and prudent;

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

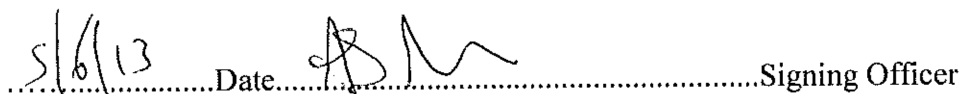
- ensure that the PCT kept proper accounting records which disclosed with reasonable accuracy at any time the financial position of the primary care trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State.

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

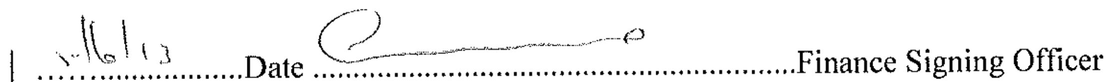
The Signing Officer and the Finance Signing Officer confirm to the best of their knowledge and belief, they have complied with the above requirements in preparing the accounts.

By order of the Permanent Secretary.

nb: sign and date in any colour ink except black



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



.........................Date ....Finance Signing Officer

Cornwall and Isles of Scilly

Cornwall and Isles of Scilly Primary Care Trust (NHS CIOS)
Organisation Code 5QP

Governance Statement

Scope of responsibility

Primary Care Trusts are accountable to Parliament and the Secretary of State for Health through the Accountable Officer. During 2012, NHS Cornwall and Isles of Scilly has worked as a cluster with Devon in preparation of transition to new commissioning arrangements.

The Accountable Officer and Chief Executive of NHS Cornwall and Isles of Scilly Trust Board have responsibility for maintaining a robust system of internal control that supports the achievement of the organisation's policies, aims and objectives, whilst also safeguarding public funds and the assets of the organisation. In his role, the Accountable Officer has attended meetings of the Shadow Health and Wellbeing Boards for Cornwall and the Isles of Scilly, Overview and Scrutiny Committees, the Professional Executive Committee, the Public Sector Group and the Local Medical Committee.

The Accountable Officer is a member of the Integrated Governance Committee of the Primary Care Trust. The Committee oversees the Primary Care Trust's management of risk issues and has attended the Primary Care Trust's Audit Committee during 2012/13.

Primary Care Trust officers represent the Accountable Officer at a number of forums and committees including the Joint Commissioning Board for Mental Health, Health and Wellbeing Boards, the Joint Executive Committee for Learning disabilities, the Children and Young People's Care Trust Board, the Older People's and Long Term Conditions Partnership Board, The Drug and Alcohol Team Action Board, the Peninsula Cancer Network and the Board of the Local Improvement Finance Trust (LIFT) company, known as Community 1st Cornwall Limited. In addition, the Accountable Officer's accountability to the Trust Board he attends meetings with NHS South and accounts to the Strategic Health Authority (SHA) for the performance of the Primary Care Trust through monthly meetings which he attends with the Director of Finance and Performance and the Director of Commissioning Development along with the Strategic Health Authority's Performance Team.

The Governance Framework of the Organisation

Our governance arrangements cover corporate, clinical, financial, information and research governance and govern the way in which we conduct ourselves as an organisation, setting the right policies and procedures and ensuring that business is conducted in a systematic way with transparency and public accountability at its heart and to ensure that we carry out our duties and responsibilities to the standards

expected of us. Governance within the Organisation is ultimately led by the Trust Board. The director of Governance and Transition and the Company Secretary advise the Board on matters of governance. All directors have access to the advice and support of the Company Secretary who is responsible for ensuring compliance with Board procedures. The Trust Board comprises the Chair as well as the executive and non-executive members. Non- executive member appointments were made by the Appointments Commission.

Additional individuals who may be invited to the Trust Board meetings are:

- The Chair of Kernow Clinical Commissioning Group
- A member of the Local Involvement Networks for Cornwall and the Isles of Scilly
- The Director of Adult Social Care.

The Board has delegated specific functions to a number of committees at which appropriate attendance has been secured throughout 2012/13. Non-executive member engagement and participation in all the key committees allows for a fuller understanding of clinical and business issues discussed at Board.

Committees of the Trust Board

The Audit Committee is a non-executive committee of the Board. The Committee was originally established in accordance with the requirements of the Audit Committee Handbook 2005. Audit Committee members have undertaken the self assessment checklist set out in the Audit Committee Handbook to assess the performance of the Committee. This indicated that the Committee was meeting all of the 'must dos' and the vast majority of the 'should dos' and 'could dos'. The Terms of Reference of the Audit Committee detail the delegated powers to enquire into matter of propriety, accountability and regularity. The Audit Committee is chaired by a non-executive director who is a qualified Accountant. There is also another non-executive of the Audit Committee with a significant operational background in accountancy.

The Remuneration and Terms of Service Committee was established in line with the requirements of the Code of Accountability and the Higgs Report. Its membership consists entirely of non-executive directors (with three members forming a quoracy). The purpose of this Committee is to decide, on behalf of the Board, the appropriate remuneration and terms of service for the Chief Executive, and in consultation with the Chief Executive, the appropriate remuneration for other very senior managers including all aspects of salary, provisions for other benefits and arrangements for termination of employment and other contractual issues.

The Integrated Governance Committee keeps an overview of governance arrangements with particular responsibilities for risk management arrangements. An annual review of the Integrated Governance Committee is presented to the Trust Board in the first quarter of the following financial year. Those reporting to the Integrated Governance Committee include the Equality and Human Rights sub-committee, Health and Safety sub-committee, Information Governance sub-committee, Joint Partnership Committee, Cornwall Local Intelligence Network for Controlled Drugs, Dignity in Care Group, User Strategy Group and Safeguarding

Children and Adults Executive Board. Minutes of the Professional Executive Committee are reported to the Integrated Governance Committee to ensure that clinical governance remains integrated with other aspects of governance across the organisation. Minutes of the Integrated Governance Committee are reported to the Audit Committee along with any issues the Chair feels warrants audit attention.

The Professional Executive Committee was established in accordance with the 2007 Directions and is chaired by the PCT Medical Director. A review of the roles and responsibilities of the Committee during 2011/12 led to the membership being extended to include members of the Clinical Commissioning Groups who have engaged well with the Committee during 2012/13. The PEC now takes primary responsibility for clinical governance arrangements across the Trust, and has shaped its agenda accordingly, including receiving regular reports from a Serious Incident Panel, ensuring that the learning from such incidents is disseminated effectively.

Kernow Clinical Commissioning Group has been established in line with the requirements of the 'Liberating the NHS' White Paper as a Committee of the PCT. Regular assurance on the work of this Committee is undertaken through the receipt of minutes at Board meetings and the attendance of Executive Directors at meetings of the Clinical Commissioning Group. The Clinical Commissioning Group was authorised as one of the first wave of CCGs and was established as a legal body on 11 December, 2012. It will take over the commissioning of services for the population of Cornwall and the Isles of Scilly on 1 April 2013.

The Finance and Performance Delivery Committee provides assurance on the overall performance and delivery of the Operating Plan for NHS Cornwall and the Isles of Scilly. This specifically applies to the delivery of national and local targets and the financial control total for the PCT. The appraisal process for business cases being presented to the Finance and Performance Delivery Committee includes prior review by a Technical Group

The Charitable Funds Committee controls, manages and monitors the use of the fund's resources. During the year expenditure exceeded income, in line with the commitment to spend historical funds held within the charity. The Audit Commission issued a 'clean' Independent Examiner's Report on the accounts. The Charitable Funds Committee will cease to exist from 1 April 2013 when the responsibility for the management of charitable funds being transferred to Cornwall Partnership Foundation Trust.

Details of members attendances at meetings is shown in appendix 1.

The Board has assessed its position and reviewed its effectiveness against the main principles of the UK Corporate Governance Code, as detailed below

Leadership

As detailed within the Corporate Governance Code the Board is led by the Chairman, supported by a Vice Chair, and sets the vision, values and strategy of the organisation. The roles of Board members are detailed within the Standing Orders of the organisation which were reviewed and agreed by the Board in March 2012.

Strategic objectives are based on the results of the Joint Strategic Needs Assessment and public consultation and are closely linked to the strategy for Reducing Health Inequalities. The strategic priorities support delivery of the vision for improved health and health outcomes – 'adding life to years and years to life'. The Board collectively challenges its position against agreed strategic objectives through its regular meetings.

The Board has also agreed the commissioning intentions for the forthcoming year which, for 2012/13, were developed in conjunction with Clinical Commissioning Groups. The Board has also overseen continued strong financial performance, despite a challenging economic environment, resulting in the PCT again meeting its control total. The Board has met regularly through 2012/13 with the agenda ordered to reflect items for discussion, decision and information ensuring a balance between strategic and operational issues and allowing sufficient time for debate through the effective contribution by Executive and Non Executive members. Agendas and papers are distributed in a timely manner to enable informed consideration before meetings to facilitate appropriate questions and challenge where. Agenda papers and minutes of Board meetings are made available to the public through the organisation's website. The Scheme of Reservation and Delegation sets out items reserved for the decision of the Board only. This includes the regulation and control of the PCT, including the approval of Standing Orders, management of the Board itself and its principal committees; approval of strategy, the Annual Operating Plan and annual budgets, Annual Report and Accounts for both general finance and funds held by the Charitable Trust, appointment of external and internal auditors, management of risk, approval of proposals for the acquisition and disposal of capital assets including land and buildings, and approval of the letting of commercial contracts with a value in excess of £1million following a competitive procurement exercise.

Regular Board Seminar sessions are held as a means of exploring issues in further depth, and providing a learning opportunity for Board members. The first part of the Board seminar includes an opportunity for the Non Executive directors to meet with the Chair, and then the Chair and Chief Executive.

Board members are required to demonstrate adherence to the seven principles of public life (the Nolan Principles), and Declarations of Interest are sought and recorded at each meeting of the Board and other key committees, including the Clinical Commissioning Group.

Effectiveness and Remuneration

During 2012/13 the Board continued to build on its strong position:

- through the establishment of Clinical Commissioning Groups
- leadership of Quality Innovation Productivity and Prevention workstreams delivering significant savings for reinvestment locally through improving quality and efficiency
- refining commissioning intentions, in partnership with the Clinical Commissioning Groups.

The Chair meets regularly with the Non Executive Directors and appraisals/development plans are conducted annually to review objectives for the following year. Annual appraisals, including development plans, for all Executive Directors are completed by the Chief Executive, and reported to the Remuneration and Terms of Service Committee. Executive directors also benefit from strong professional relationships with relevant colleagues within NHS South West.

To ensure effective decision-making the Board commissions external advice and expertise where this can add value.

The Integrated Governance Committee maintains an overview of committee structures, and information flows on behalf of the Board, ensuring that committees regularly review their Terms of Reference. Amendments were made during 2012 to accommodate the establishment of Clinical Commissioning Groups as Committees of the Board.

To ensure the health community develops to meet the needs of the population, regular Board to Board meetings are held between NHS Cornwall and Isles of Scilly and the provider trusts within Cornwall. Chairs of the various organisations also meet on a regular basis to discuss issues pertinent to the organisations involved, as do Audit Chairs.

As part of the annual operating plan process, meetings are held with partner organisations to ensure that the planning, delivery and monitoring of healthcare is co-ordinated across the local area.

While acknowledging the largely positive internal audit report (November 2012) on programme management arrangements for Quality, Innovation, Productivity and Prevention (QIPP) plans in 2012/13, it is acknowledged that there was a gap in projected savings with no clear plans as to how the savings would be made . The shortfall in savings identified, but not yet delivered, has been covered off through prudent financial planning including through deployment of contingencies and is not expected to affect the control total.

Accountability and Relations with Stakeholders

The Board receives a report at each Board outlining Finance, Performance and Quality delivery, including in relation to key targets as set out in the Annual Operating Framework for 2012/13. Board reports include a focus on areas where performance is not yet at the required standard, with a clear account of the actions being taken to ensure achievement. The Board has overseen improvements in performance throughout the year, including in relation to stroke services, waiting

times and treating patients with a fractured neck of femur.

Board meetings are held in public at venues across the PCT area to enhance accountability, with the Chair providing opportunities for members of the public to comment before key decisions are made that may impact on local communities. The Board continues work to increase public attendance at these meetings. An Annual Report, which includes the Annual Accounts, is developed and published on the website of the organisation. A summary version is also produced with input from local patient groups and other stakeholders.

The PCT holds consultations with the public which inform the commissioning of services. The Board continues to ensure that in responding to the needs of the whole population served, it is also responsive to more local issues. Plans have been completed during 2012/13 for new primary care facilities in Torpoint and Stratton Hospital has been completed in 2013/14.

The PCT has also continued to deliver patient and public involvement training to commissioning colleagues which has been rolled out to general practice staff. The PCT works with key partners such as Cornwall Council and the voluntary and community sector in developing joint opportunities to undertake engagement work. In addition, the PCT has continued to brief community networks and key community groups about changes in the NHS, and engaged locally about key initiatives such as the hospital redevelopment in Stratton.

The Section 24a report, which is a statutory, public facing, annual report on all consultations carried out with regard to commissioning activities, was very well received by partners and external stakeholders as a comprehensive data capture of the engagement and consultation work undertaken. The Themes report has fed into the Annual Operating Plan discussions so that the themes raised through involvement and engagement work drives future commissioning decisions. The Trust continues to work positively with both Local Involvement Networks and participate in 6-monthly joint meetings with Council colleagues and Local Involvement Networks (LINks). The PCT's User Strategy Group continues to flourish and members have played a key part in holding the organisation to account for its communications and engagement activity.

The Trust also continues to ensure that its engagement work specifically targets those groups with protected characteristics, with much engagement taking place with patients and staff to inform equality objectives and support implementation of the Equality Delivery System across Cornwall and the Isles of Scilly.

Staff engagement has also strengthened during 2012/13 recognising the importance of supporting staff through transition.

Remuneration

Remuneration to directors is paid in line with the national Very Senior Manager pay framework, and overseen by the Remuneration and Terms of Service Committee. In recognition of the challenging economic climate, executive directors have waived any performance related payments for 2012/13.

Risk assessment

The Integrated Governance Committee (IGC) is the committee with responsibility for risk management and is comprised of Directors and senior managers from across the organisation, including specialist leads as required. The Integrated Governance Committee reports directly to the Trust Board. The IGC reviews all risks which are exceeding their risk appetite. Reports to each PCT Board are based upon the risk appetite of the organisation, including all risks exceeding the Trust's risk appetite in the two areas of lowest risk tolerance, safety and compliance, along with principal risks (those likely to directly impact on achieving strategic objectives).

The PCT's risk appetite was determined through a Board Seminar in 2010 and with the consideration of the Integrated Governance Committee before ratification by the Board. The Appetite Statement sets out the key categories of risk for the organisation and gives each category an appetite rating indicating what grade of risk is unacceptable. Risks with a grade above that level are said to 'exceed' the agreed risk appetite and are, therefore, reportable to the relevant committees for particular consideration. The risk appetite has been determined as follows:

Risk Category	**Risk Appetite (1 = very low risk appetite and 4 = high risk tolerated)**
Quality	2
Safety	1
Prevention, health improvement and self help	3
Compliance	1
Productivity	3
Reputation	3
Innovation	4
Invest to save	3
Access to services	3
Effective partnership working	3
Performance	2

To facilitate understanding of the risk appetite the organisation has developed the following narrative:

The PCT has a measured approach to risk. We have a zero tolerance for regulatory breaches and risks to patient safety. We will do all that we can to keep risks low in respect of the quality of care provided to patients and delivery against national and local performance targets. We take a cautious approach to reputation management and bringing more care closer to home, balancing the need to promote public confidence and respond to local aspirations with the need to occasionally take unpopular decisions in order to protect the safety and quality of services delivered. We are willing to take moderate risks in relation to our work to improve health and prevent ill health, work with partners and increase productivity. We are willing to take higher risks in order to test new and innovative service delivery, ensuring we have the right safeguards in place to protect patients.

The Assurance Framework for the PCT supports the Board in gaining assurance about the effectiveness of the organisation's system of internal control. The key elements of the Assurance Framework are to identify:

- Principal objectives
- Principal risks to the achievement of those objectives
- Key controls in place to manage those risks
- Assurances on the effectiveness of those controls
- Gaps in control and assurance
- Action plans to address gaps in control and assurance.

The key principal risks and the gaps and actions in place, as at 6 March 2013, to mitigate them are as follows:

Principal risk	**Gaps in control and/ or assurance**	**Action required**
Strategic Objective 1: Reducing levels of unplanned teenage pregnancy		
Economic climate has been shown to have an impact on teenage conception rates. There is a risk that we will be unable to sustain our downward trend in under 18 conceptions.	Conception rates always subject to fluctuation and need to be kept under review. Latest ONS data due end February 2013	Review latest ONS data when received and assess if further action required
Strategic Objective 2: Help more children to achieve a healthy weight		
Not achieving an upward trend in the number of children who are a healthy weight (not underweight, overweight or obese) in Cornwall and Isles of Scilly	Position re commissioning of Tier 3 services in the future is currently unclear	Liaise with key members of CCG teams to explore development of commissioning model
Strategic Objective 3: Help people who smoke to quit and remain smoke free		
NHS CIOS Board determined 29/1/13 that there is no principal risk against this strategic objective at present	None at present	None at present
Strategic Objective 4: Reduce deaths from cancer by improving prevention, early diagnosis, treatment and long term cancer care for all		
Risk of secondary care's ability to respond to enhanced performance requirements set out in the Cancer Reform Strategy	**None at present**	**None at present**
Strategic Objective 5: Reduce the number and impact of strokes		

Failure to achieve Vital Signs stroke targets due to Community based Stroke Rehab capacity/ Early Supported Discharge (ESD)	None at present	None at present
Strategic Objective 6: Improve mental health and well-being and reduce suicides		
Failure to implement an effective strategy to prevent suicides	None at present	None at present
Strategic Objective 7: Improve care and support for people with dementia and their families		
Insufficient levels of case management, dementia diagnosis and integrated working occurring to ensure continuity of care for all people diagnosed with dementia through diagnosis to end of life by end March 2013	Primary care case management not adopted by Cornwall Partnership Foundation Trust (CFT)	Discussions continue with PCT and CFT performance teams and commissioners
Strategic Objective 8: Support the right of people nearing the end of their life to choose to be cared for in the setting of their choice		
Poor co-ordination of end of life care across providers	End of Life register still not implemented Insufficient assurance held at present	**Await results of pilot project and make recommendations for future options for KCCG to consider** **Use EoL pilot results, once broadened into wider OOH care, to monitor success in delivering appropriate EoL care to reflect patient choice**
Strategic Objective 9: Reduce the gap between people with the best health and those with the poorest health by targeting support where it is needed most		
Failure to reduce the gap between those with the best and the poorest health	Delivery of action plans Latest figures show that the	Monitor delivery of action plans Review latest ONS figures when published (due end

	difference in life expectancy in women between the least and the most deprived areas has got wider	December 2012) to assess progress in closing the gap over the long term
Strategic Objective 10: Help people to live longer and raise life expectancy in Cornwall and the Isles of Scilly to match best levels in Europe		
Failure to reduce health inequalities and raise life expectancy	None at present	None at present
Strategic Objective 12: Deliver new and existing targets set by Care Quality Commission or within the NHS CIOS Operating Plan (the 'Minimum Guarantee')		
NHS CIOS is at risk of failing to meet the national HCAI targets for 2012/13	None at present	None at present
Strategic Objective 13: To establish and implement a programme of work, supported by organisational development and enabling strategies, to successfully lead and deliver the Quality, Innovation, Productivity and Prevention (QIPP) agenda across Cornwall and the Isles of Scilly		
Inability of the PCT to successfully implement processes and achieve organisational competencies which deliver the QIPP programme for the PCT	Insufficient detail provided regarding operational plans to reduce follow-ups Some follow up protocols agreed, with others needing further development **Insufficient levels of assurance at present**	RCHT to develop detailed action plans to provide assurance that existing proposals for reductions will deliver change Develop remaining protocols Further monitoring of progress against this risk by KCCG P&D Group to obtain assurance regarding the efficacy of controls
Failure to deliver the required control total due to inability to deliver QIPP commissioner savings	Insufficient levels of assurance at present	Await finalisation of year-end accounts.
Risk that Secondary Care clinicians do not support a reduction in follow up rates, leading to no change in culture and behaviour	Some risk stratification protocols still under development Insufficient levels of assurance at present	Complete development of risk stratification protocols for all specialties Review RCHT follow up reduction information and agree prioritised implementation list for future action where gaps in control are identified

Strategic Objective 14: Maintain an effective organisation that continues to secure the delivery of high quality healthcare in Cornwall and the Isles of Scilly whilst working with partners to ensure a smooth and effective transition through NHS re-organisation		
Failure to retain adequate capacity/ capable workforce during transition (to 2013/14) will impact on business continuity and delivery of functions	None at present	None at present
If the cost of retrospective CHC reviews is higher than expected then it will place at risk the delivery of the PCT's financial control total for 2012/13, leading to impacts on reputation, performance and compliance	Insufficient capacity to carry out Needs Portrayals The likely cost of retrospective reviews is anticipated to be significantly higher that the DH anticipated. It has been mooted that a dedicated funding pot may be put in place to meet some of the financial risks with this policy implementation	Develop business case to address capacity once number of cases requiring a Needs Portrayal is known. Work closely with the SHA and finance teams to clarify funding options that may be proposed and assess possible impact on KCCG. Ensure Senior Management Team is kept appraised on any developments

The PCT has established a robust control environment to ensure that data/information is managed appropriately and securely. The PCT employs a dedicated Head of Information Governance who completes and implements the annual Information Governance Toolkit self assessment against which the organisation has self-assessed as achieving the required Level 2. Within the PCT the Information Governance sub Committee (IGSC) meets at least bi-monthly and reports to the Integrated Governance Committee. The IGSC considers the information governance risk register (an extract of the overarching risk register) at each meeting. As well as driving the agenda on compliance with the information governance toolkit, information governance incidents are considered by the sub-Committee. Membership of the IGSC is drawn from across the PCT as well as specialist technical staff from Cornwall Information Technology Services (CITS). A trained Caldicott Guardian, the Nurse Executive, supports this work particularly to assure appropriate safeguards for personal information are in place and adhered to. The PCT has allocated responsibility of Senior Information Risk Owner to the Director of Finance.

A serious untoward incident procedure for the reporting of data or information losses is in place and CITS maintains an incident log which captures any issues about the electronic management of information, especially relating to data security and access. Incidents relating to the PCT are reported to the IGSC together with the actions taken to avoid a recurrence.

One lapse of data security was reported in 2012/13 A letter and supporting documentation, outlining a specification of needs for a specific client was sent to 92 care suppliers with the aim of securing specialist care for the client. Inadvertently the specification issued, included the client's NHS number, initials of the client (potentially identifying her from a small cohort) and the husband's full name. Further sensitivity is associated with this incident as the client is currently subject to a complex legal process.

This incident happened in November 2012, and was reported to the SHA but not the ICO, as it was only rated as a Level 2 IG incident.

The risk and control framework

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

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

The PCT updates its Risk Management Strategy annually for ratification by the Board. This was done in December 2012.

The risk register for the PCT is updated on a monthly basis. The register is approved at the Integrated Governance Committee with onward reporting to Board. These arrangements, along with training and awareness for key staff, have embedded risk management as a regular, ongoing activity, owned and embedded within all directorates.

The Cluster Director of Transition and Governance is the designated Director for Risk Management for the PCT, with responsibility for day-to-day management delegated to the Corporate Risk Manager. The Director is also responsible for health, safety, fire and security. Health, safety, risk and fire training are included within the mandatory training programme.

The Cluster Director of Nursing provides the executive lead on clinical governance risks for NHS Cornwall and Isles of Scilly.

The Director of Public Health is the designated director for emergency planning, with responsibility for ensuring that the organisation is compliant with all duties in accordance with emergency preparedness and the Civil Contingencies Act 2004. The Director of Public Health is supported by an Emergency Planning Lead.

Risk management is promoted by the PCT as the responsibility of all staff and a section to this effect is included within staff job descriptions. Staff are positively encouraged to report risk and contribute to the overall risk register.

Risk management issues are discussed by a variety of staff through the Integrated Governance Committee, the Professional Executive Committee, the Information Governance and Health and Safety sub-committees and the Transition Steering Group. A Headquarters Health and Safety locality group meets regularly to discuss local concerns which can then be escalated, through reporting mechanisms, to the Health and Safety sub-committee.

All papers to the Board and committees in the PCT have frontispieces which include the requirement to link the report to relevant strategic objectives and highlight any impacts on areas such as workforce, finance, equality and diversity and environment. Processes are in place to discuss the management of partnership risk, the outcomes of which are discussed through the internal committee structures. The PCT co-ordinates a partnership risk register on behalf of key public sector organisations, which is reported to the Integrated Governance Committee within the PCT. The PCT also meets with key providers on a regular basis to consider the content of the organisations' assurance frameworks and corporate risk registers to jointly identify and manage risks that are common to the organisations involved and those risks held by one organisation that might also impinge on one or more of the other local organisations.

The PCT is compliant with all aspects of the governance arrangements for cluster PCTs.

During 2012/13, the PCT managed and implemented a Transition Programme to deliver the safe and effective transfer of statutory duties to the appropriate receiving organisations and to oversee key transition workstreams in the interim. The overall responsibility of the programme has been to ensure:

- Sufficient capability and capacity within the organisation to deliver statutory responsibilities during the transition process
- Effective communication within the organisation and externally during the transition process
- Effective transfer of functions into the appropriate receiving organisations
- Appropriate receiving organisations are suitably prepared to receive the new statutory functions, including authorisation of the CCG
- Effective closedown of the PCT.

The Transition Programme developed and maintained its own risk register. Below is an example of a risk that appeared on the Transition Risk Register

The Integrated Governance Committee has been the Committee with responsibility for overseeing the transition programme and regular reports on delivery and progress are provided to the Board.

As part of ensuring the overall aims of the transition programme are delivered, as set out above, there will be a focus on ensuring that PCT property and other fixed assets, are effectively monitored and controlled to ensure a smooth transition to successor organisations. This will address recent internal audit recommendations.

The overall transition programme will continue to be subject to internal audit during

2012/13. The last report which was presented to the Audit Committee in January 2013 reported the following:

> "We are satisfied that the PCT has ensured that it has managed the transition process effectively, with the Board kept aware of development and challenges to the process. The project plan and resultant programme management approach developed by the PCT have proved to be sound and have continued to be followed operationally to date. Kernow Clinical Commissioning Group obtained Authorisation in Wave 1 and a number of other areas are ready for transfer to receiver organisations."

Arrangements in place for the discharge of statutory functions and check for legal compliance.

The PCT retained a firm of lawyers to provide advice on the development of strategy, policy and procedures implemented across the organisation. Legal advice was also sought on demand in response to activities of the Trust to ensure compliance with appropriate legislation. Regular review of these governance tools along with the Standing Orders, Scheme of Delegation and Standing Financial Instructions provided a structured approach to ensure compliance.

In addition to the general responsibility held by Executives, a number of lead officers employed by the Trust also had a responsibility for ensuring compliance with legislation. This included the Company Secretary, Head of Information Governance, Health & Safety Officer, Controlled Drugs Accountable Officer and Local Security Management Specialist, all of whom had access either to legal advice and/or their own professional support mechanisms.

Other sources of intelligence that alerted the PCT to legislative change included briefings received in bulletins from the Department of Health, Internal Audit and the Trust's lawyers.

The frontispieces for all board and committee papers included consideration of any legal issues relating to the paper being presented.

The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements were in place and assurance was provided through the Assurance Framework and supporting committees and reporting structures. The Assurance Framework set out the assurances and controls to ensure the PCT maintained a high level focus on national requirements throughout the year.

Overview of the governance framework established for the accounts scrutiny and sign off process.

In line with the Department of Health's letter dated 17th December 2012 (gateway reference 18561) the PCT has set up arrangements to scrutinise and sign off the accounts for 2012/13. This includes the secondment of the Signing officer and Finance signing officer to the Department of Health and the appointment of non executive Directors to the audit committee.

Review of the effectiveness of risk management and internal control

In formulating the assurance framework for 2012/13, the PCT's Board confirmed its strategic objectives and continued to use the framework to ensure that the Board received adequate assurance on the effective operation of controls to manage the risks to the organisation achieving its principal objectives, including:

- Monthly integrated financial, performance and quality monitoring and reporting including in relation to progress against QIPP delivery
- Progress reports on the Transition Programme, including arrangements for public health and the progress of Kernow Clinical Commissioning Group
- An update on progress in delivering the inequalities strategy
- Updates on progress in infection prevention and control
- An update on Communications and Engagement
- An update on the development of a Health and Well-being Strategy.

A web-based integrated database (iRisk) for the risk register and assurance framework is used across the PCT. It is reviewed by managers, and approved by directors, on a monthly basis. The assurance framework is formally reviewed and updated at least bi-monthly. Executive Directors take responsibility for particular strategic objectives and the executive team collectively review the assurance framework as a whole on a monthly basis, through reports to the Finance, Performance and Delivery Committee on the risk and assurance RAG rating of strategic objectives. This enables the executive team to identify areas where further scrutiny or action may be required. In this way, the assurance framework helps to drive the Board agenda.

Management of the assurance framework is overseen by the Integrated Governance Committee at each of its quarterly meetings, and the framework is also scrutinised by the Audit Committee. The whole assurance framework is seen by the Audit Committee twice a year. In addition, the Audit Committee operates a planned timetable of more detailed scrutiny of individual elements of the assurance framework. Executive Directors are invited to the Audit Committee on a rolling programme to discuss their individual sections of the assurance framework. This ensures that every element of the framework is the subject of very detailed scrutiny at least once per year. The Board monitors the assurance framework at least twice a year and receives an update on the principal risks contained within it at each of its monthly reviews of the corporate risk register. All Board and Committee papers include reference to the strategic objective(s) and aspect(s) of the assurance framework to which they pertain, together with an indication as to whether or not the paper provides positive or negative assurance or highlights any gaps.
Assurance Framework arrangements have received a positive internal audit report for 2012/13.

The committee structure continues to provide a structured governance framework for the conduct of business and decision making, with clear reporting lines and accountability. In order to review the effectiveness of the system of internal control, assurances have been received from the work conducted by the external auditors who provide an opinion on the true and fair view of the accounts and value for money achieved and confirms that the accounts are prepared under the principles and in a

format directed by the Secretary of State. The review is also informed by the Head of Internal Audit opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of Internal Audit's work. The arrangements for internal audit comply with those described in the NHS Internal Audit Manual. The Head of Internal Audit's opinion is set out as follows:

Based on the work undertaken in 2012/13, significant assurance can be given that there is a sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently in all areas reviewed.

Cornwall & Isles of Scilly Primary Care Trust

Appendix 1

Board Member attendance

Name	Title	2012														2013					
		April		June		July		Sep		Oct		Nov		Dec		Jan		Feb		Mar	
		BRD	Rem Com	BRD	Rem Com	BRD	Rem Com	BRD	Rem Com	BRD	Rem Com	BRD	Rem Com	BRD	Rem Com	BRD	Rem Com	BRD	Rem Com	BRD	Rem Com
Andrew Williamson	**Chair**	✓		A	✓	✓		✓			✓	✓	✓		✓	✓			✓	✓	✓
Steve Moore	Chief Executive	✓		✓	A	✓		✓			✓	✓	✓		✓	✓			✓	✓	✓
Nick Ball	**Non-Executive Director**	✓		✓	✓	✓		A			✓	✓	✓		A	✓			✓	✓	
Amanda Fisk	Director of Commissioning Development	✓		✓		✓		✓				A				✓				✓	
Jim Gould	**Non-Executive Director**	A		✓	✓	A		A			✓	A	✓		✓	✓			✓	✓	
Tracey Lee	Director of Communications & Governance	✓		✓	✓	✓															
Julieann Carter	Interim Director of Governance and Transition							✓				✓				✓				✓	
Robert Knibbs	Director of Finance	✓		✓		A		✓				✓				✓				✓	
Felicity Owen	Director of Public Health	A		A		A		A				A				✓				✓	
Bridget Sampson	Director of Primary Care and Medicines Management	✓		A		✓		✓				✓				✓				✓	
Tom Sneddon	**Non-Executive Director**	A		✓	A	A		A			A	A	✓		A	A			✓	✓	✓
Julie Stone	**Non-Executive Director**	✓		✓	✓	✓		A			A	✓	✓		A	✓			A	✓	✓
Shelagh McCormick	Medical Director	✓		✓		✓		✓				✓				✓				✓	
Carol Williams	Director of Nursing	✓		A		✓		✓				✓				✓				✓	
Nigel Williams	**Non-Executive Director**	✓		✓	✓	✓		✓			✓	A	✓		✓	✓			✓	✓	✓
Paul Wyatt	**Non-Executive Director**	✓		✓	✓	✓		✓			✓	✓	✓		✓	✓			✓	✓	✓

Key	
✓	In attendance
A	Apologised
BRD	Board Meetings
Rem Com	Remuneration and Terms of Service Committee
(shaded)	Non-Executive Director Not usually an attendee

Accountable Officer: (Name) STEVE MOORE

Organisation: CORNWALL + ISLES OF SCILLY PCT

Signature

Date 23/5/2013

INDEPENDENT AUDITOR'S REPORT TO THE DEPARTMENT OF HEALTH'S ACCOUNTING OFFICER IN RESPECT OF CORNWALL AND ISLES OF SCILLY PCT ON THE PCT SUMMARISATION SCHEDULES

We have examined the summarisation schedules designated PCT01 to PCT23 of Cornwall and Isles of Scilly PCT for the year ended 31 March 2013.

This report is made solely to the Department of Health's accounting officer in respect of Cornwall and Isles of Scilly 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 of 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 accounting officer and the Trust as a body, for our audit work, for this report, or for opinions we have formed.

For the purpose of this report, the agreement of figures between the statutory financial statements and the summarisation schedules extends only to those figures within the audited financial statements which are also published in the summarisation schedules. Auditors are required to report on any differences over £250,000 between the final audited statutory financial statements and the summarisation schedules.

In our opinion the figures reported in the final audited statutory financial statements, on which we have issued an unqualified opinion, agree to the figures reported in the summarisation schedules.

Grant Thornton UK LLP

Hartwell House
55–61 Victoria Street
Bristol
BS1 6FT

Date: 7 June 2013

INDEPENDENT AUDITOR'S REPORT TO THE DEPARTMENT OF HEALTH'S ACCOUNTING OFFICER IN RESPECT OF CORNWALL AND ISLES OF SCILLY PCT

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

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

- the table of salaries and allowances of senior managers [and related narrative notes] on page 22;
- the table of pension benefits of senior managers [and related narrative notes] on page 23; and
- the table of pay multiples [and related narrative notes] on page 21.

This report is made solely to the Department of Health's accounting officer in respect of Cornwall and Isles of Scilly 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 Department of Health's accounting 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 Cornwall and Isles of Scilly PCT as at 31 March 2013 and of its net operating costs for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters

In our opinion:

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

Matters on which we report by exception

We report to you if:

- in our opinion the governance statement does not reflect compliance with the Department of Health's Guidance;
- we refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have 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;

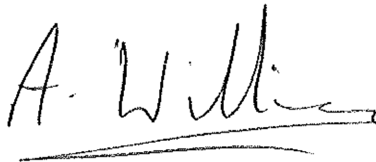
· the work of other relevant regulatory bodies or inspectorates, to the extent the results of the work have an impact on our responsibilities; and

· 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 Cornwall and Isles of Scilly PCT in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.



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

Hartwell House
55-61 Victoria Street
Bristol
BS1 6FT

Date: 7 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	**14,407**	42,656
Other costs	5.1	**976,769**	914,085
Income	4	**(36,292)**	(34,945)
Net operating costs before interest		954,884	921,796
Investment income	9	**(89)**	(94)
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**3,196**	3,430
Net operating costs for the financial year		957,991	925,132
Transfers by absorption -(gains)		**0**	0
Transfers by absorption - losses		**0**	0
Net (gain)/loss on transfers by absorption		**0**	0
Net Operating Costs for the Financial Year including absorption transfers		957,991	**925,132**
Of which:			
Administration Costs			
Gross employee benefits	7.1	**9,768**	11,710
Other costs	5.1	**11,411**	11,828
Income	4	**(768)**	(561)
Net administration costs before interest		**20,411**	**22,977**
Investment income	9	**(89)**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**858**	677
Net administration costs for the financial year		**21,180**	**23,654**
Programme Expenditure			
Gross employee benefits	7.1	**4,639**	30,946
Other costs	5.1	**965,358**	902,257
Income	4	**(35,524)**	(34,384)
Net programme expenditure before interest		**934,473**	**898,819**
Investment income	9	**0**	(94)
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**2,338**	2,753
Net programme expenditure for the financial year		**936,811**	**901,478**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**1,963**	86
Net (gain) on revaluation of property, plant & equipment	**(471)**	(1,597)
Net (gain) on revaluation of intangibles	**0**	0
Net (gain) on revaluation of financial assets	**0**	0
Net (gain)/loss on other reserves	**0**	0
Net (gain)/loss on available for sale financial assets	**0**	0
Net (gain) /loss on Assets Held for Sale	**0**	0
Release of Reserves to Statement of Comprehensive Net Expenditure	**0**	0
Net actuarial (gain)/loss on pension schemes	**0**	0
Reclassification Adjustments		
Reclassification adjustment on disposal of available for sale financial assets	**0**	0
Total comprehensive net expenditure for the year	**959,483**	**923,621**

The notes on pages 5 to 46 form part of this account.

Statement of Financial Position at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	12	**78,180**	83,513
Intangible assets	13	**31**	0
investment property	15	**0**	0
Other financial assets	21	**767**	780
Trade and other receivables	19	**21**	247
Total non-current assets		**78,999**	84,540
Current assets:			
Inventories	18	**5**	5
Trade and other receivables	19	**10,062**	15,897
Other financial assets	36	**0**	0
Other current assets	22	**0**	0
Cash and cash equivalents	23	**1,916**	5
Total current assets		**11,983**	15,907
Non-current assets held for sale	24	**275**	400
Total current assets		**12,258**	16,307
Total assets		**91,257**	100,847
Current liabilities			
Trade and other payables	25	**(49,208)**	(59,479)
Other liabilities	26,28	**0**	0
Provisions	32	**(2,151)**	(989)
Borrowings	27	**(587)**	(532)
Other financial liabilities	28	**0**	0
Total current liabilities		**(51,946)**	(61,000)
Non-current assets plus/less net current assets/liabilities		**39,311**	39,847
Non-current liabilities			
Trade and other payables	25	0	0
Other Liabilities	28	0	0
Provisions	32	(2,921)	(2,959)
Borrowings	27	(31,315)	(31,901)
Other financial liabilities	28	0	0
Total non-current liabilities		**(34,236)**	(34,860)
Total Assets Employed:		**5,075**	4,987
Financed by taxpayers' equity:			
General fund		(11,713)	(13,293)
Revaluation reserve		16,788	18,280
Other reserves		0	0
Total taxpayers' equity:		**5,075**	4,987

The notes on pages 5 to 46 form part of this account.

The financial statements on pages 1 to 46 were approved on behalf of the Department of Health on 5 June 2013 and signed on its behalf by Amanda Fisk, Designated Signing Officer.

Designated Signing Officer:

Date: 5/6/13

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

	General fund	Revaluation reserve	Other reserves	Total reserves
	£000	£000	£000	£000
Balance at 1 April 2012	(13,293)	18,280	0	4,987
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(957,991)	0	0	**(957,991)**
Net gain on revaluation of property, plant, equipment	0	471	0	**471**
Net gain on revaluation of intangible assets	0	0	0	**0**
Net gain on revaluation of financial assets	0	0	0	**0**
Net gain on revaluation of assets held for sale	0	0	0	**0**
Impairments and reversals	0	(1,963)	0	**(1,963)**
Movements in other reserves	0	0	0	**0**
Transfers between reserves	0	0	0	**0**
Release of Reserves to SOCNE	0	0	0	**0**
Reclassification Adjustments	0	0	0	**0**
Transfers between Revaluation Reserve & General Fund in respect of assets transferred under absorption	0	0	0	**0**
Net actuarial gain/(loss) on pensions	0	0	0	**0**
Total recognised income and expense for 2012-13	**(957,991)**	**(1,492)**	**0**	**(959,483)**
Net Parliamentary funding	959,571	0	0	**959,571**
Balance at 31 March 2013	**(11,713)**	**16,788**	**0**	**5,075**

	General fund	Revaluation reserve	Other reserves	Total reserves
Balance at 1 April 2011	**(17,726)**	**16,769**	**0**	**(957)**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(925,132)	0	0	(925,132)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment	0	1,597	0	1,597
Net Gain / (loss) on Revaluation of Intangible Assets	0	0	0	0
Net Gain / (loss) on Revaluation of Financial Assets	0	0	0	0
Net Gain / (loss) on Assets Held for Sale	0	0	0	0
Impairments and Reversals	0	(86)	0	(86)
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of Reserves to Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification Adjustments	0	0	0	0
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0	0
On disposal of available for sale financial assets	0	0	0	0
Net actuarial gain/(loss) on pensions	0	0	0	0
Total recognised income and expense for 2011-12	(925,132)	1,511	0	(923,621)
Net Parliamentary funding	929,565	0	0	929,565
Balance at 31 March 2012	(13,293)	**18,280**	**0**	**4,987**

Statement of cash flows for the year ended 31 March 2013

	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities		
Net Operating Cost Before Interest	**(954,884)**	(921,796)
Depreciation and Amortisation	**5,007**	5,040
Impairments and Reversals	**2,493**	2,287
Other Gains / (Losses) on foreign exchange	**0**	0
Donated Assets received credited to revenue but non-cash	**0**	0
Government Granted Assets received credited to revenue but non-cash	**0**	0
Interest Paid	**(3,069)**	(3,336)
Release of PFI/deferred credit	**0**	0
(Increase)/Decrease in Inventories	**0**	333
(Increase)/Decrease in Trade and Other Receivables	**6,628**	(2,967)
(Increase)/Decrease in Other Current Assets	**0**	0
Increase/(Decrease) in Trade and Other Payables	**(9,689)**	(1,054)
(Increase)/Decrease in Other Current Liabilities	**0**	0
Provisions Utilised	**(540)**	(1,162)
Increase/(Decrease) in Provisions	**1,506**	55
Net Cash Inflow/(Outflow) from Operating Activities	**(952,548)**	**(922,600)**
Cash flows from investing activities		
Interest Received	**89**	106
(Payments) for Property, Plant and Equipment	**(5,096)**	(4,635)
(Payments) for Intangible Assets	**0**	0
(Payments) for Other Financial Assets	**0**	0
(Payments) for Financial Assets (LIFT)	**0**	0
Proceeds of disposal of assets held for sale (PPE)	**400**	0
Proceeds of disposal of assets held for sale (Intangible)	**13**	0
Proceeds from Disposal of Other Financial Assets	**0**	0
Proceeds from the disposal of Financial Assets (LIFT)	**13**	5
Loans Made in Respect of LIFT	**0**	0
Loans Repaid in Respect of LIFT	**0**	0
Rental Revenue	**0**	0
Net Cash Inflow/(Outflow) from Investing Activities	**(4,581)**	**(4,524)**
Net cash inflow/(outflow) before financing	**(957,129)**	**(927,124)**
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**(531)**	(2,447)
Net Parliamentary Funding	**959,571**	929,565
Capital Receipts Surrendered	**0**	0
Capital grants and other capital receipts	**0**	0
Cash Transferred (to)/from Other NHS Bodies	**0**	0
Net Cash Inflow/(Outflow) from Financing Activities	**959,040**	**927,118**
Net increase/(decrease) in cash and cash equivalents	**1,911**	**(6)**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**5**	**11**
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies	**0**	0
Cash and Cash Equivalents (and Bank Overdraft) at year end	**1,916**	**5**

1. Accounting policies

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

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

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

1.1 Accounting Conventions

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

Accounting Implications of the Health and Social Care Act

The Primary Care Trust has considered the changes proposed by the Government in the Health and Social Care Act, in particular the abolition of Primary Care Trusts on 31 March 2013. As PCT services and functions will continue to be provided by other public sector entities after that date, it has been concluded that it is appropriate for the financial statements to continue to be prepared on a 'going concern' basis. In addition, we have considered the implications of the Act and we do not believe that it will have a material impact on the carrying value of any assets and liabilities as the functions of the PCT will be transferred to the various successor bodies.

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.

1.2 Critical accounting judgements and key sources of estimation uncertainty

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

Critical judgements in applying accounting policies

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

In line with IFRS accounting requirements, the PCT has assessed the substance of the contractual relationships underpinning the assets provided to the PCT under Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) agreements. In particular, the arrangements have been assessed against the requirements of IFRIC 12 which applies to such assets, and as a consequence the arrangements have been determined to be finance leases. For both PFI and LIFT, a key factor in this conclusion is the level of residual control the PCT has over the assets at the expiry of the primary lease term. For PFI, this residual control arises from the reversion of the assets to the NHS. For LIFT premises, the existence of the PCT's option to purchase at the end of the primary term is considered to be sufficient control to meet the IFRIC12 tests.

Having reached the conclusion that the arrangements should be treated as finance leases, for the LIFT schemes the PCT has to assess whether we can be reasonably certain that the option to purchase will be exercised, as this determines how the lease is accounted for. Given the time still to elapse until the option decision will be made, and the future external influences that may constrain or determine that decision, the PCT continues to conclude that, at this point, we cannot be reasonably certain that the option to purchase will be exercised. This conclusion of the option position leads us to account for the LIFT leases on the basis of the primary lease term only, not the full life of the building asset.
The nature and values of the PFI and LIFT arrangements are disclosed in Note 34.

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

1. Accounting policies (continued)

No estimates or assumptions about future conditions have been identified that have a realistic risk of adjusting reported carrying values by a material amount within the next financial year. Significant estimates are inherent in a number of operational areas including accruals for patient treatments and drugs towards the end of the accounting period and residual liabilities for costs of care for individuals who will be considered to meet the eligibility criteria for NHS funded continuing healthcare during the current or previous accounting periods. Such estimates are informed by underlying data and trends and therefore are not expected to be significantly mis-stated.

The PCT's property assets have been revalued, by a suitably qualified, independent professional, in line with our accounting policy, at 31 March 2013, in order to reduce the level of estimation inherent in determining their fair values. Where this valuation has yielded movements from existing asset values they have been accounted for in line with IFRS requirements. Any such valuation process still includes inherent estimation and the revised basis of valuation being adopted by the NHS (as set out in Note 1.7) requires modern equivalent assets to be identified in order to assess the asset's value to the PCT. Future asset values will be influenced by economic factors and by the development of healthcare technology however no significant changes from current carrying values can be reasonably foreseen.

1.3 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.

1.4 Pooled budgets

1.4.1 Mental Health Pool Fund

The PCT is party to a mental health pooled budget with Cornwall Council and Cornwall Partnership NHS Foundation Trust, which was originally entered into on 1 October 2003. Under this arrangement funds are pooled under S75 of the Health Act 2006 for the provision of adult mental health services in Cornwall and the Isles of Scilly.

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

1.4.2 Loan Equipment Pooled Fund

The PCT is party to a loan equipment pooled budget with Cornwall Council, which was originally entered into on 1st April 2005. Under this arrangement funds are pooled under S75 of the Health Act 2006 for the provision of an integrated community loan equipment service in Cornwall and the Isles of Scilly.

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

1.5 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.

1.6 Administration and Programme Costs

Treasury has set performance targets in respect of non-frontline expenditure (administration expenditure).
From 2011-12, PCTs therefore analyse and report revenue income and expenditure by "admin and programme"
For PCTs, the Department has defined "admin and programme" in terms of running costs.
The broad definition of running costs includes any cost incurred that is not a direct payment for the provision of healthcare or healthcare related services.
Expense incurred under NHS transition redundancy programmes is however classed as "programme" under Treasury budgetary control arrrangements and so is recorded as such in the financial statements.

1. Accounting policies (continued)

1.7 Property, Plant & Equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation

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

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

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

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

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

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The carrying value of non-IM&T assets after that date is estimated by uplifting costs annually by the GDP deflator and then depreciating the uplifted cost over the remaining useful life. For IM&T assets, no uplift is applied, as this better reflects the fair value of the class of asset. The IM&T assets are depreciated over the remaining useful lives.

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

Subsequent expenditure

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

1. Accounting policies (continued)

1.8 Intangible Assets

Recognition

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

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

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

Measurement

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

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

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

1. Accounting policies (continued)

1.10 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.

1.11 Government grants

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

The PCT received no government grants during the financial year 2012/13 (2011/12 : £nil)

1.12 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.

1.13 Inventories

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

1.14 Cash and cash equivalents

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

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

1.15 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).

1.16 Clinical Negligence Costs

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

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

1. Accounting policies (continued)

1.17 Employee benefits

Short-term employee benefits

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

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

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

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

1.18 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Statement of Comprehensive Net Expenditure on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

The Primary Care Trust has not incurred any research and development expenditure in 2012/13 (2011/12: nil)

1.19 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.

1.20 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.

1.21 EU Emissions Trading Scheme

The Primary Care Trust is below the threshold for participation in the EU Emissions Trading Scheme.

1. Accounting policies (continued)

1.22 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.

1.23 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.

1.24 Foreign exchange

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

1.25 Provisions

Provisions are recognised when the PCT has a present legal or constructive obligation as a result of a past event, it is probable that the PCT will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates (2.35% in respect of early staff departures) in real terms.

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

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

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

1. Accounting policies (continued)

1.26 Financial Instruments

Financial assets

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

Financial assets are initially recognised at fair value.

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

Financial assets at fair value through profit and loss

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

Held to maturity investments

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

Available for sale financial assets

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

Loans and receivables

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

Fair value is determined by reference to quoted market prices where possible. Alternative valuation techniques are disclosed where significant to the financial statements.

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

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

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

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

1. Accounting policies (continued)

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

Financial liabilities are initially recognised at fair value.

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

Financial liabilities at fair value through profit and loss

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

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

1.27 Private Finance Initiative (PFI) and NHS LIFT transactions

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

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

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

b) PFI and LIFT assets, liabilities, and finance costs
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.

LIFT assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at the present value of the minimum lease payments 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.

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

1. Accounting policies (continued)

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

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

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

c) Lifecycle replacement
Significant 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.

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

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

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

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

1. Accounting policies (continued)

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

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

IAS 27 Separate Financial Statements - subject to consultation
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IFRS 9 Financial Instruments - subject to consultation - subject to consultation
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IPSAS 32 - Service Concession Arrangement - subject to consultation
IAS 19 (Revised 2011) Employee Benefits
IAS 32 Financial Instruments: Presentation
IFRS 7 Financial Instruments: Disclosures

2 Operating segments

Following the transfer of Community services on 1st October 2011 the PCT now considers that it only has a single operating segment.

	Commissioning		**Provider**		**Total**	
	2012-13	2011-12	**2012-13**	2011-12	**2012-13**	2011-12
	£000	£000	**£000**	£000	**£000**	£000
Net expenditure before interest	954,884	883,782	0	38,014	954,884	921,796
Surplus/(deficit) before interest	8,822	8,570	0	0	8,822	8,570

3. Financial Performance Targets

3.1 Revenue Resource Limit

	2012-13 £000	2011-12 £000
The PCTs' performance for the year ended 2012-13 is as follows:		
Total Net Operating Cost for the Financial Year		925,132
Net operating cost plus (gain)/loss on transfers by absorption	**957,991**	
Adjusted for prior period adjustments in respect of errors	**0**	0
Revenue Resource Limit	**966,813**	933,702
Under/(Over)spend Against Revenue Resource Limit (RRL)	**8,822**	8,570

3.2 Capital Resource Limit

The PCT is required to keep within its Capital Resource Limit.

	2012-13 £000	2011-12 £000
Capital Resource Limit	**3,691**	4,053
Charge to Capital Resource Limit	**3,547**	4,051
(Over)/Underspend Against CRL	**144**	**2**

3.3 Provider full cost recovery duty

The PCT is required to recover full costs in relation to its provider functions.

	2012-13 £000	2011-12 £000
Provider gross operating costs	**0**	42,150
Provider Operating Revenue	**0**	(4,136)
Net Provider Operating Costs	**0**	38,014
Costs Met Within PCTs Own Allocation	**0**	(38,014)
Under/(Over) Recovery of Costs	**0**	0

3.4 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**959,571**	929,565
Cash Limit	**961,071**	929,565
Under/(Over)spend Against Cash Limit	**1,500**	**0**

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

	2012-13 £000
Total cash received from DH (Gross)	861,603
Less: Trade Income from DH	0
Less/(Plus): movement in DH working balances	0
Sub total: net advances	**861,603**
(Less)/plus: transfers (to)/from other resource account bodies (free text note required)	0
Plus: cost of Dentistry Schemes (central charge to cash limits)	18,177
Plus: drugs reimbursement (central charge to cash limits)	79,791
Parliamentary funding credited to General Fund	**959,571**

4 Miscellaneous Revenue

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Fees and Charges	**0**	0	0	40
Dental Charge income from Contractor-Led GDS & PDS	**6,969**	0	6,969	6,774
Dental Charge income from Trust-Led GDS & PDS	**0**	0	0	147
Prescription Charge income	**5,267**	0	5,267	4,848
Strategic Health Authorities	**31**	31	0	957
NHS Trusts	**69**	6	63	1,859
NHS Foundation Trusts	**27**	0	27	253
Primary Care Trusts Contributions to DATs	**0**	0	0	0
Primary Care Trusts - Other	**53**	0	53	601
Primary Care Trusts - Lead Commissioning	**0**	0	0	0
English RAB Special Health Authorities	**0**	0	0	0
NDPBs and Others (CGA)	**0**	0	0	21
Department of Health - SMPTB	**0**	0	0	0
Department of Health - Other	**0**	0	0	0
Recoveries in respect of employee benefits	**0**	0	0	0
Local Authorities	**7,653**	0	7,653	8,062
Patient Transport Services	**0**	0	0	6
Education, Training and Research	**4,121**	0	4,121	3,916
Non-NHS: Private Patients	**0**	0	0	0
Non-NHS: Overseas Patients (Non-Reciprocal)	**0**	0	0	0
NHS Injury Costs Recovery	**25**	0	25	362
Other Non-NHS Patient Care Services	**0**	0	0	0
Charitable and Other Contributions to Expenditure	**0**	0	0	0
Receipt of donated assets	**0**	0	0	130
Receipt of Government granted assets	**0**	0	0	0
Rental revenue from finance leases	**0**	0	0	0
Rental revenue from operating leases	**9,481**	0	9,481	6,160
Other revenue	**2,596**	731	1,865	809
Total miscellaneous revenue	**36,292**	**768**	**35,524**	**34,945**

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	**69,115**	0	69,115	51,360
Non-Healthcare	**0**	0	0	451
Total	**69,115**	**0**	**69,115**	**51,811**
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	**339,593**	1,927	337,666	342,382
Goods and services (other, excl Trusts, FT and PCT))	**126**	22	104	100
Total	**339,719**	**1,949**	**337,770**	**342,482**
Goods and Services from Foundation Trusts	**105,024**	214	104,810	105,328
Purchase of Healthcare from Non-NHS bodies	**193,071**	0	193,071	139,520
Social Care from Independent Providers	**1,138**	0	1,138	885
Expenditure on Drugs Action Teams	**4,591**	0	4,591	4,498
Non-GMS Services from GPs	**4,562**	1,357	3,205	4,731
Contractor Led GDS & PDS (excluding employee benefits)	**24,699**	0	24,699	25,175
Salaried Trust-Led PDS & PCT DS (excluding employee benefits)	**0**	0	0	1,195
Chair, Non-executive Directors & PEC remuneration	**112**	112	0	98
Executive committee members costs	**47**	47	0	55
Consultancy Services	**623**	593	30	290
Prescribing Costs	**85,017**	0	85,017	88,280
G/PMS, APMS and PCTMS (excluding employee benefits)	**81,527**	0	81,527	81,327
Pharmaceutical Services	**7,809**	0	7,809	7,877
Local Pharmaceutical Services Pilots	**0**	0	0	0
New Pharmacy Contract	**19,339**	0	19,339	18,718
General Ophthalmic Services	**5,007**	0	5,007	5,309
Supplies and Services - Clinical	**127**	15	112	3,702
Supplies and Services - General	**209**	77	132	1,343
Establishment	**4,863**	2,614	2,249	4,992
Transport	**61**	37	24	314
Premises	**6,603**	2,981	3,622	5,580
Impairments & Reversals of Property, plant and equipment	**2,493**	0	2,493	2,287
Impairments and Reversals of non-current assets held for sale	**0**	0	0	0
Depreciation	**5,007**	702	4,305	5,027
Amortisation	**0**	0	0	13
Impairment & Reversals Intangible non-current assets	**0**	0	0	0
Impairment and Reversals of Financial Assets	**0**	0	0	0
Impairment of Receivables	**122**	(123)	245	(5)
Inventory write offs	**0**	0	0	0
Research and Development Expenditure	**0**	0	0	0
Audit Fees	**147**	147	0	225
Other Auditors Remuneration	**26**	26	0	37
Clinical Negligence Costs	**267**	0	267	153
Education and Training	**143**	124	19	135
Grants for capital purposes	**2,932**	0	2,932	750
Grants for revenue purposes	**9,107**	0	9,107	9,723
Impairments and reversals for investment properties	**0**	0	0	0
Other	**3,262**	539	2,723	2,230
Total Operating costs charged to Statement of Comprehensive Net Expenditure	**976,769**	**11,411**	**965,358**	**914,085**
Employee Benefits (excluding capitalised costs)				
Employee Benefits associated with PCTMS	**0**	0	0	0
Trust led PDS and PCT DS	**0**	0	0	1,811
PCT Officer Board Members	**1,256**	1,256	0	999
Other Employee Benefits	**13,151**	8,512	4,639	39,846
Total Employee Benefits charged to SOCNE	**14,407**	**9,768**	**4,639**	**42,656**
Total Operating Costs	**991,176**	**21,179**	**969,997**	**956,741**
Analysis of grants reported in total operating costs				
For capital purposes				
Grants to fund Capital Projects - GMS	**122**	0	122	0
Grants to Local Authorities to Fund Capital Projects	**1,865**	0	1,865	750
Grants to Private Sector to Fund Capital Projects	**945**	0	945	0
Grants to Fund Capital Projects - Dental	**0**	0	0	0
Grants to Fund Capital Projects - Other	**0**	0	0	0
Total Capital Grants	**2,932**	**0**	**2,932**	**750**
Grants to fund revenue expenditure				
To Local Authorities	**9,107**	0	9,107	9,723
To Private Sector	**0**	0	0	0
To Other	**0**	0	0	0
Total Revenue Grants	**9,107**	**0**	**9,107**	**9,723**
Total Grants	**12,039**	**0**	**12,039**	**10,473**

5.1 (continued)

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**21,180**	19,454	1,726
Weighted population (number in units)*	**553,090**	553,090	553,090
Running costs per head of population (£ per head)	**38**	**35**	**3**
PCT Running Costs 2011-12			
Running costs (£000s)	**23,654**	21,960	1,694
Weighted population (number in units)	**553,090**	553,090	553,090
Running costs per head of population (£ per head)	**43**	**40**	**3**

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

5.2 Analysis of operating expenditure by expenditure classification

	2012-13 £000	2011-12 £000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	81,527	81,327
Prescribing costs	85,017	88,280
Contractor led GDS & PDS	24,699	25,175
Trust led GDS & PDS	0	3,006
General Ophthalmic Services	5,007	5,309
Department of Health Initiative Funding	0	0
Pharmaceutical services	7,809	7,877
Local Pharmaceutical Services Pilots	0	0
New Pharmacy Contract	19,339	18,718
Non-GMS Services from GPs	3,005	2,875
Other	0	0
Total Primary Healthcare purchased	**226,403**	232,567
Purchase of Secondary Healthcare		
Learning Difficulties	33,322	33,191
Mental Illness	75,542	72,586
Maternity	14,532	14,652
General and Acute	444,639	420,088
Accident and emergency	10,948	10,936
Community Health Services	46,020	43,662
Other Contractual	65,812	55,446
Total Secondary Healthcare Purchased	**690,815**	650,561
Grant Funding		
Grants for capital purposes	2,932	750
Grants for revenue purposes	9,107	9,723
Total Healthcare Purchased by PCT	**929,257**	**893,601**
PCT self-provided secondary healthcare included above	0	38,014
Social Care from Independent Providers	1,138	885
Healthcare from NHS FTs included above	85,625	82,226

6. Operating Leases

6.1 PCT as lessee

The PCT's operating lease commitments relate to a range of clinical and administrative premises.

The most significant lease commitment is in respect of a community hospital where another NHS body is the head lessee under a PFI arrangement. The PCT acts as intermediary landlord and recovers costs by charging the community services provider under sub-leasing arrangements that mirror the length of the community services contract.

	Land	Buildings	Other	2012-13 Total	2011-12
	£000	£000	£000	£000	£000
Payments recognised as an expense					
Minimum lease payments				**392**	715
Contingent rents				**0**	0
Sub-lease payments				**1,453**	1,387
Total				**1,845**	**2,102**
Payable:					
No later than one year	**0**	**1,792**	**14**	**1,806**	1,711
Between one and five years	**0**	**6,014**	**1**	**6,015**	6,353
After five years	**0**	**16,257**	**0**	**16,257**	16,928
Total	**0**	**24,063**	**15**	**24,078**	**24,992**
Total future sublease payments expected to be received				4,982	5,042

6.2 PCT as lessor

As a result of Transforming Community Services the PCT has retained all its fixed assets whilst at the same time divesting itself of service delivery. The majority of these assets are used in the delivery of healthcare services and are now leased to the service providers. This has accounted for the significant increase in the current year.

The PCT also subleases part of its LIFT premises and certain other premises to GP surgeries.

	2012-13	2011-12
	£000	£000
Recognised as income		
Rental Revenue	**9,481**	6,160
Contingent rents	**0**	0
Total	**9481**	6,160
Receivable:		
No later than one year	**8,932**	9,580
Between one and five years	**15,427**	25,196
After five years	**53**	54
Total	**24,412**	34,830

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	**11,207**	8,216	2,991	**10,542**	7,583	2,959	**665**	633	32
Social security costs	**930**	627	303	**930**	627	303	**0**	0	0
Employer Contributions to NHS BSA - Pensions Division	**1,374**	925	449	**1,374**	925	449	**0**	0	0
Other pension costs	**0**	0	0	**0**	0	0	**0**	0	0
Other post-employment benefits	**0**	0	0	**0**	0	0	**0**	0	0
Other employment benefits	**0**	0	0	**0**	0	0	**0**	0	0
Termination benefits	**896**	0	896	**896**	0	896	**0**	0	0
Total employee benefits	**14,407**	**9,768**	**4,639**	**13,742**	**9,135**	**4,607**	**665**	**633**	**32**
Less recoveries in respect of employee benefits	**0**	0	0	**0**	**0**	**0**	**0**	**0**	**0**
Total - Net Employee Benefits including capitalised costs	**14,407**	**9,768**	**4,639**	**13,742**	**9,135**	**4,607**	**665**	**633**	**32**
Employee costs capitalised	**0**	0	0	**0**	0	0	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**14,407**	**9,768**	**4,639**	**13,742**	**9,135**	**4,607**	**665**	**633**	**32**
Recognised as:									
Commissioning employee benefits	**14,407**			**13,742**			**665**		
Provider employee benefits	**0**			**0**			**0**		
Gross Employee Benefits excluding capitalised costs	**14,407**			**13,742**			**665**		

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

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	**35,709**	34,550	1,159
Social security costs	**2,442**	2,389	53
Employer Contributions to NHS BSA - Pensions Division	**4,505**	4,505	0
Other pension costs	**0**	0	0
Other post-employment benefits	**0**	0	0
Other employment benefits	**0**	0	0
Termination benefits	**0**	0	0
Total gross employee benefits	**42,656**	**41,444**	**1,212**
Less recoveries in respect of employee benefits	**0**	0	0
Total - Net Employee Benefits including capitalised costs	**42,656**	**41,444**	**1,212**
Employee costs capitalised	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**42,656**	**41,444**	**1,212**
Recognised as:			
Commissioning employee benefits	**13,465**		
Provider employee benefits	**29,191**		
Gross Employee Benefits excluding capitalised costs	**42,656**		

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	**7**	7	0	**27**	27	0
Ambulance staff	**0**	0	0	**1**	1	0
Administration and estates	**254**	246	8	**401**	394	7
Healthcare assistants and other support staff	**0**	0	0	**284**	272	12
Nursing, midwifery and health visiting staff	**24**	24	0	**450**	434	16
Nursing, midwifery and health visiting learners	**0**	0	0	**0**	0	0
Scientific, therapeutic and technical staff	**8**	8	0	**11**	11	0
Social Care Staff	**0**	0	0	**0**	0	0
Other	**15**	15	0	**21**	21	0
TOTAL	**308**	**300**	**8**	**1,195**	**1,160**	**35**
Of the above - staff engaged on capital projects	**0**	0	0	**0**	0	0

7.3 Ill health retirements

	2012-13 Number	2011-12 Number
Number of persons retired early on ill health grounds	**2**	10
	£000s	£000s
Total additional pensions liabilities accrued in the year	**51**	630

7.4 Exit Packages agreed during 2012-13

Exit package cost band (including any special payment element)	2012-13 *Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band	2011-12 *Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band
	Number	Number	Number	Number	Number	Number
Lees than £10,000	0	0	0	0	0	0
£10,001-£25,000	2	0	2	0	0	0
£25,001-£50,000	1	0	1	0	0	0
£50,001-£100,000	3	0	3	0	0	0
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	2	0	2	0	0	0
>£200,000	1	0	1	0	0	0
Total number of exit packages by type (total cost)	9	0	9	0	0	0
	£s	£s	£s	£s	£s	£s
Total resource cost	896,498	0	896,498	0	0	0

This note provides an analysis of Exit Packages agreed during the year. Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. 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 an formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

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

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

b) Full actuarial (funding) valuation

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

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

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

The next formal valuation to be used for funding purposes will be carried out 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	**25,296**	**255,962**	35,018	196,994
Total Non-NHS Trade Invoices Paid Within Target	**23,275**	**247,427**	32,998	185,438
Percentage of NHS Trade Invoices Paid Within Target	92.01%	96.67%	94.23%	94.13%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**4,197**	**520,660**	4,093	514,057
Total NHS Trade Invoices Paid Within Target	**3,814**	**518,285**	3,636	508,679
Percentage of NHS Trade Invoices Paid Within Target	90.87%	99.54%	88.83%	98.95%

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

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

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

9. Investment Income

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Rental Income				
PFI finance lease revenue (planned)	0	0	0	0
PFI finance lease revenue (contingent)	0	0	0	0
Other finance lease revenue	0	0	0	0
Subtotal	0	0	0	0
Interest Income				
LIFT: equity dividends receivable	0	0	0	0
LIFT: loan interest receivable	89	89	0	94
Bank interest	0	0	0	0
Other loans and receivables	0	0	0	0
Impaired financial assets	0	0	0	0
Other financial assets	0	0	0	0
Subtotal	89	89	0	94
Total investment income	89	89	0	94

10. Other Gains and Losses

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Gain/(Loss) on disposal of assets other than by sale (PPE)	0	0	0	0
Gain/(Loss) on disposal of assets other than by sale (intangibles)	0	0	0	0
Gain/(Loss) on disposal of Financial Assets - other than held for sale	0	0	0	0
Gain (Loss) on disposal of assets held for sale	0	0	0	0
Gain/(loss) on foreign exchange	0	0	0	0
Change in fair value of financial assets carried at fair value through the SoCNE	0	0	0	0
Change in fair value of financial liabilities carried at fair value through the SoCNE	0	0	0	0
Change in fair value of investment property	0	0	0	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	0	0	0	0
Total	0	0	0	0

11. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest				
Interest on obligations under finance leases	0	0	0	0
Interest on obligations under PFI contracts:				
- main finance cost	629	0	629	641
- contingent finance cost	217	0	217	193
Interest on obligations under LIFT contracts:				
- main finance cost	2,036	858	1,178	2,070
- contingent finance cost	240	0	240	145
Interest on late payment of commercial debt	0	0	0	0
Other interest expense	0	0	0	291
Total interest expense	3,122	858	2,264	3,340
Other finance costs	0	0	0	0
Provisions - unwinding of discount	74	0	74	90
Total	3,196	858	2,338	3,430

12.1 Property, plant and equipment

2012-13	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:									
At 1 April 2012	**10,779**	**64,501**	**0**	**1,703**	**5,173**	**36**	**11,159**	**646**	**93,997**
Additions of Assets Under Construction	0	0	0	3,816	0	0	0	0	**3,816**
Additions Purchased	0	136	0	0	161	0	401	0	**698**
Additions Donated	0	0	0	0	0	0	0	0	**0**
Additions Government Granted	0	0	0	0	0	0	0	0	**0**
Additions Leased	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	4,079	0	(4,101)	40	0	(26)	8	**0**
Reclassifications as Held for Sale	(170)	(105)	0	0	0	0	(580)	0	**(855)**
Disposals other than for sale	0	0	0	0	0	0	(228)	0	**(228)**
Upward revaluation/positive indexation	0	444	0	0	21	0	0	6	**471**
Impairments/negative indexation	0	(1,963)	0	0	0	0	0	0	**(1,963)**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	**0**
At 31 March 2013	**10,609**	**67,092**	**0**	**1,418**	**5,395**	**36**	**10,726**	**660**	**95,936**
Depreciation									
At 1 April 2012	**0**	**0**	**0**	**0**	**3,151**	**36**	**7,147**	**150**	**10,484**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassifications as Held for Sale	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	0	0	(228)	0	**(228)**
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	**0**
Impairments	0	1,729	0	0	291	0	473	0	**2,493**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Charged During the Year	0	3,096	0	0	325	0	1,526	60	**5,007**
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	**0**
At 31 March 2013	**0**	**4,825**	**0**	**0**	**3,767**	**36**	**8,918**	**210**	**17,756**
Net Book Value at 31 March 2013	**10,609**	**62,267**	**0**	**1,418**	**1,628**	**0**	**1,808**	**450**	**78,180**
Purchased	10,049	61,622	0	1,418	1,568	0	1,808	450	**76,915**
Donated	560	645	0	0	60	0	0	0	**1,265**
Government Granted	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2013	**10,609**	**62,267**	**0**	**1,418**	**1,628**	**0**	**1,808**	**450**	**78,180**
Asset financing:									
Owned	10,609	32,236	0	1,418	1,628	0	1,808	450	**48,149**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	30,031	0	0	0	0	0	0	**30,031**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2013	**10,609**	**62,267**	**0**	**1,418**	**1,628**	**0**	**1,808**	**450**	**78,180**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	**6,186**	**11,794**	**0**	**0**	**287**	**0**	**0**	**13**	**18,280**
Movements	(66)	(1,541)	0	0	21	0	0	6	(1,580)
At 31 March 2013	**6,120**	**10,253**	**0**	**0**	**308**	**0**	**0**	**19**	**16,700**

Additions to Assets Under Construction in 2012-13

	£000
Land	0
Buildings excl Dwellings	3,751
Dwellings	0
Plant & Machinery	65
Balance as at 31 March 2013	**3,816**

12.2 Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	**£000**
Cost or valuation:									
At 1 April 2011	**11,179**	**64,836**	**0**	**1,537**	**5,119**	**36**	**10,089**	**633**	**93,429**
Additions - purchased	0	0	0	3,183	0	0	886	0	**4,069**
Additions - donated	0	0	0	130	0	0	0	0	**130**
Additions - government granted	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	1,575	0	(1,759)	0	0	184	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	0	0	0	**0**
Revaluation & indexation gains	0	1,530	0	0	54	0	0	13	**1,597**
Impairments	0	(86)	0	0	0	0	0	0	**(86)**
Reversals of impairments	0	0	0	0	0	0	0	0	**0**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluation	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**11,179**	**67,855**	**0**	**3,091**	**5,173**	**36**	**11,159**	**646**	**99,139**
Depreciation									
At 1 April 2011	**0**	**0**	**0**	**0**	**2,786**	**36**	**5,398**	**92**	**8,312**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassifications as Held for Sale	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	0	0	0	0	**0**
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	**0**
Impairments	400	1,182	0	1,388	0	0	0	0	**2,970**
Reversal of Impairments	0	(683)	0	0	0	0	0	0	**(683)**
Charged During the Year	0	2,855	0	0	365	0	1,749	58	**5,027**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluation	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**400**	**3,354**	**0**	**1,388**	**3,151**	**36**	**7,147**	**150**	**15,626**
Net Book Value at 31 March 2012	**10,779**	**64,501**	**0**	**1,703**	**2,022**	**0**	**4,012**	**496**	**83,513**
Purchased	10,219	63,614	0	1,703	1,953	0	4,012	496	**81,997**
Donated	560	887	0	0	69	0	0	0	**1,516**
Government Granted	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**10,779**	**64,501**	**0**	**1,703**	**2,022**	**0**	**4,012**	**496**	**83,513**
Asset financing:									
Owned	10,779	32,474	0	1,703	2,022	0	4,012	496	**51,486**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	32,027	0	0	0	0	0	0	**32,027**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**10,779**	**64,501**	**0**	**1,703**	**2,022**	**0**	**4,012**	**496**	**83,513**

12.3 Property, plant and equipment

The whole of the PCT's land and buildings were revalued on 31 March 2013. The valuation was carried out by an independent valuer from the District Valuation Office. The impact of the valuation resulted in a net decrease in asset value of £3,247,866

The PCTs LIFT schemes have been valued on the same basis as in prior years. This valuation reflects the economic value of the asset during the primary lease period.

The standard asset lives for each class of asset are as follows:

Property, Plant and Equipment

- Buildings	4 - 49	years
- Plant and Machinery	5 -15	years
- Information Technology	4	years
- Furniture and Fittings	5 - 10	years

Buildings are treated on a component basis and depreciated over the remaining useful life of the component. The component values are provided as part of the formal valuation undertaken by the District Valuation Office.

LIFT assets are included under Buildings and are depreciated over the remaining term of the lease period.

The value of assets lying idle as at 31 March 2013 is £1,000,000 (2012: £1,400,000). This relates to a decommissioned hospital site.

The carrying value of materially significant Assets under Construction are reviewed at the year end in line with the requirements of IAS 16. This review has resulted no impairments being recognised in year. When schemes of material size are completed the PCT will obtain a formal valuation when the asset is operational and revise the carrying value of the asset accordingly. All other assets will be revalued as part of the end of year formal valuation.

The Primary Care Trust has received no compensation from third parties for any impairments or losses of assets during the year.

13.1 Intangible non-current assets

2012-13	Software internally generated £000	Software purchased £000	Licences & trademarks £000	Patents £000	Development expenditure £000	Total £000
At 1 April 2012	0	0	0	0	0	0
Additions - purchased	0	0	31	0	0	31
Additions - internally generated	0	0	0	0	0	0
Additions - donated	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0
Additions Leased	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Revaluation & indexation gains	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
In-year transfers to/from NHS bodies	0	0	0	0	0	0
At 31 March 2013	0	0	31	0	0	31
Amortisation						
At 1 April 2012	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Revaluation or indexation gains	0	0	0	0	0	0
Impairments charged to operating expenses	0	0	0	0	0	0
Reversal of impairments charged to operating expenses	0	0	0	0	0	0
Charged during the year	0	0	0	0	0	0
In-year transfers to NHS bodies	0	0	0	0	0	0
At 31 March 2013	0	0	0	0	0	0
Net Book Value at 31 March 2013	0	0	31	0	0	31
Net Book Value at 31 March 2013 comprises						
Purchased	0	0	31	0	0	31
Donated	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0
Total at 31 March 2013	0	0	31	0	0	31

Revaluation reserve balance for intangible non-current assets

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

13.2 Intangible non-current assets

2011-12	Software internally generated £000	Software purchased £000	Licences & trademarks £000	Patents £000	Development expenditure £000	Total £000
At 1 April 2011	**0**	**0**	**473**	**0**	**0**	**473**
Additions - purchased	0	0	0	0	0	**0**
Additions - internally generated	0	0	0	0	0	**0**
Additions - donated	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	(473)	0	0	**(473)**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation & indexation gains	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	**0**
In-year transfers to/from NHS bodies	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluation	0	0	0	0	0	**0**
At 31 March 2012	**0**	**0**	**0**	**0**	**0**	**0**
Amortisation						
At 1 April 2011	**0**	**0**	**447**	**0**	**0**	**447**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	(460)	0	0	**(460)**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation or indexation gains	0	0	0	0	0	**0**
Impairments charged to operating expenses	0	0	0	0	0	**0**
Reversal of impairments charged to operating expenses	0	0	0	0	0	**0**
Charged during the year	0	0	13	0	0	**13**
In-year transfers to NHS bodies	0	0	0	0	0	**0**
Less cumulative dep written down on revaluation	0	0	0	0	0	**0**
At 31 March 2012	**0**	**0**	**0**	**0**	**0**	**0**
Net Book Value at 31 March 2012	**0**	**0**	**0**	**0**	**0**	**0**
Net Book Value at 31 March 2012 comprises						
Purchased	0	0	0	0	0	**0**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	**0**
Total at 31 March 2012	**0**	**0**	**0**	**0**	**0**	**0**

13.3 Intangible non-current assets

The PCT capitalises software licences as intangible non-current assets where they have a useful life of more than one year and only where they are functionally interdependent from the hardware on which they are operated.

Licences are valued at historical cost and amortised over the lesser of the duration of the licence or four years.

There are no internally generated intangible non-current assets included in the accounts.

13.4 Revaluation reserve balance for intangible non-current assets

At 31 March 2013, the PCT had no revaluation reserve balance for intangible non-current assets (31 March 2012 : nil).

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

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000
Property, Plant and Equipment impairments and reversals taken to SoCNE			
Loss or damage resulting from normal operations	0	0	0
Over-specification of assets	0	0	0
Abandonment of assets in the course of construction	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen obsolescence	0	0	0
Loss as a result of catastrophe	0	0	0
Other	764	0	764
Changes in market price	1,729	0	1,729
Total charged to Annually Managed Expenditure	**2,493**	**0**	**2,493**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Loss or damage resulting from normal operations	0		
Over Specification of Assets	0		
Abandonment of assets in the course of construction	0		
Unforeseen obsolescence	0		
Loss as a result of catastrophe	0		
Other	0		
Changes in market price	1,963		
Total impairments for PPE charged to reserves	**1,963**		
Total Impairments of Property, Plant and Equipment	**4,456**	**0**	**2,493**
Total Impairments charged to Revaluation Reserve	1,963		
Total Impairments charged to SoCNE - DEL	0	0	0
Total Impairments charged to SoCNE - AME	2,493	0	2,493
Overall Total Impairments	**4,456**	**0**	**2,493**
Of which:			
Impairment on revaluation to "modern equivalent asset" basis	**1,729**	0	1,729

The impairment losses have arisen in largely as a result of the annual valuation of land and buildings carried out by the Valuation Office

The other impairment losses arise from the revaluation of equipment to net realisable value prior to disposal

15 Investment property

	31 March 2013 £000	31 March 2012 £000
At fair value		
Balance at 1 April 2012	0	0
Additions Through Subsequent Expenditure	0	0
Other Acquisitions	0	0
Disposals	0	0
Property Reclassified as Held for Sale	0	0
Loss from Fair Value Adjustments - Impairments	0	0
Gain from Fair Value Adjustments - Reversal of Impairments	0	0
Gain from Fair Value Adjustments	0	0
Transfers (to)/from Other Public Sector Bodies	0	0
Other Changes	0	0
Balance at 31 March 2013	0	0
Investment property capital transactions in 2012-13		
Capital expenditure	0	0
Capital income	0	0
	0	0

16 Commitments

16.1 Capital commitments

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

	31 March 2013 £000	31 March 2012 £000
Property, plant and equipment	158	1,889
Intangible assets	0	0
Total	158	1,889

16.2 Other financial commitments

The Primary Care Trust has not entered into any non-cancellable contracts (other than leases, LIFT and PFI contracts as disclosed in separate notes) which are material to the financial statements

	31 March 2013 £000	31 March 2012 £000
Not later than one year	0	0
Later than one year and not later than five year	0	0
Later than five years	0	0
Total	0	0

17 Intra-Government and other balances

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with other Central Government Bodies	489	0	794	0
Balances with Local Authorities	918	0	1,759	0
Balances with NHS Trusts and Foundation Trusts	41	0	7,401	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	8,614	21	39,254	0
At 31 March 2013	10,062	21	49,208	0
prior period:				
Balances with other Central Government Bodies	173	0	1,486	0
Balances with Local Authorities	894	0	5,200	0
Balances with NHS Trusts and Foundation Trusts	3,439	0	5,609	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	11,391	247	47,184	0
At 31 March 2012	15,897	247	59,479	0

18 Inventories

	Drugs £000	Consumables £000	Energy £000	Work in progress £000	Loan Equipment £000	Other £000	Total £000	Of which held at NRV £000
Balance at 1 April 2012	0	5	0	0	0	0	5	0
Additions	0	0	0	0	0	0	0	0
Inventories recognised as an expense in the period	0	0	0	0	0	0	0	0
Write-down of inventories (including losses)	0	0	0	0	0	0	0	0
Reversal of write-down previously taken to SoCNE	0	0	0	0	0	0	0	0
Transfers (to)/from other public sector bodies	0	0	0	0	0	0	0	0
Balance at 31 March 2013	0	5	0	0	0	0	5	0

19.1 Trade and other receivables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
NHS receivables - revenue	271	3,612	0	0
NHS receivables - capital	0	0	0	0
NHS prepayments and accrued income	0	0	0	0
Non-NHS receivables - revenue	7,599	8,422	21	247
Non-NHS receivables - capital	580	13	0	0
Non-NHS prepayments and accrued income	307	711	0	0
Provision for the impairment of receivables	(486)	(378)	0	0
VAT	259	0	0	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	1,532	3,517	0	0
Other receivables	0	0	0	0
Total	10,062	15,897	21	247
Total current and non current	10,083	16,144		
Included above:				
Prepaid pensions contributions	0	0		

19.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	1,184	1,513
By three to six months	1,431	219
By more than six months	56	99
Total	2,671	1,831

19.3 Provision for impairment of receivables

	2012-13 £000	2011-12 £000
Balance at 1 April 2012	(378)	(383)
Amount written off during the year	14	0
Amount recovered during the year	39	17
(Increase)/decrease in receivables impaired	(161)	(12)
Balance at 31 March 2013	(486)	(378)

20 NHS LIFT investments

	Loan £000	Share capital £000	Total £000
Balance at 1 April 2012	**777**	**3**	**780**
Additions	**0**	**0**	**0**
Disposals	**(13)**	**0**	**(13)**
Loan repayments	**0**	**0**	**0**
Revaluations	**0**	**0**	**0**
Loans repayable within 12 months	**0**	**0**	**0**
Balance at 31 March 2013	**764**	**3**	**767**
Balance at 1 April 2011	782	3	785
Additions	0	0	0
Disposals	(5)	0	(5)
Loan repayments	0	0	0
Revaluations	0	0	0
Loans repayable within 12 months	0	0	0
Balance at 31 March 2012	777	3	780

The amount disclosed as "Loan" represents the outstanding amount of sub-ordinated debt that was taken out at the financial close each LIFT schemes. The sub-ordinated debt is being repaid over the course of the initial lease term of the relevant LIFT scheme on a capital and interest basis.

The amount disclosed as "Share Capital" represents the PCTs shareholding in Community 1st Cornwall Limited (the LIFT Company) when it was incorporated. As Community 1st Cornwall is a private limited company there is no actively traded market for its shares and therefore the shares cannot be valued on an open market basis. The shares are recorded at historic cost and the PCT considers that this is a reasonable basis of valuation for accounting purposes.

21.1 Other financial assets - Current

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

21.2 Other Financial Assets - Non Current

	31 March 2013 £000	31 March 2012 £000
Opening balance 1 April	**780**	785
Additions	0	0
Revaluation	0	0
Impairments	0	0
Impairment Reversals	0	0
Transferred to current financial assets	0	0
Disposals	(13)	(5)
Transfers (to)/from Other Public Sector Bodies in year	0	0
Total Other Financial Assets - Non Current	767	780

21.3 Other Financial Assets - Capital Analysis

	31 March 2013 £000	31 March 2012 £000
Capital Expenditure	**0**	0
Capital Income	**(13)**	(5)

22 Other current assets

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

23 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**5**	11
Net change in year	**1,911**	(6)
Closing balance	**1,916**	5
Made up of		
Cash with Government Banking Service	**1,916**	1
Commercial banks	**0**	3
Cash in hand	**0**	1
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**1,916**	5
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**1,916**	5
Patients' money held by the PCT, not included above	**0**	0

24 Non-current assets held for sale

	Land	Buildings, excl. dwellings	Dwellings	Asset Under Construction and Payments on Account	Plant and Machinery	Transport and Equipment	Information Technology	Furniture and Fittings	Intangible Assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Balance at 1 April 2012	400	0	0	0	0	0	0	0	0	**400**
Plus assets classified as held for sale in the year	170	105	0	0	0	0	580	0	0	**855**
Less assets sold in the year	(400)	0	0	0	0	0	(580)	0	0	**(980)**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from other public sector bodies	0	0	0	0	0	0	0	0	0	**0**
Revaluation	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2013	**170**	**105**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**275**
Liabilities associated with assets held for sale at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
										0
Balance at 1 April 2011	400	0	0	0	0	0	0	0	0	**400**
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	13	**13**
Less assets sold in the year	0	0	0	0	0	0	0	0	(13)	**(13)**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2012	**400**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**400**
Liabilities associated with assets held for sale at 31 March 2012	0	0	0	0	0	0	0	0	0	**0**

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

At 31 March 2012	0
At 31 March 2013	88

The land sold in the year relates to a former decommissioned community hospital site.

The assets reclassified as held for sale in year relate to land and buildings previously used by the Community Service provider. These were vacated in year and the property has been actively marketed.

Information Technology assets that have been reclassified and disposed in year relate to the sale of assets to the Community Services provider. These assets were revalued by the District Valuer prior to disposal.

25 Trade and other payables

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Interest payable	**0**	0	**0**	0
NHS payables - revenue	**3,611**	3,704	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**4,261**	2,136	**0**	0
Family Health Services (FHS) payables	**16,561**	20,907	0	0
Non-NHS payables - revenue	**9,556**	15,106	**0**	0
Non-NHS payables - capital	**515**	1,097	**0**	0
Non-NHS accruals and deferred income	**14,371**	15,314	**0**	0
Social security costs	**35**	134	**0**	0
VAT	**0**	210	**0**	0
Tax	**172**	161	**0**	0
Payments received on account	**10**	1	**0**	0
Other	116	709	0	0
Total	**49,208**	59,479	**0**	0
Total payables (current and non-current)	**49,208**	**59,479**		

Other payables include £116,000 in respect of outstanding pension contributions as at 31 March 2013 (31 March 2012 : £694,000)

26 Other liabilities

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
PFI/LIFT deferred credit	**0**	0	**0**	**0**
Lease incentives	**0**	0	**0**	**0**
Other	**0**	0	**0**	**0**
Total	**0**	0	**0**	0
Total other liabilities (current and non-current)	**0**	**0**		

27 Borrowings

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Bank overdraft - Government Banking Service	**0**	0	**0**	0
Bank overdraft - commercial banks	**0**	0	**0**	0
PFI liabilities:				
Main liability	**87**	69	**6,082**	6,168
Lifecycle replacement received in advance	**0**	0	**0**	0
LIFT liabilities:				
Main liability	**500**	463	**25,233**	25,733
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**0**	0	**0**	0
Other (describe)	**0**	0	**0**	0
Total	**587**	**532**	**31,315**	**31,901**
Total other liabilities (current and non-current)	**31,902**	**32,433**		

Borrowings/Loans - Payment of Principal Falling Due in:

	DH	**Other**	**Total**
	£000s	**£000s**	**£000s**
0 - 1 Years	0	587	**587**
1 - 2 Years	0	708	**708**
2 - 5 Years	0	2,390	**2,390**
Over 5 Years	0	28,217	**28,217**
TOTAL	**0**	**31,902**	**31,902**

28 Other financial liabilities

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

29 Deferred income

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Opening balance at 1 April 2012	**0**	0	**0**	0
Deferred income addition	**38**	0	**0**	0
Transfer of deferred income	**0**	0	**0**	0
Current deferred Income at 31 March 2013	**38**	0	**0**	0
Total other liabilities (current and non-current)	**38**	**0**		

30 Finance lease obligations

The Primary Care Trust had no Finance lease obligations as at 31 March 2013 other than under PFI and LIFT arrangements as disclosed in note 34. (31 March 2012 : nil)

31 Finance lease receivables as lessor

The Primary Care Trust holds no finance leases as lessor as at 31 March 2013 (31 March 2012 : nil)

32 Provisions

	Total £000s	Pensions to Former Directors £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Restructuring £000s	Continuing Care £000s	Equal Pay £000s	Agenda for Change £000s	Other £000s	Redundancy £000s
		Comprising:								
Balance at 1 April 2012	**3,948**	0	3,053	313	0	582	0	0	0	0
Arising During the Year	**1,592**	0	243	50	0	1,299	0	0	0	0
Utilised During the Year	**(540)**	0	(351)	(19)	0	(170)	0	0	0	0
Reversed Unused	**(86)**	0	(78)	(8)	0	0	0	0	0	0
Unwinding of Discount	**74**	0	67	7	0	0	0	0	0	0
Change in Discount Rate	**84**	0	67	17	0	0	0	0	0	0
Transferred (to)/from other Public Sector bodies	**0**	0	0	0	0	0	0	0	0	0
Balance at 31 March 2013	**5,072**	**0**	**3,001**	**360**	**0**	**1,711**	**0**	**0**	**0**	**0**
Expected Timing of Cash Flows:										
No Later than One Year	**2,151**	**0**	**360**	**80**	**0**	**1,711**	**0**	**0**	**0**	**0**
Later than One Year and not later than Five Years	**1,454**	**0**	**1,440**	**14**	**0**	**0**	**0**	**0**	**0**	**0**
Later than Five Years	**1,467**	**0**	**1,201**	**266**	**0**	**0**	**0**	**0**	**0**	**0**

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at 31 March 2013	4,129
As at 31 March 2012	385

Pensions relating to Other Staff

Provisions for pensions are calculated on figures supplied by the NHS Pensions Agency using actuarial tables. As these provisions cover a long time span it is not possible to be precise over the amount and timings. This provision includes:

1) transfer of pre-1995 early retirements from the former Cornwall & Isles of Scilly Health Authority
2) provision of premature retirements of the Primary Care Trust

Legal Claims

Other legal claims relate to personal injury claims and are calculated on figures supplied by the NHS Litigation Authority, the Primary Care Trust's legal advisors and NHS Pensions Agency. It is not possible to be precise on the dates of settlement which therefore affects both the calculations and timings of the amounts due.

Continuing Healthcare

The continuing healthcare provision reflects an estimate of the expected liability relating to retrospective claims notified to the Primary Care Trust as reported in note 33 Contingent Liabilities

33 Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities		
NHS Litigation Authority	**(10)**	(21)
Community 1st Cornwall Ltd	**(510)**	(250)
Potential Claims relating to Continuing Healthcare *	**0**	(225)
Net Value of Contingent Liabilities	**(520)**	(496)
Contingent Assets		
Contingent Assets	**0**	800
Net Value of Contingent Assets	**0**	800

Contingent Liabilities

Community 1st Cornwall Ltd is a LIFT company set up to deliver healthcare estate solutions in Cornwall. The PCT holds a 20% share in this company as disclosed in note 37. The company incurs costs in respect of potential future schemes in line with the LIFT Agreement. In the normal course of business, such costs are included in the final financial scheme arrangements and recovered by the company through the lease payments. In the event that a scheme does not progress to an operational state, the development costs may fall as a liability to the PCT. At 31 March 2013, the accumulated costs incurred on potential future schemes is approximately £510,000 (2012: £250,000).

The NHS Litigation Authority figures are based on calculations provided to the Primary Care Trust by the NHS Litigation Authority.

* There are a number of retrospective continuing healthcare claims that have been received by the Primary Care Trust. The majority of these claims arose from the nationally set deadline of 30th September 2012 for historic claims. After initial review and correspondence, a significant number of registered claims have fallen away, however the complexity of individual cases means that we cannot estimate the total potential contingent liability at this stage. A provision of £1.7m has been made within the financial statements as an estimate of the expected liability based on experience of similar claims in the past

Contingent Assets

The Primary Care Trust has no material contingent assets at 31 March 2013 (31 March 2012 : £800,000)

34 PFI and LIFT - additional information

	31 March 2013 £000	31 March 2012 £000
34.1 Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI		
Total charge to operating expenses in year - OFF SOFP PFI	0	0
Service element of on SOFP PFI charged to operating expenses in year	262	182
Total	262	182
Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI		
No Later than One Year	252	262
Later than One Year, No Later than Five Years	844	770
Later than Five Years	5,564	5,891
Total	6,660	6,923

	31 March 2013 £000	31 March 2012 £000
34.2 Imputed "finance lease" obligations for on SOFP PFI contracts due		
Analysed by when PFI payments are due		
No Later than One Year	922	884
Later than One Year, No Later than Five Years	4,156	4,109
Later than Five Years	20,197	21,167
Subtotal	25,275	26,160
Less: Interest Element	(19,106)	(19,923)
Total	6,169	6,237

Charges to operating expenditure and future commitments in respect of on and off SOFP LIFT	31 March 2013 £000	31 March 2012 £000
Total Charge to Operating Expenses in year - OFF SOFP LIFT	0	0
Service element of on SOFP LIFT charged to operating expenses in year	1,061	1,031
Total	1,061	1,031

	31 March 2013 £000	31 March 2012 £000
Payments committed to in respect of off SOFP LIFT and the service element of on SOFP LIFT.		
LIFT Scheme Expiry Date:		
No Later than One Year	1,084	1,056
Later than One Year, No Later than Five Years	4,611	4,500
Later than Five Years	23,473	24,669
Total	29,168	30,225

Imputed "finance lease" obligations for on SOFP LIFT Contracts due	31 March 2013 £000	31 March 2012 £000
No Later than One Year	2,737	2,671
Later than One Year, No Later than Five Years	11,655	11,371
Later than Five Years	61,905	64,929
Subtotal	76,297	78,971
Less: Interest Element	(50,565)	(52,775)
Total	25,732	26,196

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

The PCT has considered the PFI/NHS LIFT schemes that it has entered into and considers that none of these are deemed to be treated as off-Statement of Financial Position.

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

PFI - Liskeard Community Hospital

The scheme can be described as a 30 year agreement for availability and facilities management services relating to Liskeard Community Hospital. The scheme does not result in any guarantees, commitments, rights or obligations apart from the 30 year agreement referred to above. The asset reverts to the PCT at the end of the 30 year commitment. The agreement commenced on 23 December 2003.

Under IFRIC 12, the asset is treated as an asset of the PCT; the substance of the contract is that the trust has a finance lease and payments comprise two elements – imputed finance lease charges and service charges.

The value of the lease payment is linked to the Retail Prices Index (RPI) and is uplifted annually on the anniversary of the contract.

The Primary Care Trust entered into a subleasing arrangement with Peninsula Community Health CIC Ltd for a period of four and a half years commencing on 1st October 2011.

NHS LIFT - Oak Tree Surgery, Liskeard

This scheme is primarily for the provision of a General Practitioner premises. The PCT does occupy part of the premises for the location of community staff delivering healthcare services. The contract for the provision was entered into in May 2004 on a standard 25 year term.

At the end of the 25 year term the PCT has a number of options as follows:
a) exercise an option to acquire the freehold at open market value subject to any applicable discount should this value significantly exceed the residual value as factored in the initial modelling of the scheme costs
b) enter into a further lease agreement
c) vacate the premises on the expiry of the lease term.
Under IFRIC 12, the asset is treated as an asset of the PCT; the substance of the contract is that the trust has a finance lease and payments comprise two elements – imputed finance lease charges and service charges.

The value of the lease payment is linked to the Retail Prices Index (RPI) and is uplifted annually on the anniversary of the contract.

The Primary Care Trust entered into a subleasing arrangement with Peninsula Community Health CIC Ltd for a period of four and a half years commencing on 1st October 2011 in respect of the space occupied by community healthcare staff.

NHS LIFT - Clays Health Centre, Roche

This scheme is primarily for the provision of a General Practitioner premises. The PCT does occupy part of the premises for the location of community staff delivering healthcare services. The contract for the provision was entered into in February 2005 on a standard 25 year term.

At the end of the 25 year term the PCT has a number of options as follows:
a) exercise an option to acquire the freehold at open market value subject to any applicable discount should this value significantly exceed the residual value as factored in the initial modelling of the scheme costs
b) enter into a further lease agreement
c) vacate the premises on the expiry of the lease term.

Under IFRIC 12, the asset is treated as an asset of the PCT; the substance of the contract is that the trust has a finance lease and payments comprise two elements – imputed finance lease charges and service charges.

The value of the lease payment is linked to the Retail Prices Index (RPI) and is uplifted annually on the anniversary of the contract.

The Primary Care Trust entered into a subleasing arrangement with Peninsula Community Health CIC Ltd for a period of four and a half years commencing on 1st October 2011 in respect of the space occupied by community healthcare staff.

NHS LIFT - Truro Health Park

This scheme comprises accommodation primarily for two GP's practices and community health services staff. The contract for the provision of services was entered into in April 2010 on a standard 25 year lease term.

At the end of the 25 year term the PCT has a number of options as follows:

a) exercise an option to acquire the freehold at open market value subject to any applicable discount should this value significantly exceed the residual value as factored in the initial modelling of the scheme costs
b) enter into a further lease agreement
c) vacate the premises on the expiry of the lease term.

Under IFRIC 12, the asset is treated as an asset of the PCT; the substance of the contract is that the trust has a finance lease and payments comprise two elements – imputed finance lease charges and service charges.

The value of the lease payment is linked to the Retail Prices Index (RPI) and is uplifted annually on the anniversary of the contract.

The Primary Care Trust entered into a subleasing arrangement with Peninsula Community Health CIC Ltd for a period of four and a half years commencing on 1st October 2011 in respect of the space occupied by community healthcare staff.

NHS LIFT - Praze-an-Beeble Surgery

This scheme primarily comprises accommodation for a GP practice and other health staff. The contract for the provision of services was entered into in June 2010 on a standard 25 year lease term.

At the end of the 25 year term the PCT has a number of options as follows:

a) exercise an option to acquire the freehold at open market value subject to any applicable discount should this value significantly exceed the residual value as factored in the initial modelling of the scheme costs
b) enter into a further lease agreement
c) vacate the premises on the expiry of the lease term.

Under IFRIC 12, the asset is treated as an asset of the PCT; the substance of the contract is that the trust has a finance lease and payments comprise two elements – imputed finance lease charges and service charges.

The value of the lease payment is linked to the Retail Prices Index (RPI) and is uplifted annually on the anniversary of the contract.

35 Impact of IFRS treatment - 2012-13

	Total £000	Admin £000	Programme £000
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g. LIFT/PFI)			
Depreciation charges	**1,451**	0	1,451
Interest Expense	**3,138**	0	3,138
Impairment charge - AME	**497**	0	497
Impairment charge - DEL	**0**	0	0
Other Expenditure	**1,467**	0	1,467
Revenue Receivable from subleasing	**(3,997)**	0	(3,997)
Total IFRS Expenditure (IFRIC12)	**2,556**	**0**	**2,556**
Revenue consequences of LIFT/PFI schemes under UK GAAP / ESA95 (net of any sublease income)	**(976)**	0	(976)
Net IFRS change (IFRIC12)	**1,580**	**0**	**1,580**
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12			
Capital expenditure 2012-13	0		
UK GAAP capital expenditure 2012-13 (Reversionary Interest)	0		

36 Financial Instruments

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

Currency risk

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

Interest rate risk

PCTs are not permitted to borrow. The PCT therefore has low exposure to interest-rate fluctuations. Borrowings disclosed in the Financial Statements are those arising from the accounting in respect of LIFT and PFI assets.

Credit Risk

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

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

36.1 Financial Assets	At 'fair value through profit and loss' £000	Loans and receivables £000	Available for sale £000	Total £000
Embedded derivatives	0	0	0	**0**
Receivables - NHS	0	271	0	**271**
Receivables - non-NHS	0	9,711	0	**9,711**
Cash at bank and in hand	0	1,916	0	**1,916**
Other financial assets	767	0	0	**767**
Total at 31 March 2013	**767**	**11,898**	**0**	**12,665**
Embedded derivatives	0	0	0	0
Receivables - NHS	0	1,322	0	1,322
Receivables - non-NHS	0	5,884	0	5,884
Cash at bank and in hand	0	5	0	5
Other financial assets	780	0	0	780
Total at 31 March 2012	780	7,211	0	7,991

36.2 Financial Liabilities	At 'fair value through profit and loss' £000	Other £000	Total £000
Embedded derivatives	0	0	**0**
NHS payables	0	3,611	**3,611**
Non-NHS payables	0	10,071	**10,071**
Other borrowings	0	0	**0**
PFI & finance lease obligations	0	31,902	**31,902**
Other financial liabilities	0	0	**0**
Total at 31 March 2013	**0**	**45,584**	**45,584**
Embedded derivatives	0	0	0
NHS payables	0	5,624	5,624
Non-NHS payables	0	16,203	16,203
Other borrowings	0	0	0
PFI & finance lease obligations	0	32,433	32,433
Other financial liabilities	0	0	0
Total at 31 March 2012	**0**	54,260	54,260

37 Related party transactions

Cornwall and Isles of Scilly PCT is a body corporate established by order of the Secretary of State for Health.

The Department of Health is regarded as a related party. During the year Cornwall & Isles of Scilly PCT has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

Royal Cornwall Hospitals NHS Trust
Cornwall Partnership NHS Foundation Trust
Plymouth Hospitals NHS Trust
Bristol Primary Care Trust
South Western Ambulance Services NHS Foundation Trust
Plymouth Teaching PCT
Northern Devon Healthcare NHS Trust

In addition, the Primary Care Trust has had a significant number of material transactions with other Government Departments and other central and local Government bodies, the most significant of these being Cornwall Council.

The PCT holds investment interests in our Local Improvement Finance Trust ('LIFT') company, Community 1st Cornwall Ltd (C1C Ltd). The PCT holds a 20% share in the company valued at £3,000 (31 March 2012: £3,000). In addition, the PCT holds £764,000 of sub-ordinated debt at 31 March 2013, as disclosed in note 21 (31 March 2012: £777,000).

Community 1st Cornwall Ltd also provides services to the Primary Care Trust under the terms of the LIFT contractual agreement. The PCT has met lease commitments for primary and community care assets provided by C1C Ltd: these leases are classified as finance leases and are fully disclosed in note 27. C1C Ltd has also provided £4.5 million of additional services to the Primary Care Trust under the agreement in 2012-13 (2011-12: £2.6 million): these additional services relate primarily to capital improvements to the PCT's freehold assets and other developmental work on the PCT estate.

The Primary Care Trust has the right to appoint one director to C1C Ltd. Mr Steve Moore (Chief Executive) has fulfilled this role throughout the year.

Jim Gould, Non Executive Director, is an appointed PCT governor for Cornwall Partnership NHS Foundation Trust.

Andrew Williamson CBE, PCT Chair, is an appointed PCT governor for South Western Ambulance Service NHS Foundation Trust.

All GP practices within Cornwall and Isles of Scilly have many routine and regular transactions with the PCT. Dr S McCormick (PEC Chair and Medical Director) is also a partner in Tamar Valley Medical Practice. Two GP Professional Executive Committee members are also partners in local GP practices: Dr C J Philip is a partner in Stennack Surgery and Dr G Garrod is a partner in Bottreaux Surgery. All these practices are therefore classed as 'related parties' for the purposes of these financial statements.

During 2012-13 Cornwall and Isles of Scilly PCT had the following transactions with these related party practices :

2012/13

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Bottreaux Surgery	1,357	0	37	0
Stennack Surgery	2,221	0	65	0
Tamar Valley Medical Practice	4,051	0	142	0

2011/12

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Bottreaux Surgery	1,291	0	152	0
Stennack Surgery	2,071	0	104	0
Tamar Valley Medical Practice (not Related Party in 2012/13)	n/a	n/a	n/a	n/a

The PCT is also the corporate trustee for the Cornwall and Isles of Scilly Charitable Funds.

The Charitable Fund financial systems and payments are managed separately to those of the PCT and the transactions between the two entities are minimal. In line with NHS requirements, any additional costs borne by the PCT in its role as corporate trustee are recharged to the Charitable Funds.

38 Losses and special payments

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

	Total Value of Cases £s	Total Number of Cases
Losses - PCT management costs	13,684	111
Special payments - PCT management costs	1,514	1
Total losses and special payments	15,198	112

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

	Total Value of Cases £s	Total Number of Cases
Losses - PCT management costs	3,542	10
Special payments - PCT management costs	2,514	6
Total losses and special payments	6,056	16

39 Third party assets

The Primary Care Trust holds no assets on behalf of third parties at 31 March 2013 (31 March 2012: nil)

40 Events after the end of the reporting period

The Primary Care Trust ceased to exist at the end of the 2012/13 financial year as a result of the changes brought about by the Health and Social Care Act 2012.

The functions, assets, liabilities and other interests of the Primary Care Trust have been transferred to receiver organisations in line with national policy.

The principal receivers are:

NHS Kernow Clinical Commissioning Group
NHS England
Department of Health
Cornwall Council
NHS Property Services Ltd
Community Health Partnerships Ltd

The closing assets and liabilities of the Primary Care Trust will be transferred to receiver organisations at book value in line with national policy.