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NHS

Wakefield and District Primary Care Trust

2012-13 Annual Report and Accounts

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Wakefield and District Primary Care Trust

2012-13 Annual Report

NHS
Wakefield District











Annual Report 2012-13

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FOREWORD

Welcome to our Annual Report for 2012/13 from Angela Monaghan, Chair and Mike Potts, Chief Executive

This has been a momentous year for the NHS, nationally and locally, as the Health and Social Care Act 2012 became law, heralding the end of Primary Care Trusts (PCTs) and the advent of new Clinical Commissioning Groups (CCGs).

Consequently, this is the last Annual Report for Wakefield District Primary Care Trust (known as NHS Wakefield District). The GP-led CCGs will assume responsibility for commissioning most local health care services from 1 April 2013, bringing the voice of the patient closer to the boardroom.

Business as usual for local people

This year marks the culmination of a massive change process lasting over two years, and we have worked hard to make sure that the NHS locally is in good shape to meet the requirements of the new Health and Social Care Act. Despite the upheaval of the large scale changes required, we are pleased to report that it has still been business as usual for local people. NHS professionals are still committed to helping local people lead healthier lives, and continue to work to improve health and social care services both in hospitals and in the community.

Calderdale, Kirklees and Wakefield District working together

The PCT Cluster – covering Calderdale, Kirklees and Wakefield District – have worked together since October 2011, led by one Board, with one Chair and one Chief Executive. However, while coming together under one Board, the three PCTs did not merge; each continued as a statutory body in its own right, until abolition of the PCTs at the end of March 2013.

The benefits of clustering have been substantial, enabling us to secure resilience during transition, helping us to make efficiency savings and, crucially, allowing us to provide robust support for the emerging CCGs as they prepared to take over the commissioning reins. There will be more about the CCGs later on in this report.

Patients and local people have been at the centre of everything we have done and even at this time of major change we have continued to maintain our focus on quality, ensuring patients have received the best possible clinical outcomes of their treatment and that they have had a good experience of local NHS services.

In February, Robert Francis QC published his report into the events at Mid Staffordshire Hospital. The report made harrowing reading for all of us who work in, and are responsible for, commissioning and managing NHS services. The challenge for the new system will be to embrace his recommendations and ensure that they become embedded into the NHS of the future so that the mistakes made at Mid Staffordshire Hospital are never repeated.

Our commitment

So, change and challenge have been the backdrop to all the achievements of the year and it is a tribute to both the commitment of our staff and the constructive support of our partners in the public, private and voluntary sectors that we have continued to see improvements in services and care. We were determined that local people should have confidence in local health services, and that people who currently have some of the poorest health outlooks in the country should have a healthier future.

Mike Potts
Chief Executive

Angela Monaghan
Chair

THE CHANGING FACE OF THE NHS

Different organisations have come into being as a result of the reforms embodied in the Health and Social Care Act 2012. These include clinical commissioning groups, NHS England (formerly the NHS Commissioning Board) and Health and Wellbeing Boards, as well as the transfer of public health responsibilities to local authorities.

Here you will find a guide to the key elements of these changes:

GP practices have come together into **Clinical Commissioning Groups (CCGs)** and from April 2013 they took over the majority of the commissioning responsibilities which previously have been carried out by the local PCT (NHS Wakefield District). Other health professionals and lay members are included on the Boards of the CCGs.

Clinical Commissioning Groups worked in 'shadow' form until they took over the shaping and commissioning (buying) of local health services from the Primary Care Trusts on 1 April 2013. They were set a series of priorities to work towards:

- Keeping people safe
- Preventing premature death
- Improving quality of life for people with long-term conditions
- Supporting recovery from injury and illness
- Creating a positive patient experience

Each of England's 211 CCGs went through a rigorous authorisation process to prove to NHS England that they were properly constituted and had the ability to function properly and legally. This included interviews and assessments for the Chairs and Chief Officers; submitting documents to prove that the CCG had policies and procedures either in place or as a work-in-progress, and a final assessment day.

During the assessment day, members of each CCG's Governing Body were closely questioned about their work, priorities and plans so that the inspection team was assured the organisation really was ready and able to take on local leadership of the NHS. If there were any concerns, they were expressed as conditions.

The CCGs were assessed in waves: NHS Wakefield CCG was in wave one and was authorised without conditions.

Strategic Health Authorities (SHAs) were created to manage the local NHS on behalf of the Secretary of State for Health. They were abolished on 31 March 2013.

Primary Care Trusts, including NHS Wakefield District, were abolished at the end of March 2013 and the majority of the PCT's public health responsibilities transferred to the local authority.

Commissioning Support Units (CSU): These organisations have been set up to provide specialist commissioning support which is available to CCGs if required. Our approach to developing commissioning support was to work in partnership with our CCGs to understand what they would need and whether they would want to build their own capacity, buy it in or share with other organisations. A key decision was to develop a single CSU across West and South Yorkshire and Bassetlaw.

Local Involvement Networks (LINks) were transformed into **HealthWatch** on 1 April 2013. Its purpose is to ensure that the views and feedback from patients and carers are an integral part of local commissioning across health and social care.

Health and Wellbeing Boards now bring together key decision makers to set a clear direction for the commissioning of health care, social care and public health, and to drive the integration of services across communities. CCG representatives are members of these Boards, and each has already been working in shadow form, building on existing relationships and developing their joint agenda to create a **Joint Health and Wellbeing Strategy** and **Joint Strategic Needs Assessment**.

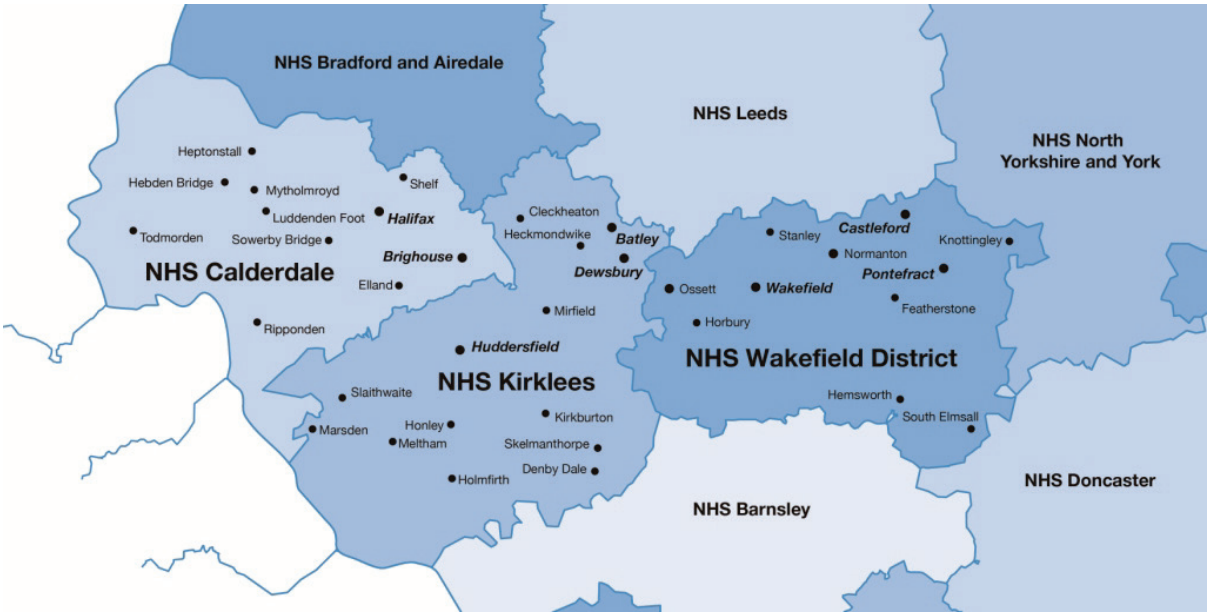
The **Wakefield Health and Wellbeing Board** brings together key organisations such as Wakefield Council, Wakefield Clinical Commissioning Group and HealthWatch Wakefield. The aim of the board is to work together and develop a strategy for improving the health and wellbeing of the people within the Wakefield district.

The priorities within the Health and Wellbeing Strategy have been drawn up using information from people who live and work in the district and from our Joint Strategic Needs Assessment. The six priorities are:

- health inequalities
- early years
- mental health
- long-term conditions
- older people
- healthy living and quality of life

In addition, there are also a number of new national bodies which will set the direction for local services, including **NHS England (**formerly the NHS Commissioning Board), **Public Health England** and **HealthWatch England**.

ABOUT US - NHS WAKEFIELD



Until 1 April 2013, NHS Wakefield District was the main NHS body responsible for healthcare and health promotion for over 335,000 people who live in the Wakefield district.

There are 40 GP practices, 35 dental practices, 73 pharmacies and 39 opticians in the district.

The PCT has commissioned - that is planned and paid for - any health services that the local population might need.

This includes hospitals, ambulances, mental health and other specialist services. We also agreed contracts with local GPs, dentists, pharmacists and optometrists to deliver high-quality services for local people.

Other local NHS services are:

- acute services provided by The Mid Yorkshire Hospitals NHS Trust in modern new hospitals at Pinderfields (Wakefield) and Pontefract, and at Dewsbury District Hospital
- mental health services provided by South West Yorkshire Partnership NHS Foundation Trust
- community nursing, therapies and other local healthcare provided by The Mid Yorkshire Hospitals NHS Trust
- emergency ambulances and patient transport provided by Yorkshire Ambulance Service

- substance misuse and sexual health services provided by Spectrum Community Interest Company

As well as making sure that services are in place for when you are unwell, a big part of what we have done is to help improve the health and wellbeing of local people. We tackled a huge variety of issues, such as smoking, obesity, substance misuse, and teenage pregnancy. We have also addressed the causes of chronic diseases such as diabetes, stroke and heart disease so that fewer people suffer from them in future. And we have helped people with long-term conditions to manage their illnesses themselves. This means that they spend less time in hospital and gives them a better quality of life.

To do this we have targeted the following areas of work:

- healthy lifestyle choices
- long-term conditions
- positive mental wellbeing
- work with older people
- early intervention (early years)
- narrowing the inequality gap between the most affluent and most deprived areas.

Changes to the structure of the NHS across England mean that all PCTs, including NHS Wakefield District, were abolished on 31 March 2013 when NHS Wakefield Clinical Commissioning Group (CCG) took over some of our responsibilities.

CCGs are made up of GP practices meaning that all of Wakefield district's GP practices are involved in commissioning healthcare. They are publicly accountable statutory organisations and a vital foundation of a new, clinically-led NHS. They plan and commission hospital, community health and mental health services on behalf of the local population.

These changes in the structure of the NHS mean local clinicians will have greater control in delivering health services.

During 2012/13 we continued to provide our robust support to the emerging NHS Wakefield Clinical Commissioning Group (CCG) to ensure they were ready to take on their full commissioning responsibilities from April 2013.

Health priorities in 2012/13

During 2012/13 the health priorities for NHS Wakefield District were:

- **Healthy living and quality of life:** stop smoking support and tobacco control; physical activity programmes; weight management programmes; National Child Measurement Programme; substance misuse services.
- **Early years:** health visiting; sexual health programmes; domestic violence interventions; antenatal and newborn screening programmes; vaccination and immunization programmes.
- **Long-term conditions:** diabetes education; NHS Health Checks; self-management of illnesses; stroke support; respiratory disease self-management programmes.
- **Older people:** falls prevention; physical activity programmes; active ageing; dementia programme.
- **Mental health:** parent and carers' counselling; debt advice in GP surgeries; dual diagnosis service; health trainers.
- **Inequalities:** health inequalities workers; community development; area-based working.

MEET THE BOARD

NHS Calderdale, Kirklees and Wakefield District PCT Cluster

NHS Calderdale, Kirklees and Wakefield District Primary Care Trusts (PCTs) became a Cluster in June 2011. Each PCT continued to be a statutory organisation in its own right, but all three were managed by a single Board which came into being on 1 October 2011.

The NHS Calderdale, Kirklees and Wakefield District Cluster Board was made up of the Chair, seven Non-Executive Directors and six Executive Directors. The Board met in public every two months with meetings held at locations around Calderdale, Kirklees and Wakefield.

Mike Potts was Chief Executive for the Cluster whilst Angela Monaghan was the Cluster Chair.

The Board was responsible for the strategy, plans and performance of NHS Calderdale, Kirklees and Wakefield District, and it assessed the delivery of health services in the locality. The Board made sure any necessary changes were made to ensure high quality services were delivered.

The executive directors during 2012/13 were:

Mike Potts - Chief Executive
Ann Ballarini - Executive Director of Commissioning and Service Development
Sue Cannon - Executive Director of Quality and Governance (Nursing)
Ian Currell - Executive Director of Finance and Efficiency
Dr Damian Riley - Executive Medical Director (a joint appointment with NHS Airedale, Bradford & Leeds)
Dr Graham Wardman, Dr Judith Hooper and Dr Andrew Furber – Executive Director of Public Health (shared one executive director position)

The non-executive directors were:

Angela Monaghan - Chair
Roger Grasby - Vice Chair
Ann Liston
Sandra Cheseldine
Mehboob Khan
Roy Coldwell
Tony Gerrard
Keith Wright (Audit Committee Chair)

Audit and Remuneration Committees

In 2012/13 NHS Calderdale, Kirklees and Wakefield District were served by a Cluster Audit Committee and Cluster Remuneration Committee.

The Cluster Audit Committee members were:

Sandra Cheseldine (NHS Wakefield)
Keith Wright (NHS Calderdale) - chair
Tony Gerrard (NHS Kirklees)

Members of the Cluster Remuneration Committee were:

Ann Liston (NHS Calderdale) - chair
Mehboob Khan (NHS Kirklees)
Roger Grasby (NHS Wakefield)

OUR RESPONSIBILITIES

Quality and safeguarding is critically important across the NHS, especially in the wake of Robert Francis' lengthy inquiry report about failings at Mid Staffordshire Hospitals NHS Foundation Trust, published in February 2013.

Responding to the Francis Report will be the work of all NHS bodies, including the CCGs, in the months to come.

Throughout the transition period, the Clinical Commissioning Groups' Heads of Quality and Safety worked to a nationally agreed quality handover and transition plan. The plan not only set out how business as usual should be maintained, but also kept up the growing emphasis on driving service improvement and quality: the PCT Cluster's enduring legacy.

A detailed, 150 page Quality Handover Document, the product of nine months' work, was delivered to the CCGs on 15 March 2013 for formal adoption by their Governing Bodies. The document was a snapshot of issues, projects and risks affecting quality and safety with a comprehensive 'who's who' stakeholder contact list to effect a seamless handover and make sure nothing was missed.

Managing the risks

Our risk management systems have enabled us to monitor and test how health services are provided, including the performance of our commissioned services against government targets and best practice standards such as treatment times and control of infection in hospitals.

Effective incident reporting, complaints and public involvement have all contributed to our risk management, and have added to our knowledge of what has been happening with our services and how the public receive and perceive NHS services.

Internal systems of control and communication have ensured that serious issues were raised in a timely and relevant way within the organisation, from specialist team meetings through to Cluster Board meetings where appropriate.

In January 2012 we aligned our risk register and risk reporting procedures, using a live database system and timeline across the three PCTs.

Our risk management teams have reported incidents nationally to the National Patient Safety Agency and to the Counter Fraud and Security Management Service. This has helped us to compare ourselves with other organisations and learn lessons to prevent similar incidents from happening in our area.

Risk management has formed part of our integrated governance arrangements; evidence shows that well managed organisations have better outcomes, including:

- safe and clinically effective services for patients
- maintenance of core services in times of emergency
- better value in our use of resources
- better health outcomes for our population.

In other words, good governance can save lives.

Safeguarding children and vulnerable adults

The health and wellbeing of children and vulnerable adults has remained a priority. It has been integral to the services we have commissioned and, during the year, we have continued to demonstrate strong local safeguarding leadership across the health economy by playing a lead role in both the Safeguarding Children Board and the Safeguarding Adults Board.

In addition, the 'Safeguarding Commissioning Policy' and the 'Comprehensive System Specification for Safeguarding Children' - both contractual requirements with provider organisations - enabled us to monitor key performance indicators for safeguarding.

During the year, we commissioned and provided a high level of training for staff employed within primary care, with over 200 staff achieving level two safeguarding children training, and 430 achieving level three. Safeguarding adults awareness raising materials were developed and distributed within primary care to assist with the requirements of the CQC registration process.

We continued to benefit from the expertise of the Named GP for Safeguarding Children which led to the establishment of a lead GP and deputy in each practice for safeguarding children. We also strengthened partnership working between GPs and health visitors.

As part of our commitment to increasing expertise in safeguarding adults, we recruited a Designated Nurse Safeguarding Adults. This role ensured that safeguarding quality standards were established in all care homes (with nursing provision) and domiciliary care providers which are monitored through the contracting process. The post also enabled us to demonstrate a high level of commitment to supporting the local authority at strategy meetings and safeguarding adult case conferences.

In the past year NHS Wakefield District has reported three safeguarding children serious incidents.

Being prepared for emergencies or incidents

During the year, emergency planning continued to be a key priority for the PCT, particularly during this period of transition and change for the NHS.

Until 1 April 2013, Primary care trusts were category one responders in the Civil Contingencies Act (2004) and, in relation to emergency preparedness, there were certain statutory obligations to which we responded and adhered:

- To assess the risk of emergencies and use this to inform planning
- To put in place and regularly test emergency plans, including training for key staff
- To put in place business continuity arrangements
- To make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- To share information and co-operate with other local responders to enhance co-ordination and efficiency

Freedom of Information Requests (FOI)

During the year, NHS Wakefield District received 12 FOI requests. The Calderdale, Kirklees and Wakefield Cluster received a further 20 requests.

Information governance breaches

NHS Wakefield District has also reported one information governance serious incident on behalf of an independent provider. This concerned the theft of electronic equipment which held patient information. This serious incident was reported to the Information Governance Ombudsman.

Customer Liaison Service and complaints

During the year our Customer Liaison Service helped 996 people with their enquiries and concerns about NHS and other services. The number of complaints received in 2012-13 was 54, broken down as follows:

Medical	32	Optical	0	Pharmaceutical	1
Dental	8	PCT	13	**TOTAL**	**54**

PERFORMANCE

Like other NHS organisations, NHS Wakefield District was responsible for making sure efficient, effective services are provided to meet the needs of people living in the area.

Our performance across directorates and services was regularly monitored and reviewed and improvements made to ensure patients received high quality healthcare services in a timely manner. Performance against key targets, such as waiting times and Yorkshire Ambulance Service journey times are shown in our Integrated Quality and Performance report produced for the Integrated Governance Group.

Highlights for this year include:

- the ongoing delivery of the four hour A&E standard and the 18 weeks referral to treatment waiting time target
- higher than national and regional average performance against the Choose and Book national target, despite our performance being at below 90%
- a reduction in the number of reported incidents of MRSA – a hospital acquired infection – across the district
- continuing to offer our local residents, aged 40 to 74 years, a free NHS health check to assess their health and identify any health risks.

It is clear that some performance challenges remain and key priorities being monitored by Wakefield CCG for 2013/14 include:

- improving performance on the 62 day cancer wait times from GP referral to first treatment.
- further increasing the number of people who successfully quit smoking. With the high number of quitters over the past five years, some of our other vulnerable and minority communities will now be targeted.
- continuing to ensure that people at high risk of stroke who experience a Transient Ischemic Attack (TIA) are assessed and treated within 24 hours.
- further improving the performance of Yorkshire Ambulance Service NHS Trust (YAS) against the ambulance response times achievements for all category A targets in 2013/14.
- improving the delivery of mental health services for patients needing assessment, or the use of the crisis resolution service to exceed target achievement levels.

Good progress in battle against sexually transmitted diseases

The number of people across the Wakefield District with the sexually transmitted diseases chlamydia, syphilis and genital warts is decreasing, according to figures released by the Health Protection Agency.

- Chlamydia in Under 25s decreased by 5% in 2011 (1,044 new cases compared to 1,099 cases in 2010)

- Chlamydia diagnoses in all age groups decreased by 4% in 2011 (1,228 new cases compared to 1,277 cases in 2010)

- Syphilis diagnoses in all age groups decreased by 5% in 2011 (18 new cases compared to 19 cases in 2010)

- Warts diagnoses in all age groups decreased by 5% in 2011 (456 new cases compared to 478 cases in 2010)

Although the figures are pleasing and reflect the tremendous effort put into making people aware of the risks of acquiring these diseases through unprotected sex, during the same timescales, rates of gonorrhoea and herpes have increased. There were 70 new gonorrhoea diagnoses in all age groups in 2011, a 3% increase. Cases of herpes were also up by a quarter with 173 new cases.

For more information visit www.wfact.co.uk/home

OUR STAFF

Valuing our staff

Recent changes to the NHS have had major implications for the people who worked for NHS Wakefield District. It has undoubtedly been a challenging year for staff as the pace of change has continued to increase. Despite this, and at a time of great uncertainty, our motivated, capable and committed team continued to work hard to ensure that healthcare in NHS Wakefield district continue to meet the needs of local people. One of our main priorities this year has been to lead and support staff as the changes come into force.

Support during organisation change

In order to support our staff colleagues through this time we organised a range of initiatives, including:

- organisational change briefings
- pensions advice sessions
- financial planning sessions
- career management workshops
- human resources drop-in sessions.

Monitoring our staff: sickness absence

We continued to monitor sickness data and provided relevant support to staff according to their needs. In 2012/13 our sickness rate was 4.00% which is above our target rate of 2.5%.

Equality and diversity

Investing in a diverse NHS workforce has enabled us to deliver a better service and improve patient care in Wakefield.

Equality is about creating a fairer society where everyone has the opportunity to fulfill their potential, and diversity is about recognising and valuing difference in its broadest sense.

We have taken our responsibilities for equality and diversity very seriously and comply with our duty to monitor our workforce on key employment indicators by ethnicity, disability status, age and gender. We try to ensure that our workforce represents our local communities and that all employees are treated fairly and equally.

Workforce comparisons 2012/13: NHS Wakefield District

Gender		
	Count	%
Male	39	16%
Female	205	84%
Disability		
No	222	91%
Yes	12	5%
Not declared	10	4%
Religious belief		
Atheism	29	12%
Buddhism	1	0%
Christianity	130	53%
Islam	5	2%
Hinduism	2	1%
Other	10	4%
Not declared	67	27%
Sexual orientation		
Lesbian	2	1%
Heterosexual	195	80%
Not declared	47	19%
Age group		
Under 25	2	1%
25 - 34	47	19%
35 - 44	76	31%
45 - 54	85	35%
55+	34	14%
Ethnic origin		
White - British	223	91%
White - Irish	2	1%
White - Any other white background	4	2%
White other European	1	0%
Mixed - White and Asian	2	1%
Mixed - Any other mixed background	1	0%
Asian or Asian British - Indian	3	1%
Asian or Asian British - Pakistani	4	2%
Black or Black British - Caribbean	2	1%
Black or Black British - African	2	1%

Our vision for diversity and equality is outlined in two main aims:

- to recruit, develop and retain a workforce that is able to deliver high quality services that are accessible, responsive and appropriate to meet the diverse needs of different groups and individuals.

- to ensure NHS Wakefield is a fair employer, achieving equality of opportunity and outcomes in the workplace.

Keeping staff Informed

During 2012/13 we kept our staff up to date with issues that may have affected them via a number of channels, including our intranet site, a weekly email bulletin and monthly staff briefings with the chief executive and other directors. Staff also had the chance to ask questions directly of the Chief Executive via the intranet and the communications team email box.

INVESTING IN SERVICES

Investment in primary care: improving access

In June 2012, NHS Wakefield District launched a campaign to make it easier for local people to see their family doctor. As part of the campaign, doctors across the district introduced a range of services to make it easier to see them, including more walk-in appointments, more pre-bookable same day appointments and telephone consultations. The campaign was supported by a range of information, including posters, leaflets, bus adverts and a Facebook page.

Supporting people to live with Chronic Obstructive Pulmonary Disease (COPD)

Patients with advanced COPD at Wakefield Hospice benefitted from a new programme designed for people too unwell to benefit from the pre-existing pulmonary rehabilitation programmes.

Largely based on other successful projects which had been well-evaluated and shown to improve the quality of life in this group of patients, each programme has run for a period of 8 weeks and includes palliative care assessments, exercise programmes and educational talks. Its aim is to improve the quality of life for patients, reduce their anxiety, increase their understanding and insight into the disease, have the opportunity to discuss end of life issues and avoid unnecessary hospital admissions.

At the conclusion of each programme, patients are discharged or signposted to appropriate services, and discussions take place with other professionals involved in their care to suggest changes in care and future plans.

New vision for eye care

People experiencing sudden eye problems can now be treated on the spot by an optician, thanks to the Primary Care Eye-care Assessment Referral Service (PEARS).

Where previously patients would have to see their GP for problems such as red eye and foreign bodies in the eye, opticians are now able to prescribe appropriate treatments, such as antibiotics, or refer patients directly to hospital when necessary.

NHS Wakefield District worked with opticians, hospital ophthalmologists and GPs to set up the new free service, with 24 opticians signed up to deliver it. The service improves patient experience by providing care closer to home, preventing waits and providing fast referral to hospital for those who need it. It also ensures more appropriate use of services in hospital.

Community dermatology service launched

In 2012, NHS Wakefield District transformed the way that dermatology services are delivered in the area.

Patients are now benefitting from a new community dermatology service which ensures that a high percentage of dermatology care is provided in a convenient community setting. Patients can either be treated in Castleford or Hemsworth with a third community venue due to open in summer 2013 in Ossett.

The community dermatology service is provided by Assura Leeds and sees patients with the types of minor dermatology concerns and skin conditions that would previously have been referred to a hospital consultant. Now only the more serious dermatology/skin conditions are referred onto hospital specialists which means that dermatology care is provided in the right place by the right people.

Residents urged to have their say

Residents across Wakefield have been helping shape future dental services for people without a regular dentist or who need urgent care out of hours.

We asked them to share their experiences of unplanned or urgent dental services in their area to help plan a new service that will cover the whole of West Yorkshire. There are currently five services across the region providing unplanned or urgent dental care, but these contracts - formerly managed by the primary care trusts covering Kirklees, Calderdale and Wakefield, Airedale, Bradford and Leeds – will come to an end in March 2014 requiring a new service to be introduced.

The key benefit of having a West Yorkshire-wide services is that people will no longer be limited to accessing the service in their own district - for example Wakefield - but will have choice across West Yorkshire. This could be an advantage for those who live and work in different areas and need to see a dentist urgently.

Shopping village chosen as site for new breast screening unit

Junction 32 Outlet Shopping Village, just off the M62 in Castleford, has been chosen as the new home for a breast screening service in the Wakefield District.

The convenient site will provide women in Castleford, Knottingley, Airedale and Pontefract with easy access to facilities in high quality surroundings.

The breast screening service, which screens eligible women every three years, operates from a combination of static sites and mobile units across the Wakefield district. Riverside Medical Centre in Castleford previously hosted one of the mobile

units, but it had to be re-sited last October due to repeated criminal activity which resulted in service disruption and the expense of repairs.

The new easily accessible site offers a convenient service to patients in the area.

NHS 111 launches in Wakefield

The new NHS 111 service was launched across Wakefield in March 2013 as part of a phased launch across Yorkshire and the Humber.

The easy to remember number, which replaces the NHS Direct telephone number, is available 24 hours a day, 365 days a year to help people access the health care and advice they need, wherever they are and no matter what time of day it is.

On dialling NHS 111 callers are put through to a team of fully trained advisers and experienced nurses, receive a clinical assessment and are then directed to the local service that can help them best at that time.

For more information visit www.nhs.uk/111

THE FUTURE

The NHS Wakefield Clinical Commissioning Group (CCG) took on full commissioning responsibilities in April 2013.

During 2012/13 the CCG has operated in shadow form, increasingly taking on the responsibilities of NHS Wakefield. This means that NHS Wakefield Clinical Commissioning Group (CCG) already has a wealth of experience and understands the health needs of local people.

They will continue the work already done to transform community health services and their vision is to commission quality services that will further improve patients' experiences of care and health outcomes, by involving and listening to patients, practices, partners and staff when redesigning services.

Their priorities are: prevention, urgent care, care closer to home, end of life care, care for older people, dementia, long term conditions, and maternity, children and young people's services.

The NHS Wakefield Clinical Commissioning Group covers 40 GP practices and has a registered population of 354,096 patients in the Wakefield area. It is chaired by Dr Phil Earnshaw, a practising GP based in Ferrybridge. Jo Webster is the Chief Officer and its headquarters are in Wakefield. The Board includes practice nurse, secondary care and lay representation.

NHS Wakefield Clinical Commissioning Group
White Rose House
West Parade
Wakefield
West Yorkshire
WF1 1LT

Telephone: 01924 213050

Meeting the Challenge

Transforming health services in North Kirklees and Wakefield District

On 4 March 2013, the two PCTs began a formal three months public consultation exercise on proposals to transform services across North Kirklees and Wakefield District. It was led by the two Clinical Commissioning Groups and the Senior Responsible Officer is Jo Webster, Chief Officer of NHS Wakefield CCG.

The proposals are clinically driven, aimed at saving more lives and improving outcomes and recovery for patients. They involve:

- Centralising specialist services for emergency care, maternity services, emergency and complex surgery, inpatient paediatrics and specialist and intensive care for babies at Pinderfields Hospital in Wakefield
- Moving non-complex, routine planned surgery to Pontefract and Dewsbury Hospitals
- Substantial development of care outside hospital to provide more care closer to where people live and release capacity within the acute hospitals.

Under the proposals, Dewsbury and Pontefract Hospitals would retain A&E units with only the most serious cases being taken to Pinderfields. All three hospitals would continue to offer a full range of outpatient clinics and midwife-led maternity services.

The proposals were developed following a substantial pre-consultation exercise involving a wide range of partner and stakeholder organisations including representatives of patients and the local communities. External experts including the National Clinical Advisory Team assessed the proposals and agreed they were the most appropriate and viable way of providing the standard and quality of services required.

The main drivers for change are:

- Desire to achieve the best possible outcomes for patients.
- There are insufficient numbers of specialists available to provide high quality care, 24 hours a day, seven days a week in line with national standards and best practice across all three hospitals
- Increasing opportunities for care outside hospital, which is consistent with patient feedback
- Evolving techniques and technology that alter the way patients are treated
- Need to achieve best value for public money

The public consultation exercise includes:

- Eight public meetings
- Over 40 roadshows
- Development of a 12 page consultation summary document – including a feedback questionnaire – delivered to more than 240,000 homes
- A substantial number of meetings and other events with smaller groups and individuals
- Focus groups
- Telephone survey
- Dedicated website, email address and phone line

- Drop-in sessions with senior clinicians
- Media activity

The consultation exercise is being independently monitored and assessed by The Consultation Institute. A final decision based on analysis of consultation output undertaken by an independent third party is due to be made at the end of July 2013. If approved, it is expected that implementation of the proposals will take approximately four years.

FINANCE

Annual accounts – report of the Financial Director

The PCT's financial statements have been prepared in accordance with the Resource Accounting Manual (RAM) issued by HM Treasury. The full details of the accounting policies adopted by the Primary Care Trust can be obtained from our Audited Accounts (see appendix 1).

The accounts attached to the Annual Report reflect the financial decisions of the PCT and the achievement of objectives for the twelve month period ending 31 March 2013.The PCT has achieved its statutory financial duties within a challenging economic environment.

The PCT has:

- achieved operational financial balance, that is, it's expenditure is not in excess of its income.
- contained expenditure within its resource limit and has reported a £3,101,000 surplus at the end of the year as required by NHS North of England. An element of this surplus will be carried forward for use in the NHS Wakefield Clinical Commissioning Group in 2013/14.
- remained within its cash limit, with a year end cashbook balance of £6,000.

In line with all NHS organisations, the PCT have signed up to the Prompt Payment Code, which requires us to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. Details of our achievement of the payment of all invoices within 30 days are noted in Note 8.1 to the audited accounts.

The statutory Accounts have been audited by KPMG, at a cost of £125,000; other audit services were provided during the year at a cost of £38,000.

Remuneration report

<u>About the remuneration report</u>

Section 234B and Schedule 7A of the Companies Act, as interpreted for the public sector, require NHS bodies to prepare a remuneration report containing information about the remuneration of directors. In the NHS, the report will cover those senior managers "having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments."

<u>Membership of the Cluster Remuneration and Terms of Service Committee (RTSC)</u>

The Cluster Remuneration and Terms of Service Committee (RTSC) comprises the Chair (Ann Liston) and two non-executive directors: (Mehboob Khan and Roger Grasby). The non-executive director who chairs the Audit Committee does not attend

in order to make sure separation of duties. The Chief Executive is in attendance (except when his own terms and conditions are considered). The committee is supported by the Directorate of Human Resources and Organisational Development.

The role of the Remuneration and Terms of Service Committee

The role of the RTSC is to make decisions about appropriate remuneration and terms of service for the Chief Executive, directors, clinical executive members' allowances and in exceptional circumstances individual issues arising for staff on Agenda for Change terms. This includes the determination of basic pay for the Chief Executive and other directors, together with any annual uplifts and performance bonuses.

Statement of the policy on remuneration of higher paid employees for current and future financial years

NHS Wakefield District works within the Pay Framework for Very Senior Managers in Strategic and Special Health Authorities, Primary Care Trusts and Ambulance Trusts as set out by the Department of Health and which became operable from 1 April 2007. This helps to make sure that NHS Wakefield District is able to recruit, retain and motivate high calibre staff and is consistent, competitive and comparable to other PCTs.

Explanation of methods used to assess whether performance conditions were met and why those methods were chosen

The RTSC reviews appropriate levels of pay for the Chief Executive and other directors under the very Senior Managers Framework. In line with best employment practice, where performance should be assessed by the line manager, the Chief Executive conducts the performance assessments for the directors. The Chairman assesses the performance of the Chief Executive. Assessments are conducted using established appraisal and personal development review processes, which include clearly defined responsibilities with measurable objectives. The discretionary element of pay is covered by performance bonus arrangements as referred to above in the section on the statement of the remuneration of higher paid employees.

Explanation of relative importance of the relevant proportions of remuneration which are, and which are not, subject to performance conditions

Please refer to information on the role of the Remuneration and Terms of Service Committee.

Summary and explanation of policy on the duration of contracts, notice periods and termination payments

Chief Executive and director appointments are made on a substantive basis, with notice provisions normally six months clearly identified and articulated in the contract.

Significant awards made to past senior managers during 2012/13

Alan Wittrick was seconded to another NHS organisation during 2012-13. He received a redundancy payment during the year of £225-230k.

Salary and pension entitlements of senior managers for 2012/13

Salary and pension entitlements for senior managers in 2012/13 are set out in the tables on pages 28 – 32.

Directors' remuneration report (audited by an independent auditor)

NHS Calderdale, Kirklees and Wakefield District Cluster

As from 1 April 2012 the PCT was part of the NHS Calderdale, Kirklees and Wakefield Cluster (NHS CKW). Costs were split across the NHS CKW cluster on a unified weighted capitation percentage basis: Calderdale 21.68% Kirklees 43.73% and Wakefield 34.59%. This table shows Wakefield's share of the cost of each named individual for 2012/13.

	2012/2013			2011/2012		
Name and title	**Salary** (bands of £5000)	**Benefits in kind** £000s (rounded to £100)	**Other** (bands of £5000)	**Salary** (bands of £5000)	**Benefits in kind** £000s (rounded to £100)	**Other** (bands of £5000)
Mike Potts, Chief Executive **(Note D)**	45-50	1.7	45-50	35-40	1.2	0
Jonathan Molyneux, Interim Executive Director of Finance and Efficiency	0	0	5-10	45-50	0	0
Ian Currell, Executive Director of Finance and Efficiency	30-35	0	0	0	0	0
Ann Ballarini, Executive Director of Commissioning and Service Development **(Note D)**	30-35	1.0	45-50	40-45	1.3	0
Peter Flynn, Director of Performance and Commissioning Development	30-35	1.7	0	25-30	1.2	0
June Goodson-Moore, Director of HR and Organisational	See **Note A**					

Development						
Matt Walsh, Executive Medical Director	10-15	0	0-5	25-30	0	5-10
Damien Riley, Executive Medical Director	See **Note A**					
Sue Cannon, Executive Director of Quality and Governance (Nursing)	30-35	0	0	25-30	0	0
Gillian Galdins, Director of Corporate Development and Transition	20-25	1.0	70-75	See **Note B**		
Angela Monaghan, Cluster Chair	10-15	0	0	5-10	0	0
Keith Wright, Cluster Non-Executive	0-5	0	0	0-5	0	0
Ann Liston, Cluster Non-Executive	0-5	0	0	0-5	0	0
Roy Coldwell, Cluster Non-Executive	0-5	0	0	0-5	0	0
Mehboob Khan, Cluster Non-Executive	0-5	0	0	0-5	0	0
Tony Gerrard, Cluster Non-Executive	0-5	0	0	0-5	0	0
Sandra Cheseldine, Non-Executive Associate	0-5	0	0	5-10	0	0
Roger Grasby, Cluster Non-Executive	0-5	0	0	10-15	0.5	0

NHS Wakefield District only

	2012/2013			2011/2012		
Name and Title	**Salary** (bands of £5000)	**Benefits in kind** £000s (rounded to £100)	**Other** (bands of £5000)	**Salary** (bands of £5000)	**Benefits in kind** £000s (rounded to £100)	**Other** (bands of £5000)
Gillian Galdins, Chief Operating Officer **(Note B)**	20-25	9	0	80-85	5.8	0
Joanne Webster, Chief Operating Officer **(Note C)**	95-100	6.2	0	90-95	5.8	0
Andrew Furber, Director of Public Health	105-110	0	0	95-100	0	5-10

Notes

Note A: These people held roles across the NHS Calderdale, Kirklees and Wakefield (NHS CKW) and NHS Airedale, Bradford and Leeds (NHS ABL) clusters providing strategic HR and Communications advice. All costs were incurred by NHS ABL.

Note B: This person moved into a NHS CKW Cluster role from 1 July 2012.

Note C: This person was previously Director of Commissioning at Wakefield until 31 July 2012.

Note D: Other early exit package costs paid to the NHS Pensions Agency, rather than the individual, are not included in this note.

CKW Cluster remuneration report (audited by an independent auditor)

This table shows the full cost of each named individual for the period stated.

Name and Title	**Dates**	**Full Costs Salary** (Bands of £5000)	**Benefits in kind £000s** (Rounded to £100)	**Other** (Bands of £5000)
Mike Potts, Chief Executive **(Note B)**	01.04.12 to 31.03.13	140-145	5.0	140-145
Jonathan Molyneux, Interim Executive Director of Finance and Efficiency	01.04.12 to 23.06.12	0	0	20-25
Ian Currell, Executive Director of Finance and Efficiency	23.04.12 to 31.03.13	95-100	0	0

Ann Ballarini, Executive Director of Commissioning and Service Development **(Note B)**	01.04.12 to 31.03.13	95-100	2.3	140-145
Peter Flynn, Director of Performance and Commissioning Development	01.04.12 to 31.03.13	90-95	5.0	0
June Goodson-Moore, Director of HR and Organisational Development	01.04.12 to 31.03.13	See **Note A**		
Matt Walsh, Executive Medical Director	01.04.12 to 31.07.12	35-40	0	5-10
Damien Riley, Executive Medical Director	01.08.12 to 31.03.13	See **Note A**		
Sue Cannon, Executive Director of Quality and Governance (Nursing)	01.04.12 to 31.03.13	90-95	0	0
Gillian Galdins, Director of Corporate Development and Transition	01.07.12 to 31.03.13	60-65	2.8	205-210
Angela Monaghan, Cluster Chair	01.04.12 to 31.03.13	35-40	0	0
Keith Wright, Cluster Non-Executive	01.04.12 to 31.03.13	10-15	0	0
Ann Liston, Cluster Non-Executive	01.04.12 to 31.03.13	5-10	0	0
Roy Coldwell, Cluster Non-Executive	01.04.12 to 31.03.13	5-10	0	0
Mehboob Khan. Cluster Non-Executive	01.04.12 to 31.03.13	5-10	0	0
Tony Gerrard, Cluster Non-Executive	01.04.12 to 31.03.13	10-15	0	0
Sandra Cheseldine, Non-Executive Associate	01.04.12 to 31.03.13	10-15	0	0
Roger Grasby, Cluster Non-Executive	01.04.12 to 31.03.13	10-15	0	0

Notes

Note A: These people held roles across the NHS Calderdale, Kirklees and Wakefield (CKW) and NHS Airedale, Bradford and Leeds (NHS ABL) clusters providing strategic human resources and communications advice. All costs were incurred by NHS ABL.

Note B: Other early exit package costs paid to the NHS Pensions Agency, rather than to the individual, are not included in this note.

Pensions disclosure (audited by an independent auditor)

	Real increase in pensions at age 60 (bands of £2,500)	Real increase in pension lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2012 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2012 (bands of £5,000)	CETV at 31 March 2013 £000	CETV at 31 March 2012 £000	Real increase in CETV £000
NHS Wakefield District employed staff							
Joanne Webster	0-2.5	2.5-5	15-20	50-55	267	226	29
Andrew Furber	0-2.5	2.5-5	15-20	55-60	314	274	26
Gillian Galdins **(Note A)**	(0-2.5)	(0-2.5)	35-40	105-110	0	669	-704
Ann Ballarini	(0-2.5)	(0-2.5)	25-30	85-90	0	628	-660
NHS Calderdale, Kirklees and Wakefield District Cluster employed staff							
Mike Potts	(0-2.5)	(5-7.5)	65-70	200-205	0	1440	-1515
Ian Currell	0-2.5	5-7.5	25-30	80-85	426	365	42
Peter Flynn	0-2.5	0-2.5	20-25	60-65	442	393	29
Sue Cannon	(0-2.5)	(5-7.5)	40-45	130-135	921	883	-8

Note A: This person moved into a NHS CKW Cluster role from 1 July 2012, having previously worked as the Chief Operating Officer at Wakefield. The above details reflect the whole of 2012-13.

Cash equivalent transfer value

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued

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

Real increase in CETV

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

Pension liabilities

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. Note 7.5 to the Audited Accounts is the relevant accounting policy providing more detail. Further information can be found in the Audited Accounts and Annual Report of NHS Pensions.

Exit packages

Further information on any Exit packages can be found in Note 7.4 to the Audited Accounts.

Tax arrangements of public sector appointees

In line with HM Treasury guidance, where personal service companies have been engaged, we have taken actions to gain assurance that they are adequately accounting for, and responsible for, their own tax and NI arrangements. During the year we engaged three persons through these arrangements.

Pay multiples

	2012/13	2011/12
Mid-point of highest paid director	£107,500	£102,500
Median remuneration	£34,189	£31,454
Pay multiple	3.14	3.26

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

The banded remuneration of the highest paid director in NHS Wakefield District in the financial year 2012-13 was £107,500 (2011-12, £102,500).

This was 3.14 times (2011-12, 3.26) the median remuneration of the workforce, which was £34,189 (2011-12, £31,454).

The highest paid director was calculated on a full time equivalent basis of the cost incurred by the organisation. Where a director worked across the Calderdale, Kirklees and Wakefield (CKW) Cluster, the entities proportion was grossed up to full year costs.

The median salary was calculated using staff in post at the year end. The salaries for part time staff were then grossed up to reflect a full time equivalent. The median point of those salaries was then calculated.

In 2012-13, one (2011-12, two) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £84,688 to £120,330 (2011-12, £88,643 - £120,330)

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.

Cluster Board and Wakefield declarations of interest register 2012/13

Name	**Position**	**Declarations of interest**
Mike Potts	Chief Executive	None
Jonathan Molyneux	Interim Executive Director of Finance and Efficiency	None
Ian Currell	Executive Director of Finance and Efficiency	None
Ann Ballarini	Executive Director of Commissioning and Service Development	None
Peter Flynn	Director of Performance and Commissioning Intelligence	None
June Goodson-Moore	Executive Director of Workforce and Corporate Development	Executive Director for NHS Airedale, Bradford and Leeds A Partner Governor for Leeds and York Mental Health Partnership Trust
Dr Matt Walsh	Medical Director	Ownership of a $^{2}/_{7}$ share of premises at Thornton Medical Centre, Bradford (a PMS practice with a Bradford contract) Spouse is an employee of Calderdale and Huddersfield Foundation Trust.

Dr Damian Riley	Executive Medical Director	National Clinical Assessment Service – trainer and clinical assessor Woodhouse Surgery, Leeds – general practitioner
Sue Cannon	Executive Director of Quality and Governance (Nursing)	None
Gill Galdins	Chief Operating Officer – NHS Wakefield District and Director of Corporate Development and Transition (Cluster)	None
Dr Andrew Furber	Director of Public Health – NHS Wakefield District	Trustee – North to North Health Partnership Honorary Senior Clinical Lecturer – Sheffield University
Jo Webster	Chief operating officer – Wakefield	None
Julie Lawreniuk	Chief Operating Officer - NHS Calderdale	None
Graham Wardman	Executive Director of Public Health – NHS Calderdale	None
Dr Judith Hooper	Director of Public Health – NHS Kirklees	Employed by GP contractor to NHS Calderdale, Kirklees and Wakefield District – GP assistant Meltham Road Surgery Partner provides services under contract to NHS Calderdale, Kirklees and Wakefield via Bradford Teaching Hospitals NHS Foundation Trust – Tier 2 Pain Service South Kirklees Clinical Lead for Kirklees Chronic Pain.
Carol McKenna	Chief Operating Officer – NHS Kirklees	None
Sue Ellis	Director of Human Resources and Organisational Development	Spouse is an Employee at Gilthwaites First School, Denby Dale Church Council Secretary and worship leader Denby Dale Methodist Church
Angela Monaghan	Chair	None

Keith Wright.	Non Executive Director	Director of ICATs Ltd. (a dormant company) NHS consultancy support to NHS organisations.
Ann Liston	Non Executive Director	Independent Member of West Yorkshire Police Authority Counsellor and external training manager - Leeds Counselling Treasurer, Hope Baptist Church, Hebden Bridge
Roy Coldwell	Non Executive Director	Trustee and Company Secretary of Catalyst Science Discovery Centre Director of RS Clare and Company Lubricants manufacturer Non-Executive Director PICME - Business Improvement Consultancy Risk Management Consultant – HFL Risk Services.
Mehboob Khan	Non Executive Director	Councillor of Kirklees School Governor, Greenhead College, Huddersfield Member of West Yorkshire Fire Authority. Board members of the Standards Board of England Board member of Local Government Association Council of Europe Shareholder in Excol Consulting Ltd
Tony Gerrard	Non Executive Director	Director of Tony Gerrard Associates Ltd.
Sandra Cheseldine	Non Executive Director	Chair of the Trustees Board for Wakefield District Citizens Advice Bureau
Roger Grasby	Non Executive Director	Independent Member – West Yorkshire Police Authority Justice of the Peace – Wakefield/Pontefract Bench

		Non-legal member – Employment Tribunal Chair/Director, Spectrum Community Health CIC Ltd

Disclosure of information for audit purposes

Andrew Buck, Chief Officer – NHS England (West Yorkshire Area Team) - has signed a letter of representation that confirms, after making enquiries of directors and non-executive directors, that all accounting records and all other records and related information have been made available to our external auditor in the course of the 2012/13 audit.

Department of Health

NHS

Wakefield and District Primary Care Trust

2012-13 Accounts

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Wakefield and District Primary Care Trust

2012-13 Accounts

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

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

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

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

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

Signed.....Designated Signing Officer

Name: Mr Andy Buck, Signing Officer, West Yorkshire Area Team

Date 6/6/13

STATEMENT OF RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

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

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

- make judgements and estimates which are reasonable and prudent;

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

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

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

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

By order of the Permanent Secretary.

06 June 2013 .....Signing Officer

06 June 2013 .....Finance Signing Officer

NHS WAKEFIELD DISTRICT (Wakefield District Primary Care Trust)

5N3 Wakefield District

GOVERNANCE STATEMENT 2012/13

1.0 Scope of Responsibility

The Board is accountable for internal control. As Accountable Officer and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. Patient safety remains our first priority and I take personal responsibility for this along with safeguarding the public funds and the organisation's assets, as set out in the Accountable Officer Memorandum. I am also responsible for ensuring that the organisation is administered efficiently and effectively within our resources. Internal auditors have throughout the year reviewed governance arrangements and found these to be satisfactory.

NHS Wakefield District PCT is part of the local health and social care economy that aims to improve health wellbeing for the people of Wakefield. It supports the development of local services to deliver better health, in partnership with other stakeholders. Our Operating Plan set out our objectives and targets for the short and medium term. The Board oversees delivery of our Strategic and Operating Plans, supported by its sub-committee arrangements which maintain focus on our local priorities. The NHS North of England assesses and monitors performance of the PCT against national and local objectives through the reporting arrangements in place with the regional office.

2.0 The Governance Framework of the Organisation

NHS Wakefield District PCT operates within a cluster arrangement with the three Boards of Calderdale, Kirklees and Wakefield District Primary Care Trusts which has responsibility for overseeing the transition to the new structure of the NHS. This arrangement retained the three Boards as accountable and responsible for the commissioning of safe and effective local health services within the financial resources.

There is one executive management structure including one Chief Executive and Accountable Officer for the three organisations and one set of executive directors and non executive directors who sat on the Boards of all three organisations. Standing Orders and Standing Financial Instructions were in place.

As Chief Executive I appointed a Chief Operating Officer for NHS Wakefield District PCT until June 2012 with responsibility for operational management of the organisation to ensure a sound governance framework within the organisation on my behalf. A Shadow Accountable Officer for NHS Wakefield Clinical Commissioning Group (CCG) was in place from July 2012, when the Chief Operating Officer role ceased.

2.1 Board Committee Structure

The governance structure had the following cluster wide Board Committees in place:

- Audit Committee
- Remuneration and Terms of Service Committee
- Governance Committee
- Clinical Commissioning Executives
- Yorkshire and the Humber Specialised Commissioning Group
- Joint Committee of the West Yorkshire Commissioning Support Unit (from July 2012)
- Procurement Committee (from October 2012)

The Clinical Commissioning Executive was supported by three reporting sub- groups covering Audit and Governance, Finance and Performance and Quality.

Terms of reference agreed by the Board were in place for all Board sub committees.

Membership of the Board committees was in line with the Standing Orders of Wakefield District Primary Care Trust, with two Non Executive Directors as members of the Audit Committee. There was a balance of Directors and Non Executive Directors who collectively took responsibility for the organisation. Once appointed, the Shadow Accountable Officer of the CCG attended Board meetings.

Good attendance was maintained at Board and Board subcommittee meetings throughout 2012/13 and this is demonstrated in the minutes.

The Committee structure was re-assessed during the year and the following changes were made to support an effective governance framework:

- Joint Committee of West Yorkshire Commissioning Support Unit (WYCSU) established with the neighbouring cluster, NHS Airedale, Bradford and Leeds, to establish and oversee the management of the WYCSU in shadow form during 2012/13 , operating within Standing Financial Instructions, to ensure it is fit for purpose as a CSU from April 2013

- Governance Committee - terms of reference revised and approved by the Board twice to refocus the committee's work to support transition (once in June 2012 to reflect changes to membership and once in September 2012 to ensure the Committee focussed on assurance relating to handover and transition issues)

- The frequency of Board meetings was reviewed in July 2012, being reduced for the latter part of the year as the Clinical Commissioning Executive began to prepare to work as a Shadow Governing Body, with the Shadow Accountable Officer reporting to the Board

- A Procurement Committee was established by the Board once the frequency of Board meetings was reduced to ensure that procurement decisions were managed in a timely manner.

- Amendments were made to the terms of reference of the Commissioning Executive Committee and Standing Financial Instructions to enable the Chief Operating Officer and Shadow Accountable Officer to take on delegated limits.

The Cluster Board has had an independent review of the effectiveness of its governance arrangements from internal auditors who confirmed an audit opinion of significant assurance for governance arrangements

2.2 Coverage of work by Board

During 2012/13 the Board meetings covered a wide range of work which is outlined below.

- Chief Executive Reports
- Quality and Performance Reports
- Finance and QIPP reports
- Board Assurance Framework
- Governance and Risk Reports
- Transformation Report
- Commissioning Development and Transition Reports
- CCG report
- Review of Committee minutes
- Annual Reports

Seven Board meetings were held in public during the year. The Board also held business meetings during the year.

2.3 Audit Committee

The Audit Committee performed the key role of reviewing and monitoring the system of internal control during 2012/13, supported by an Audit and Governance group which reported to the Clinical Commissioning Executive. The chair of the Audit and Governance group is a Non Executive Director and a member of the Cluster Audit Committee, ensuring linkage between the two groups.

These arrangements have included regular reports on the work and findings of the internal and external auditors. Minutes of the Audit Committee were reported regularly to the Board and minutes of the Audit and Governance Group were reviewed by the Cluster Audit Committee.

2.4 Transition

To ensure that there was appropriate focus on governance, transition and closedown I appointed a Director of Corporate Development and Transition from July 2012, who

established a Transition Programme Office and Transition and Closedown Steering Group to oversee effective handover and closure, reporting to the Governance Committee on progress with transition.

The following actions for completing operational handover and closure and ensuring scrutiny of these arrangements are given below.

- Two events held across West Yorkshire with receiver organisations, to confirm the details of the transition process, supported by legal advisors
- Face to face meetings to produce the due diligence information in preparation of transfer scheme documentation.
- Attendance at the Public Health Transition Steering Group meetings
- Attendance at the CCG senior management team meetings
- Engagement with West Yorkshire Commissioning Support Unit (WYCSU) transition team
- Clarification of sign off process for transition for NHS Commissioning Board
- 'Page turn' process for the quality handover document with providers
- Programme highlight report produced for Cluster Governance Committee
- Assurance on transition process from Internal audit, through attendance at Steering Group meetings and a high level review to consider the governance arrangements and structures in place to manage the transition, confirming that the programme was well structured and key milestones had been achieved
- External audit (KPMG) have also received the appropriate level of information to provide assurance
- All ongoing risks have a future risk destination identified within the risk register
- Risks will be handed over as part of the quality and legacy process
- Quality Assembly held on 19 March 2013 for the formal handover of the quality documentation to receivers
- Board scrutiny of transfer documentation on 21 March 2013, including review of corporate legacy documentation

2.5 Accounts Scrutiny and Handover for 2012/13

In line with Department of Health guidance the Calderdale, Kirklees and Wakefield PCT cluster will establish a cluster wide sub-committee of the Department of Health's own Audit and Risk committee. This sub-committee will meet in early June to review the annual report, financial statements and governance statements of the three PCTs prior to sign off by the West Yorkshire Area Team Director and Director of Finance. The three existing members of the cluster Audit Committee have agreed to be members of this committee.

To support this committee in discharging it's functions the four local CCGs will review the PCT annual report, financial statements and governance statements through their own Audit Committees in April and May and will provide feedback to the cluster wide Audit sub-committee.

In addition draft governance statements will be reviewed by the PCT's Executive Team and cluster Audit Committee during March. A draft annual report will be reviewed by the

cluster Chief Executive and Chair in March. Their feedback will be available for the audit sub committee to review at its meeting in June.

2.6 Corporate Governance

The organisation has in place a corporate governance framework with standing orders, standing financial instructions, a scheme of delegation, and a code of conduct. This has been revised during the year to reflect changed governance arrangements to enable shadow clinical commissioning groups to make financial decisions within an agreed framework.

Whilst there is no national corporate governance code in place for PCTs (such as the Monitor Code of Governance for Foundation Trusts), the PCT is compliant with principles within this code including:

- a Board of directors in place meeting regularly to discharge their duties
- a clear division of responsibilities of the Chair and Chief Executive
- a balance of Executive and Non Executive Directors
- information and professional development – a number of Board Business meetings have been held.

I confirm that effective arrangements have been in place during 2012/13 for the discharge of statutory duties, that there have been no irregularities and that the organisation has been legally compliant.

2.7 Partnership Governance

The Health and Wellbeing Board has been established in shadow form in Wakefield since March 2011. This is supported by the main public sector organisations in Wakefield, alongside the private and voluntary sectors. The Chair of the Clinical Commissioning Group (CCG) Board, which is operating in shadow during 2012/13, is a member of the Health and Wellbeing Board. NHS Wakefield District plays a significant part in the collaborative working within the region. This is particularly important in the light of future financial pressures and the need to create a system with much lower management costs.

The Strategic Plan highlights how NHS Wakefield CCG will work together to develop a single approach to delivery in Wakefield and will continue to focus on this as the local Clinical Commissioning Group arrangements develop. Close partnership working has taken place with local clinicians, the local authority, Mid Yorkshire Hospitals Trust, neighbouring CCGs, patients and the public and other partners to understand the planned changes to the configuration of hospital and community services in Wakefield that are detailed in the consultation document and website: www.meetingthechallenge.co.uk.

3.0 The Risk and Control Framework

The Chief Operating Officer, on my behalf, was responsible for maintaining the corporate risk register for NHS Wakefield District. The organisation has maintained a corporate risk register which in turn has populated the cluster-wide risk register. Directors, managers and all staff work together to provide an integrated approach to the management of risk.

A standardised and approved Cluster wide Risk Management Strategy has been utilised within the organisation which sets out how risks are identified, assessed, managed and controlled. A key element in the system is the maintenance of the corporate Risk Register, including the Assurance Framework.

The PCT risk assessment processes are supported and delivered through the use of a bespoke risk register and risk reporting system.

The corporate risk register is managed under a regulated programme including sign off by Senior Management Teams. A High Level risk log of all risks scoring above a threshold is reviewed and scrutinised by Cluster Executive, Governance Committee and ultimately the Board. The Audit Committee also reviewed the risks.

Over the 2012/13 period the risks have been aligned to the receiving organisations including the Clinical Commissioning Groups who have utilised the same system and process with assurances being provided to the Cluster Executive team and the Cluster Board.

The Board Assurance Framework has been developed around the objectives within the cluster accountability framework and has been presented to the Governance Committee, Audit Committee and Board.

During 2012/13 the organisation took a range of actions to reduce risk and provide assurance about risk mitigation. This included:

- Continuing improvement to the quality of commissioned health services including MYHT and partners on financial and operational performance of the Mid Yorkshire Hospitals Trust
- Closely monitoring compliance with national and local infection prevention and control targets of acute providers
- Ongoing review and testing of emergency preparedness and resilience planning within the organisation and its stakeholders
- Ensuring that the organisation is complying with its Information Governance and data protection responsibilities
- Completing a detailed review of all contracts and contract documentation to ensure safe handover to successor bodies
- Supporting the transition of PCT functions and resources to new receiver organisations including the management of risks and challenges to the organisation. In particular, the ability to implement the changes with the associated impact on our staff, while ensuring that patients continue to receive safe, high quality care and that good value for money is delivered.
- Managing the financial risk agenda including cost improvement and QIPP

agendas to meet the pressures across the NHS and public sector, while also maintaining staff engagement and ensuring appropriate staffing levels to deliver changes to the commissioning architecture and supporting the establishment of clinical commissioning groups.

- Managing the risks of commissioned Trusts not achieving Foundation Trust status and the implications for the local health economies.

3.1 Data Security

Risks relating to information governance continue to be monitored closely through the Risk Register. The Senior Information Risk Owner (SIRO) has responsibility for ensuring organisational information risk is properly identified and managed and that appropriate assurance mechanisms exist. The SIRO is familiar with risk management and the organisation's response to risk. Any incident reports are thoroughly investigated and the lessons learned shared throughout the organisations.

Risks relating to data security appear on the risk register and, due to good controls meaning there have been no serious incidents or security issues, lapses remain at low level. There have been no information security incidents to report to the Information Commissioner.

The organisation continues achieved level "2" compliance against the requirements of the Calderdale, Kirklees and Wakefield cluster Information Governance Toolkit annual assessment.

3.2 Prevention and Deterrence of Risks

To provide assurances about the prevention of risk, the organisational governance framework consider any potential risks and their impact by:

- including an assessment of risk within Board and Committee papers
- ensuring risk management has an integral role in all major projects and developments within the organisation, keeping a specific risk register, for specific projects and escalating risk on to the corporate risk register.

Risk management policies and procedures were also in place during the year to ensure that risk was managed consistently throughout the organisation.

Regular updates on counter fraud were given at the Audit Committee, with counter fraud representatives attending the local Audit and Governance Group and providing updates on any investigations, raising awareness of fraud amongst staff as a deterrent.

4.0 Review of the Effectiveness of Risk Management and Internal Control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control and risk management processes in practice.

The governance arrangements in place within NHS Wakefield District during 2012/13 managed risk and provided assurance to the Board as described below:

Governance Committee

The Governance Committee reviewed the risks identified within the Board Assurance

Framework and Corporate Risk Register on a regular basis.

Audit Committee

The Audit Committee reviewed financial issues including the annual accounts. The Committee also sought assurance on the effectiveness of internal control from internal and external audit reports and opinions, counter fraud progress reports and the Board Assurance Framework. Internal and External Auditors actively participate in the Audit Committee.

The Head of Internal Audit Opinion for 2012/13 gave an audit opinion of significant assurance which is consistent with this Governance Statement which confirms that there were no significant control issues during the year.

Remuneration and Terms of Service Committee

This Committee ensured that governance arrangements were in place to manage remuneration and terms of service issues on behalf of the Board.

Clinical Commissioning Executive (CCE)

The CCG has been operating in shadow form with delegated budgetary responsibility in 2012/13, overseen by the Clinical Commissioning Executive. This formal subcommittee of the PCT Cluster Board ensured clinical engagement on a broad range of operational and strategic issues and was responsible for the majority of the commissioning budgets throughout 2012/13. The terms of reference for this Committee contained specific details on managing conflicts of interest.

Three sub groups supported the CCE in monitoring the system of internal control. These were:

- Audit and Governance Group
- Finance and Performance Group
- Quality Group.

These groups provided assurance in the areas of corporate governance, financial governance and clinical governance.

In addition, I am assured that significant risks to the organisation were being managed by the following:

- Chief Operating Officer / Shadow Accountable Officer
- Senior Management Team
- Internal Audit - opinions (including the Head of Internal Audit opinion) and reports by Internal Audit
- External Audit - opinion and reports from our external auditors
- Performance reports
- Governance and risk reports
- Investigation reports and action plans following serious incidents

- Safeguarding reports / Serious Case Reviews for Children

Where any weaknesses are identified a system is in place to manage these.

5.0. Conclusion

In line with the definition of significant issues, 2012/13 Governance Statement Guidance (Gateway Reference: 18561) I have not identified any significant issues during the year.

My review confirms that during 2012/13 NHS Wakefield had effective arrangements in place for the stewardship of the organisation.

Signing Officer : Andy Buck

Organisation: West Yorkshire Area Team

Signature: Andy Buck

Date: 6/6/13

WESTERN CHESHIRE PRIMARY CARE TRUST

CLUSTER OF NHS CHESHIRE, WARRINGTON AND WIRRAL PRIMARY CARE TRUSTS

ANNUAL GOVERNANCE STATEMENT 2012/13

My review confirms that each Primary Care Trust had a generally sound system of internal control that supported the achievement of its policies, aims and objectives. The Primary Care Trust Cluster was established on 1st June 2011.

Scope of responsibility

The Board was accountable for internal control. As Accountable Officer and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

There was regular contact between the Strategic Health Authority and the Primary Care Trust which allows for any concerns to be addressed

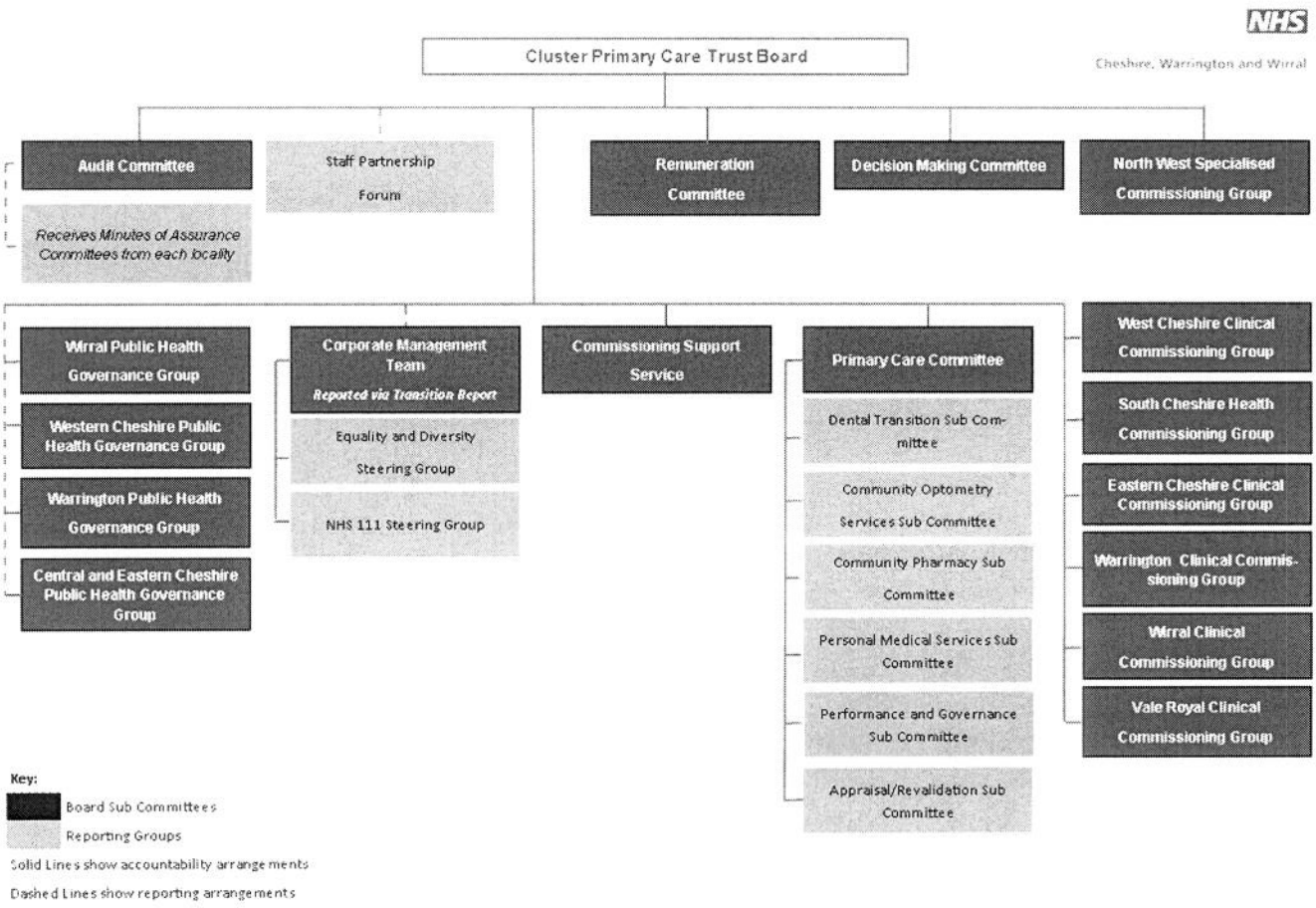
With respect to partnership working across the Local Health Economy, I met regularly with the Local Authority Chief Executives and as necessary with the Chief Executives of the providers within the Primary Care Trust area. The Primary Care Trust participates in partnership arrangements for children's services, adult services and health and well-being. The post of Joint Director of Public Health is jointly accountable to the Local Authority and the Primary Care Trust. There are a range of joint commissioning appointments across different organisations.

The governance framework of the organisation

The NHS Cheshire, Warrington and Wirral Board was established on 6th June 2011 by the Establishment Agreement contained in Section A of the Standing Financial Instructions/Standing Orders (initially approved by Board on 6th June and updated and approved on 2nd November 2011). A diagram of the Governance Structure for the Cluster is shown below.

The Board has the following Sub-Committees which have delegated responsibilities as part of the Scheme of Reservation and Delegation.

- Audit Committee
- Remuneration Committee
- Decision Making Committee
- Primary Care Committee
- West Cheshire Clinical Commissioning Group
- South Cheshire Clinical Commissioning Group
- Eastern Cheshire Clinical Commissioning Group
- Warrington Clinical Commissioning Group
- Wirral Clinical Commissioning Group
- Vale Royal Clinical Commissioning Group
- North West Specialised Commissioning Group



The Board sub-committees all have terms of reference which have been approved by the Board. The Board also had a number of reporting groups from whom they receive minutes as part of the assurance process. These groups included:

- Public Health Governance Groups/Steering Groups for each Primary Care Trust (reported via the Transition Update Board Papers)
- Corporate Management Team (reported via the Transition Update Board Papers)
- Staff Partnership Forum

The Board met regularly either formally where meetings were held in public or informally for the Board's own development. Copies of the Formal Board agendas and papers are available on each of the Primary Care Trust websites and were published 5 working days in advance of the meeting. The minutes of the Board meetings and minutes of supporting groups as outlined below contain details of the attendance of members and any apologies received. The Board developed the following vision and values:

- Honesty and Integrity - by showing respect, fairness and trust to all our staff during a period of major change;
- Clear leadership - to develop positive attitudes and actions recognising the potential for people to make a difference; and by having the courage to take necessary tough decisions in order to successfully deliver the new NHS;
- Collaborative support - to all staff and teams to secure success with Clinical Commissioning, Commissioning Support and Public Health;
- Working creatively - with partners based on the common objective to keep our population at the centre of all we do.

These values were developed to provide focus for the Board in their role as a Cluster Primary Care Trust Board during the transitional period for the NHS. The Board fully complied with the UK Corporate Governance Code and was effective in discharging it roles and responsibilities.

The Audit Committee was responsible for ensuring compliance with statutory requirements and provided assurance to the Board on internal control and governance matters (both clinical and non-clinical), that supported the achievement of the organisation's objectives. The Audit Committee highlights have included:

- Monitoring the impact of wider NHS transition on the Cluster, including commissioning support arrangements, CCG development and the establishment of the NHS Commissioning Board. This included consideration of the impacts on areas of corporate priority including HR and Information Technology. The Committee also considered specific guidance on financial closedown of PCTs;
- Review of areas of financial focus including key aspects of the financial statements such as final accounts timetables, segmental reporting requirements and review of accounting policies. The Committee also reviewed tender waivers, progress against QIPP and losses & special payments;
- Regular updates from internal auditors including plans, progress reports, final reports issued and the Director of Internal Audit annual opinion; the Committee also tracked audit recommendations to ensure these were implemented. The outstanding recommendations have been transferred to the Clinical Commissioning Groups and this process is embedded as part of their governance frameworks;
- Regular updates from external auditors including plans, progress reports, annual governance reports and annual audit letters. The external auditors also provided updates on the transfer of responsibilities to the new external audit provider;
- Review of the Board Assurance Framework as part of the Committee's role to oversee the establishment and maintenance of an effective system of integrated governance, risk management and internal control;
- Updates from each of the PCT/localities and the hosted North West Specialised Commissioning Team focussing on local performance and transition issues; and,
- Review of counter fraud progress reports.

Throughout the year the Board has received copies of the Clinical Commissioning Group Board minutes. These have provided assurances of their delegated responsibilities which include the majority of commissioning budgets and performance of providers. Risk is an agenda item for all Clinical Commissioning Groups and mechanisms are in place to escalate risks for Board attention, where appropriate. Key points reported via these Sub-Committees have included:

- Monitoring of the Clinical Commissioning Group Financial Position;
- Finalising the Clinical Commissioning Group Staffing Structure and developing the organisational development plan;
- Development of a Planning Framework including contracts and the strategic plan for 2012/13;
- Preparing for Formal Board Meetings in public and undertaking Board development programmes;
- Reviewing commissioned services and preparing to implement any willing provider;
- Developing assurance frameworks for managing risk and reporting to the Primary Care Trust Cluster Board;

The NHS Cheshire, Warrington and Wirral Scheme of Reservation and Delegation clearly states that Quality is delegated to the Clinical Commissioning Groups to oversee for their respective providers.

In addition to regular reporting to Clinical Commissioning Group Boards, any exceptions including serious incidents are reported to the Primary Care Trust Cluster. Clinical Commissioning Groups are responsible for ensuring that exceptions are reported in a timely manner to the Primary Care Trust Cluster and that actions

are taken by the providers and themselves to address the exceptions. These exceptions are also included in the Quality Accounts for providers on an annual basis.

At its last formal Board Meeting in March 2013, the corporate handover document for NHS Cheshire Warrington & Wirral (NHS CWW) Cluster was presented. It is intended that this document will signpost all new NHS organisations who take responsibility for Primary Care Trust functions from 1 April 2013 to the key risks, issues and areas of concern of which those new bodies need to be aware as they assume responsibility for the discharge of their functions.

The Corporate Handover document should be read in conjunction with the Quality Handover document which sets out the key quality and safety issues for NHS Cheshire Warrington & Wirral Cluster. This was also presented to the Primary Care Trust Cluster Board in March 2013. Both documents are available on the Primary Care Trust websites as part of the Board papers.

From 1 April 2013 when PCTs were abolished, Area Team Directors continued to discharge the responsibilities associated with the financial closedown of PCTs. The production of the accounts for 2012/13 was supported by LAT Directors of Finance (DoFs). This has included:

- preparation and sign off of PCT accounts for 2012/13;
- support for the completion of the Department's resource account;
- designation of closing balances to residual organisations;
- management of local discharge of balances transferred to the Department; and
- management of payroll queries and other related payroll issues.

However, when PCTs ceased to be statutory bodies on 1 April 2013, the statutory status of the essential scrutiny and governance function provided by Audit Committees has been lost. To maintain rigour in the process, we have established an Audit Sub-Committee of the Department of Health Audit & Risk Committee, to support the final accounts process. This approach will draw on the expertise of current Audit Committee members when forming the Sub-Committee. This arrangement will provide a mechanism with the appropriate status to discharge the function.

The non-executive directors (NEDs) that form the Sub-Committee have been identified locally and include the previous chair of the PCT Cluster. They have been appointed by the Department's Permanent Secretary following local nomination. The Cluster Audit Sub-Committees took place in May and June 2013 to agree the accounts in line with national timescales.

Risk assessment

The Corporate Risk Register enabled the Cluster to understand its comprehensive risk profile. It records dependencies between risks and links between risks on the Board Assurance Framework and the risk registers of individual functions.

The Corporate Risk Register is derived from a number of sources:

- escalation from Risk Registers held by:
  - Clinical Commissioning Groups
  - Commissioning Support Service
  - Public Health Departments
  - Primary Care
  - Cluster wide e.g. Emergency Planning.
- the business planning system, which determined the Primary Care Trusts' principle objectives, corporate activities such as the planning process or business case development, external inspections (e.g. Health and Safety Executive) complaints/ incidents and litigation.

Items for the Risk Register which were a standing item on agendas of:

- The Board
- Audit Committee
- Remuneration and Terms of Service Committee
- Clinical Commissioning Group Boards
- Public Health Governance Committees
- Commissioning Support Service Board
- Primary Care Committee.

The Corporate Risk Register is a dynamic document, held by the Cluster Office. It forms part of the legacy document for when the Primary Care Trusts are abolished. Risks identified as significant or complex were entered on to the Corporate Risk Register, quality assured by the Corporate Management Team before escalation to the Board.

The Assurance Framework was developed in accordance with guidelines provided by the Department of Health.

This is a high level document that recorded the principal risks that could have impacted on the Cluster achieving its strategic objectives. It provided a framework for reporting key information to the Board. It provided assurance that risks were managed effectively and objectives were delivered and also identified which of the Primary Care Trusts' objectives were at risk because of gaps in controls or assurance about them.

During 2012/13 the following risks were highlighted to the Cluster Board:

- Ensuring a robust PCT closedown as part of NHS transition arrangements, including the need to successfully identify and transfer assets and liabilities;
- Assurances need to be in place that commissioned services are safe and of good quality. This risk has been mitigated through inclusion of quality and safety aspects in all contracts and robust contract monitoring arrangements;
- The need to successfully implement the NHS '111' programme. The Cluster has established a Steering Group with representation across all CCGs to implement and monitor progress against key milestones; and,
- The need to support CCGs engagement in the QIPP agenda – this has been mitigated through each CCG having approved, individual QIPP plans and securing GP involvement in QIPP projects.

Principal risks were not considered in isolation, but derived from the prioritisation of risks fed upwards through the whole organisation, including Risk Registers and Assurance Frameworks held and managed by Clinical Commissioning Groups, Public Health Departments, Commissioning Support Service and Primary Care. In this way the Risk Registers will contribute to the Board Assurance Framework and ensure that system risks are identified and monitored.

All Clinical Commissioning Groups/Public Health/Primary Care/Commissioning Support Service minutes are submitted to every formal Cluster Board and each of the groups attends the Board on a rolling basis or when there is a specific item which requires Board approval. The Cluster has a Single Audit Committee which is enabling and supporting the development of local governance groups (inc QIPP governance). Regular quality meetings are held with providers (see further detail below) and Clinical Commissioning Groups. The Chief Executive meets formally with Clinical Commissioning Group Chairs and Chief Officers bi-monthly and with Directors of Public Health also monthly. The Cluster is part of the Regional Management Board in Cheshire and Warrington and the Health and Local Government meetings in Wirral. There is also

senior Cluster attendance at all Health & Wellbeing Boards. Delegated arrangements are detailed in Standing Orders and Financial Instructions

During 2012/13 there were no lapses of data security. Therefore no incidents were reported to the information commissioner relating to any of the Primary Care Trusts.

The risk and control framework

The Risk Management Strategy sets out the responsibility and role of the Chief Executive in relation to Risk Management. The Board took direct responsibility for the monitoring of the assurance framework and for risk management.

Board committees were supported by the governance structure and have received reports from a number of other Trust and locality-wide groups, to ensure that all significant risks were highlighted to the Board.

The Assurance Framework identified those risks deemed as strategically significant to the objectives of the organisation. Risk Management was embedded within the organisation and the process was been cascaded to service areas to assist with the development of an organisation-wide risk awareness culture. This was supported by operational risk registers which enabled risk management decision-making to occur as near as practicable to the risk source, and for those risks that cannot be dealt with locally to be passed upwards to the appropriate level within the organisation.

The Primary Care Trust Assurance Framework, Corporate Risk Register and Top Risks were reviewed and updated regularly. Risks were identified via a number of routes, including reports from staff and senior managers, incidents, complaints and Primary Care Trust Committees. The Cluster Team was responsible for ensuring all risks were appropriately graded and that action plans were regularly monitored.

The Primary Care Trust undertook a wide range of mandatory and statutory training for all staff and there was a greater emphasis on staff training during 2012/13 following the introduction of e-learning. Staff were required to undertake training in relation to Counter Fraud, Equality and Diversity, Fire Safety, Infection Control, Information Governance, Safeguarding Children and Adults as well as Health and Safety. This training was mandatory for all staff and was a key part of the organisation's core induction. This ensured that risk management, risk assessment and incident reporting were highlighted together with key Trust strategies, policies and procedures. These included risk management strategy, infection control, and complaints.

Statutory & Mandatory training compliance rates across the Cluster were taken as at January 2013. Overall the Cluster was 70.6% compliant across the 8 core courses, which was an increase of 1.6% on the October figure. However, training compliance reduced in comparison to the previous year as a result of the NHS Transition. Compliance reports were sent out to the locality HR Teams so that discussion with line managers about ongoing compliance action could be undertaken. Two out of the eight courses are achieving the National compliance rates of 85% or higher".

The Trust has ensured:

- Director objectives were aligned with key Corporate Objectives.
- The Primary Care Trust is committed to engaging local independent contractors to facilitate the development of good governance and risk management processes.
- The Primary Care Trust seeks independent assurances from third party providers of services to the Primary Care Trust over the effectiveness of internal controls in place. Relevant reports covering the review of third party provider controls are presented to the Audit Committee during the year.
- Control measures are in place to ensure that all the organisations' obligations under equality, diversity and human rights legislation are complied with.

Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of Internal Audit's work. The overall level of the Head of Internal Audit Opinion is one of significant assurance. Significant assurance can be given that there was a generally sound system of internal control designed to meet the organisation's objectives and that controls were generally being applied consistently. However some weaknesses in the design or inconsistent application of controls put the achievement of particular objectives at risk. Executive managers within the organisation who had responsibility for the development and maintenance of the system of internal control provided me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that managed the risks to the organisation achieving its principal objectives have been reviewed.

My review is also informed by:

- Attendance and debate at the Corporate Management Team Meetings, Primary Care Trust Board, and reports from the Audit Committee.
- The achievement of financial duties and the financial position of the Primary Care Trust.

Assessments from Mersey Internal Audit which report:

- Classified the Assurance Framework at the highest level 'A': 'An Assurance Framework has been established which is designed and operating to meet the requirements of the Annual Governance Statement and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation'.
- Responses to staff and patient surveys and other external reviews.

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

In addition I am aware of the importance of the roles of the following:

- The Board, The Board's role is to provide active leadership of the Trust within a framework of prudent and effective controls that enable risk to be assessed and managed
- The Audit Committee, as part of an integrated committee structure, is pivotal in advising the Board on the effectiveness of the system of internal control. Any significant internal control issues would be reported to the Board via the Audit Committee. An Audit Committee report has been produced outlining how the Committee complied with its duties delegated to it by the Primary Care Trust Board in its Terms of Reference.
- Executive Directors' roles and responsibilities in ensuring systems of internal control are in place and implemented effectively.
- Internal Audit provides reports to each meeting of the Audit Committee and full reports to the Director of Finance and key officers. The Audit Committee also receives details of any actions that remain outstanding from the follow up of previous audit work. The Director of Finance also meets regularly with the Audit Manager.
- External Audit – provides external audit annual management letter and progress reports to the Audit Committee.

Significant Issues

Financial Position at Year End for NHS Cheshire, Warrington and Wirral

The Cluster Plans were for an overall budget of £3.3 billion, which includes £1.1 billion in respect of the North West wide Specialist Commissioning function. The total surplus planned and delivered for the year is £10.3 million, excluding impairments. In addition, it is worth noting the challenging Quality, Innovation, Productivity and Prevention savings of £107.4 million, of which £55.7 million was cash releasing.

NHS 111 Programme

The 111 Programme had an established governance process for mobilisation actions which were required along with an established, and now on-going clinical governance assurance process since the "go live" of the service at the end of March. The Cluster role was to ensure that the mobilisation requirements were fulfilled and any outstanding actions were managed by way of a risk register as part of the joint mobilisation arrangements with Merseyside. This was due to the contract for the 111 programme being provided on a joint Cheshire and Mersey footprint.

The Cluster also ensured that the clinical governance arrangements were implemented and a structure of local clinical advisory groups (LCAG) established. Each LCAG (based around Out of Hours Services) will be led by a Clinical Commissioning Group, who will be responsible for co-ordinating and establishing the LCAGs, who will report through the 'county' specific clinical governance groups and ultimately via a clinical lead to the North West Clinical advisory group.

Financial Position

Western Cheshire Primary Care Trust has delivered a surplus of £2.030 million for the year-ended 31 March 2013. This is the year-end control total agreed with NHS North West Strategic Health Authority. This position will be delivered despite a significant increase in the cost of secondary care activity which has been mitigated by an underspend against the primary care prescribing budget and the use of contingencies. The surplus reflects a consolidated financial position including hosted services; North West Specialised Commissioning Team and Cheshire Health Agency.

Within the reported position, £8.133 million of recurrent funding has been used non-recurrently to support reform and pump-prime Quality, Innovation, Productivity and Prevention initiatives. The PCT achieved QIPP savings of £19.206 million during 2012/13.

Performance Issues

The Countess of Chester Trust has performed well for 2012/13 in relation to delivery of the Accident and Emergency 4 hour Standard and the 18 weeks elective targets. Over the last year the trust has had some issues with capacity in diagnostics to deliver the diagnostics standard, however recovery plans were put in place and the required standard is now delivering. The Trust has struggled to consistently deliver the 62 day Cancer pathway, however this has been recognised and the commissioners and the Trust have worked together to both identify and resolve the issues including the involvement of the Intensive support Team to support this .

The Trust has not achieved its target for Methicillin-Resistant Staphylococcus Aureus and Clostridium Difficile. Significant work has been undertaken at the Countess of Chester to minimise the levels of health care acquired infections. The focus needs to be on community acquired infections in discussions with public health. The two week urgent referral for a suspected cancer standard has been met. However, the 62 day treatment standard has not been achieved. The Countess of Chester has finalised an action plan to improve the Cancer 62 day performance with the Cancer Network.

Specific Issues

North West Specialised Commissioning Team

During 2012/13, the North West Office of the North of England Specialised Commissioning Group continued to focus on the transition to the NHS Commissioning Board as well as delivering business critical functions. As described in last year's Annual Governance Statement, in January 2012, the Chief Executives of the Primary Care Trust Clusters for the North East, North West and Yorkshire & the Humber agreed to bring together the three Specialised Commissioning Groups in the North of England to form the North of England Specialised Commissioning Group. This Group was established with effect from January 2012 and met regularly during 2012/13.

The North of England Specialised Commissioning Group was supported by three Regional Operating Groups, the North West, North East and Yorkshire and Humber. The North West Specialised Commissioning Operating Group met on a bi-monthly basis during the year, chaired by its host PCT Cluster Chief Executive. Its membership included executive directors from the five North West PCT Clusters. The main objective of the North West Specialised Commissioning Operating Group was to provide sound governance and assurance to support the commissioning of specialised and secure services in the North West, including the robust management of risk in relation to financial, clinical and political issues. The Group took an overview of the 2012/13 contracting round and received finance and activity performance reports on the contracts for specialised services throughout the year. This supported the continuation of business critical functions and provided an opportunity for the Assurance Framework and Risk Register to be regularly reviewed.

In addition, staff in the North West office contributed to the full range of national specialised commissioning transition work streams prior to the formal establishment of the NHS Commissioning Board and ensured that operational and governance structure and processes within the North West office were amended in line with national guidance as it was issued.

Conclusion

To the best of my knowledge, the governance arrangements in place are effective with the exception of the significant issues reported above.

Accountable Officer: Moira Dumma

Organisation: Western Cheshire Primary Care Trust

Signature: 

Date: 3.6.2013

INDEPENDENT AUDITOR'S REPORT TO THE SIGNING OFFICERS OF WAKEFIELD DISTRICT PRIMARY CARE TRUST

We have audited the financial statements of Wakefield District Primary Care Trust (PCT) for the year ended 31 March 2013 on pages I to IV and 1 to 39. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England. We have also audited the information in the Remuneration Report that is subject to audit.

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

Respective responsibilities of Signing Officer and auditor

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

Scope of the audit of the financial statements

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of Wakefield District PCT as at 31 March 2013 and of its expenditure and income for the year then ended; and

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

INDEPENDENT AUDITOR'S REPORT TO THE SIGNING OFFICERS OF WAKEFIELD DISTRICT PRIMARY CARE TRUST

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

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

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

In our opinion:

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

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

Matters on which we are required to report by exception

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

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

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

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

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

- our review of the Governance Statement; and

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

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

INDEPENDENT AUDITOR'S REPORT TO THE SIGNING OFFICERS OF WAKEFIELD DISTRICT PRIMARY CARE TRUST

Certificate

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

..... 6 June 2013

Paul Lundy for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
1 The Embankment
Neville Street
Leeds
LS1 4DW

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	**10,441**	12,944
Other costs	5.1	**670,509**	657,106
Income	4	**(20,175)**	(19,782)
Net operating costs before interest		**660,775**	650,268
Investment income	9	**0**	0
Other (Gains)/Losses	10	**8**	(14)
Finance costs	11	**(97)**	89
Net operating costs for the financial year		**660,686**	650,343
Transfers by absorption - (gains)		**0**	
Transfers by absorption - losses		**0**	
Net (gain)/loss on transfers by absorption		**0**	
Net Operating Costs for the Financial Year including absorption transfers		**660,686**	**650,343**
Of which:			
Administration Costs			
Gross employee benefits	7.1	**7,134**	8,200
Other costs	5.1	**8,743**	12,038
Income	4	**(3,980)**	(4,156)
Net administration costs before interest		**11,897**	**16,082**
Investment income	9	**0**	0
Other (Gains)/Losses	10	**8**	(14)
Finance costs	11	**0**	89
Net administration costs for the financial year		**11,905**	**16,157**
Programme Expenditure			
Gross employee benefits	7.1	**3,307**	4,744
Other costs	5.1	**661,766**	645,068
Income	4	**(16,195)**	(15,626)
Net programme expenditure before interest		**648,878**	**634,186**
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**(97)**	0
Net programme expenditure for the financial year		**648,781**	**634,186**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**88**	52
Net (gain) on revaluation of property, plant & equipment	**(192)**	(370)
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*	**660,582**	**650,025**

*This is the sum of the rows above plus net operating costs for the financial year after absorption accounting adjustments.
The notes on pages 5 to 39 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	11,697	11,841
Intangible assets	13	0	0
Investment property	15	0	0
Other financial assets	21	0	0
Trade and other receivables	19	0	0
Total non-current assets		11,697	11,841
Current assets:			
Inventories	18	0	0
Trade and other receivables	19	2,133	3,423
Other financial assets	36	0	0
Other current assets	22	0	0
Cash and cash equivalents	23	6	5
Total current assets		2,139	3,428
Non-current assets held for sale	24	0	120
Total current assets		2,139	3,548
Total assets		13,836	15,389
Current liabilities			
Trade and other payables	25	(29,796)	(40,848)
Other liabilities	26,28	0	0
Provisions	32	(2,760)	(4,192)
Borrowings	27	0	0
Other financial liabilities	36.2	0	0
Total current liabilities		(32,556)	(45,040)
Non-current assets plus/less net current assets/liabilities		(18,720)	(29,651)
Non-current liabilities			
Trade and other payables	25	0	0
Other Liabilities	28	0	0
Provisions	32	(5,377)	0
Borrowings	27	0	0
Other financial liabilities	36.2	0	0
Total non-current liabilities		(5,377)	0
Total Assets Employed:		(24,097)	(29,651)
Financed by taxpayers' equity:			
General fund		(28,766)	(34,262)
Revaluation reserve		4,669	4,611
Other reserves		0	0
Total taxpayers' equity:		(24,097)	(29,651)

The notes on pages 5 to 39 form part of this account.

The financial statements on pages *[I to IV]* were approved by the Board on and signed on its behalf by

Signing Officer: Date: 6/6/13

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	**(34,262)**	**4,611**	**0**	**(29,651)**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(660,686)	0	0	**(660,686)**
Net gain on revaluation of property, plant, equipment	0	192	0	**192**
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	(88)	0	**(88)**
Movements in other reserves	0	0	0	**0**
Transfers between reserves	46	(46)	0	**0**
Release of Reserves to SOCNE	0	0	0	**0**
Reclassification Adjustments				
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	**(660,640)**	**58**	**0**	**(660,582)**
Net Parliamentary funding	666,136	0	0	**666,136**
Balance at 31 March 2013	**(28,766)**	**4,669**	**0**	**(24,097)**
Balance at 1 April 2011	**(39,161)**	**4,612**	**0**	**(34,549)**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(650,343)	0	0	(650,343)
Net Gain/(loss) on Revaluation of Property, Plant and Equipment	0	370	0	370
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	(5)	0	(5)
Impairments and Reversals	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	366	(366)	0	0
Release of Reserves to Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification Adjustments				
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0	0
On disposal of available for sale financial assets	0	0	0	0
Net actuarial gain/(loss) on pensions	0	0	0	0
Total recognised income and expense for 2011-12	(649,977)	(1)	0	(649,978)
Net Parliamentary funding	654,876	0		654,876
Balance at 31 March 2012	**(34,262)**	**4,611**	**0**	**(29,651)**

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	**(660,775)**	(650,268)
Depreciation and Amortisation	**538**	881
Impairments and Reversals	**0**	0
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	**0**	0
Release of PFI/deferred credit	**0**	0
(Increase)/Decrease in Inventories	**0**	360
(Increase)/Decrease in Trade and Other Receivables	**1,290**	4,371
(Increase)/Decrease in Other Current Assets	**0**	0
Increase/(Decrease) in Trade and Other Payables	**(10,744)**	(11,583)
(Increase)/Decrease in Other Current Liabilities	**0**	0
Provisions Utilised	**(1,501)**	(902)
Increase/(Decrease) in Provisions	**5,543**	1,861
Net Cash Inflow/(Outflow) from Operating Activities	**(665,649)**	**(655,280)**
Cash flows from investing activities		
Interest Received	**0**	0
(Payments) for Property, Plant and Equipment	**(598)**	(109)
(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)	**112**	513
Proceeds of disposal of assets held for sale (Intangible)	**0**	0
Proceeds from Disposal of Other Financial Assets	**0**	0
Proceeds from the disposal of Financial Assets (LIFT)	**0**	0
Loans Made in Respect of LIFT	**0**	0
Loans Repaid in Respect of LIFT	**0**	0
Rental Revenue	**0**	0
Net Cash Inflow/(Outflow) from Investing Activities	**(486)**	**404**
Net cash inflow/(outflow) before financing	**(666,135)**	**(654,876)**
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**0**	0
Net Parliamentary Funding	**666,136**	654,876
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	**666,136**	**654,876**
Net increase/(decrease) in cash and cash equivalents	**1**	**0**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**5**	**5**
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	**6**	**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

Going Concern

Under the provisions of *The Health and Social Care Act 2012 (Commencement No.4. Transitional, Savings and Transitory Provisions) Order 2013,* Wakefield District PCT was dissolved on 1st April 2013. The PCT's functions, assets and liabilities transferred to other public sector entities as outlined in Note 42, Events after the Reporting Period. Where reconfigurations of this nature take place within the public sector, Government accounting requires that the activities concerned are to be considered as continuing operations, and so the closing entity prepares accounts on a "going concern" basis. The SOFP has therefore been drawn up at 31 March 2013 on the same basis as in previous years, reporting balances on the same basis as would a continuing entity. In particular, there has been no general revaluation of assets or liabilities, and no disclosures have been made under IFRS 5 *Non-current Assets Held for Sale and Discontinued Operation.*

Transforming Community Services (TCS) transactions

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

Acquisitions and Discontinued Operations

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

Critical accounting judgements and key sources of estimation uncertainty

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

1. Accounting policies (continued)

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.

Revaluations of land and buildings – the District Valuer performed a desktop exercise. Carrying values were not materially different from market value

The PCT followed the national guidelines when making judgements about the PCT closure costs.

For 2012-13 there is no requirement for a national restatement of 2011-12 figures. The DH will draw up consolidated accounts that show 2011-12 figures as presented to Parliament that year (i.e. without adjustment for local Prior Period Adjustments - PPAs) unless the cumulative value of local PPAs is material to the DH as a whole. The PCT did not have any local PPAs.

Key sources of estimation uncertainty
Property Plant and Equipment – estimates of asset lives may impact the depreciation charged and the carrying amount in the SOFP, but the risk is significantly reduced by the engagement of the District Valuer

Treasury discount rates which apply to various aspects of provisions, pensions and financial instruments – which are prescribed in the NHS Manual for Accounts

Key provisions including those associated with continuing care where a range of possible outcomes exist. The PCT The analysis of revenue and expenditure between administration and programme costs will require a degree of estimation regarding appropriate categorisation

Some March expenditure has been estimated, as the accounts have to be prepared before we usually receive some charges. Close liaison has been maintained with providers in order that these estimates are as accurate as possible. Any over or under estimations have been allocated to the organsation where the respective function transfers to, on the Statement of the Financial Position (Balance Sheet).

1. Accounting policies (continued)

Key sources of estimation uncertainty (continued)

Quality Outcomes Framework - The Quality Outcomes Framework (QOF) is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results. There are two elements to the payment made to GP's. The aspiration element, this is an upfront payment paid in equal instalments during the financial year, based on 70% of previous years total payment and is paid as an incentive for practices to adhere to QOF. Wakefield District Primary Care Trust also pay an additional aspiration payment to practices based on 25% of the previous years total payment, to ease cashflow. The second element is achievement. This payment is the difference between what practices should actually receive and the payment already made through the aspiration element. This payment is made in a lump sum at the beginning of the subsequent financial year. The qualifying period for QOF runs 1st April to 31st March. The value of the estimate included in the accounts is £565k (2011-12 £1,079k)

Dental - The PCT receives financial information from NHS Dental Services who process prescription and remunerate dental contractors. Each dental contractor has a contract to perform a certain amount of activity (Units of Dental Activity or UDA) at an agreed price per UDA. The dental contractors are then paid 1/12 of the total contract value each month. If dental practices under perform against their activity target the practice will be asked to either make up the underperformance in the following financial year or repay the PCT. No payment is made for overperformance. The value of the estimate in the accounts is £984k (£1.1m 2011-12)

Property Plant and Equipment useful lives - The life of buildings is determined by the District Valuer when valuations are performed. The PCT uses this life to depreciate the asset until the next revaluation. Useful economic life of plant and equipment is adopted by the PCT as determined by the Department of Health. At each Statement of Financial Position date the PCT reviews the useful lives of its plant and equipment. Assessing the appropriateness of useful life of plant and equipment requires the PCT to consider a number of factors such as physical condition and future economic use of the asset. An incorrect estimate of the useful life or residual value may impact the depreciation recognised in the Statement of Comprehensive Net Expenditure and the carrying amount of the asset in the Statement of Financial Position, Note 12.1 refers.

As a result of the introduction of deadlines for the assessment of a patient's eligibility for continuing healthcare funding, a significant number of retrospective claims for continuing healthcare funding up to 31 March 2013 have been received by the PCT. A provision has been made for the expected cost of these claims, but actual costs will only be confirmed on completion of in-depth case reviews which will be completed in the following financial year. Actual claim values will differ from the estimates made, but the overall difference is not expected to be material.

1. Accounting policies (continued)

1.2 Revenue and Funding

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

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

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

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

1.3 Care Trust Designation

Wakefield District Primary Care Trust is not designated by the Secretary of State under s45 of the Health and Social Care Act 2001 as a Care Trust.

1.4 Pooled budgets

The PCT has entered into a pooled budget with Wakefield Metropolitan District Council. Under the arrangement funds are pooled under S75 of the NHS Act 2006 for Learning Disability Services, the Integrated Community Equipment Service (now including Wheelchair Services and Short Breaks) and Adult Mental Health Services. Activities and a memorandum note to the accounts provides details of the joint income and expenditure.

The pools for Learning Disability Services and the Integrated Community Equipment Service are hosted by the Local Authority. The pool for Adult Mental Health Services is hosted by the Primary Care Trust. As a commissioner of healthcare services, the Primary Care Trust makes contributions to the pool, which are then used to purchase healthcare services. The Primary Care Trust accounts for its share of the assets, liabilities, income and expenditure of the pool as determined by the pooled budget agreement.

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 arrangements 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 a cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

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

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value. An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive net expenditure in the Statement of Comprehensive Net Expenditure.

Subsequent expenditure

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

1. Accounting policies (continued)

1.8 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.

The PCT does not have any intangible assets.

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

1. Accounting policies (continued)

1.10 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.

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

The PCT does not hold any inventories.

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

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.

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 PCT does not participate 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 rate of -1.8% for short term, -1.0% for medium term and +2.2% for long term (2.35% in respect of early staff departures) in real terms.

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

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

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

1. Accounting policies (continued)

1.26 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

Available for sale financial assets

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

Loans and receivables

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

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

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

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

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

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

1. Accounting policies (continued)

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

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

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

1.27 Private Finance Initiative (PFI) and NHS LIFT transactions
The PCT does not have any Private Finance Initiative (PFI) or NHS LIFT transactions.

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
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IPSAS 32 - Service Concession Arrangement - subject to consultation

2. Operating segments

Wakefield District Primary Care Trust is a commissioner of healthcare services for the population of the Wakefield district. The Primary Care Trust no longer provides healthcare services as an organisation. In this respect it is deemed that one organisational segment is in operation and this is reported to the board.

	Commissioner		Provider		Total	
	2012-13	2011-12	**2012-13**	2011-12	**2012-13**	2011-12
	£000	£000	**£000**	£000	**£000**	£000
Revenue Resource Limit	**663,787**	653,417	**0**	0	**663,787**	653,417
Income - External	**20,175**	19,782	**0**	0	**20,175**	19,782
Income - Segmental	**0**	0	**0**	0	**0**	0
Expenditure - External	**680,861**	670,125	**0**	0	**680,861**	670,125
Expenditure - Segmental	**0**	0	**0**	0	**0**	0
Less Non Discretionary Expenditure	**0**	0	**0**	0	**0**	0
Segment surplus	**3,101**	3,074	**0**	0	**3,101**	3,074

On 1 April 2011 most healthcare services of the former Provider Segment were transferred out of the organisation to alternative providers as part of the national Transforming Community Services agenda. The delivery of these services has been transferred under contractual terms to Mid Yorkshire Hospitals Trust, South West Yorkshire Partnership Foundation Trust and Spectrum Healthcare, a new community interest company.

On 1 May 2011 the remaining provider functions were transferred to Wakefield Metropolitan District Council.

IFRS 8 requires disclosure of expenditure relating to a single supplier which is greater than 10% of total expenditure. During the financial year ending 31/03/13 Wakefield District PCT expended resources totalling £265m with Mid Yorkshire Hospitals NHS Trust (2011/12 £267m).

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	**660,686**	650,343
Net operating cost plus (gain)/loss on transfers by absorption		
Adjusted for prior period adjustments in respect of errors	**0**	0
Revenue Resource Limit	**663,787**	653,417
Under/(Over)spend Against Revenue Resource Limit (RRL)	**3,101**	**3,074**

The PCT's revenue resource limit is shown after the return of £0m from the Strategic Investment Fund (SIF). The balance of SIF at 31/03/13 is.£2.75m.

3.2 Capital Resource Limit

	2012-13 £000	2011-12 £000
The PCT is required to keep within its Capital Resource Limit.		
Capital Resource Limit	**1,250**	0
Charge to Capital Resource Limit	**170**	(10)
(Over)/Underspend Against CRL	**1,080**	**10**

3.3 Provider full cost recovery duty

	2012-13 £000	2011-12 £000
The PCT is required to recover full costs in relation to its provider functions.		
Provider gross operating costs	**0**	0
Provider Operating Revenue	**0**	0
Net Provider Operating Costs	**0**	0
Costs Met Within PCTs Own Allocation	**0**	0
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	**666,136**	**654,876**
Cash Limit	**666,136**	**654,876**
Under/(Over)spend Against Cash Limit	**0**	**0**

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

	2012-13 £000
Total cash received from DH (Gross)	579,610
Less: Trade Income from DH reported on AoB form 98 Inc Exp	
Less/(Plus): movement in DH drs on AoB form 98 Cr Dr	
Sub total: net advances	**579,610**
(Less)/plus: transfers (to)/from other resource account bodies (free text note required)	
Plus: cost of Dentistry Schemes (central charge to cash limits)	16,165
Plus: drugs reimbursement (central charge to cash limits)	70,361
Parliamentary funding credited to General Fund	**666,136**

4 Miscellaneous Revenue

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Fees and Charges	**0**	0	0	0
Dental Charge income from Contractor-Led GDS & PDS	**5,422**	0	5,422	5,193
Dental Charge income from Trust-Led GDS & PDS	**0**	0	0	0
Prescription Charge income	**3,616**	0	3,616	3,674
Strategic Health Authorities	**709**	41	668	874
NHS Trusts	**2,264**	2,226	38	2,673
NHS Foundation Trusts	**248**	228	20	559
Primary Care Trusts - Contributions to DATs	**0**	0	0	0
Primary Care Trusts - Other	**225**	190	35	68
Primary Care Trusts - Lead Commissioning	**0**	0	0	0
English RAB Special Health Authorities	**118**	118	0	0
NDPBs and Others (CGA)	**0**	0	0	0
Department of Health - SMPTB	**0**	0	0	0
Department of Health - Other	**1**	0	1	1
Recoveries in respect of employee benefits	**225**	74	151	566
Local Authorities	**6,101**	244	5,857	4,833
Patient Transport Services	**0**	0	0	0
Education, Training and Research	**0**	0	0	0
Non-NHS: Private Patients	**0**	0	0	0
Non-NHS: Overseas Patients (Non-Reciprocal)	**0**	0	0	0
NHS Injury Costs Recovery	**0**	0	0	0
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	0
Receipt of Government granted assets	**0**	0	0	0
Rental revenue from finance leases	**0**	0	0	0
Rental revenue from operating leases	**0**	0	0	0
Other revenue	**1,246**	859	387	1,341
Total miscellaneous revenue	**20,175**	**3,980**	**16,195**	**19,782**

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	47,375		47,375	34,909
Non-Healthcare	1,354	1,354	0	1,030
Total	48,729	1,354	47,375	35,939
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	305,638	107	305,531	310,864
Goods and services (other, excl Trusts, FT and PCT)	1,403	0	1,403	478
Total	307,041	107	306,934	311,342
Goods and Services from Foundation Trusts	59,164	1,986	57,178	60,418
Purchase of Healthcare from Non-NHS bodies	85,548	0	85,548	72,976
Social Care from Independent Providers	0	0	0	0
Expenditure on Drugs Action Teams	2,619	0	2,619	2,285
Non-GMS Services from GPs	2,993	0	2,993	3,080
Contractor Led GDS & PDS (excluding employee benefits)	21,645	0	21,645	22,619
Salaried Trust-Led PDS & PCT DS (excluding employee benefits)	0	0	0	0
Chair, Non-executive Directors & PEC remuneration	109	109	0	62
Executive committee members costs	0	0	0	0
Consultancy Services	497	497	0	121
Prescribing Costs	58,920	0	58,920	61,000
G/PMS, APMS and PCTMS (excluding employee benefits)	54,666	0	54,666	57,388
Pharmaceutical Services	380	0	380	414
Local Pharmaceutical Services Pilots	0	0	0	0
New Pharmacy Contract	16,504	0	16,504	16,739
General Ophthalmic Services	3,585	0	3,585	3,601
Supplies and Services - Clinical	102	16	86	20
Supplies and Services - General	0	0	0	9
Establishment	1,811	1,683	128	1,730
Transport	66	53	13	95
Premises	2,241	2,241	0	2,434
Impairments & Reversals of Property, plant and equipment	0	0	0	0
Impairments & Reversals of non-current assets held for sale	0	0	0	0
Depreciation	538	538	0	881
Amortisation	0	0	0	0
Impairment & Reversals Intangible non-current assets	0	0	0	0
Impairment & Reversals of Financial Assets	0	0	0	0
Impairment of Receivables	(8)	(8)	0	(68)
Inventory write offs	0	0	0	0
Research and Development Expenditure	0	0	0	0
Audit Fees	125	125	0	161
Other Auditors Remuneration	38	38	0	30
Clinical Negligence Costs	187	187	0	10
Education and Training	404	376	28	203
Grants for capital purposes	0	0	0	0
Grants for revenue purposes	100	0	100	135
Impairments and reversals for investment properties	0	0	0	0
Other	2,505	(559)	3,064	3,482
Total Operating costs charged to Statement of Comprehensive Net Expenditure	670,509	8,743	661,766	657,106
Employee Benefits (excluding capitalised costs)				
Employee Benefits associated with PCTMS	0	0	0	0
Trust led PDS and PCT DS	0	0	0	0
PCT Officer Board Members	466	466	0	814
Other Employee Benefits	9,975	7,057	2,918	12,130
Total Employee Benefits charged to SOCNE	10,441	7,523	2,918	12,944
Total Operating Costs	680,950	16,266	664,684	670,050
Analysis of grants reported in total operating costs				
For capital purposes				
Grants to fund Capital Projects - GMS	0	0	0	0
Grants to Local Authorities to Fund Capital Projects	0	0	0	0
Grants to Private Sector to Fund Capital Projects	0	0	0	0
Grants to Fund Capital Projects - Dental	0	0	0	0
Grants to Fund Capital Projects - Other	0	0	0	0
Total Capital Grants	0	0	0	0
Grants to fund revenue expenditure				
To Local Authorities	0	0	0	0
To Private Sector	0	0	0	135
To Other	100	0	100	0
Total Revenue Grants	100	0	100	135
Total Grants	100	0	100	135

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	12,294	11,527	767
Weighted population (number in units)*	385,616	385,616	385,616
Running costs per head of population (£ per head)	31.88	29.89	1.99
PCT Running Costs 2011-12			
Running costs (£000s)	16,157	15,429	728
Weighted population (number in units)	385,616	385,616	385,616
Running costs per head of population (£ per head)	41.90	40.01	1.89

* 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	54,666	57,388
Prescribing costs	58,920	61,000
Contractor led GDS & PDS	21,645	22,619
Trust led GDS & PDS	0	0
General Ophthalmic Services	3,585	3,601
Department of Health Initiative Funding	0	0
Pharmaceutical services	380	414
Local Pharmaceutical Services Pilots	0	0
New Pharmacy Contract	16,504	16,739
Non-GMS Services from GPs	2,993	0
Other	1,323	0
Total Primary Healthcare purchased	**160,016**	161,761
Purchase of Secondary Healthcare		
Learning Difficulties	3,538	3,568
Mental Illness	66,703	59,622
Maternity	20,562	20,779
General and Acute	310,960	298,805
Accident and Emergency	30,453	29,892
Community Health Services	60,473	59,471
Other Contractual	11,005	12,689
Total Secondary Healthcare Purchased	**503,694**	484,826
Grant Funding		
Grants for capital purposes	0	0
Grants for revenue purposes	100	135
Total Healthcare Purchased by PCT	**663,810**	**646,722**
PCT self-provided secondary healthcare included above	0	0
Social Care from Independent Providers	0	0
Healthcare from NHS FTs included above	59,163	57,656

For 2011/12 Non-GMS Services from GPs, £3,080k, was included under GMS/PMS/APMS/PCTMS

6. Operating Leases

The PCT has entered into lease arrangements to secure property for conducting the business of healthcare and associated administration. All arrangements have been assessed individually and determined to be operating leases with reference to IAS 17.

There were no material leasing arrangements entered into during 2012/13.

The PCT has entered into operating leases for the provision of motor vehicles for employees deemed to have met the criteria as set out in the Primary Care Trusts lease car policy. Vehicles are leased for a period of three years and the aggregate sum of annual payments for 2012/13 is £65k (2011/12 £75K).

Transforming Community Services
The receiver organisations of the provider services functions previously undertaken by the PCT have rights to occupy premises under business transfer arrangements. This right to occupy constitutes an embedded leasing arrangement as defined by IFRIC 4. All risks and rewards of ownership rest with the PCT and as such the arrangements have been deemed to be operating leases. The right to occupy (licence) are not for a fixed term therefore it is not possible to disclose future minimum receipts.

The mechanism for this arrangement is for income to be generated from the recharge of costs incurred by the PCT on behalf of the provider organisation. This relates to an effective rent for service occupation. The provider is funded for this expense by way of a contract variation.

The values of these transactions are not considered material and do not appear in the operating lease notes.

6.1 PCT as lessee

	Land £000	Buildings £000	Other £000	Total £000	2011-2012 £000
Payments recognised as an expense					
Minimum lease payments				**1,008**	1,072
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**1,008**	**1,072**
Payable:					
No later than one year	**0**	**878**	**0**	**878**	1,001
Between one and five years	**0**	**4,241**	**0**	**4,241**	3,587
After five years	**0**	**5,015**	**0**	**5,015**	6,712
Total	**0**	**10,134**	**0**	**10,134**	**11,300**

In addition to the above, Wakefield District PCT has entered into certain financial arrangements involving the use of GP premises, as assessed under:

IAS17 Leases

SIC27 Evaluating the substance of transactions involving the legal form of a lease

IFRIC4 Determining whether an arrangement contains a lease

The PCT has determined that those operating leases must be recognised, but, as there is no defined term in the arrangements entered into, it is not possible to analyse the arrangements over financial years. The financial value included in the Statement of Net Comprehensive Expenditure for 2012/13 is £5,926k (2011/12 £5,926k)

6.2 PCT as lessor

The Primary Care Trust has no leasing arrangements with third parties from the perspective of a lessor, other than the TCS transactions noted above.

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	8,573	5,835	2,738	7,634	5,196	2,438	939	639	300
Social security costs	648	441	207	577	393	184	71	48	23
Employer Contributions to NHS BSA - Pensions Division	1,131	769	362	1,007	685	322	124	84	40
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	89	89	0	89	89	0	0	0	0
Total employee benefits	10,441	7,134	3,307	9,307	6,363	2,944	1,134	771	363
Less recoveries in respect of employee benefits (table below)	(225)	(74)	(151)	(225)	(74)	(151)	0	0	0
Total - Net Employee Benefits including capitalised costs	10,216	7,060	3,156	9,082	6,289	2,793	1,134	771	363
Employee costs capitalised	0	0	0	0	0	0	0	0	0
Gross Employee Benefits excluding capitalised costs	10,441	7,134	3,307	9,307	6,363	2,944	1,134	771	363
Recognised as:									
Commissioning employee benefits	10,441			9,307			1,134		
Provider employee benefits	0			0			0		
Gross Employee Benefits excluding capitalised costs	10,441			9,307			1,134		

	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	186	61	125	186	61	125	0	0	0
Social Security costs	14	5	9	14	5	9	0	0	0
Employer Contributions to NHS BSA - Pensions Division	25	8	17	25	8	17	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	225	74	151	225	74	151	0	0	0

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	8,915	8,725	190
Social security costs	670	655	15
Employer Contributions to NHS BSA - Pensions Division	1,168	1,144	24
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	2,191	2,191	0
Total gross employee benefits	12,944	12,715	229
Less recoveries in respect of employee benefits	(566)	(475)	(91)
Total - Net Employee Benefits including capitalised costs	12,378	12,240	138
Employee costs capitalised	0	0	0
Gross Employee Benefits excluding capitalised costs	12,944	12,715	229
Recognised as:			
Commissioning employee benefits	12,944		
Provider employee benefits	0		
Gross Employee Benefits excluding capitalised costs	12,944		

A provision was made in 2011/12 for redundancies following restructuring of £2,239k, but £1,043k was not used and so has been released in 2012/13

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	2	2	0	2	2	0
Ambulance staff	0	0	0	0	0	0
Administration and estates	204	177	27	203	191	12
Healthcare assistants and other support staff	0	0	0	0	0	0
Nursing, midwifery and health visiting staff	19	19	0	20	20	0
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	12	12	0	16	16	0
Social Care Staff	0	0	0	0	0	0
Other	0	0	0	0	0	0
TOTAL	237	210	27	242	229	12
Of the above - staff engaged on capital projects	0	0	0	0	0	0

7.3 Staff Sickness absence and ill health retirements

	2012-13 Number	2011-12 Number
Total Days Lost	2,208	10,201
Total Staff Years	245	1,055
Average working Days Lost	9.00	9.67

The 2012-13 figures represent the calendar year 1st January 2012 to 31st December 2012.
The 2011-12 figures represent the calendar year 1st January 2011 to 31st December 2011.

	2012-13 Number	2011-12 Number
Number of persons retired early on ill health grounds	1	0
	£000s	£000s
Total additional pensions liabilities accrued in the year	167	0

7.4 Exit Packages agreed during 2012-13

	2012-13			2011-12		
Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**
	Number	**Number**	**Number**	**Number**	**Number**	**Number**
Lees than £10,000	**0**	**1**	**1**	5	5	**10**
£10,001-£25,000	**0**	**1**	**1**	2	2	**4**
£25,001-£50,000	**0**	**1**	**1**	1	2	**3**
£50,001-£100,000	**0**	**1**	**1**	0	3	**3**
£100,001 - £150,000	**2**	**1**	**3**	0	0	**0**
£150,001 - £200,000	**2**	**0**	**2**	1	1	**2**
>£200,000	**2**	**0**	**2**	0	0	**0**
Total number of exit packages by type (total cost)	**6**	**5**	**11**	**9**	**13**	**22**
	£s	**£s**	**£s**	**£s**	**£s**	**£s**
Total resource cost	1,035,556	261,245	**1,296,801**	311,000	478,200	**789,200**

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 a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

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

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

b) Full actuarial (funding) valuation

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

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

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

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

c) Scheme provisions

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

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

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

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

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

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

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

8. Better Payment Practice Code

8.1 Measure of compliance

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**12,109**	**97,071**	11,268	82,055
Total Non-NHS Trade Invoices Paid Within Target	**11,559**	**92,831**	10,941	79,927
Percentage of NHS Trade Invoices Paid Within Target	95.46%	95.63%	97.10%	97.41%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3,228**	**418,859**	3,078	416,729
Total NHS Trade Invoices Paid Within Target	**3,112**	**418,145**	2,967	416,490
Percentage of NHS Trade Invoices Paid Within Target	96.41%	99.83%	96.39%	99.94%

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

The PCT did not receive any investment income.

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	14
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	(8)	(8)	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	(8)	(8)	0	14

11. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest				
Interest on obligations under finance leases	0	0	0	0
Interest on obligations under PFI contracts:				
- main finance cost	0	0	0	0
- contingent finance cost	0	0	0	0
Interest on obligations under LIFT contracts:				
- main finance cost	0	0	0	0
- contingent finance cost	0	0	0	0
Interest on late payment of commercial debt	0	0	0	0
Other interest expense	0	0	0	0
Total interest expense	0	0	0	0
Other finance costs	0	0	0	0
Provisions - unwinding of discount	(97)	0	(97)	89
Total	(97)	0	(97)	89

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	3,767	7,887	0	0	1,014	0	3,666	623	16,957
Additions of Assets Under Construction									0
Additions Purchased	0	290	0	0	0	0	0	0	290
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	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	192	0	0	0	0	0	0	192
Impairments/negative indexation	(77)	(11)	0	0	0	0	0	0	(88)
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	3,690	8,358	0	0	1,014	0	3,666	623	17,351
Depreciation									
At 1 April 2012	0	0	0	0	870	0	3,644	602	5,116
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	0	0	0	0	0	0	0	0	0
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Charged During the Year	0	489	0	0	32	0	7	10	538
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	0
At 31 March 2013	0	489	0	0	902	0	3,651	612	5,654
Net Book Value at 31 March 2013	3,690	7,869	0	0	112	0	15	11	11,697
Purchased	3,690	7,869	0	0	112	0	15	11	11,697
Donated	0	0	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	3,690	7,869	0	0	112	0	15	11	11,697
Asset financing:									
Owned	3,690	7,869	0	0	112	0	15	11	11,697
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	3,690	7,869	0	0	112	0	15	11	11,697

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & 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	2,498	2,090	0	0	19	0	0	4	4,611
Movements (specify)	(125)	183	0	0	0	0	0	0	58
At 31 March 2013	2,373	2,273	0	0	19	0	0	4	4,669

Additions to Assets Under Construction in 2012-13

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

12.2 Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	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	**3,815**	**7,512**	**0**	**0**	**1,014**	**0**	**3,646**	**623**	**16,610**
Additions purchased	0	468	0	0	0	0	20	0	**488**
Additions donated	0	0	0	0	0	0	0	0	**0**
Additions government granted	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	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	421	0	0	0	0	0	0	**421**
Impairments	(48)	(4)	0	0	0	0	0	0	**(52)**
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	(510)	0	0	0	0	0	0	**(510)**
At 31 March 2012	**3,767**	**7,887**	**0**	**0**	**1,014**	**0**	**3,666**	**623**	**16,957**
Depreciation									
At 1 April 2011	**0**	**0**	**0**	**0**	**825**	**0**	**3,506**	**414**	**4,745**
Reclassifications		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	0	0	0	0	0	0	0	0	**0**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Charged During the Year	0	510	0	0	45	0	138	188	**881**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluation	0	(510)	0	0	0	0	0	0	**(510)**
At 31 March 2012	**0**	**0**	**0**	**0**	**870**	**0**	**3,644**	**602**	**5,116**
Net Book Value at 31 March 2012	**3,767**	**7,887**	**0**	**0**	**144**	**0**	**22**	**21**	**11,841**
Purchased	3,767	7,887	0	0	144	0	22	21	**11,841**
Donated	0	0	0	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**3,767**	**7,887**	**0**	**0**	**144**	**0**	**22**	**21**	**11,841**
Asset financing:									
Owned	3,767	7,887	0	0	144	0	22	21	**11,841**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**3,767**	**7,887**	**0**	**0**	**144**	**0**	**22**	**21**	**11,841**

12.3 Property, plant and equipment

A full revaluation of all property assets was undertaken on 1st April 2009 and an interim valuation obtained as at 31st March 2013 by the office of the District Valuer. For specialist property assets, in line with HM Treasury requirements, the valuation method changed on 1st April 2009 to modern equivalent asset (MEA) basis. The interim revaluation of property assets has led to a net increase in value for buildings of £181k and a net reduction of £77k relating to land.

Economic Lives of Non-Current Assets

	Min Life Years	Max Life Years
Property, Plant and Equipment		
Buildings exc Dwellings	0	90
Dwellings	0	0
Plant & Machinery	0	10
Transport Equipment	0	0
Information Technology	0	5
Furniture and Fittings	0	8

13.1 Intangible non-current assets

2012-13	Software internally generated	Software purchased	Licences & trademarks	Patents	Development expenditure	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2012	**0**	**12**	**0**	**0**	**0**	**12**
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**
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**	**12**	**0**	**0**	**0**	**12**
Amortisation						
At 1 April 2012	**0**	**12**	**0**	**0**	**0**	**12**
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**	**12**	**0**	**0**	**0**	**12**
Net Book Value at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**
Net Book Value at 31 March 2013 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 2013	**0**	**0**	**0**	**0**	**0**	**0**

Revaluation reserve balance for intangible non-current assets

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

13.2 Intangible non-current assets

2011-12	Software internally generated	Software purchased	Licences & trademarks	Patents	Development expenditure	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2011	**0**	**12**	**0**	**0**	**0**	**12**
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	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation & indexation gains	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	**0**
In-year transfers to/from NHS bodies	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluation	0	0	0	0	0	**0**
At 31 March 2012	**0**	**12**	**0**	**0**	**0**	**12**
Amortisation						
At 1 April 2011	**0**	**12**	**0**	**0**	**0**	**12**
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**
Less cumulative dep written down on revaluation	0	0	0	0	0	**0**
At 31 March 2012	**0**	**12**	**0**	**0**	**0**	**12**
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**

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	0	0	0
Changes in market price	0	0	0
Total charged to Annually Managed Expenditure	**0**		**0**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Loss or damage resulting from normal operations	0	0	0
Over Specification of Assets	0	0	0
Abandonment of assets in the course of construction	0	0	0
Unforeseen obsolescence	0	0	0
Loss as a result of catastrophe	0	0	0
Other	0	0	0
Changes in market price	88	88	0
Total impairments for PPE charged to reserves	**88**	88	0
Total Impairments of Property, Plant and Equipment	**88**	**88**	**0**
Intangible asset impairments and reversals charged 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	0	0	0
Changes in market price	0	0	0
Total charged to Annually Managed Expenditure	**0**	**0**	**0**
Intangible Asset impairments and reversals charged to the Revaluation Reserve			
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
Unforeseen obsolescence	0	0	0
Loss as a result of catastrophe	0	0	0
Other	0	0	0
Changes in market price	0	0	0
Total impairments for Intangible Assets charged to Reserves	**0**	**0**	**0**
Total Impairments of Intangibles	**0**	**0**	**0**

Financial Assets charged to SOCNE			
Loss or damage resulting from normal operations	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Loss as a result of catastrophe	0	0	0
Other	0	0	0
Total charged to Annually Managed Expenditure	**0**	**0**	**0**
Financial Assets impairments and reversals charged to the Revaluation Reserve			
Loss or damage resulting from normal operations	0	0	0
Loss as a result of catastrophe	0	0	0
Other	0	0	0
TOTAL impairments for Financial Assets charged to reserves	**0**	**0**	**0**
Total Impairments of Financial Assets	**0**	**0**	**0**
Non-current assets held for sale - impairments and reversals charged to SOCNE			
Loss or damage resulting from normal operations	0	0	0
Abandonment of assets in the course of construction	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen obsolescence	0	0	0
Loss as a result of catastrophe	0	0	0
Other	0	0	0
Changes in market price	0	0	0
Total charged to Annually Managed Expenditure	**0**	**0**	**0**
Total impairments of non-current assets held for sale	**0**	**0**	**0**
Inventories - impairments and reversals charged to SOCNE			
Loss or Damage Resulting from Normal Operations	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen Obsolescence	0	0	0
Loss as a Result of a Catastrophe	0	0	0
Other	0	0	0
Changes in Market Price	0	0	0
Total charged to Annually Managed Expenditure	**0**	**0**	**0**
Total Impairments of Inventories	**0**	**0**	**0**
Investment Property impairments charged to SOCNE			
Loss or Damage Resulting from Normal Operations	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen Obsolescence	0	0	0
Loss as a Result of a Catastrophe	0	0	0
Other	0	0	0
Changes in Market Price	0	0	0
Total charged to Annually Managed Expenditure	**0**	**0**	**0**
Total Investment Property impairments charged to SOCNE	**0**	**0**	**0**
Investment Property impairments and reversals charged to the Revaluation Reserve			
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
Unforeseen Obsolescence	0	0	0
Loss as a Result of a Catastrophe	0	0	0
Other	0	0	0
Changes in Market Price	0	0	0
TOTAL impairments for Investment Property charged to Reserves	**0**	**0**	**0**
Total Investment Property Impairments	**0**	**0**	**0**
Total Impairments charged to Revaluation Reserve	88	88	0
Total Impairments charged to SOCNE - DEL	0	0	0
Total Impairments charged to SOCNE - AME	0	0	0
Overall Total Impairments	**88**	**88**	**0**
Of which:			
Impairment on revaluation to "modern equivalent asset" basis	**0**	0	0

As a result of the interim revaluation carried out by the District Valuer dated 31st March 2013, and a review of the assets the Primary Care Trust has incurred impairments totalling £88k. Gains on revaluation have been credited to the revaluation reserve. Impairments have been taken to the appropriate revaluation reserve with any excess charged to the Statement of Comprehensive Net Expenditure.

15 Investment property

The PCT does not hold any investment properties.

16 Commitments

16.1 Capital commitments

The PCT has no contracted capital commitments.

16.2 Other financial commitments

The PCT has no other financial commitments.

17 Intra-Government and other balances

	Current receivables £000	Non-current receivables £000	Current payables £000	Non-current payables £000
Balances with other Central Government Bodies	909	0	3,689	0
Balances with Local Authorities	442	0	2,618	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	179	0	2,864	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	603	0	20,625	0
At 31 March 2013	**2,133**	**0**	**29,796**	**0**
Prior period:				
Balances with other Central Government Bodies	260	0	1,523	0
Balances with Local Authorities	293	0	2,460	0
Balances with NHS Trusts and Foundation Trusts	2,005	0	6,540	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	865	0	30,325	0
At 31 March 2012	**3,423**	**0**	**40,848**	**0**

18 Inventories

The PCT does not hold any inventories.

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	**727**	2,180	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**0**	0	**0**	0
Non-NHS receivables - revenue	**1,041**	707	**0**	0
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**4**	467	**0**	0
Provision for the impairment of receivables	**0**	(19)	**0**	0
VAT	**361**	85	**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	**0**	0	**0**	0
Other receivables	**0**	3	**0**	0
Total	**2,133**	3,423	**0**	0
Total current and non current	**2,133**	3,423		
Included above:				
Prepaid pensions contributions	**0**	0		

The great majority of trade is with other NHS bodies, including other Primary Care Trusts as commissioners for NHS patient care services. As Primary Care Trusts are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

19.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	**330**	236
By three to six months	**39**	66
By more than six months	**(2)**	0
Total	**367**	302

19.3 Provision for impairment of receivables

	2012-13 £000	**2011-12 £000**
Balance at 1 April 2012	**(19)**	(87)
Amount written off during the year	**11**	0
Amount recovered during the year	**8**	80
(Increase)/decrease in receivables impaired	**0**	(12)
Balance at 31 March 2013	**0**	(19)

20 NHS LIFT investments

The PCT does not hold any NHS LIFT investments

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	0	0
Additions	0	0
Revaluation	0	0
Impairments	0	0
Impairment Reversals	0	0
Transferred to current financial assets	0	0
Disposals	0	0
Transfers (to)/from Other Public Sector Bodies in year	0	0
Total Other Financial Assets - Non Current	0	0

21.3 Other Financial Assets - Capital Analysis

	31 March 2013 £000	31 March 2012 £000
Capital Expenditure	0	0
Capital Income	0	0

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	5
Net change in year	1	0
Closing balance	6	5
Made up of		
Cash with Government Banking Service	6	4
Commercial banks	0	1
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	6	5
Bank overdraft - Government Banking Service	0	0
Bank overdraft - Commercial banks	0	0
Cash and cash equivalents as in statement of cash flows	6	5
Patients' money held by the PCT, not included above	0	0

24 Non-current assets held for sale

	Land	Buildings, excl. dwellings	Dwellings	Assets 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	120	0	0	0	0	0	0	0	0	**120**
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	0	**0**
Less assets sold in the year	(120)	0	0	0	0	0	0	0	0	**(120)**
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	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
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	432	191	0	0	0	0	0	0	0	**623**
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	0	**0**
Less assets sold in the year	(307)	(191)	0	0	0	0	0	0	0	**(498)**
Less impairment of assets held for sale	(5)	0	0	0	0	0	0	0	0	**(5)**
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	**120**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**120**
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	0

As of 1st April 2012 there was one property classed as held for sale, Knottingley Health Centre. During the year no further properties have been declared as held for sale. The sale of Knottingley was realised during the year, at its market value of £120k.

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		
NHS payables - revenue	**5,821**	7,636	**0**	0
NHS payables - capital	**0**	57	**0**	0
NHS accruals	**0**	0	**0**	0
Family Health Services (FHS) payables	**10,977**	13,590	**0**	0
Non-NHS payables - revenue	**3,392**	8,992	**0**	0
Non-NHS payables - capital	**165**	416	**0**	0
Non-NHS accruals	**8,913**	9,798	**0**	0
Social security costs	**108**	104	**0**	0
VAT	**0**	0	**0**	0
Tax	**275**	119	**0**	0
Payments received on account	**0**	0	**0**	0
Other	**145**	136	0	0
Total	**29,796**	40,848	**0**	0
Total payables (current and non-current)	**29,796**	**40,848**		

26 Other liabilities

The PCT has no other liabilities

27 Borrowings

The PCT has no borrowings

28 Other financial liabilities

The PCT has no other financial liabilities

29 Deferred income

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Opening balance at 1 April 2012	**0**	133	**0**	0
Deferred income addition	**0**	0	**0**	0
Transfer of deferred income	**0**	(133)	**0**	0
Current deferred Income at 31 March 2013	**0**	0	**0**	0
Total other liabilities (current and non-current)	**0**	**0**		

30 Finance lease obligations

The PCT has no finance lease obligations.

31 Finance lease receivables as lessor

The PCT has no finance lease receivables.

Finance Lease Commitments

The PCT has no finance lease commitments.

32 Provisions

Comprising:

	Total	Pensions to Former Directors	Pensions Relating to Other Staff	Legal Claims	Restructuring	Continuing Care	Equal Pay	Agenda for Change	Other	Redundancy
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Balance at 1 April 2012	**4,192**	0	0	204	776	434	0	0	539	2,239
Arising During the Year	**7,703**	0	0	0	0	7,703	0	0	0	0
Utilised During the Year	**(1,501)**	0	0	(91)	(20)	0	0	0	(258)	(1,132)
Reversed Unused	**(2,160)**	0	0	(109)	(739)	0	0	0	(269)	(1,043)
Unwinding of Discount	**(97)**	0	0	(4)	(17)	0	0	0	(12)	(64)
Change in Discount Rate	**0**	0	0	0	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	**8,137**	**0**	**0**	**0**	**0**	**8,137**	**0**	**0**	**0**	**0**
Expected Timing of Cash Flows:										
No Later than One Year	**2,760**	**0**	**0**	**0**	**0**	**2,760**	**0**	**0**	**0**	**0**
Later than One Year and not later than Five Years	**5,377**	**0**	**0**	**0**	**0**	**5,377**	**0**	**0**	**0**	**0**
Later than Five Years	**0**	**0**	**0**	**0**	**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	183
As at 31 March 2012	424

Continuing Care provisions relate to retrospective continuing care criteria claims. The value of these claims is estimated based on the likely future obligation when considering the number of claims received and their potential value.

33 Contingencies

	31 March 2013	31 March 2012
	£000	£000
Contingent liabilities		
Equal Pay	**0**	0
Other	**(10,600)**	0
Amounts Recoverable Against Contingent Liabilities	**0**	0
Net Value of Contingent Liabilities	**(10,600)**	0

There is a potential that additional retrospective continuing health care criteria claims could become eligible for payment, estimated at £10.6m. This is the maximum estimate and any actual materialisation is expected to be significantly less.

Contingent Assets		
Contingent Assets	**875**	875
Net Value of Contingent Assets	**875**	875

The PCT has a contingent asset relating to 6 properties used to provide residential care for patients with mental health or learning disability needs.

The purchase of these properties was funded in part or whole by grants from NHS bodies which were predecessor bodies of Wakefield District PCT. The PCT has a legal charge over these properties which was placed on them at the time the grants were made.

If the properties cease to be used to provide the care services specified in the legal charges the PCT is entitled to receive a some of money which is specified by reference to the market value of the properties/value of the grant at that time. The aggregate value of the legal charges is £875k. This is based on the current market value of the properties as assessed by the District Valuer. The properties are difficult to value precisely and the amounts realised may be different when the properties are sold.

34 PFI and LIFT - additional information

The PCT does not have any PFI or LIFT schemes

35 Impact of IFRS treatment - 2012-13

Not appicable to Wakefield PCT

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.

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	727	0	**727**
Receivables - non-NHS	0	1,041	0	**1,041**
Cash at bank and in hand	0	6	0	**6**
Other financial assets	0	0	0	**0**
Total at 31 March 2013	**0**	**1,774**	**0**	**1,774**
Embedded derivatives	0	0	0	0
Receivables - NHS	0	2,180	0	2,180
Receivables - non-NHS	0	707	0	707
Cash at bank and in hand	0	5	0	5
Other financial assets	0	0	0	0
Total at 31 March 2012	0	2,892	0	2,892

36.2 Financial Liabilities	At 'fair value through profit and loss' £000	Other £000	Total £000
Embedded derivatives	0	0	**0**
NHS payables	0	5,821	**5,821**
Non-NHS payables	0	14,679	**14,679**
Other borrowings	0	0	**0**
PFI & finance lease obligations	0	0	**0**
Other financial liabilities	0	8,137	**8,137**
Total at 31 March 2013	**0**	**28,637**	**28,637**
Embedded derivatives	0	0	0
NHS payables	0	7,693	7,693
Non-NHS payables	0	23,134	23,134
Other borrowings	0	0	0
PFI & finance lease obligations	0	0	0
Other financial liabilities	0	4,192	4,192
Total at 31 March 2012	**0**	35,019	35,019

37 Related party transactions

Details of related party transactions with individuals are as follows:

Board and sub committee members register a formal declaration of interest with the PCT. Details of their related party transactions are as follows:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£	£	£	£
Dr Phil Earnshaw - Novus Health Ltd	1,169		118	
Dr Phil Earnshaw - PMS Contract	1,156			
Dr A Sheppard - Novus Health Ltd	1,169		118	
Dr A Sheppard - PMS Contract	1,544			
Dr A Sheppard - Safe Haven Service	29			
Dr A Biswas - Novus Health Ltd	1,169		118	
Dr A Biswas - PMS Contract	1,624			
Dr C Harries - Novus Health Ltd	1,169		118	
Dr C Harries - PMS Contract	1,386			
Dr D Brown - Kings Building Partnership	144			
Dr D Brown - Novus Health Ltd	1,169		118	
Dr D Brown - PMS Contract	1,480			
Dr I Hanney - Novus Health Ltd	1,169		118	
Dr I Hanney - PMS Contract	1,171			
Dr P Dewhirst - Novus Health	1,169		118	
Dr P Dewhirst - PMS Contract	346			
Mr S Bryan - Novus Health Ltd	1,169		118	
Mr S Bryan - PMS Contract	862			

The Department of Health is regarded as a related party. During the year Wakefield District PCT has had a significant number of material transactions with the

Yorkshire and the Humber Strategic Health Authority
Mid Yorkshire Hospitals NHS Trust
South West Yorkshire Partnership Foundation Trust
Leeds Teaching Hospitals NHS Trust
Yorkshire Ambulance Service
Barnsley Primary Care Trust
Barnsley Hospitals NHS Foundation Trust
Calderdale Primary Care Trust
Calderdale and Huddersfield NHS Foundation Trust
Kirklees Primary Care Trust
Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Sheffield Teaching Hospitals Foundation Trust
Bradford Teaching Hospitals NHS Foundation Trust
York Hospitals NHS Foundation Trust
Nottingham Healthcare NHS Trust
NHS Supply Chain
NHS Litigation Authority

In addition, the PCT has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Wakefield Metropolitan District Council.

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	0	0
Special payments - PCT management costs	0	0
Losses in respect of the provision of family practitioner services	0	0
Special payments in respect oft he provision of family practitioner services	0	0
Total losses	0	0
Total special payments	0	0
Total losses and special payments	0	0

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	37	1
Special payments - PCT management costs	48,309	4
Losses in respect of the provision of family practitioner services	0	0
Special payments in respect oft he provision of family practitioner services	0	0
Total losses	37	1
Total special payments	48,309	4
Total losses and special payments	48,346	5

39 Third party assets

The PCT did not hold any third party assets at 31st March 2013 (2012-13 Nil).

40 Pooled budgets

Section 75 of the NHS Act 2006 allows partnership arrangements between National Health Service bodies, Local Authorities and other agencies in order to improve and co-ordinate services. Each partner makes a contribution to the pooled budget, with the aim of focusing services and activities for a client group. Funds contributed are normally used for the services represented in the pooled budget and allow the organisations involved to act in a more cohesive way.

As at 31st March 2013 the PCT has three pooled budgets under Section 75 of the NHS Act 2006. These pools relate to People with Learning Difficulties (created in 2002-03), the Integrated Community Equipment Services (created on January 2004),and Adult Mental Health Services created 2006-07.

Services to People with Learning Disabilities

The PCT in association with Wakefield Metropolitan District Council has created a pooled budget for People with Learning Disabilities. Wakefield Metropolitan District Council act as the host and lead commissioner for the pool.

The details of the contributions and expenditure are disclosed below:

	2012-13 £000	2011-12 £000
Funding		
Contribution from Wakefield District PCT	3,538	3,568
Contribution from Wakefield MDC	18,594	18,593
Surplus b/f from previous year	(146)	
Adjustment to 2011-12 Closing Balance (see note below)	564	
Total	**22,550**	**22,161**
Expenditure		
Fieldhead Resettlement	8,452	8,078
Other PLD services	14,098	13,863
Total	**22,550**	**21,941**
Net surplus (deficit)	**0**	**220**

Integrated Community Equipment Service, Wheelchairs and Short Breaks

The PCT in association with Wakefield MDC has established an Integrated Community Equipment Service, Wheelchairs and Short Breaks pool .This has meant the creation of a pooled budget with the local authority as the lead commissioner and provider.

The details of the contributions and expenditure are disclosed as below:

	2012-13 £000	2011-12 £000
Funding		
Contribution from Wakefield District PCT	2,756	1,162
Contribution from Wakefield MDC	841	841
Surplus b/f from previous year	96	295
Adjustment to 2011-12 Closing Balance (see note below)	146	
Accruals	165	
Total	**4,004**	**2,298**
Expenditure		
Service Provision	3,872	2,202
Total	**3,872**	**2,202**
Net Surplus	**132**	**96**

Adult Mental Health Services

The PCT in association with Wakefield Metropolitan District Council has created a pooled budget for adults requiring mental health services. The PCT acts as the host and lead commissioner for the pool.

The details of the contributions and expenditure are disclosed below:

	2012-13 £000	2011-12 £000
Funding		
Contribution from Wakefield District PCT	22,751	23,111
Contribution from Wakefield MDC	5,144	3,751
Total	**27,895**	**26,862**
Expenditure		
Community Mental Health Teams	6,526	6,632
Access and CRISIS services	4,377	4,199
Clinical Services	9,562	10,007
Other	7,427	6,170
Total	**27,892**	**27,008**
Net Surplus (deficit)	**3**	**-146**

Adjustment to 2011-12 Closing Balance
this has arisen due to WMDC producing their final figures after the closure of the PCT's accounts last year.

Drug Action Team

The Department of Health require disclosure of a memorandum where a Primary Care Trust is to host the National Treatment Agency's substance misuse budget under a pooled budget arrangement. Wakefield District PCT is the host for the National treatment Agency's substance misuse budget for Wakefield District however, this is not a pooled budget as defined by FRS9. The income arises from Department of Health resource allocations to the Primary Care Trust which amounted to £3,584k for the 2012-13 financial year.(2011-12 £4,163k)

41 Cashflows relating to exceptional items

There were no cashflows relating to exceptional items.

42 Events after the end of the reporting period

The main functions carried out by Wakefield District PCT in 2012-13 are to be carried out in 2013-14 by the following public sector bodies. An estimate of the value of the function transferred is also stated

	£ million
NHS Wakefield Clinical Commissioning Group - Commissioning of Secondary Care	475
NHS England - Commissioning of Primary Care and Specialised Commissioning	145
Wakefield Metropolitan District Council - Public Health programme	19

All fixed assets(£11,697k), together with the associated Revaluation Reserves (£4,669k), have transferred to NHS Property Services on 1st April 2013. These were considered operational at the year end, and so have not been impaired in the PCT books. It is for the successor body to consider whether, in 2013-14, it is necessary to review these for impairment.