Department of Health

NHS

Western Cheshire Primary Care Trust

2012-13 Annual Report and Accounts

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Western Cheshire Primary Care Trust

2012-13 Annual Report

NHS
Western Cheshire
Your partner for longer healthier lives

NHS WESTERN CHESHIRE
ANNUAL REPORT 2012/13

Foreword

We are very pleased to introduce the Annual Report for the year 2012/13, a year which has been very challenging, not only for Primary Care Trusts but for the NHS as a whole.

We began the year finalising the arrangements for the fundamental changes to the NHS heralded in the NHS White Paper, and ended by transferring our statutory responsibilities to successor organisations.

As a result of the changes to the NHS architecture, NHS Cheshire, Warrington and Wirral was formed on 1st June 2011 as a single Cluster Primary Care Trust Board for each of the four Primary Care Trusts: NHS Central and Eastern Cheshire, NHS Warrington, NHS Western Cheshire and NHS Wirral. The Cluster Board comprises a senior management team which covers the four constituent PCTs and Non-Executive Directors from each Primary Care Trust.

In times of rapid change, it is those organisations with committed staff, effective management and robust systems and processes in place that are able to both adapt quickly and deliver their responsibilities. We believe that we have demonstrated this through 2012/13 as described in this Report.

Our legacy will be to ensure that the transition to the new NHS commissioning structures is managed smoothly for the benefit of the population of Cheshire, Warrington and Wirral.

It is important to recognise that we could not have achieved this rapid transformation without the loyalty and dedication of all our staff who work together tirelessly to ensure that our local people and visitors receive the best health care possible. Once again, we would like to take this opportunity to thank everyone in our Primary Care Trusts and Cluster for their commitment and hard work during a tough transitional period.

Kathy Cowell
Chair

Moira Dumma
Chief Executive

Contents

Publication arrangements

The Annual Report and a full copy of the Annual Accounts will be published on the Department of Health website.

Paper copies (and alternative formats) of the Annual Report will also be available on request to members of the public free of charge through the Department.

Introduction

The area we cover

NHS Western Cheshire served people registered with general practices listed within the Primary Care Trust area (i.e. most of the area covered by the newly-created Cheshire West and Chester Council (excluding Winsford and Northwich), a total population of 259,130 people. This included patients living outside the area who are registered with local GP practices.

For 2012/13 NHS Western Cheshire's revenue resource limit was £ 499,837,000 and Specialised Commissioning income was £1,079,317,000.

Our role

Through our Clinical Commissioning Group (CCG), our Director of Public health and our Cluster Primary care team we **identified** the health needs of local people to ensure they have access to health and healthcare services they need within the resources allocated. We then **commissioned** (or bought) care from a range of healthcare providers - hospitals, community services, GPs, dentists, opticians (optometrists) and pharmacists. This included the third sector (voluntary, charity and not-for-profit organisations) and private sector.

Our CCG also set **quality standards** and worked in partnership with our providers to hold them to account. They did this by building strong partnerships, especially with local GPs, hospitals and our local authority partners and voluntary and independent organisations.

We also had a duty to **listen** to what people tell us they want from their Health Service and to **demonstrate** how we have taken their views into account when we planned services.

We use the term "providers of NHS care" to describe a broad range of services: hospitals, clinics, GPs, dentists, community pharmacists, and optometrists. We worked in partnership with other organisations such as local councils and the voluntary sector, to improve the health and wellbeing of the residents of Western Cheshire.

The majority of the providers of NHS care are hospital and community-based health services. However, the world is changing and, though care remains free at the point of use, we also look to the third sector (voluntary, charity and not-for-profit organisations) as well as independent providers to deliver some care.

Locally, our main providers of hospital care were the Countess of Chester Hospital NHS Foundation Trust, Wirral University Hospitals NHS Foundation Trust (Arrowe Park and Clatterbridge), North Cheshire Hospitals NHS Trust and Mid Cheshire Hospitals NHS Trust. Mental health services were commissioned mainly from Cheshire and Wirral Partnership NHS Foundation Trust.

Outside of hospital, our Primary Care Team commissions services from 37 dental practices, 39 general medical practices, 40 community optometry practices (opticians) and 59 pharmacies. Our main community services were commissioned from Cheshire and Wirral Partnership NHS Foundation Trust. We also commissioned a diverse range of other services from other providers such as specialist NHS Trusts, hospices, North West Ambulance Service NHS Trust, Cheshire West and Chester Council and the voluntary and private sector.

Our Core Purpose

Our Core Purpose is *"To ensure we enable everyone in Western Cheshire to live a longer and healthier life."*

Our Healthcare Strategy *Transforming Health and Healthcare: Getting It Right* identifies our six strategic goals to achieve better health outcomes for people in Western Cheshire:

1. Ensure that all babies and children have the best possible start in life
2. Reduce the number of people who smoke, are obese or drink alcohol to excess
3. Ensure that people in Western Cheshire enjoy good health into old age
4. Promote positive mental health for people living and working in Western Cheshire
5. Close the gap in life expectancy by preventing cancers and detecting them earlier
6. Close the gap in life expectancy by preventing heart attacks and strokes

You can view our Healthcare Strategy within the *Publications* section of www.wcheshirepct.nhs.uk

Management Arrangements, NHS Cheshire, Warrington and Wirral

NHS Cheshire, Warrington and Wirral ("the Cluster") was formally constituted on 1st June 2011 and was a Primary Care Trust Cluster of four Primary Care Trusts comprising NHS Central and Eastern Cheshire, NHS Warrington, NHS Western Cheshire and NHS Wirral.

The Cluster covered the four Primary Care Trust areas as outlined above and was responsible for developing six Clinical Commissioning Groups (CCGs). Western Cheshire has formed one Clinical Commissioning Group. The Cluster patch also encompassed eight NHS provider trusts and four local authority areas. The total population of the Cluster was 1.2 million and total budget was £3.3 billion.

The responsibilities of the Cluster were as follows:

- Commissioning:
  - Hospital Services
  - Community Services
  - Continuing Care
- Continuous Improvement
- Planning, Partnership, Cooperation
- Governance & Finance
- Public Engagement
- Equality & Human Resources
- Information Governance
- Resilience
- Health & Safety

Primary Care Trusts clustered to manage the transition to the new NHS system. This reduced the risk of individual organisational pressures, with a reducing management and financial management capacity, by creating a single Board and Executive Team. It also enabled emerging Clinical Commissioning Groups and Health & Wellbeing Boards to develop, as well as ensuring staff moved into new roles with CCGs, Commissioning Support, Local Authorities and NHS Commissioning Board. The Cluster also supported the provider element of the transition including progress to Foundation Trust status.

Individual Primary Care Trusts remained the statutory NHS bodies. The Cluster Chief Executive was the Accountable Officer for each of the four Primary Care Trusts (and all six CCGs).

The NHS Cheshire, Warrington and Wirral Board had a single governance structure with the CCG Boards/Executives as Sub-Committees as well as the Audit, Remuneration and Primary Care Committees.

The Cluster was also the host for the North West Specialised Commissioning Team and the Board received their minutes for assurance. A full copy of the NHS Cheshire, Warrington and Wirral Constitution and Governance Structure can be seen in the Corporate Governance Manual available on the Primary Care Trusts' websites.

Any risks from each of the Primary Care Trusts were escalated to the Board via the Assurance Framework and were reported at formal Board meetings. For further information about the Cluster Board Meetings please visit the Primary Care Trust website at www.wcheshirepct.nhs.uk

The Cluster Board is responsible for implementing systems and processes to ensure that business was carried out in an appropriate manner, met statutory duties and managed risks. The Board was accountable for internal controls and, as the Accountable Officer, the Chief Executive was responsible for maintaining a sound system of internal control within which policies were implemented and objectives achieved.

Each year the Board prepared an Annual Governance Statement which set out how the Board discharged its responsibilities. This Statement is provided in full at Appendix 1.

The Cluster Board was the Board for each of the four PCTs and had common membership except for the Director of Public Health, where there was one per PCT. Current members are shown below. Full membership details and period of office are provided at Appendix 2.

Non Executive Directors:

Kathy Cowell - Chair
Farath Arshad
Sheryl Bailey
John Church
John Gartside
James Kay
Iain Purchase

Executive Directors:

Chief Executive	Kathy Doran/Moira Dumma
Director of Finance	Simon Holden/ Phillip Wadeson/Russell Favager
Director of Commissioning Development	Joanne Forrest/ Alison Tonge
Director of Human Resources	Michelle Chadwick
Director of Nursing, Performance and Quality	Cathy Maddaford
Chief Operating Officer, Cheshire and Merseyside Commissioning Support Unit	Neil Ryder

Director of Public Health: (on rotation from each Primary Care Trust-one vote)

Dr Heather Grimbaldeston
Fiona Johnstone
Dr Rita Robertson
Julie Webster/Caryn Cox

Medical Directors: (one vote)

Dr Bill Forsyth
Dr Shyamal Mukherjee
Dr Maureen Swanson

Non-voting member - Director of Communications and Engagement

Martin McEwan

A Declaration of Interests by the Board Members and Executive Team forms Appendix 3. Full details of remuneration of Board Members is provided at Appendix 4.

External scrutiny and accountability

We were scrutinised by Cheshire West and Chester Borough Council's Health and Wellbeing Overview and Scrutiny Committee, our Local Involvement Network (LINk), the North West Strategic Health Authority/Northern Region and the Department of Health.

Audit Committee

The Board had an Audit Committee which regularly reviewed the establishment and maintenance of an effective system of integrated governance, risk management and internal control that operated across the whole of the Cluster's activities and supported the organisation's goals. The Committee consisted of three Non-Executive Directors and was independent of the Chairman and Chief Executive. It reported directly to the Board.

NHS REFORM AND THE ROAD TO TRANSITION

During 2012/13 the Primary Care Trust, working through the Cluster, made preparations for the implementation of NHS reforms, subject to successful passage of the Health and Social Care Act which received Royal Assent on 27th March 2012.

On 31st March 2013, the Primary Care Trust was abolished. The new local health system will consist of the following organisations and remits:

NHS England: supports NHS services nationally and ensures that money spent on NHS services provides the best possible care for patients. It funds local CCGs to commission services for their communities and ensures that they do this effectively. Some specialist services will continue to be commissioned by NHS England centrally where this is most efficient. Working with leading health specialists, NHS England brings together expertise to ensure national standards are consistently in place across the country. Throughout its work it promotes the NHS Constitution and the Constitution's values and commitments. The local representative for NHS England is Cheshire, Warrington and Wirral Area Team.

Public Health England: provides national leadership and expert services to support public health and works with local government, the NHS and other key partners to respond to health protection emergencies.

The *NHS Trust Development Authority:* supports NHS trusts to improve so they can take advantage of the benefits of foundation trust status when they are ready.

Health Education England: makes sure the healthcare workforce has the right skills and training to improve the care patients receive. It supports a network of Local Education and Training Boards that plan education and training of the workforce to meet local and national needs.

Locally, *Health and Wellbeing Boards:* will bring together local organisations to work in partnership and Healthwatch will provide a powerful voice for patients and local communities.

Clinical Commissioning Groups (CCGs): made up of doctors, nurses and other professionals, will buy services for patients, while local councils formally take on their new roles in promoting public health.

The local CCG for Western Cheshire Primary Care Trust is Western Cheshire. Throughout 2012/13, the CCG has been working with full delegated authority and has been fully authorised as at April 2013. It is now a statutory body with an Accountable Officer and having statutory duties as outlined in the Health and Social Care Act 2012. Further information can be found on the website.

Emergency Planning, Response and Resilience

Throughout 2012/13 the PCT Cluster was the lead PCT responsible for emergency planning, response and resilience (EPRR). Towards the end of the financial year the PCT Cluster also had responsibility for working with the Cheshire, Warrington and Wirral Area Team of the NHS Commissioning Board to hand over responsibility for EPRR from the PCT Cluster to the Area Team.

The PCT Cluster's EPRR responsibility consisted of two distinct roles:

(a) the statutory duties of each of the four PCTs as *Category 1 Responders* under the Civil Contingencies Act (2004), and those responsibilities for PCTs as outlined in *The NHS Emergency Planning Guidance 2005*[1] and its supporting guidance;

(b) the role as *Lead PCT* for EPRR across Cheshire, Halton and Warrington – the coordinating PCT for the strategic leadership of the whole of the NHS in Cheshire during an emergency/

[1] Department of Health, October 2005 (Gateway Reference: 5638)

adverse incident – which was undertaken by NHS Western Cheshire (now the PCT Cluster) under a memorandum of understanding with NHS North West (now NHS North of England).

During the transition PCT Clusters were charged with the following responsibilities:

(a) maintaining an effective response to emergencies/ adverse incidents. As such the Cluster's Chief Executive issued instructions to ensure that:
    - each individual PCT maintained an on call rota,
    - on call rotas for the Cheshire-wide NHS Strategic Commander and their Tactical Advisors were maintained;

(b) assisting the Cheshire, Warrington and Wirral Area Team in the establishment of its EPPR arrangements.

Guidance was also issued setting out the EPRR roles for the NHS Commissioning Board (together with its Regions and Area Teams) and CCGs from April 2013. Key documents include:

(a) *Health Emergency Preparedness, Resilience and Response from April 2013: Summary of the principal roles of health sector organisations* (Department of Health, July 2012);
(b) *Transitional Assurance Process for EPRR* (NHS Commissioning Board, October 2012);
(c) *The role of 'Accountable Emergency Officers' for EPPR* (NHS Commissioning Board, December 2012);
(d) *Command and Control Framework for the NHS during significant incidents and emergencies* (NHS Commissioning Board, January 2013);
(e) *Business Continuity Management Framework* (NHS Commissioning Board, January 2013);
(f) *Core Standards for EPRR* (NHS Commissioning Board, January 2013).

This guidance focuses on planning for emergencies/ major incidents and the ability of the NHS to respond to such incidents (i.e. for those incidents that only affect the NHS and those which affect all multi-agency partners). Selected tasks include:

(a) establishing Local Health Resilience Partnerships (LHRPs) which are to meet quarterly as a forum to facilitate NHS emergency preparedness and resilience with a membership drawn from local acute, ambulance, community and mental health providers, together with representatives from public health;
(b) training those Area Team senior managers who will be members of on call rotas to a national core standard;
(c) establishing new on call rotas to strategically manage the response of the NHS within each Area Team;
(d) establishing Area Team Incident Coordination Centres and developing Incident response Plans.

Supporting the Cluster's Chief Executive in her role as Accountable Officer for ensuring robust and effective EPRR arrangements are in place and have been maintained were:

(a) the Director of Nursing and Performance – who held executive responsibility on behalf of the PCT Cluster;
(b) the Head of NHS Resilience – who held managerial and operational responsibility.

As the Cheshire, Warrington and Wirral Area Team has started to appoint its own staff:

(a) Accountable Officer responsibility was transferred from the Cluster's Chief Executive to the Area Team Director (from 1 October 2012);
(b) executive responsibility for EPRR was transferred from the Cluster's Director of Nursing & Performance to the Area Team's Director of Operations & Delivery (from March 2013);

(c) managerial and operational responsibility was shared between the Cluster's Head of NHS resilience and the Area Team's Head of EPRR since mid-December 2012, with a formal transfer taking place to the Area Team's Head of EPRR at the beginning of March 2013.

In line with national guidance, a memorandum of understanding was prepared to delegate the PCT Cluster's EPRR responsibility to the Cheshire, Warrington and Wirral Area Team. This came into effect from 31st March 2013. However, in line with the Cluster PCT's responsibility to assist the Cheshire, Warrington and Wirral Area Team in the establishment of its EPPR arrangements, individual PCT and NHS Strategic Command on call rotas (including those for Tactical Advisors) were maintained until the end of March 2013. As a sign of the close cooperation between the PCT Cluster and the Cheshire, Warrington and Wirral Area Team, the Area Team Director and some of her fellow Directors have already been included on the Cheshire NHS Strategic Commander on call rota.

To ensure the robustness of local EPRR arrangements, since July 2012 the Cluster had undertaken the following audit and/ or reviews of:

(a) NHS provider major incident plans and arrangements;
(b) NHS provider business continuity plans and arrangements;
(c) Local health system (i.e. both NHS provider and emerging CCG) escalation plans.

Particularly through the work of the Cluster's Head of NHS Resilience, the PCT Cluster had also ensured that the NHS continued to be represented and actively involved in the work of the Cheshire Local Resilience Forum (LRF). Through the LRF the NHS continues to:

(a) contribute to the development and review of multi-agency emergency plans and processes;
(b) contribute the NHS perspective into post-incident debriefs;
(c) update multi-agency partners on the organisational changes to the NHS, especially the changing roles and responsibilities for EPRR;
(d) ensure the NHS is adequately represented at LRF-sponsored training and exercises, including Control of Major Accident Hazards (COMAH) exercises organised by local councils.

Since January 2013, as part of the transition from the PCT Cluster to the Cheshire, Warrington and Wirral Area Team, the Area Team's Head of EPRR increasingly took the place of representing the NHS at LRF/ multi-agency meetings from the Cluster's Head of NHS Resilience.

Whilst managing the transition, the PCT Cluster (and more recently the Cheshire, Warrington and Wirral Area Team), have been involved in preparations for the Olympics and Paralympics and in various incident/ event responses including the Olympic Torch Relay, a chemical suicide and NHS winter escalation (including the activation of the Critical Care Plan in conjunction with Merseyside).

In addition, and in line with the NHS Commissioning Board's guidance – *Transitional Assurance Process for EPRR* (October 2012), regular '*EPRR Implementation Tracker*' returns on the progress of developing the new EPRR arrangements locally have been submitted to the NHS North of England Cluster/ NHS Commissioning Board North (as appropriate). Feedback to date has been positive, with no significant gap/ area of weakness identified in the local development of plans (although though it was recognised they are under development).

Part of this assurance process was an EPRR Impartial Review between representatives from the Cluster/ Area Team and NHS Commissioning Board North. Written evidence, prepared by the PCT Cluster/ Area Team was submitted for this review including:

(a) the Terms of Reference for the Cheshire, Warrington and Wirral LHRP together with the minutes of its first 2 meetings (held in November 2012 and January 2013);
(b) the Cheshire, Warrington and Wirral LRHP's *3-year Strategy*, its *Concept of Operations* and the latest version of the Area Team's/ LHRP's *Joint Annual EPRR Work Plan for Quarter 4 of 2012/3 and 2013/4* (all national requirements);

(c) correspondence to the Chair of the Cheshire LRF (Assistant Chief Constable McCormick from Cheshire Police) and briefing provided the LRF's General Working Group as to how the NHS will continue to be an effective and influential partner of the LRF;
(d) the arrangements for training on call staff and establishing on call rotas, together with a briefing on the proposal to establish a shared on call rota between the six CCGs in Cheshire, Warrington and Wirral (i.e. each CCG is required to have an on call rota in place, although it is permissible for this to be shared);
(e) an EPRR memorandum of understanding between the Cheshire, Warrington and Wirral Area Team, local NHS providers (i.e., acute, ambulance, community and mental health) and CCGs;
(f) the latest draft of the Cheshire, Warrington and Wirral Area Team's Incident Response Manual.

The outcome of this review was positive with NHS Commissioning Board (North) being assured of the arrangements being developed locally.

MANAGING RISK, INVESTIGATING EVENTS AND LEARNING FROM THE EXPERIENCE OF PATIENTS

Ensuring safe healthcare – managing risks

NHS health professionals will try to do everything possible to ensure people are treated properly and quickly. However, sometimes things can go wrong and patients can feel that their experience of healthcare could have been better. It is important that we are informed of any concerns or complaints so that improvements can be made.

A formal complaints system was in place and followed NHS procedures and good practice by adopting the Health Service Ombudsman's 'Principles of Good Complaints Handling' and 'Principles for Remedy'. A yearly report was presented to the Board detailing the number of complaints and the actions the PCT has taken.

Compliments and complaints

Treasury's Guidance on 'Managing Public Money' sets out the steps public bodies should take where they have caused injustice or hardship by maladministration or service failure. Revised Principles for Remedy, issued in May 2010, set out six principles that represent best practice and are directly applicable to NHS procedures.

The key principles were:

1. Getting it right
2. Being customer focused
3. Being open and accountable
4. Acting fairly and proportionately
5. Putting things right
6. Seeking continuous improvement

In 2012/13 the PCT received 49 formal complaints. It is through patient feedback that we were able to learn from complaints to monitor and improve services where required, to ensure we met the needs of our patients in the future. As Commissioners of local Health Services we monitored the complaints received for trends and took appropriate action to reduce the risk of identified trends happening again.

Knowing when patients have had a good experience is as important as knowing when things have not gone well. A record of compliments was kept and feedback was given to the service in question.

The Patient Advice and Liaison Service

The Patient Advice and Liaison Service (PALS) is an informal way for patients to raise any concerns with their healthcare. The PALS team work on the patients behalf by liaising with healthcare staff, listening to concerns and providing information and advice In 2012/13 there were 642 contacts made with the PALS team.

For further advice and help:

- The Complaints Department can provide advice and further information regarding the NHS complaints procedure

- The Independent Complaints Advocacy Service (ICAS) provides advice and support to people who want to complain about the NHS. Details are available at www.carersfederation.co.uk/icas
- The Department of Health's website also has information on the NHS complaints procedure www.dh.gov.uk/health/contact-dh/complaints

Looking after personal data

As technological advances multiply, so do people's concerns about the safety of their personal data. This concern was addressed at the highest level within the PCT. Staff received annual Information Governance training. Privacy Impact Assessments were also carried out before introducing a new project or changing a service involving person-identifiable information.

We continued to develop and agree Information Sharing Protocols, working in partnership with health, social care, other statutory bodies, commercial healthcare bodies and the voluntary sector.

The Primary Care Trust had to submit an information governance self assessment to the Department of Health each year and the Information Governance Group continued to monitor the work required. Our current compliance is 66%.

The work undertaken by the Primary Care Trust Cluster during 2012/13 as part of the information governance assurance programme, together with the annual compliance against the Information Governance Toolkit, achieved improved scores year on year, which demonstrated good performance in this area.

SUMMARY OF PERSONAL DATA INCIDENTS IN 2012/13 ACROSS THE CLUSTER		
Category	**Nature of Incident**	**Total**
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	0
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	1
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	6
V	Other	0

Disclosure of serious untoward incidents

The National Patient Safety Agency identified some incidents that were described as 'Never Events'. These are largely preventable events which should not occur if all the appropriate procedures are followed. There were 3 never events reported in 2012/13 which were investigated fully and appropriate action taken, as necessary.

For further information, please contact Sue McGorry, Quality and Safety Manager Cheshire, Warrington and Wirral Area Team on 01925 406076.

VALUING OUR STAFF: WORKFORCE AND ORGANISATIONAL DEVELOPMENT

Equality and Diversity

The New Equality Bill was passed in April 2010. All the sections of the new Act were in place which means that all statutory bodies (including the PCT) were required to produce a new equality document by the end of July 2011.

Consultation and Engagement was a key part of the duties. Information gained from the events was used to develop and improve services and to improve the patient experience. Disabled people were actively involved in the development of services including the Mystery Shopper project, website design and deaf awareness training and guidelines.

Community Development Workers were a key link to local communities including Black, Minority and Ethnic (BME) groups, Gypsy and Travellers and the Polish community. They fed back the main problems faced by local communities and helped the PCT develop positive solutions.

Staff Well Being and Engagement

Involving our staff

We actively encouraged and promoted staff involvement at all levels of activity. A number of formal and informal forums and committees were in place to ensure this happened. Commitment to working in partnership with our staff side colleagues was formally through the Partnership Forum.

We kept our staff well informed through staff briefings, an e-bulletin and regular Intranet updates, in addition to events on specific topics, emails, and our website, all of which encourage feedback, we also included a staff support section designed to help staff cope with change, managing the transition and relieving stress.

Staff Support

NHS Western Cheshire was fully committed to the health and positive wellbeing of its employees, the health and wellbeing of the workforce was crucial to the delivery of the improvements in patient care envisaged in the NHS Constitution. The Trust Health and Wellbeing Strategy was routinely monitored, reported and discussed with staff representatives via the staff forum. All staff had access to a comprehensive Occupational Health Service.

Targeted Health and Wellbeing interventions were delivered in line with the Health and Wellbeing strategy and action plan. Events held have included; mini health checks, complimentary therapy sessions, self defence classes, yoga sessions, pre-retirement sessions to mention just a few.

Monitoring sickness absence

We proactively managed both short-term and long-term sickness absence in line with our Attendance Management policy. Sickness absence was monitored on a monthly basis and reported quarterly to the Board.

In terms of sickness absence, note 7.3 to the Accounts shows that the average working days lost for the year is 7.95 (2011/12: 5.82 days).

Caring for the environment

The NHS had a target to reduce carbon emissions by 26% by 2020. In 2012/13, work continued towards improving the efficiency of our buildings. This built on work done in previous years to help staff reduce their business miles by making video and teleconferencing available and promoting a "cycle to work" scheme. We also introduced staff briefings using live web casts to allow staff to see and be briefed by Directors without the need to travel across the Cluster footprint.

Sustainability Report

All NHS Trusts, Primary Care Trusts and strategic health authorities were required to produce a Sustainability Report in 2012/13 as part of their Annual Report. The Sustainability Report is provided at Appendix 5.

FINANCIAL COMMENTARY 2012/13

Introduction

Primary Care Trusts have a statutory duty to spend within their available budget; referred to as delivering operational financial balance. As at 31st March 2013, Western Cheshire Primary Care Trust has delivered this as well as other financial duties and has applied its resources effectively.

This position has been delivered despite a significant increase in the cost of secondary care activity which has been mitigated by good underspends against other budget areas and the full use of contingencies which had been set aside for that purpose.

During 2012/13 approximately 60% of the Primary Care Trust's resource was delegated to NHS West Cheshire CCG who were formally authorised with effect from 5th December 2012. The group acted as a formal Sub-Committee of the NHS Cheshire, Warrington and Wirral Cluster Primary Care Trust with commissioning responsibility for secondary care contracts, primary care prescribing and health services jointly commissioned with the local authority and voluntary sector.

The reported financial position at 31st March 2013 represents a consolidated position including the year end financial positions of hosted services. Further details are provided in note 2 'operating segments' to the financial statements. Performance of hosted services is as follows:

- North West Specialised Commissioning Team; £33,000 surplus, and
- Cheshire Health agency; £88,000 surplus.

Financial performance targets

Note 3 to the Primary Care Trust's accounts reports performance against the financial performance targets. All financial duties have been achieved as demonstrated below:

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		432,330
Net operating cost plus (gain)/loss on transfers by absorption	**497,807**	
Adjusted for prior period adjustments in respect of errors	**0**	0
Revenue Resource Limit	**499,837**	434,296
Under/(Over)spend Against Revenue Resource Limit (RRL)	2,030	1,966

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	**1,640**	1,015
Charge to Capital Resource Limit	**1,468**	928
Underspend Against CRL	**172**	**87**

3.3 Provider full cost recovery duty

During 2012/13 Western Cheshire Primary Care Trust did not provide community services. This was following the transfer of Community Care Western Cheshire to a local foundation trust as part of the transforming community services innitiative.

3.4 Under/(Over)spend against cash limit

	2012-13	2011-12
	£000	£000
Total Charge to Cash Limit	485,891	437,157
Cash Limit	485,891	437,157
Under/(Over)spend Against Cash Limit	**0**	**0**

Better payment practice code

Western Cheshire Primary Care Trust aimed to pay its creditors in accordance with the confederation of British Industry's Prompt Payment Code and government accounting rules. Despite a period of significant transition performance during the year has been maintained. Performance against the better payment practice code is reported in note 8 to the primary care trust's accounts and can be summarised as follows:

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	10,092	83,079	10,767	84,281
Total Non-NHS Trade Invoices Paid Within Target	9,776	80,974	10,441	82,538
Percentage of NHS Trade Invoices Paid Within Target	96.87%	97.47%	96.97%	97.93%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	5,998	1,570,909	5,608	1,267,956
Total NHS Trade Invoices Paid Within Target	5,862	1,561,215	5,476	1,257,634
Percentage of NHS Trade Invoices Paid Within Target	97.73%	99.38%	97.65%	99.19%

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.

Late Payment of Commercial Debts (interest) Act 1998

There were no payments arising from claims made by businesses under this legislation (2011/12, £0), nor was any compensation paid to cover debt recovery costs (2011/12, £0).

Audit Fees

The Primary Care Trust's appointed external auditors for the audit of the 2012/13 accounts are Grant Thornton UK LLP. The external audit team will be made up, in the main, of staff who have previously audited the Primary Care Trust's accounts working for the Audit commission.

External audit fees for 2012/13 were £154,857 (including VAT).
Internal audit services were provided by Mersey Internal Audit Agency at a cost of £101,711.

Running costs

The following Primary Care Trust running costs, both in total, and per head of population, are reported in note 5 to the accounts:

	Total	Commissioning services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	10,984	10,281	703
Weighted population (number in units)*	238,372	238,372	238,372
Running costs per head of population (£ per head)	46	43	3
PCT Running Costs 2011-12			
Running costs (£000s)	10,421	9,532	889
Weighted population (number in units)	238,372	238,372	238,372
Running costs per head of population (£ per head)	44	40	4

* 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

Exit packages

During 2012/13 there were a number of exit packages agreed. There were 47 departures (37 voluntary redundancy and 10 compulsory redundancy) at a total cost of £3,466,814 (£2,746,448 voluntary redundancy and £720,366 compulsory redundancy).

REMUNERATION REPORT

Terms of Reference for the Remuneration Committee

The Remuneration Committees of Primary Care Trusts made recommendations to their Boards on remuneration and on terms of service for the Chief Executive and very senior managers to ensure they are fairly rewarded for their individual contribution to the organisation within the requirements of the nationally developed Framework for Very Senior Managers. Advice to Boards on such remuneration includes all aspects of salary, provisions for other benefits including pensions and cars as well as arrangements for termination of employment and other contractual terms. Additionally, the Remuneration Committee:

- Made recommendations to the Board on the remuneration, allowances and terms of service of other officer members to ensure they are fairly rewarded for their individual contribution to the organisation.
- Monitored and evaluated the performance of individual and other senior officer members.
- Advised on and oversaw appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

Composition of the Committee

The Committee comprised the Board Chairman and at least two other non-officer members.

Remuneration Committee membership

Three Non-Executive Directors were members of the Remuneration Committee.

Remuneration of senior managers – current/ previous financial year

The Remuneration Committee determined the salaries of the following Directors' and senior managers' posts: Chief Executive, Directors, senior managers (on local contracts). The remuneration packages for these senior posts comprised base salary in the light of the requirements of the national Very Senior Managers policy.

On the inception of the consolidated PCT Cluster Board on 1st June 2011, Cluster Executive and Non-Executive Directors were appointed to all four PCTs hence we have shown remuneration shared equally between the four constituent PCTs. The remuneration report shown here relates to this PCT's share of the total remuneration. Directors of Public Health relate to one PCT each and they shared Board level responsibility.

A consolidated report for the entire Cluster can be found in Appendix 4.

Pay scales and benefits

Executive Directors may receive taxable benefits from the Primary Care Trust's lease car scheme as part of their remuneration.

Pensions

All Directors for the Primary Care Trust have access to the NHS Pension Scheme which provides pensions on a final salary basis. Employees are entitled to join the NHS Pensions Scheme. Further details are provided in the Annual Accounts and in Appendix 4 of this annual report.

Performance management

The NHS has adopted nationally an annual appraisal system for all of its employees. The Remuneration Committee's minutes state that the current organisation's objectives and appraisal system would continue to be the method by which performance and achievement of corporate objectives would be measured.

Service Agreements Appointment - Chief Executive and Directors

The Chief Executive and Directors have contractual status which expired on 31st March 2013 when the PCT ceased or earlier for those who have ceased to act during the year.

Termination of appointment – Chief Executive and Directors

Other than in circumstances where the contract is being terminated by summary dismissal, the employee shall be entitled to receive six months' notice of termination. The employee is required to give the Primary Care Trust six months' notice of their intention to terminate this employment.

Contractual Information -Year ended 31st March 2013

As part of NHS reforms, PCTs have been abolished from 31st March 2013. As such, the employment contracts of all CWW Cluster Board members will end on that date unless stated as earlier. Details of period of office of members is provided at Appendix 2.

Department of Health

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

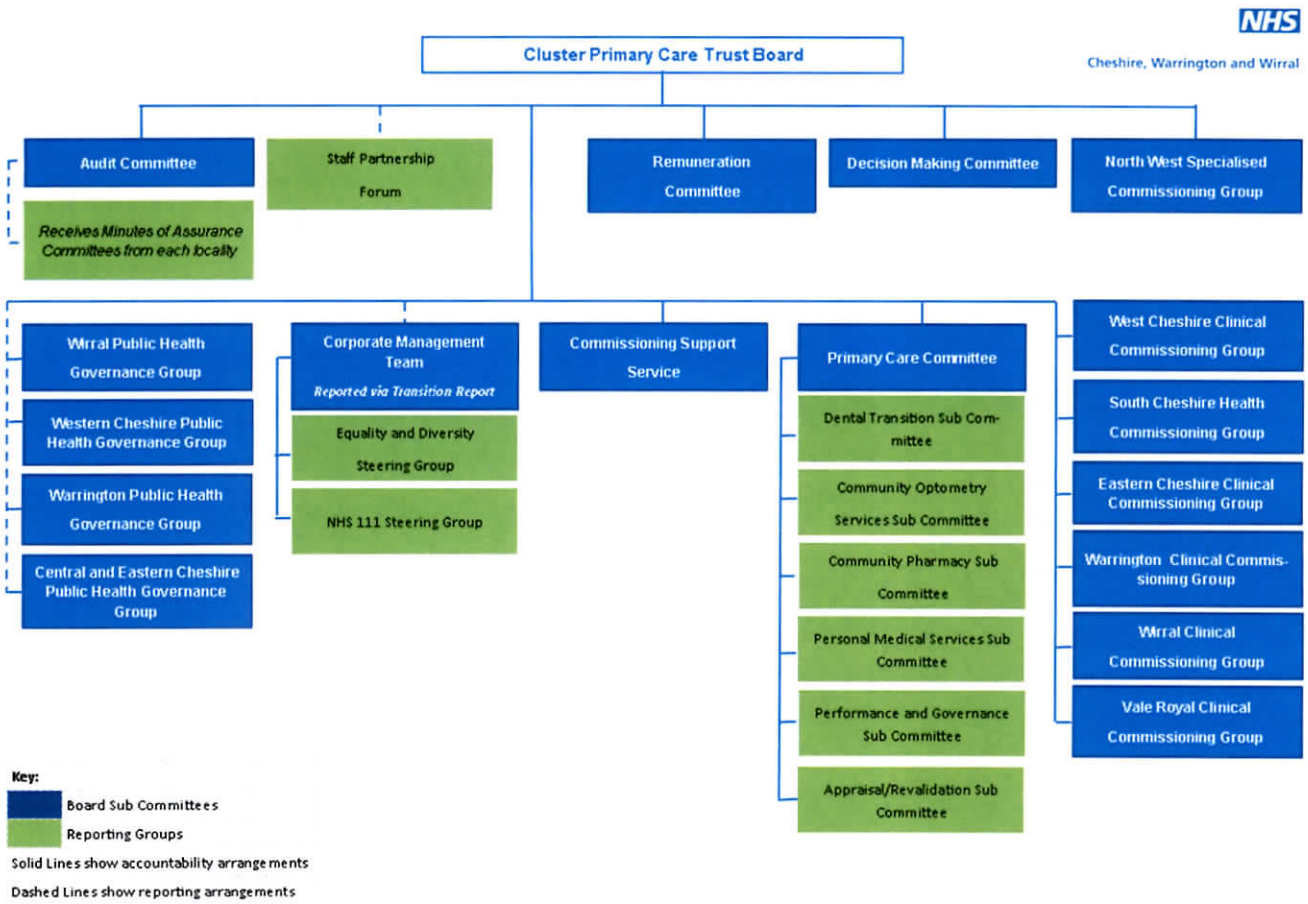
With respect to partnership working across the Local Health Economy, I met regularly with the Local Authority Chief Executives and as necessary with the Chief Executives of the providers within the Primary Care Trust area. The Primary Care Trust participates in partnership arrangements for children's 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

APPENDIX 2

BOARD MEMBERS

Current Board Members and Period of Office

Name	Position	Start Date
Moira Dumma	Chief Executive	1st October 2012
Michelle Chadwick	Executive Director of Human Resources	
Russell Favager	Executive Director of Finance	14th January 2013
Cathy Maddaford	Executive Director of Quality & Performance/ Executive Nurse	
Shayamal Mukherjee	Medical Director	
Maureen Swanson	Medical Director	
Neil Ryder	Chief Operating Officer – Cheshire and Merseyside Commissioning Support Unit	
Fiona Johnstone	Executive Director of Public Health (Wirral)	
Heather Grimbaldeston	Executive Director of Public Health (Central and Eastern Cheshire)	
Rita Robertson	Executive Director of Public Health (Warrington)	
Caryn Cox	Executive Director of Public Health (Western Cheshire)	1st December 2012
Martin McEwan	Director of Communications and Engagement	
Alison Tonge	Executive Director of Commissioning Development	1st November 2012
Kathy Cowell	Chair	
James Kay	Non-Executive Director –Vice Chair	
John Gartside	Non-Executive Director-Vice Chair	
John Church	Non-Executive Director-Vice Chair	
Farath Arshad	Non-Executive Director	
Iain Purchase	Non-Executive Director	
Sheryl Bailey	Non-Executive Director	

Former Serving Board Members and Period of Office

Name	Position	End Date
Kathy Doran	Chief Executive	1st October 2012
Julie Webster	Executive Director of Public Health (Western Cheshire)	30th November 2012
Phil Wadeson	Executive Director of Finance	1st September 2012 to 11th January 2013
Simon Holden	Executive Director of Finance	3rd August 2012
Joanne Forrest	Executive Director of Commissioning Development	30th November 2012
Bill Forsyth	Medical Director	31st May 2012

Appendix 3 – Register of Cluster Board Interests

NAME	POSITION	INTERESTS DECLARED	DATE REVIEWED
Farath Arshad	Non-Executive Director	• Research Active Academic with collaboration involving NHS Partners (NMHIS, Trafford NHS Trust, RLBUHT, Mersey Care, Alder Hey) • Advisor on Board of Informatics, Merseyside	March 2013
Sheryl Bailey	Non-Executive Director	• NIL	March 2013
Michelle Chadwick	Director of Human Resources and Organisational Development	• NIL	March 2013
Kathy Cowell	Chair	• Chairman – Your Housing Group (Housing Association), 2012 - 2015 • Member - East Cheshire Hospice Strategic Growth Committee, 2009 - • Board Member - Cheshire Community Foundation, 2011 – • Deputy Lieutenant of Cheshire	March 2013
John Church	Vice Chair / Non-Executive Director (Western Cheshire Locality Chair)	• Public Member of Wirral University Teaching Hospital NHS Foundation Trust • Public Member of Countess of Chester NHS Foundation Trust • Public Member of Cheshire and Wirral Partnership NHS Foundation Trust • Church Warden at St Nicholas Church, Burton-in-Wirral • Board Member of NHS North West Social Value Foundation • Trustee Board Director of Save the Family • PCC Secretary of St Nicholas Church, Burton	March 2013
Kathy Doran	Chief Executive	• Trustee - Reader Organisation (Sept 2011) • Member of NIHR Advisory Board and NIHR Public Health Advisory Board • Involved with a range of voluntary sector organisations in contract with NHS Wirral	March 2013
Joanne Forrest	Managing Director (Warrington)	• NIL	Left November 2013
John Gartside	Non-Executive Director (Warrington Locality Chair)	• Board Member – Big Lottery • Vice Chair - Big Lottery Fund England Committee • Magistrate – Warrington Bench (JP) • Deputy Lieutenant for Cheshire • Freeman of the Warrington Borough • Trustee and Company Secretary of the Tim Parry Jonathan Ball Foundation for Peace • Trustee of Warrington Wolves Foundation • Daughter (Lucy Gartside) is a Consultant in Organisational Development, Human Resources and Commissioning • Trustee of 'Spirit of 2012' – Olympic Legacy Fund	March 2013
Heather Grimbaldeston	Director of Public Health (Central & Eastern Cheshire)	• NIL	April 2012
Simon Holden	Director of Finance	• Chairman of Governors, Pear Tree School • Treasurer, Cheshire Centre for Independent Living • Business Mentor, Princes Trust	Left in September 2013
Fiona Johnstone	Director of Public Health (Wirral)	• Post of Director of Public Health (Wirral) is a joint appointment with Wirral Borough Council	March 2013
James Kay	Non-Executive Director	• Public Member of Wirral University Teaching Hospital NHS Foundation Trust	March 2013

NAME	POSITION	INTERESTS DECLARED	DATE REVIEWED
	(Wirral Locality Chair)	• Productions Director of Riverside Players (Registered Charity and Community Theatre Group)	
Cathy Maddaford	Director of Nursing, Performance and Quality	• Non Foundation Council Member of Chester University • Magistrate on the West Cheshire Nech	March 2013
Martin McEwan	Director of Communications and Engagement	• Wirral University Teaching Hospital NHS Foundation Trust Stakeholder Governor • Trustee (Board Member) of Greater Merseyside Connexions • Interim Director of Marketing and Communications, Alder Hey NHS Foundation Trust	March 2013
Dr Shyamal Mukherjee	Medical Director (Wirral)	• Partner of Central Park Medical Centre, Wirral • Member/Past President Rotary club of Wallasey • Trustee Reader's Organisation -Charity Voluntary Sector • Trustee Inspire - Respiratory Charity • Chair – Wirral Ethnic Health and Social Care Advisory Group • Board Member - Wirral Multicultural Organisation • Board Member/ex officio - CCG Group, Wirral • Wife (Dr A Mukherjee) is partner of Central Park Medical Centre, Wirral • Daughter (Dr R Mukherjee) is partner of Central Park Medical Centre, Wirral	March 2013
Iain Purchase	Non-Executive Director	• NIL	April 2012
Rita Robertson	Director of Public Health (Warrington)	• NIL	March 2013
Neil Ryder	Managing Director (Western Cheshire)	• Trustee – Cartrenfi (Charitable Trust)	April 2012
Dr Maureen Swanson	Medical Director (Western Cheshire)	• NIL	March2013
Julie Webster	Director of Public Health (Western Cheshire)	• Director – Cheshire and Warrington Sports Partnership • Class B Director – Leisure Community Interest Company, Cheshire West and Chester • Public Member of Cheshire and Wirral Partnership NHS Foundation Trust • Public Member of Countess of Chester Hospital NHS Foundation Trust	Left November 2012
Moira Dumma	Chief Executive /Local Area Team Director	• Self appointed as Area Team Director, Cheshire Warrington and Wirral in NHS Commissioning Board	March 2013
Alison Tonge	Director of Commissioning/Local Area Team Director of Commissioning	• NIL	March 2013
Russell Favager	Director of Finance/Local Area Team Director of Finance	• NIL	January 2013
Caryn Cox	Director of Public Health, Western Cheshire	•	December 2012
Phil Wadeson	Finance Director	• Nil	May 2013

Appendix 4 - Western Cheshire PCT - Audited

Cluster arrangements came into effect from 1 June 2011. At that date a number of directors from the 4 PCTs within the Cluster took on senior roles working across the Cluster as part of the new Cluster working arrangements. NHS guidance states that the remuneration costs of these individuals can be apportioned across the individual PCTs. The CWW Cluster has decided to notionally apportion these costs equally across the 4 PCTs and the costs for West Cheshire PCT are set out in the table below. The full costs to the CWW Cluster are also provided within the following tables.

Salaries & Allowances for Senior Employees of NHS Cheshire, Wirral & Warrington (from 1st April 2012 - 31st March 2013)

The comparative remuneration costs for 2011/12 relate to the 10 months from the start of Cluster arrangements. The amounts for the two month period prior to the Cluster formation are on the final page. The PCTs responsible for paying individual directors remuneration are highlighted in the notes at the foot of the tables.

	2012/13				2011/12		
Name & Title	Salary (bands of £5,000)	Other Remuneration (bands of £5,000) [9]	Bonus Payments (bands of £5,000)	Benefits in Kind (to nearest £100)	Salary (bands of £5,000)	Other Remuneration (bands of £5,000	Benefits in Kind (to nearest £100)
Cluster Staff (Notional Apportionment)							
Primary Care Trust Cluster Board							
Moira Dumma - Chief Executive [6] Commenced October 1st 2012	0	0	0	0	0	0	0
Russell Favager- Director of Finance [6] Commenced January 14th 2013	0	0	0	0	0	0	0
Phil Wadeson- Director of Finance [5] Commenced September 1st 2012 – Ceased January 11th 2013	5-10	0	0	0	0	0	0
Cathy Maddaford - Director of Nursing Quality & Performance [3]	20-25	45-50	0	7	20-25	0	5
Michelle Chadwick - Director of Human Resources & Organisational Development [4]	25-30	0	0	6	15-20	0	0
Martin McEwan - Director of Communications & Engagement (non voting) [1]	20-25	5-10	0	12	15-20	0	9
Kathy Doran - Chief Executive [1] Ceased October 1st 2012	15-20	15-20	0	8	30-35	0	6
Simon Holden - Director of Finance [2] Ceased August 31st 2012	10-15	0	0	0	20-25	0	0
Cathy Gritzner - Director of Commissioning Development [1] Ceased March 31st 2012	0	0	0	0	20-25	0	1
Joanne Forrest - Director of Commissioning Development- Commenced April 1st2012 -- Ceased November 30th 2012 [3/4]	15-20 [4]	55-60 [3]	0	0	0	0	0
Alison Tonge - Director of Commissioning Development- Commenced November1st2012 [6]	0	0	0	0	0	0	0
Neil Ryder – Chief Operating Officer -- Cheshire and Merseyside Commissioning Support Unit/ MD W Cheshire PCT [3]	25-30	0	0	8	15-20	0	7

Medical Directors (One shared vote)

Bill Forsyth - Medical Director - Central & Eastern Cheshire PCT Ceased May 31st 2012 [2]	0-5	0	0	0	20-25	0	0
Maureen Swanson - Medical Director – Warrington PCT & Western Cheshire PCT [3/4]	25-30	55-60	0	0	20-25	0	0
Shyamal Mukherjee - Medical Director - Wirral PCT [1]	5-10	5-10	0	0	5-10	0	0

Non Executives

Kathy Cowell - Chair [2]	10-15	0	0	0	5-10	0	0
Melinda Acutt - Non Executive Director (until 30 January 2012) [1]	0	0	0	0	0-5	0	0
Fareth Arshad - Non Executive Director [4]	0-5	0	0	0	0-5	0	0
Sheryl Bailey - Non Executive Director [3]	0-5	0	0	0	0-5	0	0
John Gartside - Non Executive Director [4]	5-10	0	0	0	5-10	0	0
James Kay - Non Executive Director [1]	5-10	0	0	0	5-10	0	0
Iain Purchase - Non Executive Director [2]	0-5	0	0	0	0-5	0	0
John Church - Non Executive Director [3]	5-10	0	0	0	5-10	0	0

Other Primary Care Trust Senior Staff (Full Costs)
Directors of Public Health (One shared vote)

Julie Webster - Director of Public Health - Western Cheshire PCT To November 30th 2012	80-85	0	0	0	65 - 70	0	30
Caryn Cox - Director of Public Health - Western Cheshire PCT [3] From December 1st 2012	25-30	0	0	0	0	0	0

Cluster Board – Remuneration in Full

	2012/13				2011/12		
Name & Title	**Salary (bands of £5,000)** **£000**	**Other Remuneration (bands of £5,000)** [9] **£000**	**Bonus Payments (bands of £5,000)** **£000**	**Benefits in Kind (rounded to nearest £00)** **£00**	Salary (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000	Benefits in Kind (rounded to nearest £00) £00
Primary Care Trust Cluster Board (Remuneration in full)							
Kathy Doran - Chief Executive [1] Ceased October 1st 2012	70-75	70-75	0	30	125 - 130	0	24
Simon Holden - Director of Finance [2] Ceased September 1st 2012	45 - 50	0	0	0	95 - 100	0	0
Joanne Forrest - Director of Commissioning Development Ceased November 30th 2012 [3/4]	65-70 [4]	220-225 [3]	0	0	0	0	0
Cathy Maddaford - Director of Nursing Quality & Performance [3]	95 - 100	190-195	0	28	80 - 85	0	21
Michelle Chadwick - Director of Human Resources & Organisational Development [4]	105-110	0	0	25	70 - 75	0	0
Martin McEwan - Director of Communications & Engagement (non voting) [1]	80 - 85	25-30	0	46	65 - 70	0	35
Neil Ryder – Chief Operating Officer – Cheshire and Merseyside Commissioning Support Unit/ Managing Director Western Cheshire PCT [3]	100-105	0	0	31	65-70	0-5	28
Phil Wadeson - Director of Finance Appointed September 1st 2012 to January 11th 2013 [5]	25-30	0	0	0	0	0	0
Medical Directors (One shared vote)							
Bill Forsyth - Medical Director - Central & Eastern Cheshire PCT [2]	15-20	0	0	0	85-90	0	0
Maureen Swanson - Medical Director - Warrington PCT & Western Cheshire PCT [3/4]	115-120	225-230	0	0	95-100	0	0
Shyamal Mukherjee - Medical Director - Wirral PCT [1]	25 - 30	20-25	0	0	20 - 25	0	0

Non-Executive Directors

Kathy Cowell - Chair [2]	40 - 45	0	0	0	35 - 40	0	0
Melinda Acutt - Non Executive Director (until 30th January 2012) [1]	0	0	0	0	5 - 10	0	0
Fareth Arshad - Non Executive Director [4]	5 - 10	0	0	0	5 - 10	0	0
Sheryl Bailey - Non Executive Director [3]	10 - 15	0	0	0	10 - 15	0	0
John Gartside - Non Executive Director [4]	30 - 35	0	0	0	25 - 30	0	0
James Kay - Non Executive Director [1]	35 - 40	0	0	0	30 - 35	0	0
Iain Purchase - Non Executive Director [2]	5 -10	0	0	0	5 - 10	0	0
John Church - Non Executive Director [3]	30 - 35	0	0	0	25 - 30	0	0

Pension Benefits for Senior Employees at NHS Cheshire, Wirral & Warrington 2012/13

Name	Real increase (decrease) in pension at 60 (bands of £2,500) £000	Real increase (decrease) in pension lump sum at 60 (bands of £2,500) £000	Total accrued pension at 60 as 31/03/2013 (bands of £5,000) £000	Lump sum at 60 to accrued pension at 31/03/13 (bands of £5,000) £000	Cash Equivalent Transfer Value as at 31/03/2013 £000	Cash Equivalent Transfer Value as at 31/03/2012 £000	Real increase (decrease) in Cash Equivalent Transfer Value £000
Primary Care Trust Cluster Board							
Kathy Doran - Chief Executive 1/10	(2.5 – 0)	2.5 – 5.0	55 - 60	165 - 170	0	1,068	0
Simon Holden - Director of Finance 2	5 - 7.5	17.5 - 20	45 - 50	140 - 145	786	637	117
Joanne Forrest - Director of Commissioning Development to November 30th 2012 3/ 4/10	(2.5 – 0)	(5.0 – 2.5)	35-40	115 - 120	0	730	0
Cathy Maddaford - Director of Nursing Quality & Performance 3	0 - 2.5	0 – 2.5	40 - 45	120 - 125	0	0	0
Michelle Chadwick - Director of Human Resources & Organisational Development 4	0 – 2.5	0- 2.5	5 - 10	20 - 25	136	96	35
Martin McEwan - Director of Communications & Engagement (non-voting) 1	0 - 2.5	0	5 - 10	0	66	48	11
Medical Directors (One shared vote)							
Bill Forsyth - Medical Director - Central & Eastern Cheshire PCT 2/10	0 – 2.5	2.5 – 5.0	70 - 75	210 - 215	0	1,546	0
Maureen Swanson - Medical Director - Warrington PCT & Western Cheshire PCT 3/10/11	(2.5 - 0)	(7.5 - 5)	60 - 65	180 - 185	**0**	711	0
Shyamal Mukherjee - Medical Director - Wirral PCT 1/7							
Directors of Public Health (One vote)							
Julie Webster- Director of Public Health - Western Cheshire PCT to November 30th 2012 1/3	(2.5 – 0)	(2.5 – 0)	25 -350	85 - 90	530	499	5
Caryn Cox- Director of Public Health - Western Cheshire PCT 3	7.5-10	25-30	7.5-10	25-30	145	0	145
Other Senior Officers							
Neil Ryder – Chief Operating Officer – Cheshire and Merseyside Commissioning Support Unit / Managing Director Western Cheshire PCT 3	0 - 5	10-15	30-35	90-95	519	401	97

Notes

1 - Indicates staff employed in a role in the PCT Cluster but are ultimately employed and paid by Wirral PCT

2 - Indicates staff employed in a role in the PCT Cluster but are ultimately employed and paid by Central & Eastern Cheshire PCT

3 - Indicates staff employed in a role in the PCT Cluster but are ultimately employed and paid by Western Cheshire PCT

4 - Indicates staff employed in a role in the PCT Cluster but are ultimately employed and paid by Warrington PCT

5- Indicates a member of staff employed in a role in the PCT Cluster but ultimately employed and paid by Liverpool PCT

6 - Indicates staff employed in a role in the PCT Cluster but are ultimately employed and paid by NHS bodies outside the local NHS community at no cost to the Cluster. Russell Favager and Alison Tonge were remunerated by NHSCB and Moira Dumma was remunerated by NHS South Birmingham.

7 - Not a member of the NHS Pension Scheme.

8 - Non-Executive Directors do not receive pensionable remuneration at the Cluster and no pension benefits accrue to the positions they hold.

9 - Other remuneration amounts include exit packages for Cluster Board Directors.

10. The Cash Equivalent Transfer Values (CETV) at March 31st 2013 are nil for these directors due to the fact that they are in receipt of pension benefits during 2012/13

11. The opening CETV value at March 31st 2012 for M Swanson has been altered from £1,357 due to receipts of pension benefits in 2012/13

The above roles within the PCT Cluster are considered to be split equally between each of the PCTs.

In the interest of reducing bureaucracy and limiting the complexity and volume of these transactions, the PCT Cluster has agreed not to recharge the notional costs between respective organisations. However Western Cheshire PCT has recharged the full salary of Joanne Forrest and a portion of the salary of Maureen Swanson (35-40 band) to Warrington PCT. A portion of the salary of Julie Webster (30-35 band) has also been recharged to Wirral PCT.

The roles of those within the emerging clinical commissioning groups have not been included within the disclosures for 2012/13. These roles do not meet the NHS reporting requirements as having responsibility for directing or controlling the major activities of this NHS body.

Western Cheshire Primary Care Trust Pay Multiples

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

The banded remuneration of the highest paid director in Western Cheshire PCT in the financial year 2012/13 was £115,545 (2011/12- £117,500). This was 3.19 times the median remuneration of the work force which was £36,233 (2011/12 – 3.8 times and £31,100)

In 2012/13, 3 employees received remuneration in excess of the highest-paid director. Remuneration ranged from £125,000 to £145,000 (2011/12 - £140,000 to £145,000).

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include employer pension contributions and the cash equivalent transfer value of pensions. Salaries used in the calculations were annualised.

NHS Western Cheshire from 1st April 2011 - 31st May 2011

Salary and Pension entitlements of PCT Board, Clinical Executive Committee Members, and Senior Managers

This table shows the remuneration costs attributable to the PCT up to the date of the start of Cluster arrangements

		2011/12				2010/11			
Name & Title		Salary (bands of £5,000)	Other Remuneration (bands of £5,000	Bonus Payments (bands of £5,000)	Benefits In Kind (rounded to nearest £00)	Salary (bands of £5,000)	Other Remuneration (bands of £5,000	Bonus Payments (bands of £5,000)	Benefits In Kind (rounded to nearest £00)
Executive Directors and Senior Managers		£'000	£'000	£'000	£'00	£'000	£'000	£'000	£'00
H Bellairs - Chief Executive (Ceased employment 30th June 2011)	(1) (2)	35-40	280-285		17	140-145			76
M Swanson - Medical Director	(3)	15-20				120-125			5
I Crossley - Director of Finance, Economic & Market Development		15-20				105-110			
C Maddaford - Director of Patient Safety and Governance		10-15			4	80-85			25
J Hughes - Director of Strategy and Performance Improvement		10-15			4	85-90			27
A Lee - Director of Clinical Commissioning/Interim Chief Operating Officer West Cheshire Health Consortium		10-15			7	85-90			39
N Ryder - Director of Collaborative Commissioning		10-15			5	85-90			33
J Forrest - Former Managing Director Community Care Western Cheshire	(4)	15-20			10	105-110			60
W Meredith - Director of Public Health	(5)	10-15				85-90			14
J Webster - Interim Director of Public Health		10-15				80-85			
J Develing - Chief Officer North West Specialised Commissioning		15-20			9	110-115			58
K Howell - Director National High Secure North West Specialised Commissioning (Ceased employment 31 March 2011)						100-105			43
Non Executive Directors									
J Church - Chair		5-10				30-35			
E Wiffen		0-5				5-10			
M Hogg		0-5				5-10			
R Hopwood (Commenced 21st October 2010)		0-5				0-5			
D Clark		0-5				5-10			
S Bailey		0-5				10-15			
J Dawson		0-5				5-10			
E Davison		0-5				5-10			
Non Executive Advisors									
M Gibson (Ceased 11th October 2011)		0-5				5-10			
R Hopwood (Ceased 20th October 2010)						0-5			
Clinical Executive Committee									
H Charles-Jones* - Chair		10-15				25-30	25-30		
Dr A McAlavey * - Clinical Advisor		0-5				35-40			
Dr G Faulks *	(6)					25-30			
Dr Jeremy Perkins		0-5				25-30			

Notes - NHS Western Cheshire from 1st April 2011 - 31st May 2011 - Note

(1) H Bellairs - Chief Executive. Joint appointment with Warrington PCT from 1st October 2010. £10,000 - £15,000** recharged to Warrington PCT.

(2) H Bellairs - Chief Executive. Ceased employment 30th June 2011. Compensation for loss of office £280,000 - £285,000

(3) M Swanson - Medical Director. Joint appointment with Warrington PCT from 1st December 2010. £0 - £5,000** recharged to Warrington PCT

(4) J Forrest - Ceased as Managing Director Community Care Western Cheshire 31st December 2010. Seconded to Warrington PCT from 1st January 2011. £15,000 - £20,000** recharged to Warrington PCT.

(5) W Meredith - Director of Public Health - seconded to the Department of Health from 1st April 2010. £10,000 -£15,000** recharged to the Department of Health

(6) Clinical Champion - deemed not part of the decision making process for the Primary Care Trust Board in April/May 2011

* Salaries shown for GPs include reimbursement for locum costs at the standard rate but exclude earnings from GMS/PMS contracts.

**recharges before employment costs (e.g.NIC and pension contributions).

Appendix 5 - Sustainability Report

What is your Trust identification code?	5NN
What is your Trust name?	Western Cheshire PCT

What was your total expenditure on energy in each of the last five financial years?

	2008/09	2009/10	2010/11	2011/12	2012/13	% Reduction	£ Reduction	Hip Operations
Energy Cost £	276,798	307,126	272,528	147,600	188,780	-28	41,180	7
					28%		41180	

What is the NPV of the savings expected as as a result of your plans to change your organisation to make it more sustainable. What length of time does this assessment cover?

		Nurses
NPV		0
Time period		

What weight of the waste you generate is recycled, and what does this represent as a proportion of total waste?

	2012/13	Proportion	Percentage
Total Waste	90.6		
Recycled waste	67.95	0.75	75

What was your total consumption of energy in each of the last five years (MWh), what was your floor area (in order to calculate energy intensity), what proportion of your energy comes form renewable sources and how much of your energy is generated on site?

	2008/09		2009/10		2010/11		2011/12		2012/13		
Oil											
Gas	3738.05		3773.05		4032.598		2355		3152		
Coal											
Renewables											0
Other											
Electricity		1824		2005		1386		560		503	Risen/Fallen
TOTAL		5562.05		5778.05		5418.598		2915		3655	risen

	2011/12	2012/13
Floor Area (m2)	15,277	15,277
	0.19	0.24

Proportion of Energy Generated on site

We do not generate any energy.

Is the tariff which you pay for electricity a "green" or "renewable" tariff?

What was your Operating Expenditure (per the financial statements) in the last 2 financial years?

2011/12	2012/13
1,349,365,000	1,349,365,000

Energy as a proportion of costs

2011/12	2012/13
0.01	0.01

What were your gross scope 1-3 carbon emissions over the last 5 years, and how were they constituted?

	UNIT		2008/09	2009/10	2010/11	2011/12	2012/13
Emissions as a result of Electricity Consumption	kWh	Electricity	591	548	601	241	216
Emissions as a result of Gas Consumption	kWh	Gas	645	666	722	435	583
Emissions as a result of Business Travel - Air	km	Air					
Emissions as a result of Business Travel - Road	miles	Road	6	455	411	88	88
Emissions as a result of Business Travel - Rail	miles	Rail					
Emissions as a result of Other activities	tonnes Co2e	Other					

CONVERSION FACTORS

2008/09	2009/10	2010/11	2011/12	2012/13
0.60815	0.59668	0.58982	0.58982	0.58982
0.20435	0.20435	0.20435	0.20435	0.20435
0.20124	0.20124	0.20124	0.20124	0.20124
0.37604	0.37604	0.37604	0.37604	0.37604
0.06715	0.06715	0.06715	0.06715	0.06715

2008/09	2009/10	2010/11	2011/12	2012/13	INCLUSION
359.4167	326.9806	354.4818	142.1466	127.4011	-14.746
131.8058	136.0971	147.5407	88.89225	119.1361	30.2438
0	0	0	0	0	0
2.25624	171.0682	154.5524	33.09152	33.09152	0
0	0	0	0	0	0
0	0	0	0	0	0

Change in Emissions 15.4983 increased 15.4983
Scope 3 0

If you gather data on your Other (Scope 3) emissions, please enter details as to what this assessment includes in the form of the sentence
"Our Other emissions value includes healthcare purchased from non NHS organisations, emissions arising from water and waste use, purchased pharaceuticals and medical instruments, staff, patient and visitor travel."

What was your water consumption in m3 in the last 4 financial years?

	2008/09	2009/10	2010/11	2011/12	2012/13	Gross reduction		
Water consumption	11,467	14190	17209	8462	5381	-3081	reduced	3081

What was your total expenditure on water in the last financial year? £21,889

What was your gross expenditure on the CRC Energy Efficiency Scheme in 2012/13? £121,983 Complete

What was your expenditure on official business travel in 2012/13? £222,581 Complete

What was your expenditure on waste disposal in the following categories:

	2011/12	2012/13
Total Waste arising		
Waste sent to landfill	£10,057	£10,057
Waste recycled/reused	£2,849	£2,849
Waste incinerated/energy from waste	£13,618	£13,618

If you have consumed finite resources, and in in doing so incurred material expenditure, then please complete the following boxes

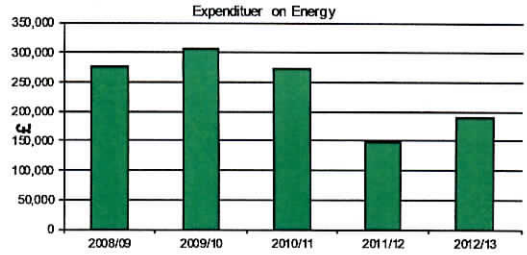
Expenditure	
Nature of resource	

	Yes/No	
Has your Board approved a Sustainable Development Management Plan in the last 12 months?	No	1
Has your board approved plans which address the potential need to adapt the organisation's activities (models of care) as a result of climate change?	No	2
Has your board approved plans which address the potential need to adapt the organisation's buildings or estates as a result of climate change?	Yes	3
Does your board consider sustainability issues as part of its risk management process?	Yes	4
Have you developed policies on sustainable procurement?	No	5
Have you begun to calculate carbon emissions related to procurement of goods and services?		
Is there a Board Level lead for Sustainability on your Board?	No	6
If Yes - What is their name?		
Are sustainability issues, such as carbon reduction, included in the job descriptions of all staff?	No	7
When was your last staff energy awareness campaign?	24th July 2009	8
If it is an ongoing process please enter yes into the orange box on this line	No	
If you have not conducted an energy awareness campaign, please enter No into the box on this line	No	
Do you have a Sustainable Transport Plan?	No	9

If you have used estimation, please indicate what quarters this estimation applies to:

Q1	Yes
Q2	Yes
Q3	Yes
Q4	Yes

-28%



The NHS aims to reduce its carbon footprint by 10% between 2009 and 2015. Reducing the amount of energy used in our organisation contributes to this goal

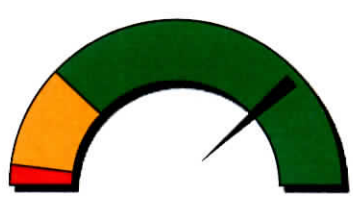
There is also a financial benefit which comes from reducing our energy bill.

Our energy costs have increased by 28% in 2012/13, the equivalent of 7 hip operations.

£0,000

We have not yet quantified our plans to reduce carbon emissions and improve our environmental sustainability

68 tonnes

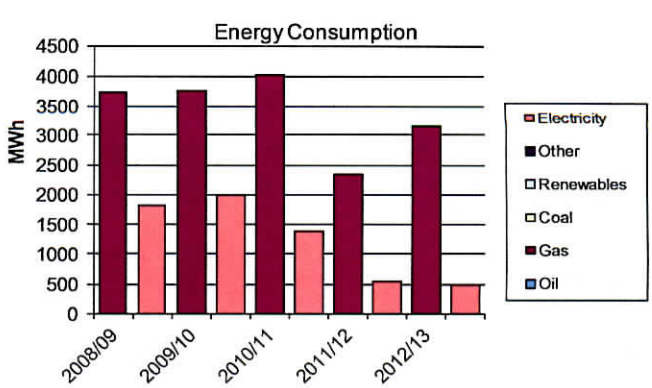


Percentage of Waste Recycled

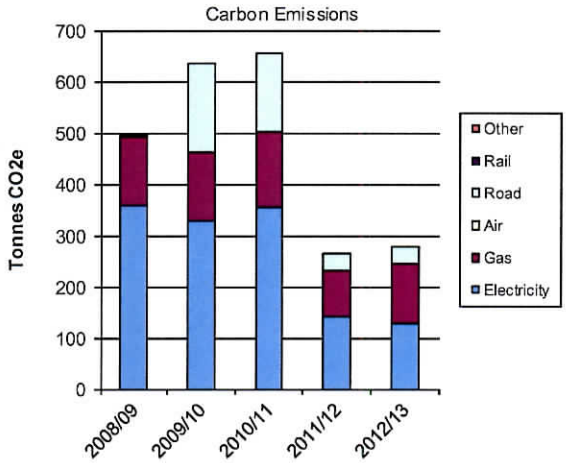
We recover or recycle 67.95 tonnes of waste, which is 75% of the total waste we produce.

Our total energy consumption has risen during the year, from 2,915 to 3,655 MWh

Our relative energy consumption has changed during the year, from 0.19 to 0.24 MWh/square metre.

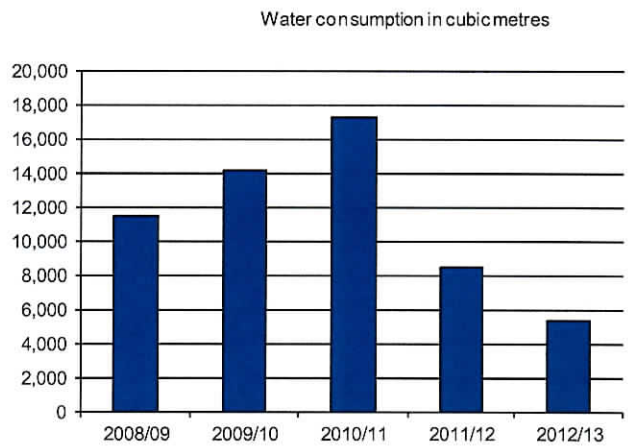


Renewable energy represents 0.0% of our total energy use. We do not generate any energy. We have not made arrangements to purchase electricity generated from renewable sources



Our measured greenhouse gas emissions have increased by 0,015 tonnes this year.

0



Our water consumption has reduced by 3,081 cubic meters in the recent financial year.

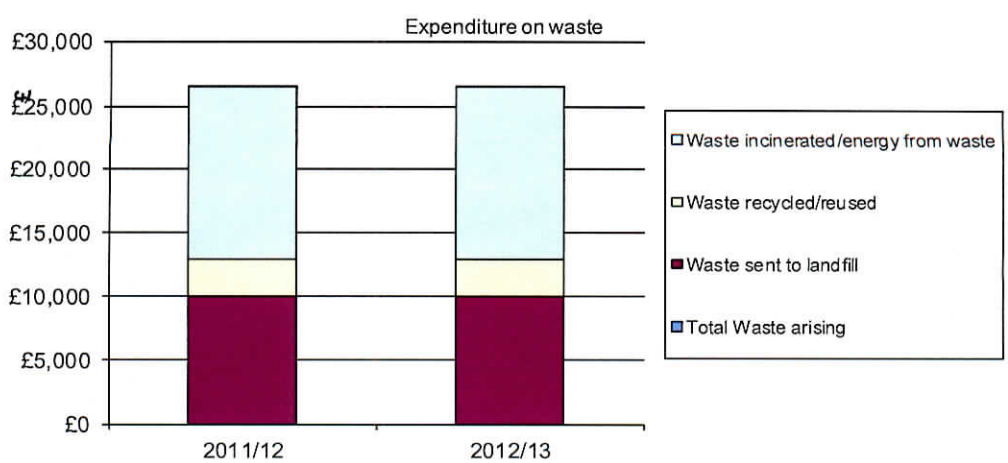
In 2012/13 we spent £21,889 on water.

During 2012/13 our gross expenditure on the CRC Energy Efficiency Scheme was £121,983

The CRC Energy Efficiency Scheme is a mandatory scheme aimed at improving energy efficiency and cutting emissions in large public and private sector organisations.

During 2012/13 our total expenditure on business travel was £222,581.

Our expenditure on waste in the last two years was incurred as follows:



Our organisation has an up to date Sustainable Development Management Plan. Having an up to date Sustainable Development Management plan is a good way to ensure that an NHS organisation fulfils its commitment to conducting all aspects of its activities with due consideration to sustainability, whilst providing high quality patient care. The NHS Carbon Reduction Strategy asks for the boards of all NHS organisations to approve such a plan.

We consider neither the potential need to adapt the organisation's activities nor its buildings and estates as a result of climate change.

Adaptation to climate change will pose a challenge to both service delivery and infrastructure in the future. It is therefore appropriate that we consider it when planning how we will best serve patients in the future.

Sustainability issues are not included in our analysis of risks facing our organisation. NHS organisations have a statutory duty to assess the risks posed by climate change. Risk assessment, including the quantification and prioritisation of risk, is an important part of managing complex organisations.

We plan to start work on calculating the carbon emissions associated goods and services we procure. In addition to our focus on carbon, we are also committed to reducing wider environmental and social impacts associated with the procurement of goods and services. This will be set out within our policies on sustainable procurement.

There is no Board Level lead for Sustainability. A Board Level lead for Sustainability ensures that sustainability issues have visibility and ownership at the highest level of the organisation.

Sustainability issues, such as carbon reduction, are not currently included in the job descriptions of all staff. Our last staff awareness campaign was conducted on the 1st May 2011. "A sustainable NHS can only be delivered through the efforts of all staff". Staff awareness campaigns have been shown to deliver cost savings and associated reductions in carbon emissions.

Our organisation does not have a Sustainable Transport Plan. The NHS places a substantial burden on the transport infrastructure, whether through patient, clinician or other business activity. This generates an impact on air quality and greenhouse gas emissions. It is therefore important that we consider what steps are appropriate to reduce or change travel patterns.

Appendix 6 - Off-payroll engagements

For off-payroll engagements at a cost of over £58,200 per annum that were in place as of 31st January 2012

	NHS Western Cheshire
No. In place on 31 January 2012	2
Of which:	[redacted]
No. that have since come onto the Organisation's payroll	0
Of which:	[redacted]
No. that have since been re-negotiated/re-engaged to include to include contractual clauses allowing the (department) to seek assurance as to their tax obligations	0
No. that have not been successfully re-negotiated, and therefore continue without contractual clauses allowing the (department) to seek assurance as to their tax obligations	0
No that have come to an end	0
Total at 31st March 2013	2

For all new off-payroll engagements between 23rd August 2012 and 31st March 2013, for more than £220 per day and more than 6 months

	NHS Western Cheshire
No. of new engagements	1
Of which:	[redacted]
No. of new engagements which include contractual clauses giving the department the right to request assurance in relation to income tax and National Insurance obligations	0
Of which:	[redacted]
No. for whom assurance has been accepted and received	0
No. for whom assurance has been accepted and not received	0
No. that have been terminated as a result of assurance not being received	0
Total at 31st March 2013	1

Department of Health

NHS

Western Cheshire Primary Care Trust

2012-13 Accounts

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Western Cheshire Primary Care Trust

2012-13 Accounts

Department of Health

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

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

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

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

Signed.....Designated Signing Officer

Name: MOIRA DONNA

Date.....3.6.2013

Department of Health

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

3.6.2013 Date ..... Signing Officer

3/6/13 Date ..... Finance Signing Officer

Grant Thornton

INDEPENDENT AUDITOR'S REPORT TO THE DEPARTMENT OF HEALTH'S ACCOUNTING OFFICER IN RESPECT OF WESTERN CHESHIRE PRIMARY CARE TRUST

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

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

- the table of salaries and allowances of senior managers and related narrative notes on pages 32 to 35 and on page 37;
- the table of pension benefits of senior managers and related narrative notes on pages 36 to 37; and
- the pay multiples narrative on page 38.

This report is made solely to the Department of Health's accounting officer in respect of Western Cheshire Primary Care Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Department of Health's accounting officer and the Trust as a body, for our audit work, for this report, or for opinions we have formed.

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

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

Scope of the audit of the financial statements

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

any apparent material misstatements or inconsistencies we consider the implications for our report.

In addition, we are required to obtain evidence sufficient to give reasonable assurance that the expenditure and income reported in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

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

Opinion on other matters

In our opinion:

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

Matters on which we report by exception

We report to you if:

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

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

We have nothing to report in these respects.

Other matters on which we are required to conclude

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

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

- our review of the annual governance statement, and
- our locally determined risk based work on the transition to new commissioning arrangements.

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

Certificate

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

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

Royal Liver Building
Liverpool
L3 1PS

7 June 2013

Statement of Comprehensive Net Expenditure for year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure			
Gross employee benefits	7.1	**13,850**	15,446
Other costs	5.1	**1,583,007**	1,333,919
Income	4	**(1,099,050)**	(917,051)
Net operating costs before interest		**497,807**	432,314
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**0**	16
Net operating costs for the financial year		**497,807**	432,330
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		**497,807**	**432,330**
Of which:			
Administration Costs			
Gross employee benefits	7.1	**9,512**	8,341
Other costs	5.1	**5,187**	5,622
Income	4	**(3,715)**	(3,597)
Net administration costs before interest		**10,984**	**10,366**
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**0**	0
Net administration costs for the financial year		**10,984**	**10,366**
Programme Expenditure			
Gross employee benefits	7.1	**4,338**	7,105
Other costs	5.1	**1,577,820**	1,328,297
Income	4	**(1,095,335)**	(913,454)
Net programme expenditure before interest		**486,823**	**421,948**
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**0**	16
Net programme expenditure for the financial year		**486,823**	**421,964**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**145**	132
Net (gain) on revaluation of property, plant & equipment	**(75)**	(518)
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**	
Release of Reserves to Statement of Comprehensive Net Expenditure	**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*	**497,877**	**431,944**

*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 32 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	**17,916**	19,235
Intangible assets	13	**0**	41
investment property	16	**0**	0
Other financial assets	22	**0**	0
Trade and other receivables	20	**0**	0
Total non-current assets		**17,916**	19,276
Current assets:			
Inventories	19	**0**	0
Trade and other receivables	20	**8,728**	25,849
Other financial assets		**0**	0
Other current assets	23	**0**	0
Cash and cash equivalents	24	**10**	0
Total current assets		**8,738**	25,849
Non-current assets held for sale		**0**	0
Total current assets		**8,738**	25,849
Total assets		**26,654**	45,125
Current liabilities			
Trade and other payables	25	**(21,605)**	(27,853)
Other liabilities	26,28	**(2)**	(2)
Provisions	32	**(3,027)**	(3,262)
Borrowings	27	**0**	0
Other financial liabilities	28	**0**	0
Total current liabilities		**(24,634)**	(31,117)
Non-current assets plus/less net current assets/liabilities		**2,020**	14,008
Non-current liabilities			
Trade and other payables	25	0	0
Other Liabilities	26	(438)	(440)
Provisions	32	0	0
Borrowings	27	0	0
Other financial liabilities	28	0	0
Total non-current liabilities		**(438)**	(440)
Total Assets Employed:		**1,582**	13,568
Financed by taxpayers' equity:			
General fund		(2,962)	8,954
Revaluation reserve		4,544	4,614
Other reserves		0	0
Total taxpayers' equity:		**1,582**	13,568

The notes on pages 5 to 32 form part of this account.

The financial statements on pages 1 to 32 were approved by the Audit Sub Committee of the Department of Health and signed on its behalf by

Designated Signing Officer: Mira Dhume Date: 3.6.2013

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	**8,954**	**4,614**	**0**	**13,568**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(497,807)			**(497,807)**
Net gain on revaluation of property, plant, equipment		75		**75**
Net gain on revaluation of intangible assets		0		**0**
Net gain on revaluation of financial assets		0		**0**
Net gain on revaluation of assets held for sale		0		**0**
Impairments and reversals		(145)		**(145)**
Movements in other reserves			0	**0**
Transfers between reserves*	0	0		**0**
Release of Reserves to SOCNE		0		**0**
Reclassification Adjustments				
Transfers between Revaluation Reserve & General Fund in respect of assets transferred under absorption	0	0		**0**
Net actuarial gain/(loss) on pensions	0		0	**0**
Total recognised income and expense for 2012-13	**(497,807)**	**(70)**	**0**	**(497,877)**
Net Parliamentary funding	485,891			**485,891**
Balance at 31 March 2013	**(2,962)**	**4,544**	**0**	**1,582**
Balance at 1 April 2011	*4127*	*4228*	*0*	*8,355*
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	*(432,330)*			*(432,330)*
Net Gain / (loss) on Revaluation of Property, Plant and Equipment		*518*		*518*
Net Gain / (loss) on Revaluation of Intangible Assets		*0*		*0*
Net Gain / (loss) on Revaluation of Financial Assets		*0*		*0*
Net Gain / (loss) on Assets Held for Sale		*0*		*0*
Impairments and Reversals		*(132)*		*(132)*
Movements in other reserves			*0*	*0*
*Transfers between reserves**	*0*	*0*		*0*
Release of Reserves to Statement of Comprehensive Net Expenditure		*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*
Total recognised income and expense for 2011-12	*(432,330)*	*386*	*0*	*(431,944)*
Net Parliamentary funding	*437,157*			*437,157*
Balance at 31 March 2012	*8,954*	*4,614*	*0*	*13,568*

Statement of cash flows for the year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities			
Net Operating Cost Before Interest		**(497,807)**	(432,314)
Depreciation and Amortisation		**1,139**	1,184
Impairments and Reversals		**1,619**	1,636
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**	(16)
Release of PFI/deferred credit		**0**	0
(Increase)/Decrease in Inventories		**0**	0
(Increase)/Decrease in Trade and Other Receivables		**17,121**	(314)
(Increase)/Decrease in Other Current Assets		**0**	0
Increase/(Decrease) in Trade and Other Payables		**(6,180)**	(7,572)
(Increase)/Decrease in Other Current Liabilities		**(2)**	(1)
Provisions Utilised		**(2,777)**	(1,148)
Increase/(Decrease) in Provisions		**2,542**	2,901
Net Cash Inflow/(Outflow) from Operating Activities		**(484,345)**	**(435,644)**
Cash flows from investing activities			
Interest Received		**0**	0
(Payments) for Property, Plant and Equipment		**(1,536)**	(1,353)
(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)		**0**	0
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		**(1,536)**	**(1,353)**
Net cash inflow/(outflow) before financing		**(485,881)**	**(436,997)**
Cash flows from financing activities			
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**0**	(160)
Net Parliamentary Funding		**485,891**	437,157
Capital Receipts Surrendered		**0**	0
Capital grants and other capital receipts		**0**	0
Cash Transferred (to)/from Other NHS Bodies (free text note required)		**0**	0
Net Cash Inflow/(Outflow) from Financing Activities		**485,891**	**436,997**
Net increase/(decrease) in cash and cash equivalents		**10**	**0**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**0**	**0**
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		**10**	**0**

1. Accounting policies

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

The Secretary of State for Health has directed that the financial statements of Primary Care Trusts shall meet the accounting requirements of the Primary Care Trust Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2012-13 Primary Care Trusts 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 Primary Care Trust 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 Primary Care Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Primary Care Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting Conventions

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

Acquisitions and Discontinued Operations

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

Critical accounting judgements and key sources of estimation uncertainty

In the application of the Primary Care Trust'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.

- Management has designated the GMS contractual arrangements to be operating leases in accordance with International Financial Reporting Interpretations Committee (IFRIC) 4 '*Determining whether an arrangement contains a lease*' and International Accounting Standards (IAS17) *'leases*'. The impact of this judgement is that costs in relation to GP surgeries and health centres are taken to the operating cost statement instead of being capitalised as assets in the
- Management has decided that legal charges held over properties used for care in the community services are not assets of the Primary Care Trust under IFRIC 12 '*Service Concession Arrangements*'. The assets underlying the legal charges have not been recognised in the balance sheet.
- The Primary Care Trust as lessor has leased land and buildings to a third party lessee under a long term lease. Management has judged that the lease of land is an operating lease and the lease of the building is a sale given the 200
- The Primary Care Trust has worked with a third party developer to build a primary care facility. The Primary Care Trust, as lessor, has granted a 124 year lease on the associated land, to the developer. The Primary Care Trust, as lessee, has entered into a 21 year sub-lease with the GP practices. Management have decided that both of these leases are operating leases and are, therefore, included in note 6 to these accounts.

Key sources of estimation uncertainty

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

- Management has estimated the useful economic life of buildings based on guidance from Royal Institute of Chartered Surveyors (RICS) qualified surveyors. Any deviation in useful economic lives from those estimated could significantly impact depreciation and impairment charges.
- Non Current Assets were valued by the District Valuer as at 31 March 2013 and management has used this valuation to estimate the carrying value of non current assets. This process will be repeated on a five yearly basis as a minimum. Interim valuations will also be undertaken either on specific assets or on the whole estate if there is reason to believe that valuations have materially changed. The carrying value of all non current assets is identified in notes 12 and 13 to
- Primary Care practice prescribing information is received by the Primary Care Trust approximately 6 weeks following the end of each reporting period. Management have estimated the year-end prescribing expenditure based on the forecast provided by the Prescription Pricing Division of the NHS Business Services Authority. This forecast is based on 10 months actual prescribing data. Analysis of previous year's data would suggest that there is no reason for this forecast to be materially different to actual year-end prescribing results.
- Following a ruling by the NHS Ombudsman, the Primary Care Trust is potentially liable for continuing healthcare restitution payments from Western Cheshire residents who have previously been denied continuing healthcare funding by the Primary Care Trust or its predecessor organisations. Management have calculated a provision to reflect the likely cost of all known restitution claims following both IAS37 *'provisions, contingent liabilities and contingent assets*' and the Primary Care Trust's accounting policy (note 1.24).

The PCT was not able to fully investigate all of the large number of claims received during the year prior to its demise. It used a model based on the judgement of officers with experience of investigating claims to estimate the probability of claims progressing through the various identified stages in the model to establish the number of claims to be provided for. A sample of 20 cases across the Cluster was used to support one of the stages; for the estimate of success for patients in residential care homes. This approach provided an estimate of the conversion rate for successful claims, which fell within a range of between 13.3% and 15.0% with an average of 14.3% across the 4 primary care trusts across Cheshire, Warrington and Wirral Primary Care Trust Cluster. The estimated cost per claim and average weeks were based on historic data to produce the likely overall liability.

The calculation of the provisions for closedown claims has required a significant degree of judgement and estimation. Within Cheshire, Warrington and Wirral Primary Care Trust Cluster a consistent approach has been adopted whilst also building in local intelligence in relation to the average claim period and average cost per week.

The provision made in the 2012/13 financial statements is £2,692,000 (note 32) with a contingent liability of £1,958,000 (note 33).

1. Accounting policies (continued)

1.2 Revenue and Funding

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

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

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

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

1.3 Pooled budgets

Western Cheshire Primary Care Trust did not enter into any pooled budget arrangement during 2012/13.

1.4 Taxation

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

1.5 Administration and Programme Costs

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

From 2011-12, Primary Care Trusts therefore analyse and report revenue income and expenditure by "admin and programme".
For Primary Care Trusts, 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 classified to "programme" under Treasury budgetary control arrangements and so is recorded as such in the financial statements.

1.6 Property, Plant & Equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation

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

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

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

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

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

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

1. Accounting policies (continued)

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

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

1.7 Intangible Assets
Recognition
Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Primary Care Trust'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 Primary Care Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:
- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

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

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

1.8 Depreciation, amortisation and impairments
Freehold land, properties under construction and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Primary Care Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Primary Care Trust 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 Primary Care Trust 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.

1. Accounting policies (continued)

1.8 Depreciation, amortisation and impairments (cont.)

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

1.9 Donated assets

Western Cheshire Primary Care Trust does not hold any donated assets.

1.10 Government grants

Western Cheshire Primary Care Trust does not hold any government grants.

1.11 Non-current assets held for sale

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

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

1.12 Inventories

Western Cheshire Primary Care Trust does not hold any inventories.

1.13 Cash and cash equivalents

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

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

1.14 Losses and Special Payments

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

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

1.15 Clinical Negligence Costs

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

The NHSLA operates a risk pooling scheme under which the Primary Care Trust 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 Primary Care Trust is disclosed at Note 32.

1. Accounting policies (continued)

1.16 Employee benefits

Short-term employee benefits

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

Retirement benefit costs

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

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

1.17 Research and Development

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

1.18 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.19 Grant making

Under section 256 of the National Health Service Act 2006, the Primary Care Trust 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 Primary Care Trust has a present legal or constructive obligation which occurs when all of the conditions attached to the payment have been met.

1.20 EU Emissions Trading Scheme

Western Cheshire Primary Care Trust is not involved in the EU Emission Trading Scheme.

1. Accounting policies (continued)

1.21 Contingencies

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

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

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

1.22 Leases

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

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 Primary Care Trust 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 Primary Care Trust'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.

The Primary Care Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Primary Care Trust'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 Primary Care Trust's net investment outstanding in respect of the leases.

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

1.23 Foreign exchange

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

1.24 Provisions

Provisions are recognised when the Primary Care Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Primary Care Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

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

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Primary Care Trust 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.

1. Accounting policies (continued)

1.25 Financial Instruments

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

Financial liabilities are initially recognised at fair value.

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

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

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

IAS 19 (Revised 2011) Employee Benefits
IAS 27 Separate Financial Statements - subject to consultation
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IAS 32 Financial Instruments: Presentation
IFRS 7 Financial Instruments: Disclosures, not applied in 2013
IFRS 9 Financial Instruments - subject to consultation - subject to consultation
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IPSAS 32 - Service Concession Arrangement - subject to consultation

2 Operating segments

International Financial Reporting Standards require the primary care trust to analyse financial performance across decision making segments. For financial year 2012/13 there are 2 key decision making segments as demonstrated by the following table. Approximately 60% of the Western Cheshire Primary Care Trust's (segment 1) budget has been delegated to NHS West Cheshire Clinical Commissioning Group as a formal sub-committee of NHS Cheshire, Warrington and Wirral Primary Care Trust Cluster. However, NHS Cheshire, Warrington and Wirral Board is the key decision making body and, therefore, the clinical commissioning group has not been classed as an operating segment.

The accounting policies outlined in note 1 to the accounts have been adopted by both segments. Further details of the income and expenditure of the operating segments are provided below:

	Segment 1 NHS Western Cheshire	**Segment 2 North West Specialised Commissioning Team**	**Total - Western Cheshire Primary Care Trust**
	2012/13 £000	**2012/13 £000**	**2012/13 £000**
Employee benefits	9,755	4,095	13,850
Other costs	507,818	1,075,189	1,583,007
Income	(19,733)	(1,079,317)	(1,099,050)
PCT net operating costs before interest	497,840	(33)	497,807
Finance costs			0
Net operating costs for the financial year	497,840	(33)	497,807
Resource Funding	(499,837)		(499,837)
Operating Segment surplus	**(1,997)**	**(33)**	**(2,030)**

NHS Western Cheshire - Segment 1

NHS Western Cheshire has a total commissioning budget of approximately £ 500 million and procures, commissions and contracts for healthcare services for the registered population of Western Cheshire. Approximately 60% of this budget is delegated to NHS West Cheshire clinical Commissioning Group. This segment represents approximately 19% of the gross expenditure reported in note 5 to these accounts.

North West Specialised Commissioning Team - Segment 2.

The North West Specialised Commissioning Team commission specialised health services on behalf of 24 primary care trusts across the North West, including Western Cheshire. The team has separate governance and reporting arrangements with key decisions made at the North West Specialised Commissioning Group. This segment represents approximately 68% of the gross expenditure reported in note 5 to these accounts.

2011/12 Note 2. Operating Segments

	NHS Western Cheshire	***North West Specialised Commissioning Team***	***Total - Western Cheshire Primary Care Trust***
	2011/12 £000	***2011/12 £000***	***2011/12 £000***
Employee benefits	*11,821*	*3,625*	*15,446*
Other costs	*430,866*	*903,053*	*1,333,919*
Income	*(10,394)*	*(906,657)*	*(917,051)*
PCT net operating costs before interest	*432,293*	*21*	*432,314*
Finance costs	*16*		*16*
Net operating costs for the financial year	*432,309*	*21*	*432,330*
Resource Funding	*(434,296)*		*(434,296)*
Operating Segment surplus	***(1,987)***	***21***	***(1,966)***

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	**497,807**	*432,330*
Adjusted for prior period adjustments in respect of errors	**0**	*0*
Revenue Resource Limit	**499,837**	*434,296*
Under/(Over)spend Against Revenue Resource Limit (RRL)	2,030	*1,966*

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	**1,640**	*1,015*
Charge to Capital Resource Limit	**1,468**	*928*
Underspend Against CRL	**172**	*87*

3.3 Under/(Over)spend against cash limit

	2012-13 £000	*2011-12 £000*
Total Charge to Cash Limit	**485,891**	*437,157*
Cash Limit	**485,891**	*437,157*
Under/(Over)spend Against Cash Limit	**0**	*0*

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

	2012-13 £000
Total cash received from DH (Gross)	431,119
Less: Trade Income from DH	0
Less/(Plus): movement in DH working balances	0
Sub total: net advances	**431,119**
(Less)/plus: transfers (to)/from other resource account bodies (free text note required)	0
Plus: cost of Dentistry Schemes (central charge to cash limits)	11,888
Plus: drugs reimbursement (central charge to cash limits)	42,884
Parliamentary funding credited to General Fund	**485,891**

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	**4,422**		4,422	*4,362*
Dental Charge income from Trust-Led GDS & PDS	**0**		0	*0*
Prescription Charge income	**2,197**		2,197	*1,837*
Strategic Health Authorities	**149**	0	149	*575*
NHS Trusts	**79**	0	79	*4,236*
NHS Foundation Trusts	**11**	0	11	*326*
Primary Care Trusts Contributions to DATs	**0**		0	*0*
Primary Care Trusts - Other	**9,734**	0	9,734	*1,888*
Primary Care Trusts - Lead Commissioning	**1,068,872**	3,715	1,065,157	*891,150*
English RAB Special Health Authorities	**0**	0	0	*0*
NDPBs and Others (CGA)	**0**	0	0	*0*
Department of Health - SMPTB	**0**	0	0	*0*
Department of Health - Other	**0**	0	0	*0*
Recoveries in respect of employee benefits	**0**	0	0	*0*
Local Authorities	**29**	0	29	*112*
Patient Transport Services	**0**		0	*0*
Education, Training and Research	**796**	0	796	*814*
Non-NHS: Private Patients	**0**		0	*0*
Non-NHS: Overseas Patients (Non-Reciprocal)	**0**		0	*0*
NHS Injury Costs Recovery	**0**		0	*0*
Other Non-NHS Patient Care Services	**12,098**	0	12,098	*10,904*
Charitable and Other Contributions to Expenditure	**0**		0	*0*
Receipt of donated assets	**0**		0	*0*
Receipt of Government granted assets	**0**		0	*0*
Rental revenue from finance leases	**0**	0	0	*0*
Rental revenue from operating leases	**434**	0	434	*434*
Other revenue	**229**	0	229	*413*
Total miscellaneous revenue	**1,099,050**	**3,715**	**1,095,335**	*917,051*

Western Cheshire Primary Care Trust hosts the North West Specialised Commissioning Team (segment 2; note 2). The miscellaneous revenue figure reported in note 4 includes £ 1,079 million relating to this organisation (£907 million, 2011/12). This figure excludes approximately £ 109 million of expenditure relating to inter-company trading with the primary care trust.

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	**78,111**		78,111	*53,150*
Non-Healthcare	**3,714**	1,098	2,616	*2,350*
Total	**81,825**	**1,098**	**80,727**	*55,500*
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	**172,293**	77	172,216	*134,805*
Goods and services (other, excl Trusts, FT and PCT))	**3,447**	0	3,447	*64*
Total	**175,740**	**77**	**175,663**	*134,869*
Goods and Services from Foundation Trusts	**1,148,704**	406	1,148,298	*963,011*
Purchase of Healthcare from Non-NHS bodies	**59,176**		59,176	*61,235*
Social Care from Independent Providers	**0**		0	*0*
Expenditure on Drugs Action Teams	**4,633**		4,633	*4,417*
Non-GMS Services from GPs	**554**	400	154	*484*
Contractor Led GDS & PDS (excluding employee benefits)	**16,750**		16,750	*16,721*
Salaried Trust-Led PDS & PCT DS (excluding employee benefits	**0**		0	*0*
Chair, Non-executive Directors & PEC remuneration	**228**	228	0	*208*
Executive committee members costs	**0**	0	0	*0*
Consultancy Services	**1,853**	547	1,306	*664*
Prescribing Costs	**36,537**		36,537	*39,454*
G/PMS, APMS and PCTMS (excluding employee benefits)	**34,584**	0	34,584	*35,514*
Pharmaceutical Services	**302**		302	*958*
Local Pharmaceutical Services Pilots	**0**		0	*0*
New Pharmacy Contract	**9,820**		9,820	*9,469*
General Ophthalmic Services	**2,010**		2,010	*2,174*
Supplies and Services - Clinical	**614**	7	607	*618*
Supplies and Services - General	**32**	32	0	*21*
Establishment	**1,112**	687	425	*1,035*
Transport	**143**	110	33	*115*
Premises	**1,286**	535	751	*2,366*
Impairments & Reversals of Property, plant and equipment	**1,619**	0	1,619	*1,636*
Impairments and Reversals of non-current assets held for sale	**0**	0	0	*0*
Depreciation	**1,098**	615	483	*1,128*
Amortisation	**41**	0	41	*56*
Impairment & Reversals Intangible non-current assets	**0**	0	0	*0*
Impairment and Reversals of Financial Assets	**0**	0	0	*0*
Impairment of Receivables	**(66)**	0	(66)	*63*
Inventory write offs	**0**	0	0	*0*
Research and Development Expenditure	**0**	0	0	*0*
Audit Fees	**154**	154	0	*220*
Other Auditors Remuneration	**0**	0	0	*36*
Clinical Negligence Costs	**0**	0	0	*0*
Education and Training	**215**	114	101	*83*
Grants for capital purposes	**0**	0	0	*0*
Grants for revenue purposes	**0**	0	0	*0*
Impairments and reversals for investment properties	**0**	0	0	*0*
Other	**4,043**	177	3,866	*1,864*
Total Operating costs charged to Statement of Comprehensi	**1,583,007**	**5,187**	**1,577,820**	*1,333,919*
Employee Benefits (excluding capitalised costs)				
Employee Benefits associated with PCTMS	**0**	0	0	*5*
Trust led PDS and PCT DS	**0**	0	0	*0*
PCT Officer Board Members	**890**	890	0	*802*
Other Employee Benefits	**12,960**	8,622	4,338	*14,639*
Total Employee Benefits charged to SOCNE	**13,850**	**9,512**	**4,338**	*15,446*
Total Operating Costs	**1,596,857**	**14,699**	**1,582,158**	*1,349,365*

Western Cheshire Primary Care Trust hosts the North west Specialised Commissioning Team (segment 2; note 2). The operating costs reported in note 5.1 includes £ 1,079 million relating to this organisation (£907 million, 2011/12). This figure excludes approximately £ 109 million of expenditure relating to inter-company trading with the primary care trust.

Primary care staff costs include £0 for early retirements prior to 6 March 1995 (£0, 2011/12).

During 2012/13 there were no capital grants to local authorities or the private sector.

	Total	Commissioning services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**10,984**	10,281	703
Weighted population (number in units)*	**238,372**	238,372	238,372
Running costs per head of population (£ per head)	**46**	**43**	**3**
PCT Running Costs 2011-12			
Running costs (£000s)	**10,421**	9,532	889
Weighted population (number in units)	**238,372**	238,372	238,372
Running costs per head of population (£ per head)	**44**	**40**	**4**

* 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	34,584	*35,519*
Prescribing costs	36,537	*39,454*
Contractor led GDS & PDS	16,750	*16,721*
Trust led GDS & PDS	0	*0*
General Ophthalmic Services	2,010	*2,174*
Department of Health Initiative Funding	0	*0*
Pharmaceutical services	302	*958*
Local Pharmaceutical Services Pilots	0	*0*
New Pharmacy Contract	9,820	*9,469*
Non-GMS Services from GPs	554	*484*
Other	0	*0*
Total Primary Healthcare purchased	**100,557**	*104,779*
Purchase of Secondary Healthcare		
Learning Difficulties	6,848	*4,207*
Mental Illness	51,034	*48,614*
Maternity	17,063	*17,428*
General and Acute	220,503	*176,680*
Accident and emergency	20,855	*17,776*
Community Health Services	70,032	*49,310*
Other Contractual	580	*2,277*
Total Secondary Healthcare Purchased	**386,915**	*316,292*
Grant Funding		
Grants for capital purposes	0	*0*
Grants for revenue purposes	0	*0*
Total Healthcare Purchased by PCT	**487,472**	*421,071*
PCT self-provided secondary healthcare included above	0	*0*
Social Care from Independent Providers	0	*0*
Healthcare from NHS FTs included above	0	*0*

6. Operating Leases

6.1 PCT as lessee

	Land £000	Buildings £000	Other £000	2012-13 Total £000	*2011-12 £000*
Payments recognised as an expense					
Minimum lease payments				**231**	*249*
Contingent rents				**0**	*0*
Sub-lease payments				**0**	*0*
Total				**231**	*249*
Payable:					
No later than one year	**0**	**199**	**72**	**271**	*208*
Between one and five years	**0**	**1,198**	**53**	**1,251**	*1,136*
After five years	**0**	**4,996**	**0**	**4,996**	*5,282*
Total	**0**	**6,393**	**125**	**6,518**	*6,626*
				0	*0*

During 2011/12 the Primary Care Trust , as lessee, entered into a 21 year leasing arrangement with a third party for the provision of primary care premises.

Leasing arrangements under General Medical Services (GMS)

Western Cheshire Primary Care Trust has entered into certain financial arrangements involving GP premises. Under IAS 17 (leases), SIC 27 (evaluating the substance of transactions involving the legal form of a lease) and IFRIC 4 (determining whether an arrangement contains a lease), the PCT has determined that these operating leases must be recognised. However, 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 operating costs for 2012/13 is £1.850 million (2011/12, £1.996 million).

6.2 PCT as lessor

Western Cheshire Primary Care Trust, as lessor, has leased land and buildings to a third party lessee under a long term lease (200 years, 196 remaining). In addition , as from April 2011, the Primary Care Trust entered into a lease arrangement, as a lessor, with a local NHS Foundation Trust in respect of premises retained by the Primary Care Trust following the transfer of community services as part of the Transforming Community Services initiative.

	2012-13 £000	*2011-12 £000*
Recognised as income		
Rental Revenue	**434**	*434*
Contingent rents	**0**	*0*
Total	**434**	*434*
Receivable:		
No later than one year	**2**	*2*
Between one and five years	**9**	*9*
After five years	**429**	*431*
Total	**440**	*442*

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	**10,694**	7,788	2,906	**9,318**	7,154	2,164	**1,376**	634	742
Social security costs	**921**	720	201	**921**	720	201	**0**	0	0
Employer Contributions to NHS BSA - Pensions Division	**1,314**	1,004	310	**1,314**	1,004	310	**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	**921**	0	921	**921**	0	921	**0**	0	0
Total employee benefits	**13,850**	**9,512**	**4,338**	**12,474**	**8,878**	**3,596**	**1,376**	**634**	**742**
Less recoveries in respect of employee benefits (table below)	**0**	0	0	**0**	**0**	**0**	**0**	**0**	**0**
Total - Net Employee Benefits including capitalised costs	**13,850**	**9,512**	**4,338**	**12,474**	**8,878**	**3,596**	**1,376**	**634**	**742**
Employee costs capitalised	**0**	0	0	**0**	0	0	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**13,850**	**9,512**	**4,338**	**12,474**	**8,878**	**3,596**	**1,376**	**634**	**742**
Recognised as:									
Commissioning employee benefits	**13,850**			**12,474**			**1,376**		
Provider employee benefits	**0**			**0**			**0**		
Gross Employee Benefits excluding capitalised costs	**13,850**			**12,474**			**1,376**		

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

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	**10,177**	9,983	194
Social security costs	**1,014**	994	20
Employer Contributions to NHS BSA - Pensions Division	**1,374**	1,347	27
Other pension costs	**0**	0	0
Other post-employment benefits	**0**	0	0
Other employment benefits	**0**	0	0
Termination benefits	**2,881**	2,881	0
Total gross employee benefits	**15,446**	**15,205**	**241**
Less recoveries in respect of employee benefits	**0**	0	0
Total - Net Employee Benefits including capitalised costs	**15,446**	**15,205**	**241**
Employee costs capitalised	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**15,446**	**15,205**	**241**
Recognised as:			
Commissioning employee benefits	**15,446**		
Provider employee benefits	**0**		
Gross Employee Benefits excluding capitalised costs	**15,446**		

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	**5**	5	0	*5*	*5*	*0*
Ambulance staff	**0**	0	0	*0*	*0*	*0*
Administration and estates	**221**	200	21	*238*	*230*	*8*
Healthcare assistants and other support staff	**0**	0	0	*2*	*1*	*1*
Nursing, midwifery and health visiting staff	**12**	12	0	*11*	*10*	*1*
Nursing, midwifery and health visiting learners	**0**	0	0	*0*	*0*	*0*
Scientific, therapeutic and technical staff	**13**	13	0	*19*	*18*	*1*
Social Care Staff	**0**	0	0	*0*	*0*	*0*
Other	**4**	4	0	*1*	*1*	*0*
TOTAL	**255**	**234**	**21**	*276*	*265*	*11*
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	**2,050**	*1,689*
Total Staff Years	**258**	*290*
Average working Days Lost	7.95	*5.82*

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	**2**	**3**	**5**	*2*	*0*	*2*
£10,001-£25,000	**1**	**3**	**4**	*1*	*0*	*1*
£25,001-£50,000	**2**	**12**	**14**	*0*	*0*	*0*
£50,001-£100,000	**2**	**10**	**12**	*0*	*0*	*0*
£100,001 - £150,000	**1**	**3**	**4**	*0*	*0*	*0*
£150,001 - £200,000	**2**	**3**	**5**	*0*	*0*	*0*
>£200,000	**0**	**3**	**3**	*1*	*0*	*1*
Total number of exit packages by type (total cost	**10**	**37**	**47**	*4*	*0*	*4*
	£'s	**£'s**	**£'s**	*£'s*	*£'s*	*£'s*
Total resource cost	720,365	2,746,447	**3,466,812**	*335,000*	*0*	*335,000*

This note provides an analysis of Exit Packages agreed during the year. Redundancy and other departure costs have been paid in accordance with the provisions of the NHS voluntary and compulsory redundancy schemes. 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. The expense associated with these departures may have been recognised in part or 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	**10,092**	**83,079**	*10,767*	*84,281*
Total Non-NHS Trade Invoices Paid Within Target	**9,776**	**80,974**	*10,441*	*82,538*
Percentage of NHS Trade Invoices Paid Within Target	96.87%	97.47%	*96.97%*	*97.93%*
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**5,998**	**1,570,909**	*5,608*	*1,267,956*
Total NHS Trade Invoices Paid Within Target	**5,862**	**1,561,215**	*5,476*	*1,257,634*
Percentage of NHS Trade Invoices Paid Within Target	97.73%	99.38%	*97.65%*	*99.19%*

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

There were no payments arising from claims made by businesses under this legislation (2011/12, £0), nor was any compensation paid to cover debt recovery costs (2011/12, £0)

9. Investment Income

Western Cheshire Primary Care Trust did not receive any investment income (2011/12, £0).

10. Other Gains and Losses

There were no gains or losses (2011/12, £0).

11. Finance Costs

There were no finance costs during 2012/13(2011/12, £16,000).

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	**7,116**	**10,924**	**0**	**448**	**605**	**69**	**3,926**	**77**	**23,165**
Additions Purchased	0	1,211	0		0	0	257	0	**1,468**
Reclassifications	0	605	0	0	(605)	0	0	0	**0**
Upward revaluation/positive indexation	75	0	0	0	0	0	0	0	**75**
Impairments/negative indexation	0	(145)	0	0	0	0	0	0	**(145)**
Cumulative dep netted off cost following revaluatio	0	(2,467)	0	0	0	0	0	0	**(2,467)**
At 31 March 2013	**7,191**	**10,128**	**0**	**448**	**0**	**69**	**4,183**	**77**	**22,096**
Depreciation									
At 1 April 2012	**723**	**0**	**0**	**0**	**259**	**69**	**2,802**	**77**	**3,930**
Reclassifications	0	294	0		(294)	0	0	0	**0**
Impairments	5	1,614	0	0	0	0	0	0	**1,619**
Charged During the Year	0	559	0		35	0	504	0	**1,098**
Cumulative dep netted off cost following revaluatio	0	(2,467)	0		0	0	0	0	**(2,467)**
At 31 March 2013	**728**	**0**	**0**	**0**	**0**	**69**	**3,306**	**77**	**4,180**
Net Book Value at 31 March 2013	**6,463**	**10,128**	**0**	**448**	**0**	**0**	**877**	**0**	**17,916**
Purchased	6,463	10,128	0	448	0	0	877	0	**17,916**
Total at 31 March 2013	**6,463**	**10,128**	**0**	**448**	**0**	**0**	**877**	**0**	**17,916**
Asset financing:									
Owned	6,463	10,128	0	448	0	0	877	0	**17,916**
Total at 31 March 2013	**6,463**	**10,128**	**0**	**448**	**0**	**0**	**877**	**0**	**17,916**

Assets under construction comprise professional fees incurred for the development of Northgate and Blacon Medical Centres as part of the NHS Western Cheshire Transforming the Care Environment programme.

12.2 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	**3,471**	**1,124**	**0**	**0**	**0**	**19**	**0**	**0**	**4,614**
Movements (specify)	75	(145)	0	0	0	0	0	0	**(70)**
At 31 March 2013	**3,546**	**979**	**0**	**0**	**0**	**19**	**0**	**0**	**4,544**

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	*7,218*	*15,481*	*0*	*715*	*567*	*69*	*3,665*	*77*	*27,792*
Additions - purchased	*0*	*267*	*0*	*362*	*38*	*0*	*261*	*0*	*928*
Reclassifications	*0*	*629*	*0*	*(629)*	*0*	*0*	*0*	*0*	*0*
Revaluation & indexation gains	*30*	*488*	*0*	*0*	*0*	*0*	*0*	*0*	*518*
Impairments	*(132)*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*(132)*
Cumulative dep netted off cost following revaluatio	*0*	*(5,941)*	*0*	*0*	*0*	*0*	*0*	*0*	*(5,941)*
At 31 March 2012	*7,116*	*10,924*	*0*	*448*	*605*	*69*	*3,926*	*77*	*23,165*
Depreciation									
At 1 April 2011	*0*	*4,410*	*0*		*225*	*64*	*2,331*	*77*	*7,107*
Impairments	*723*	*913*	*0*	*0*	*0*	*0*	*0*	*0*	*1,636*
Charged During the Year	*0*	*618*	*0*		*34*	*5*	*471*	*0*	*1,128*
Cumulative dep netted off cost following revaluatio	*0*	*(5,941)*	*0*	*0*	*0*	*0*	*0*	*0*	*(5,941)*
At 31 March 2012	*723*	*0*	*0*	*0*	*259*	*69*	*2,802*	*77*	*3,930*
Net Book Value at 31 March 2012	*6,393*	*10,924*	*0*	*448*	*346*	*0*	*1,124*	*0*	*19,235*
Purchased	*6,393*	*10,924*	*0*	*448*	*346*	*0*	*1,124*	*0*	*19,235*
At 31 March 2012	*6,393*	*10,924*	*0*	*448*	*346*	*0*	*1,124*	*0*	*19,235*
Asset financing:									
Owned	*6,393*	*10,924*	*0*	*448*	*346*	*0*	*1,124*	*0*	***19,235***
At 31 March 2012	***6,393***	***10,924***	***0***	***448***	***346***	***0***	***1,124***	***0***	***19,235***

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**	**594**	**0**	**0**	**0**	**594**
At 31 March 2013	**0**	**594**	**0**	**0**	**0**	**594**
Amortisation						
At 1 April 2012	**0**	**553**	**0**	**0**	**0**	**553**
Charged during the year	0	41	0	0	0	**41**
At 31 March 2013	**0**	**594**	**0**	**0**	**0**	**594**
Net Book Value 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*	*594*	*0*	*0*	*0*	*594*
At 31 March 2012	*0*	*594*	*0*	*0*	*0*	*594*
Amortisation						
At 1 April 2011	*0*	*497*	*0*	*0*	*0*	*497*
Charged during the year	*0*	*56*	*0*	*0*	*0*	*56*
At 31 March 2012	*0*	*553*	*0*	*0*	*0*	*553*
Net Book Value at 31 March 2012	*0*	*41*	*0*	*0*	*0*	*41*
Net Book Value at 31 March 2012 comprises						
Purchased	*0*	*41*	*0*	*0*	*0*	*41*
Total at 31 March 2012	*0*	*41*	*0*	*0*	*0*	*41*

13.3 Economic Lives of Non-Current Assets

	Min Life Years	Max Life Years
Intangible Assets		
Software Licences	1	2
Licences and Trademarks	0	0
Patents	0	0
Development Expenditure	0	0
Property, Plant and Equipment		
Buildings exc Dwellings	15	33
Dwellings	0	0
Plant & Machinery	2	15
Transport Equipment	1	1
Information Technology	2	5
Furniture and Fittings	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			
Changes in market price	1,619		1,619
Total charged to Annually Managed Expenditure	**1,619**		**1,619**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Changes in market price	145		145
Total impairments for PPE charged to reserves	**145**		**145**
Total Impairments of Property, Plant and Equipment	**1,764**	**0**	**1,764**

Following a District Valuer revaluation of the primary care trust's non-current assets as at 31 March 2013, the operating cost has been charged with an impairment of £1.619 million. All of this relates to property, plant and equipment.

15 Non-current assets held for sale

Western Cheshire Primary Care Trust does not have any non-current assets held for sale at 31 March 2013 (31 March 2012, £0).

16 Investment property

Western Cheshire Primary Care Trust does not have any investment property (31 March 2012, £0).

17 Commitments

17.1 Capital commitments

There were no capital commitments under capital expenditure contracts as at 31 March 2013 (31 March 2012, £0).

17.2 Other financial commitments

There were no other financial commitments at 31 March 2013 (31 March 2013, £0).

18 Intra-Government and other balances

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with other Central Government Bodies	4,470	0	725	0
Balances with Local Authorities	0	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	2,316	0	8,808	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	1,942	0	12,072	0
At 31 March 2013	**8,728**	**0**	**21,605**	**0**
prior period:				
Balances with other Central Government Bodies	5,538	0	1,730	0
Balances with Local Authorities	20	0	455	0
Balances with NHS Trusts and Foundation Trusts	15,868	0	11,973	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	4,423	0	13,695	0
At 31 March 2012	**25,849**	**0**	**27,853**	**0**

19 Inventories

Western Cheshire Primary Care Trust does not carry any stock (31 March 2012, £0).

20.1 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	**6,786**	21,061	**0**	*0*
Non-NHS receivables - revenue	**1,318**	4,130	**0**	*0*
Non-NHS prepayments and accrued income	**501**	547	**0**	*0*
Provision for the impairment of receivables	**0**	(66)	**0**	*0*
VAT	**111**	126	**0**	*0*
Other receivables	**12**	51	**0**	*0*
Total	**8,728**	25,849	**0**	*0*
Total current and non current	**8,728**	25,849		

20.2 Receivables past their due date but not impaired

	31 March 2013 £000	*31 March 2012 £000*
By up to three months	**3,730**	*8,569*
By three to six months	**35**	*92*
By more than six months	**260**	*900*
Total	**4,025**	*9,561*

20.3 Provision for impairment of receivables

	2012-13 £000	*2011-12 £000*
Balance at 1 April 2012	**(66)**	*(13)*
Amount written off during the year	**0**	*10*
Amount recovered during the year	**0**	*(63)*
(Increase)/decrease in receivables impaired	**66**	*0*
Balance at 31 March 2013	**0**	*(66)*

21 PFI and NHS LIFT investments

Western Cheshire Primary Care Trust has not entered into any PFI or NHS LIFT arrangements in either 2011/12 or 2012/13.

22 Other financial assets

Western Cheshire Primary Care Trust does not have any other financial assets (2011/12, £0).

23 Other current assets

Western Cheshire Primary Care Trust does not have any other current assets (2011/12, £0).

24 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**0**	0
Net change in year	**10**	0
Closing balance	**10**	0
Made up of		
Cash with Government Banking Service	**10**	0
Commercial banks	**0**	0
Cash in hand	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**10**	0
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**10**	0
Patients' money held by the PCT, not included above	**0**	0

25 Trade and other payables

	Current		Non-current	
	31 March 2013 £000	*31 March 2012 £000*	**31 March 2013 £000**	31 March 2012 £000
Interest payable	**0**	*0*		
NHS payables - revenue	**9,533**	*13,703*	**0**	0
NHS payables - capital	**0**	*0*	**0**	0
NHS accruals and deferred income	**0**	*0*	**0**	0
Family Health Services (FHS) payables	**7,657**	*8,908*		
Non-NHS payables - revenue	**3,360**	*4,759*	**0**	0
Non-NHS payables - capital	**77**	*145*	**0**	0
Non_NHS accruals and deferred income	**186**	*201*	**0**	0
Social security costs	**(21)**	*(4)*		
VAT	**0**	*0*	**0**	0
Tax	**386**	*39*		
Payments received on account	**0**	*16*	**0**	0
Other	427	*86*	0	0
Total	**21,605**	*27,853*	**0**	0
Total payables (current and non-current)	**21,605**	*27,853*		

26 Other liabilities

	Current		Non-current	
	31 March 2013 £000	*31 March 2012 £000*	**31 March 2013 £000**	*31 March 2012 £000*
Other	**2**	*2*	**438**	*440*
Total	**2**	*2*	**438**	*440*
Total other liabilities (current and non-current)	**440**	*442*		

27 Borrowings

At 31 March 2013 West Cheshire Primary Care Trust did not have any borrowings (31 March 2012, £0).

28 Other financial liabilities

Western Cheshire Primary Care Trust does not have any other financial liabilities (31 March 2012, £0).

29 Deferred income

	Current		Non-current	
	31 March 2013 £000	*31 March 2012 £000*	**31 March 2013 £000**	*31 March 2012 £000*
Opening balance at1 April 2012	**196**	*196*	**0**	*0*
Expended in year	**(73)**			
Current deferred Income at 31 March 2013	**123**	*196*	**0**	*0*
Total other liabilities (current and non-current)	**123**	*196*		

30 Finance lease obligations

At 31 March 2013 Western Cheshire Primary Care Trust has not entered into any finance lease arrangements (31 March 2012, £0).

31 Finance lease receivables as lessor

At 31 March 2013 Western Cheshire Primary Care Trust has not entered into any finance lease arrangements as a lessor (31 March 2012, £0).

32 Provisions

Comprising:

	Total £000s	Pensions to Former Directors £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Restructuring £000s	Continuing Care £000s	Equal Pay £000s	Agenda for Change £000s	Other £000s	Redundancy £000s
Balance at 1 April 2012	**3,262**	0	0	13	0	613	0	30	60	2,546
Arising During the Year	**3,027**	0	0	9	0	2,692	0	0	0	326
Utilised During the Year	**(2,777)**	0	0	(13)	0	(158)	0	0	(60)	(2,546)
Reversed Unused	**(485)**	0	0	0	0	(455)	0	(30)	0	0
Unwinding of Discount	**0**	0	0	0	0	0	0	0	0	0
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	**3,027**	**0**	**0**	**9**	**0**	**2,692**	**0**	**0**	**0**	**326**
Expected Timing of Cash Flows:										
No Later than One Year	**3,027**	**0**	**0**	**9**	**0**	**2,692**	**0**	**0**	**0**	**326**
Later than One Year and not later than Five Years	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Later than Five Years	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

£9,000 is included as a provision in relation to the NHS Litigation Authority at 31 March 2013 in respect of clinical negligence liabilities of the primary care trust (31 March 2012, £13,000).

A provision of £326,000 has been included for the anticipated costs of compulsory redundancies within the North West Specialised Commissioning Team (hosted service segment 2 - note 2).

A provision of £2,692,000 has been included for in respect of the potential costs of restitution payments resulting from the NHS Ombudsman's ruling of continuing healthcare. The provision has been calculated in line with the primary care trust's accounting policies (see note 1, key source of estimation uncertainty and 24, provisions) and has been calculated using a model that is consistent with primary care trusts across Cheshire, Warrington and Wirral with local intelligence applied for average claim period and weekly cost per bed..

33 Contingencies

	31 March 2013 £000	*31 March 2012 £000*
Contingent liabilities		
Equal Pay	0	*0*
Other	(1,958)	*(975)*
Amounts Recoverable Against Contingent Liabilities	0	*0*
Net Value of Contingent Liabilities	**(1,958)**	***(975)***
Contingent Assets		
Contingent Assets	0	*0*
Net Value of Contingent Liabilities	**0**	*0*

Contingent liabilities classed as 'other' relate to the potential future cost of the NHS Ombudsman's ruling on continuing healthcare. This is in addition to the £2,692,000 provided for as at 31 March 2013 (note 32) and assumes that an additional 10% of requests for restitution pass through the initial review of application and go on to the formal decision stage of the claims management process.

34 Financial Instruments

Financial risk management

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

Currency risk

The PCT is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The PCT 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.

34.1 Financial Assets	**At 'fair value through profit and loss' £000**	**Loans and receivables £000**	**Available for sale £000**	**Total £000**
Embedded derivatives	0			**0**
Receivables - NHS		6,786		**6,786**
Receivables - non-NHS		1,318		**1,318**
Cash at bank and in hand		10		**10**
Other financial assets	0	12	0	**12**
Total at 31 March 2013	**0**	**8,126**	**0**	**8,126**
Embedded derivatives	0			0
Receivables - NHS		21,061		21,061
Receivables - non-NHS		4,064		4,064
Cash at bank and in hand		0		0
Other financial assets	0	51	0	51
Total at 31 March 2012	0	25,176	0	25,176

34.2 Financial Liabilities	**At 'fair value through profit and loss' £000**	**Other £000**	**Total £000**
Embedded derivatives	0		**0**
NHS payables		17,190	**17,190**
Non-NHS payables		3,437	**3,437**
Other borrowings		0	**0**
PFI & finance lease obligations		0	**0**
Other financial liabilities	0	0	**0**
Total at 31 March 2013	**0**	**20,627**	**20,627**
Embedded derivatives	0		0
NHS payables		22,611	22,611
Non-NHS payables		4,904	4,904
Other borrowings		0	0
PFI & finance lease obligations		0	0
Other financial liabilities	0	0	0
Total at 31 March 2012	**0**	27,515	27,515

35. Related party transactions

Western Cheshire Primary Care Trust is a corporate body established by order of the Secretary of state for Health. In accordance with the national policy of the 'clustering' of primary care trusts, with effect from 1 June 2011, NHS Cheshire, Warrington and Wirral (primary care trust cluster) assumed responsibility as the corporate body with the PCT's in the cluster operating under a single board. During financial year 2011/13 the following transactions took place between Western Cheshire Primary Care Trust and organisations that have a related party relationship with board members of the PCT cluster. For 2012-13 related party transactions are based on interests disclosed by members of the cluster board, as these persons have control and significant influence over the organisation.

Related party transactions during the period 1 April 2012 - 31 March 2013

Name and title	Relationship to related party	Related party	Payments to Related Party £ 2012-13	Payments to Related Party £ *2011-12*	Receipts from Related Party £	Receipts from Related Party £ *2011-12*	Amounts owed to Related Party £ 2012-13	Amounts owed to Related Party £ *2011-12*	Amounts due from Related Party £ 2012-13	Amounts due from Related Party £ *2011-12*
John Church - Vice Chair/Non-Executive Director	Member									
James Kay - Non Executive Director	Member									
Martin McEwan - Director of Communications and Engagement	Stakeholder Governor	Wirral University Teaching Hospital NHS Foundation Trust.	29,467,000	*25,591,000*	*0*	*0*	1,903,000	*277,000*	*0*	*83,000*
Martin McEwan - Director of Communications and Engagement	Interim Director	Marketing and Communications, Alder Hey NHS Foundation Trust	84,092,000	83,976,000	*0*	0	42,000	*18,000*	*0*	*0*
John Church - Vice Chair/Non-Executive Director	Member	Cheshire & Wirral Partnership NHS Foundation Trust	66,455,000	*64,793,000*	383,000	*2,000*	1,128,000	*734,000*	167,000	*1,516,000*
Julie Webster - Interim Director of Public Health	Member	Countess of Chester Hospital NHS Foundation Trust	136,147,000	*127,729,000*	8,000	*131,000*	1,053,000	*2,702,000*	27,000	*38,000*
Julie Webster - Interim Director of Public Health	Member	Cheshire and Warrington Sports Partnership	0	*250*	0	*0*	480	*0*	0	*0*
Julie Webster - Director of Public Health	Director									
Julie Webster - Director of Public Health	Director of Public Health	Cheshire West and Chester Council	4,722,724	4,324,219	67,064	94,087	499,786	289,221	5,211	
Caryn Cox - Director of Public Health	Director of Public Health									
John Gartside - Non Executive Director	Freeman of the Borough	Warrington Borough Council	44,860	*20,000*	0	*0*	0	*0*	0	*0*
Cathy Maddaford - Director of Nursing Performance and Quality	Non Foundation Council Member	University of Chester.	2,662	*19,631*	0	*0*	51,475	*0*	0	*0*
Simon Holden - Director of Finance	Treasurer	Cheshire Centre for Independent Living	320,174	*12,180*	0	*0*	0	*0*	0	*0*
		Central & Eastern PCT	18,225,000	*16,617,000*	69,294,000	*52,577,000*	20,000	*12,000*	757,000	*980,000*
PCT's that are part of clustering arrangement for NHS Cheshire, Warrington and Wirral		Warrington PCT	7,000	*190,000*	27,098,000	*25,630,000*	9,000	*2,000*	0	*6,000*
		Wirral PCT	460,000	*688,000*	49,511,000	*43,665,000*	156,000	*29,000*	55,000	*318,000*

Phil Wadeson was appointed as the joint Director of Finance for NHS Merseyside Cluster and the NHS Cheshire, Warrington and Wirral (CWW) Cluster for the period 1 September 2012 to 10 January 2013 and continued to support the NHS CWW Cluster to the end of January 2013. He is deemed to have a related party interest in all four of the NHS Merseyside Cluster PCTs.

The practices of the following General Practitioners, who are members of the West Cheshire Clinical Commissioning Group Board, have received payments under GMS/PMS funding arrangements:
Drs Charles-Jones, McAlavey, Millard, Westmorland, Pomfret and Perkins.

The Department of Health is regarded as a related party. During the year NHS Western Cheshire PCT has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are:
- NHS North West
- Primary Care Trusts; (other than those listed above) Halton and St Helens PCT
- NHS Trusts (in addition to those listed above):

Mid Cheshire Hospital NHS FT, Warrington & Halton Hospitals NHS FT, Central Manchester University Hospitals NHS FT, Royal Liverpool Children's Hospital, Royal Liverpool & Broadgreen University Hospitals NHS Trust, Aintree University Hospitals NHS FT, Clatterbridge Centre for Oncology NHS FT, Liverpool Heart & Chest NHS FT, North West Ambulance Service NHS Trust, Christie Hospital NHS FT, University Hospital of North Staffordshire NHS Trust, Robert Jones & Agnes Hunt Orthopaedic NHS Trust, Walton Centre for Neurology & Neurosurgery NHS FT
- NHS Pensions Agency,
- NHS Estates Agency
- NHS Litigation Authority;
- NHS Business Services Authority

In addition, the PCT has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Cheshire West and Chester (see details above) and Cheshire East Councils.

36 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	158,311	13
Losses in respect of the provision of family practitioner services	0	0
Special payments in respect of he provision of family practitioner services	0	0
Total losses	0	0
Total special payments	158,311	13
Total losses and special payments	158,311	13

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	19,477	39
Special payments - PCT management costs	755,266	23
Losses in respect of the provision of family practitioner services	0	0
Special payments in respect of he provision of family practitioner services	0	0
Total losses	19,477	39
Total special payments	755,266	23
Total losses and special payments	774,743	62

37 Third party assets

Western Cheshire Primary Care Trust does not hold any third party assets.

38 Cashflows relating to exceptional items

there were no exceptional items during the reporting period.

39 Events after the end of the reporting period

As part of NHS reform, 'Liberating the NHS' the landscape of commissioning organisations will be subject to significant change. With effect from 1 April 2013, primary care trusts will cease to exist with commissioning responsibilities transferring to clinical commissioning groups, NHS England and local authorities.

The Department of Health has made detailed arrangements for the transfer of balances (assets / liabilities / contractual commitments) at their recognised carrying value such that there will be no surplus or deficit arising from this transfer. It is for the successor body to consider whether, in 2013/14, it is necessary to review these for impairment.

The PCT has a Transfer Agreement showing the expected destination of these balances but the final details have not yet been confirmed The Department's arrangements ensure that all assets, liabilities and contractual obligations of the PCT will be transferred to other bodies within the public sector.

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

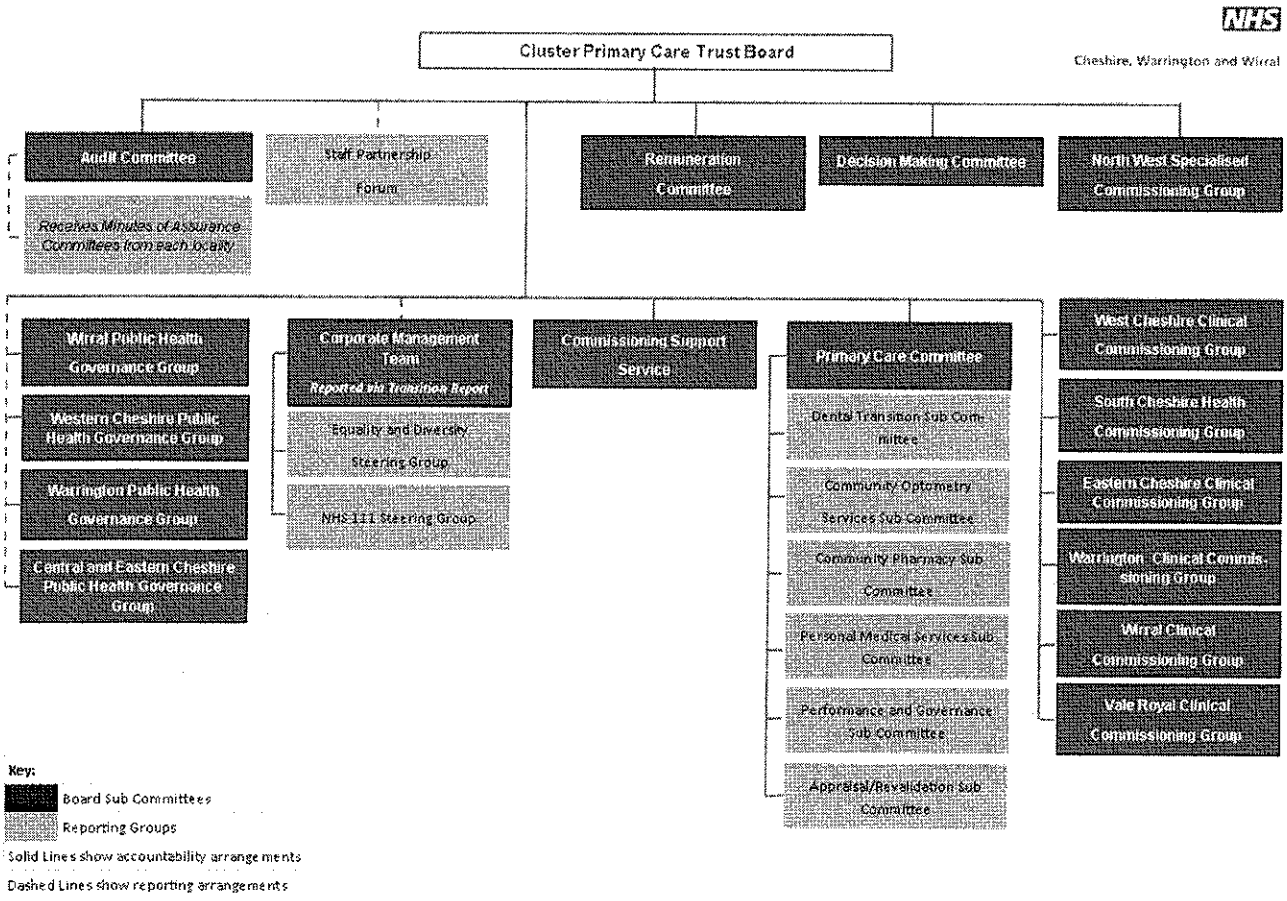
With respect to partnership working across the Local Health Economy, I met regularly with the Local Authority Chief Executives and as necessary with the Chief Executives of the providers within the Primary Care Trust area. The Primary Care Trust participates in partnership arrangements for children's 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.

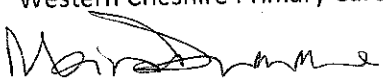
In addition, staff in the North West office contributed to the full range of national specialised commissioning transition work streams prior to the formal establishment of the NHS Commissioning Board and ensured that operational and governance structure and processes within the North West office were 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