Peterborough Primary Care Trust

2012-13 Annual Report and Accounts

You may re-use the text of this document (not including logos) free of charge in any format or medium, under the terms of the Open Government Licence. To view this licence, visit www.nationalarchives.gov.uk/doc/open-government-licence/

© Crown copyright

Published to gov.uk, in PDF format only.

www.gov.uk/dh

Peterborough Primary Care Trust

2012-13 Annual Report

NHS Peterborough Annual Report 2012-13

Foreword by Chair and Chief Executive

Welcome to this year's annual report for NHS Peterborough which reflects the key achievements for healthcare in Peterborough over the last year and looks forward to the year ahead for clinical commissioning.

The past year has been one of great change in the NHS as a whole and in NHS Peterborough, but throughout this year our focus has remained on ensuring that we offer quality healthcare services to Peterborough residents.

This has been an exciting year in the development of clinical commissioning and we have worked side by side with GPs to establish Cambridgeshire and Peterborough Clinical Commissioning Group (CCG), culminating in formal authorisation on 23 January 2013.

The new Clinical Commissioning Group became a statutory organisation on 1 April 2013, taking over most of the responsibilities of the former Primary Care Trusts, NHS Cambridgeshire and NHS Peterborough. The CCG took over responsibility for the £850 million budget for Cambridgeshire, Peterborough and parts of Hertfordshire and Northamptonshire.

Throughout all of these changes quality has remained our focus as well as ensuring that our patients continue to receive quality healthcare services they need. This report details our performance over the past year and how we have been doing in our final year as commissioners of your healthcare.

This final year has been a momentous year for the Country with both the Queen's Diamond Jubilee and the Olympics taking part. Both of these events have given us opportunities to promote healthy living in Peterborough and give advice to the public about choosing the right healthcare service at the right time.

In June 2012 we committed to improving services in the community for people recovering from stroke which included:

- A new hydrotherapy service
- A new mobilisation and physical activity exercise programme
- Working alongside the Stroke Association: continuing to provide communication and long term support services

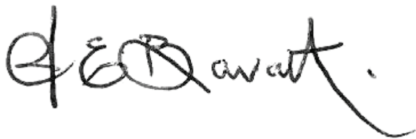
Our community health champions were launched in July 2012; these are volunteers who promote positive health and wellbeing within the community or workplace. Volunteers can assist in activities such as organised five-a-side football matches or group walks, or promoting breastfeeding and teaching healthy lifestyle skills to new mums and dads.

Peterborough's Hospital Alcohol Liaison Project (HALP) received national recognition in September when it was shortlisted for a prestigious Health Service Journal Award. The project places alcohol liaison workers in Peterborough City Hospital to identify and engage patients, whose admission is alcohol related and work with them to prevent or reduce further admissions.

From April 2013 the commissioning of most of the healthcare services for Peterborough will be in the hands of clinicians in Cambridgeshire and Peterborough Clinical Commissioning Group, we wish them well and know that working alongside staff, GPs and partner organisations they will continue to improve outcomes for the people of Peterborough.

In preparation for the end of the PCT we have produced a close down report and legacy document.

Finally, we would like to thank our staff, our Board, our partners and all those who we work with for their help and support over the past year.



John Barratt

Chair

Andrew Reed

Accountable Officer

Our organisation

NHS Peterborough is the Primary Care Trust for Peterborough and was established on 1 October 2006. Our role is to plan and buy healthcare services for people in Peterborough.

This is our final year in existence with the NHS Reforms seeing commissioning of healthcare services being handed over to GPs as part of the new Clinical Commissioning Groups. As a Primary Care Trust our role has been to buy and oversee primary care services (GPs, dentists, pharmacists and opticians), secondary care services such as hospitals and mental health services and health services in the community such as district nursing. We also fund, buy and oversee other specialist treatments from providers in the independent sector.

We are responsible for improving the health of over 170,000 people in Peterborough. The area we cover is mixed urban and rural and we have high levels of deprivation in urban areas.

Our vision

NHS Peterborough's strategic vision is:

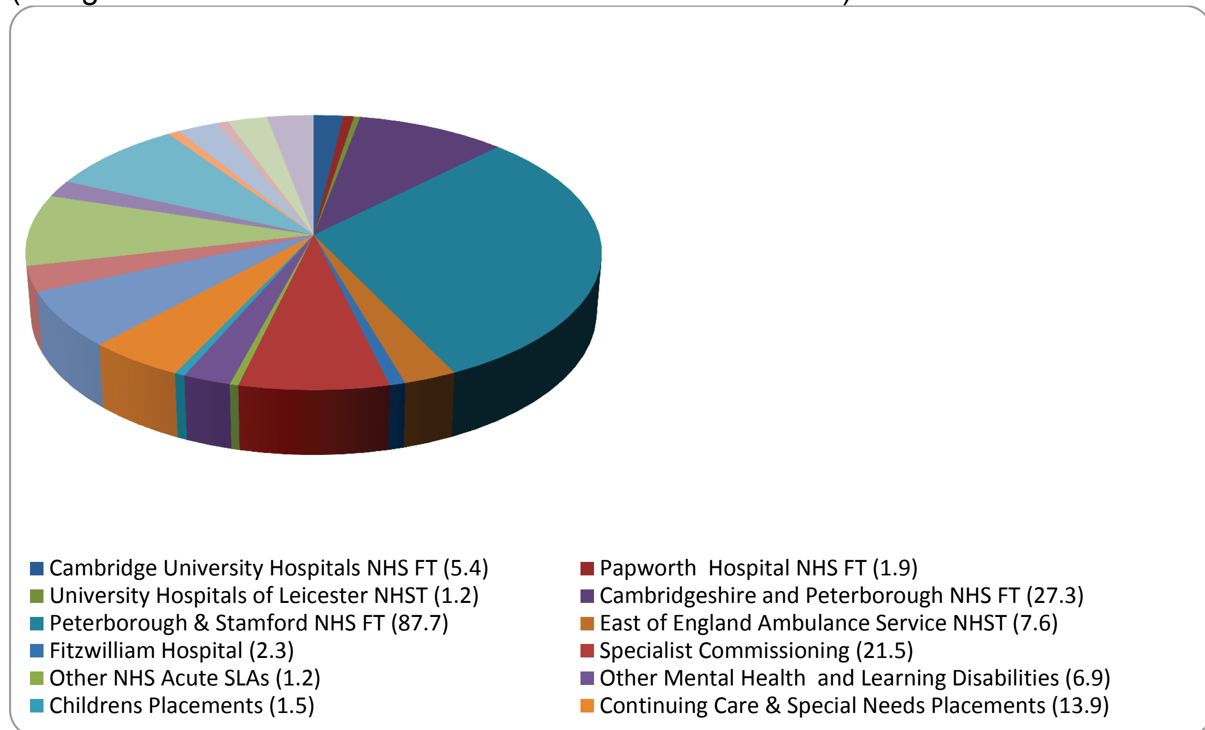
"In Peterborough we want to empower every person to be as healthy as they can be, so that they can live longer, healthy, independent and self-determined lives."

Our values

- We are here to help, inform and facilitate people in improving their health whilst recognising that ultimately each person is responsible for the lifestyle choices they make.
- We recognise that our populations are diverse and we will aim to commission (buy) a choice of high-quality responsive health and social care services which meet their needs.
- Resources will be distributed fairly and targeted to those with the highest health need.
- We will deliver the best possible value for money.
- Working in partnership is critical to making real improvements in health and care.
- We value our staff and will provide them with good opportunities for personal development.

Where did the money go in 2012-13?

(All figures below are shown rounded to the nearest million)



Total spend was £288,314k

Sustainability

NHS Peterborough is a sustainable organisation committed to:

- Establishing and publishing our organisational carbon footprint through the activities and assets to which the Primary Care Trust has direct responsibility i.e. business travel, electric, gas, oil and water consumption as well as waste disposal.

- By 2015 reducing carbon emissions by 10% from a 2007/08 baseline.

- Reducing the amount of waste produced by 5% by 2010 and by 25% by 2020.

- Increasing recycling figures to 50% of domestic waste arising by 2015 then by 75% by 2020.

- Reducing carbon emissions from the PCT owned and leased estate by 10% by 2015 then 30% by 2020.

Governance

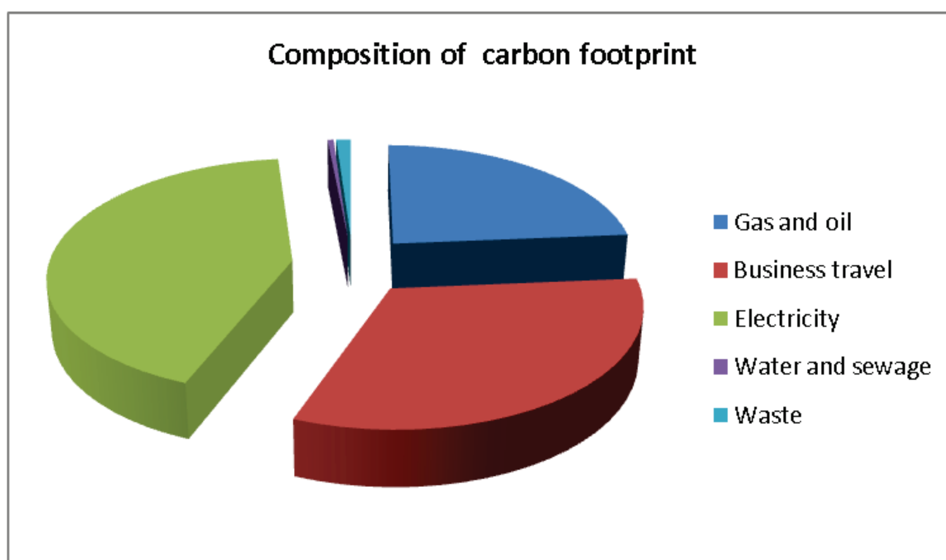
As a sustainable organisation committed to improving health outcomes and reducing carbon emissions we have structured and organised the on-going journey of sustainability through:

- An established sustainable development management plan which sets out the key priority areas and the metrics by which we can judge success.
- A project management structure that enables the Director of Finance to give the PCT Board assurance that progress is being made.
- The appointment of a Non-Executive Director with lead responsibility for sustainability.
- Regular reports to NHS Midlands and East and the Department of Health.

Progress this year

Although we established the composition of our carbon footprint in 2011/12 which is set out below, we were unable to do this in 2012/2013 as the information was not recorded. This means that although we established that we had already met our overall 2015 targets for reducing carbon emissions in 2011/12, we are unable to report if we have maintained this reduction during 2012/13

Figures for 2011/12



Since the last annual report we have:

- Already exceeded the 2015 50% recycling target across the county for example by consistently achieving recycling rates of 56% for sites in Peterborough.

- Seen an increase in costs associated with waste destined for landfill and dry recycling through higher collection charges and increased volumes of waste being generated. Currently there is a £60 per tonne price differential in favour of recycling over landfill, so there is a real financial incentive to promote and undertake recycling.

- Continued to work collaboratively with Peterborough City Council, and Peterborough Environment City Trust on raising staff awareness and behavioural changes on the use of energy and recycling.

- Continued pilot work for GP Practices to reduce energy and to access national framework energy contracts.

- Not been able to undertake any substantive work on identifying the extent of carbon emissions generated through clinical commissioning activity and procurement strategies. However, we have established some key areas of work that we believe will need to be taken forward by the Cambridgeshire and Peterborough Clinical Commissioning Group in partnership with Local Commissioning Groups, Local Authorities and service provider organisations in county.

Legacy

We have been working with the Clinical Commissioning Group on how best to build on the work accomplished to date, but to also consider the opportunities and work streams ensuring that the Clinical Commissioning Group is at the forefront of sustainable development. The Clinical Commissioning Group has identified the following priority areas which it has committed to taking forward:

- Developing local understanding of the sustainability agenda by measuring the environmental impacts of the organisation's activities and assessing the potential impact of environmental change on future care needs and services.

- Empowering staff to take responsibility for reducing the environmental impact of their own activities. This will be taken forward through the Good Corporate Citizen Model and self-assessment.

- Actively exploiting the synergies between environmental sustainability and other objectives. For example, by identifying changes that may bring health or financial benefits as well as environmental ones.

- Exploring the opportunities presented by new technologies such as telehealth and telecare, and by the use of new technologies in managing the core business of the Clinical Commissioning Group.

- Improving medicines management and prescribing practices to reduce inefficient of wasteful use of pharmaceuticals.

- Commissioning services that will support sustainable practices in service providers and the supply chain. Promoting the importance of using contractual levers with our main providers to encourage/incentivise change.

- Engaging with patients and the public to build wider support for environmentally sustainable approaches to delivering care.

Emergency preparedness

Emergency planning, resilience and response are important aspects of protecting the health of local people. NHS Peterborough has worked with NHS Cambridgeshire during 2012-13 to ensure that the transition to the new organisations in the NHS on 1 April 2013 is as smooth as possible, while maintaining and operating the current Joint Major Incident Plan and Business Continuity Plan until 31 March 2013.

NHS Peterborough and NHS Cambridgeshire jointly lead the Health and Social Care Emergency Planning Group which is a sub-group of the Cambridgeshire and Peterborough Local Resilience Forum (CPLRF), which has membership from local hospitals and community health services and co-ordinates emergency planning across the health system in Cambridgeshire and Peterborough.

Examples of recent activity include planning and preparation for the Olympics, and for the potential impact of any industrial action, whilst also participating in a number of emergency planning exercises and organisational workshops.

In accordance with the Department of Health directives, a new Cambridgeshire and Peterborough Local Health Resilience Partnership (CP LHRP) has been formed to be a strategic forum for organisations in the local health sector, including private and voluntary sector where appropriate. It facilitates health sector preparedness and

planning for emergencies at Cambridgeshire and Peterborough Local Resilience Forum (CPLRF) level. It supports the NHS, Public Health England (PHE) and local authority (LA) representatives on the CPLRF in their role to represent health sector Emergency Planning, Resilience and Response (EPRR) matters.

In order to take forward tactical and operational Health and Social Care emergency planning issues, the CPLRF Health and Social Care emergency planning group will work to both the CPLRF and the CP LHRP to ensure that a consistent approach is taken, links to both the CPLRF and LHRP are maintained and that the attendance by emergency planning practitioners is optimised.

Equality and diversity

NHS Peterborough is committed to developing an organisational culture that promotes equality and diversity in commissioning of our services, workforce and service provision with involvement of the local community sector representative of protected characteristic groups. This will ensure future NHS organisations i.e. Clinical Commissioning Groups (CCG) are equipped to meet their public sector equality duty relating to the Equalities Act 2010 but importantly all patients experience good patient care.

During the year NHS Peterborough has been working using the Equality Delivery System (EDS) national framework through engagement with staff and local interest groups to help the NHS to improve the way in which people from different groups are treated as patients, carers and employees. All EDS work achieved during 2012-13 contributed to the CCG authorisation process successfully. The CCG will therefore start as the new responsible organisation following the demise of Peterborough and Cambridgeshire PCTs from 1 April 2013 and take forward the EDS legacy already set into the future for Peterborough.

EDS is designed to make improvements for patients and staff and applies to people afforded protection, by the Equality Act 2010, from unfavourable treatment because of specified ‘protected’ characteristics.

Protected characteristics

- Age
- Disability
- Gender re-assignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race including national identity and ethnicity
- Religion or belief
- Sex/gender
- Sexual orientation

NHS Peterborough is working closely with the CCG to support it through this year of transition, before it takes over fully from the Primary Care Trusts from April 2013.

Cambridgeshire & Peterborough Clinical Commissioning Group will be led locally by clinicians in partnership with their communities, commissioning quality services that ensure value for money and the best possible outcomes for those who use them. This means EDS is a core part of that vision and therefore ensures engagement and inclusion of protected characteristics group in commissioning of local of services to meet local need.

Achievements in 2012-13:

As reported last year all systems were put in place for embedding EDS into NHS Peterborough. This included top level buy-in, high level governance structure with a Non-Executive Board champion, EDS leads, the Cambridgeshire wide provider cluster group, local interest group and staff partnerships and associated work as presented below:

- Engagement and feedback events with staff and local interests including the local LINk.
- Rating events jointly with staff, local interest groups representative of protected characteristic groups, PCT and provider leads.
- Established annual improvement plans approved by the PCT Board and scrutiny committee.
- Progress reported regularly to the Board, scrutiny committee.
- Over 40 equality impact assessments completed.
- Established equality and diversity training as a mandatory requirement.
- Established a three year framework contract for provision of interpreting services for Peterborough to include services for deaf/blind people.
- Delivered embedding ambassadors in community health three times successfully through two trained trainers from the local community. Further funding was received for year two.
- The EDS Leads are also trained trainers for the HealthWrap training, part of the PREVENT DOH requirement and Cancer Champions, part of the Anglia Cancer Network regional initiative.
- Met the requirements by 6 April 2012 to publish a compliance statement, annual and assurance reports and improvement plan for EDS. The same will be published for April 2013.
- The EDS lead achieved a level four accredited qualification in leadership and equality.

- Produced the fourth edition of the cultural awareness resource pack to support staff.

In October 2012 Geeta Pankhania and Suchitra Rampal received a regional award from Sir Neil McKay under the organisation category for the creative and innovative approach used for staff engagement across NHS Peterborough and NHS Cambridgeshire for their 'INSTYLE' events.

The future of health in Peterborough

On 1 April 2013 the future of healthcare in Cambridgeshire and Peterborough was handed over to Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) enabling GPs to be in the driving seat of healthcare changes.

Cambridgeshire and Peterborough CCG serves a population of 830,000 people, has a budget of £850 million, 109 member practices and eight local commissioning groups and is one of the largest Clinical Commissioning Groups in the country.

We have a federation of eight local commissioning groups which are:

- Borderline
- Cam Health
- CATCH
- Hunts Care Partners
- Hunts Health
- Isle of Ely
- Peterborough
- Wisbech

The Local Commissioning Groups are sub-committees of the Governing Body, report quarterly to the Governing Body on provider performance and are responsible for ensuring that there is patient and public involvement at a local level.

They also have delegated budgets for local decision making with central accountability and governance.

CCG: Our vision:
Led locally by clinicians in partnership with their communities, commissioning quality services that ensure value for money and the best possible outcomes for those who use them.

CCG: Our Mission:
To empower our communities to keep healthy and to commission good quality healthcare for all those who need it.

CCG: Our Values:

- Patient focused - Our population, patients and their families are at the centre of our thoughts and actions we will commission care tailored to their need.
- Quality driven - We will constantly strive to be the best we can be as individuals and as an organisation and we will ensure that this is reflected in our commissioning decisions.
- Work locally – Through our Local Commissioning Groups working within their communities.
- Excellent – Our aim is to be an excellent organisation, for our communities, clinicians and our staff.

CCG: Our priorities:

Clinicians and managers worked together using public health intelligence to develop three main priorities for the CCG to focus on. These are:

- Frail elderly
- End of life care
- Tackling inequalities focussing on heart disease

We have set up three Programme Boards with representatives from our partner health organisations, local authorities and patients all involved to help drive through our work around these three priority areas.

At the same time as providing a CCG wide focus for our work each local commissioning group should work towards these priorities reflecting their different population needs and services.

Patient reference group

To ensure that the patient voice is at the heart of everything the CCG does we have developed a patient reference group which is a formal sub-committee of the Shadow CCG Governing Body.

It is chaired by the CCG Lay Member with responsibility for patient and public involvement Rebecca Stephens. The membership is made up of eight Patient Reps from LCG Boards and seats for Health watch representatives from the LCG areas.

The patient reference group will:

- Ensure meaningful engagement locally and CCG wide.
- Comment on and advise on service change proposals.
- Provide intelligence to the CCG Governing Body on patient concerns.
- Ensure join up between LCG work on service redesign.
- Does not replace statutory duties to inform, engage & consult.
- Report formally to Board in public.

Involving you

NHS Peterborough aimed to ensure that people are fully engaged with the Board and all of our decision-making bodies. We engaged with our staff, local groups and organisations in service development and improvements, and sought to ensure that in an increasingly diverse city, information on our organisation and how to access our services is available to all.

The views of local people are invaluable to us - and we would like to thank everyone who took the time to contribute to, or attended one of our public engagement events during 2012-2013.

Scrutiny Committee for Health Issues (OSC) and Peterborough Local Involvement Network (LINk)
NHS Peterborough involves these two key stakeholders in all consultations and engagement work from the outset. The Peterborough LINk (Local Involvement Network) continues to have representation at NHS Peterborough Board level. The Cabinet member for health from Peterborough City Council also sits on the Commission for Health Issues.

Patient reference group
During this period of transition Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) has identified as a priority and has a duty to take account of representation made by persons who represent the interests of the communities it serves. The Governing Body of the CCG has established a sub-committee of the Governing Body which is known as the Patient Reference Group.

The focus of the Patient Reference Group (PRG) will be on providing an independent view of the work of the CCG that is external to the day-to-day running of the organisation. It will also help to ensure that, in all aspects of the CCG's business the public voice of the local population is heard and that opportunities are created and protected for patient and public empowerment in the work of the CCG.

Local Commissioning Groups
During this year we have been supporting the eight local commissioning groups with their patient groups. These are groups of people who inform and influence decisions and proposals made by NHS Peterborough and contribute to the planning and development of existing and new services. If you would like to be involved in patient groups, or want more information please contact our engagement team using the contact details below.

NHS Peterborough Public Consultation Forum and Borderline Patients' Forum
These are groups of people who inform and influence decisions and proposals made by NHS Peterborough and contribute to the planning and development of existing and new services. These forums represent many different groups from around the area. If you would like to be involved in these forums, or want more information please contact our engagement team using the contact details below.

Partnership Boards and forums
NHS Peterborough supports a number of partnership boards that were set up to bring together patients, service users, providers, the voluntary sector and interested others to ensure that all services are working together to meet their current and future needs.
Partnerships and forums include:

- Older People's Partnership Board
- Learning Disability Partnership Board
- Mental health partnership Board
- Carer's Partnership Board
- Maternity Services Liaison Committee
- Peterborough Senior Citizens Forum
- Disability Forum.

Engagement Work for 2012-13

Throughout 2012-13, we continued to engage with stakeholders in developments and changes to the organisation and specific service redesigns, including:

- End of Life Services redesign
- Carers Strategy
- Musculoskeletal Referral Pathways
- Community lower endoscopy service
- Community dermatology services
- Community ultrasound service
- Community cataract services
- Joint strategic needs assessment (JSNA)
- Any Qualified Provider procurements for:
    - Vasectomy services
    - Dexa-scanning services

'The Right Care at The Right Time' a consultation on the primary and urgent care commissioning strategy for Peterborough.

During 2011, NHS Peterborough consulted on the future of primary and urgent care services for the whole of Peterborough. There was overall support for the proposals preferred by NHS Peterborough, however some issues which were raised and addressed include:

- Access to public transport – the new location for North Street/Lincoln Road Surgery would be within 0.25 miles of the current location. Stagecoach and Peterborough City Council also agreed to review bus routes should the new health centre for Dogsthorpe, Welland and Parnwell patients be approved.
- Access to GP appointments – an action plan is now in place to support practices to bring in better management systems.
- People questioned whether the Primary Care Trust would have the capacity to deliver the changes outlined in the proposals when they would no longer exist by April 2013. - . As an organisation NHS Peterborough felt it had a duty to attempt a to put in place a strategic direction for Primary and Urgent Care that would ensure that series were efficient, cost effective, good quality and fit for purpose now and into the future.

What we are doing:
This consultation outcome was delayed following an investigation by the competition and co-operation panel. This investigation concluded and the Board of NHS Peterborough met on 28 March 2012 to consider the outcomes of this consultation.

During 2012 – 13 we have begun to implement the outcomes of this consultation:

Urgent care
One phase of this project is to procure a new Minor Injury and Illness service. The original timetable for this project was to start to operate the new service from April 2013. Due to delays in the financial and procurement planning this service is now planned to begin in July 2013.

April 2013
- GP out of hours services will continue to run from the City Care Centre.
- The Alma Road Equitable Access centre closed on 31 March 2013.
- The Alma Road site is owned by the NHS which transferred to NHS Property Company (NHS Prop Co) on 1 April. The PCT is working with the local community to inform NHS Prop Co on the best options for future use for the site.

July 2013
- The Minor Injury and Illness Unit opened, and includes medical cover and diagnostics, following a procurement process.

Primary care centres

The four new premises approved in principle by the PCT Board in March 2012 are being progressed by the practices with the PCT as follows:

- Hampton: Site selected, planning permission obtained and business case presented to the PCT Board for approval in January. Forecast to open early 2014.
- East Peterborough: Full business case approved in September 2011, site selected and full planning commenced. Forecast to open late 2013/early 2014.
- North St/63 Lincoln Road: preferred site being finalised, the Full Business Case was presented to PCT Board January 2013, then planning approval was commenced. Forecast opening Autumn 2014.
- Orton – Business Case Approved, scheme is waiting on an agreement with supermarket to confirm plans before commencing full planning.

Authorisation for Cambridgeshire and Peterborough Clinical Commissioning Group
During this transition year as the Primary Care Trust comes to an end and hands over the responsibility for commissioning to the Clinical Commissioning Group for Cambridgeshire and Peterborough, we have engaged widely with GPs, clinicians, key organisations and stakeholders, as well as patients and the wider public so that people understand the new health system as it develops. We have discussed these

changes widely, and asked people what they thought about these changes. We have strived to explain what is happening as the new legislation took shape and new organisations were able to emerge.

Getting Involved
If you want to have more of a say on your local health services, then why not get involved with the NHS? You can either respond to our consultations individually (these will be advertised locally and will be available on our website), or you can become more directly involved by contacting our Engagement Team on 01733 758500, or e-mail engagement@cambridgehireandpeterborough.nhs.uk.

PALS/Complaints report 2012-13

Patient Experience

NHS Peterborough has remained committed to monitoring patients' experience as an indicator of the quality of care and services we commission within Primary Care and acute NHS Trusts.

The key areas of focus have been:

- Patient Advice and Liaison Service (PALs) comments and enquires
- Complaints

We have reviewed our Complaints policy to ensure that it incorporates the Parliamentary and Health Service Principles of Remedy: Getting it right, being customer focused, being open and accountable, acting fairly and proportionately, putting things right and seeking continuous improvement.

Data around PALs comment and enquires and complaints are collated regularly and provide a more holistic view of care through the patients' eyes. Combined with other quality and safety measures and outcomes, we are able to determine where our own services and commissioned services are excelling and areas for improvement.

PALs enquires received 2012-13

The total number of PALS enquires across NHS Peterborough in 2012-13 were 1,573. The key themes identified through PALS enquires were:

- Accessing treatment
- Dissatisfaction with the complaints process
- Staff attitude
- General information on registering with a dental practice

All PALS enquires were followed up and responded to by the Patients' Experience team.

Annual Complaints for Commissioner Services

There were nine complaints against NHS Peterborough service in 2012-13 as outlined below.

2012- 2013	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total
Concerns (informal) – Commissioner	3	1	0	0	**4**
Formal	1	1	3	1	**6**
Conciliation cases	0	0	0	0	**0**

There were a total of five formal complaints as outlined below according to themes and departments.

	FINANCE	Miscell.	PERFORMANCE	Total
Access to medical staff	0	0	1	1
Communication/Information	1	0	0	1
Delay in diagnosis/treatment or referral	0	2	0	2
Medication/Pharmacy	0	1	0	1
Totals:	1	3	1	5

Due to the very low number of complaints received this year, there are no discernible trends.

Medical services - complaints

There was an increase in the number of complaints received from the primary care services this year compared with 2011-12. A total of 37 complaints were made against GPs or practice staff during April 2012 and March 2013. The table below provide an overview of complaints.

Complaints by Subject	1st Qtr	2nd Qtr	3RD Qtr	4th Qtr	Total
Access to Medical Staff	1	0	0	0	**1**
Admin	0	1	0	1	**2**
Clinical Care	6	5	1	3	**15**
Communication	0	2	1	0	**3**
Delay diagnosis/treatment/referral	3	2	3	0	**8**
Other	0	1	1	0	**2**
Staff Attitude	2	0	0	0	**2**
System Failure	1	0	0	0	**1**
Medication/Pharmacy	0	0	0	1	**1**
Records	0	1	0	1	**2**

Total:	13	12	6	6	37

The key themes were:

- Delayed diagnosis/treatment referrals
- Ineffective communication
- Concerns with clinical care

Most of the complaints were resolved by providing detailed explanation and apologies. Several of the cases proved complex and protracted and involved the independent conciliation service. A key outcome for one such case included one Practice introducing a system where all requests for a 'patient summary' has to be sanctioned by a doctor prior to distribution.

Dental services - complaints review

A total of 11 complaints were made against dental practices and staff during April 2012 and March 2013.

The table below provide an overview of complaints:

Complaints by Subject	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	Total
Attitude	0	0	0	1	**1**
Clinical Care	2	1	0	2	**5**
Delay diagnosis/treatment/referral	1	1	0	0	**2**
Dental Issues	1	1	1	0	**3**
Total:	**4**	**3**	**1**	**3**	**11**

The key themes which emerged were around general dental issues, and clinical care.

One example of a complaint:

"The patient complained of long standing pain following an unsuccessful root canal treatment plus poor attitude of dentist and staff. Dental advisor reviewed the patient's care and complaints handling. The treatment was considered reasonable but there was poor communication and delays in referring patient for NHS endodontic treatment which contributed to complaint. The Practice agreed to pay £200 towards patient's travel costs to another Provider and concluded treatment on the tooth in the final resolution of the complaint.

Most of the complaints were resolved by providing detailed explanation and apologies. For the more complex cases difficult to resolve, the involvement of the independent dental advisor was required. No significant outcomes arose from the various cases."

Other services- complaints review

There was one case for pharmaceutical complaints in 2012-13, and no ophthalmic complaints for 2012-13.

Our staff – sickness rates

Sickness rates:

	2011-12* **Number**	2012-13 Number
Total Days Lost	**13,670**	2,878
Average working Days Lost	**13.6**	8.3

*This figure includes provider staff sickness rates (Peterborough Community Services). These staff transferred to Peterborough City Council or Cambridgeshire Community Services in the latter part of 2011/12, and are therefore not included in the 2012/13 calculation.

Staff in post at 31 March 2012

Employee numbers by head count	**NHS Peterborough**	**Hosted**	**Total**
Scientific and Technical	14	0	14
Administrative and Clerical	101	19	120
Medical and Dental	6	0	6
Nursing and Midwifery	0	0	0
Total	**121**	**19**	**140**

The table above shows employee numbers by headcount, while those in note 7.2 within the accounts shows whole time equivalent.

Staff in post at 31 March 2013

Employee numbers by head count	NHS Peterborough	Hosted	Total
Scientific and Technical	10	0	10
Administrative and Clerical	84	0	84
Medical and Dental	5	0	5
Nursing and Midwifery	1	0	1
Total	**100**	**0**	**100**

Hosted staff transferred to Bedford Hospital NHS Trust on 28th February 2013. This represented 15 Admin and Clerical staff.

The table above shows employee numbers by headcount, while those in note 7.2 within the accounts shows whole time equivalent.

Improving quality

Having quality as the keystone for all healthcare organisations is a central pillar of the requirements for transition to clinical commissioning enacted in the Health and Social Care Act 2012. NHS Peterborough has robust systems for holding commissioned providers to account for the quality of their services and to improve outcomes for patients.

Transition to clinical commissioning

NHS Peterborough's Healthcare Governance team has undergone transition into the Quality, Safety and Patient Experience team required as part of the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and the associated Local Commissioning Groups (LCGs). The new team combines a mixture of new staff bringing innovative skills and existing members retaining organisational memory. The new team has worked with all the LCGs to support their focus on quality, including development of quality standards, GP support, and management of intelligence relating to local commissioned services.

Quality monitoring

NHS Peterborough is working with all providers to make the best use of the tools available to improve the quality of care for our patients and service users. This

includes use of dashboards and frameworks to identify areas of good practice, and any concerns.

Each of our providers gives us monthly performance reports about the quality of their clinical care. We hold monthly clinical quality review meetings with all our hospitals and other service providers, where concerns and risks are analysed and addressed. There is also opportunity for reviewing good practice, to be disseminated across the health economy.

Learning is shared through a range of health economy wide forums. The Directors of Nursing have developed a strong communication network which is used to share, learn and challenge where necessary.

Announced and unannounced quality and patient safety visits

We continue to go into provider organisations to observe practice and talk to staff and patients about the quality and outcomes of care. The visits are both unannounced and announced, and can be driven by intelligence received about concerns in specific areas, or can be part of a regular review of all providers.

Examples of announced visits included themed reviews looking at systems in place to manage clinical audit and risk management in providers. Unannounced visits have been driven by concerns raised over issues such as healthcare acquired infections and themes from serious incidents.

Deep Dive investigations

Where there are specific concerns about a provider's services, NHS Peterborough has carried out an in-depth review - a deep dive - to get to the root cause of problems and identify improvements required. For example a review of district nursing in Cambridgeshire and Peterborough included feedback from GPs and analysis of workforce metrics to ensure a complete picture of the service was obtained to allow strategic joined-up improvement goals to be set.

Learning from incidents

It is important that we learn from situations where care given to patients was not as expected so that we can minimise the risk of similar incidents happening in the future. In order to do this, there needs to be a process for reporting such incidents so that analysis can take place and appropriate changes made as required.

In addition there are clear national processes and timeframes for providers to follow when more serious incidents (SIs) occur. These are monitored rigorously and themes are identified. For example, analysis led to a detailed review of antenatal and new-born screening incidents with pathways strengthened as a result.

A review of providers' processes was undertaken in 2012 to ensure that they were robust and that learning was being implemented. There have also been visits to providers to review learning from never events (events that should not occur if care is of a high standard) to share information and learning.

Learning events were held quarterly with providers to share information and learning across the health economy and newsletters and targeted emails were also distributed to share learning as required.

Commissioning for quality and innovation (CQUIN)

The Commissioning for Quality and Innovation (CQUIN) payment framework is an incentive scheme, giving Trusts resources to achieve improvements in care over and above those stipulated in their contract as part of accepted care. These focus on quality across the areas of safety, effectiveness and patient experience.

The CQUIN schemes were negotiated with providers, incorporating national, local and provider specific schemes. Monitoring of achievement of the requirements for each provider was undertaken on a quarterly basis.

National schemes included:

- Screening of patients for developing a venous thromboembolism and receiving preventative measures as required.
- Involvement and feedback from patients about their experience of the service and care received – the friends and family test.
- Screening patients for dementia, appropriate assessment and referral.
- Safety thermometer – review of the numbers of patients with pressure ulcers, falls, urinary catheter infections and venous thromboembolisms.

Quality accounts

All providers of acute, mental health, learning disability, community services and ambulance services produce and publish a Quality Account each year, showing the quality of the services they have provided, and setting priorities for improvement in quality for the next year.

The aim of the Quality Account is to:

- Increase NHS accountability by making a greater level of information about the quality of healthcare services available to the public.
- Support provider boards and senior managers to focus on quality improvements by reporting nationally on quality across the entire range of their services. They are also required to state what improvements they plan to make.

Each trust which publishes an account receives a statement from NHS Peterborough, which they are required to publish in their account. This gives commentary on the improvements highlighted in the account, the priorities for future improvement, and details of the joint working between the organisations, and any concerns or issues that have been highlighted.

Infection Prevention and Control

Infection prevention and control has remained an important indicator of quality care and service delivery to patients. Mandatory reportable infections MRSA bacteraemia and Clostridium difficile, are monitored monthly against the annual trajectory targets set by the Department of Health to ensure a continual reduction is maintained. The period of 2012-13 has proved to be a difficult year to maintain the reduction seen in previous years and all providers have failed to meet the Clostridium difficile targets.

Evidence of assurance was requested against the 10 recommendations as set out in **Clostridium difficile: How to deal with the problem (DH, 2009).** Remedial action plans have been required from providers to address the situation and to ensure good practice is embedded to reduce risks to patients.

Harm free care meetings were held with providers to discuss this issue and safety thermometer data which includes pressure ulcers, catheter associated urinary tract infections, falls and venous thrombosis evaluation.

Pre 72 hour pressure ulcers

During the year the infection prevention and control team has also taken on the role of change champions for the NHS Midlands and East pressure ulcer ambition to eliminate avoidable grade 2, 3 & 4 pressure ulcers. Root cause analysis is completed for pre 72 hour (community onset) cases to determine the level of need by those patients in their own home and through primary care practice. It has also helped to challenge practice of providers.

Findings from this include:

- Better communication between health care providers is required; and
- Inconsistent practice in care homes (residential and nursing).

Areas for attention include:

- Awareness in primary care;
- Education and support to care homes on prevention; and
- Patient education leaflets regarding risks from changes to nutrition and fluid intake and use of pressure relieving equipment.

Safeguarding children

Safeguarding children has remained a priority for NHS Peterborough during 2012-13 and will continue through the transition into the Clinical Commissioning Group.

Quality Assurance is provided in several ways:

- NHS Peterborough and all health provider organisations are fully compliant with national statutory standards.
- Safeguarding children standards are included within all health contracts and service level agreements.

- Quality indicators for safeguarding children are included within the NHS Peterborough's quality monitoring processes.
- A GP resource pack has been produced and distributed quarterly to support GP practices in their safeguarding children work.
- NHS Peterborough chairs the multi-agency Local Safeguarding Children's Board Health Safeguarding Subcommittee. There is a full engagement with multi agency working on safeguarding children demonstrated by the attendance at the Local Safeguarding Children Boards and other sub groups.
- NHS Peterborough plays a central role in the serious case reviews process by reviewing health economy investigations, monitoring actions and disseminating the learning.
- NHS Peterborough co-ordinate the child death review process, including rapid response service which ensures that relevant issues are identified and addressed to improve the safety of children in the county.

Safeguarding vulnerable adults

Safeguarding vulnerable adults has received an increasingly high profile nationally, with attention focussing on the care of vulnerable groups in both hospitals and residential settings. Additionally, there are responsibilities for health providers to register with the Care Quality Commission (CQC). This includes a self-assessment of their ability to safeguard vulnerable adults. NHS Peterborough continues to monitor safeguarding practice against the CQC standards in partnership with local authorities.

NHS Peterborough is represented at the Safeguarding of Vulnerable Adults Partnership Board which provides strategic leadership in adult safeguarding. In recent months our representation has increased in recognition of the new arrangements for Clinical Commissioning Groups.

An Adult Safeguarding Lead Nurse has been appointed for Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) who has responsibility to ensure there are comprehensive arrangements in place for safeguarding adults in all commissioned services.

A training strategy is in the process of being developed in relation to Adult Safeguarding which includes the Mental Capacity Act and can be used for guidance in adherence to good practice by GPs and other providers.

Improving quality in primary care

As part of the new structure of the NHS, the National Commissioning Board (now called NHS England) will be playing a different role from the clinical commissioning groups in exercising its commissioning functions, as it will not be in a position to provide any primary care development support to practices. This was identified as a

potential gap in the system, as CCGs will need to deliver on the improving quality in primary care agenda.

In NHS Peterborough we have recruited a primary care quality improvement team that enables us to retain local provider knowledge and whose team members already have effective, trustworthy relationships with GP practices. We hope that this will bridge the gap and provide LCGs and their constituent practices with the level of support required to meet this agenda.

Improving the quality of primary care is a key indicator within the operating plans for the CCG. We are committed to ensuring that the local health care system is founded on high quality primary care provision that will facilitate the delivery of more pathways of care being provided in primary care.

General practice is delivering a wider range of services in primary care settings especially in the area of the management of long-term conditions and is increasingly playing an important role in co-ordinating care provided in other settings.

Reducing variation and improving access

The primary care quality improvement team will support LCGs and practices to address the following:

- **Reduce variability in quality of primary care**: Quality of primary care is variable across Peterborough with evidence of some excellent practice. It is critical that this variability in quality of provision is reduced if we are to improve the health outcomes for our cluster population. The CCG will be utilising an agreed set of quality indicators to support this agenda.
- **Improvements in Access**: Levels of satisfaction with access to our primary care providers in Peterborough is variable. The team will work closely with practices to identify potential areas for improvement in order to meet the needs of their practice populations.

Monitoring and improvement of quality

There are a number of agencies that will have a role to play in both the monitoring and the improvement of quality in primary care in the restructured NHS. The quality of primary care will be assessed by:

- **"The regulator"**- the Care Quality Commission (from April 2013) with the aim of ensuring that General Practices like all other NHS organisations are providing care that meets essential standards of quality and safety apply across both health and adult social care.
- **"The commissioner"** - the NHS England, will have responsibility for monitoring performance and that practices are meeting the requirements of their contract whilst the Health and Well-Being Boards of the local authorities will be reviewing the provision of primary care from the perspective of local people.

- **Clinical Commissioning Groups (CCGs)** will have duty to collaborate with the NHS England in continuously improving the quality of primary care and Cambridgeshire & Peterborough CCG will take be taking a pro-active approach to this.

Complex case management

Complex case management is responsible for NHS continuing healthcare. This is a process whereby a patient is deemed to have a primary health need and meets the criteria for full funding from NHS Peterborough. The team is also responsible for assessing patients in nursing homes to determine if they have nursing needs and meet the criteria for an allowance.

The team also assess patients for specialised rehabilitation for a period of time to promote independence and improve their quality of life. Another responsibility is the assessing of patients who may have both health and social needs, and the health needs cannot be met by local services or funded by the local authority. Over the past year the team have dealt with requests from the public for assessments of their relatives for un-assessed periods known as 'retrospective assessments'. We received 818 requests for assessments from the public who believe that their relative should have been funded by NHS Peterborough or NHS Cambridgeshire. The team have responded to the initial requests in a timely manner.

The team have also enabled many people who sadly are at the end of their life to achieve their end of life choice to die at home or in a nursing home.

The team endeavours to ensure that patients and their relatives are involved in the assessment process and they know them best.

The team have also in collaboration with other stakeholders played a significant role in assessing and promoting good practice in nursing homes.

Our performance

We continually monitor and measure our performance against local and national targets to ensure that the services we commission on your behalf continue to meet your needs.

During 2012-13 we have focused our attention on:

- Ensuring that all key performance measurements are regularly communicated to all our stakeholders.
- Ensuring that monthly performance reviews take place with the major providers of health services in Peterborough and cover Service Performance and Clinical Quality
- Holding providers (from whom we commission services) to account for the responsiveness and quality of services provided.
- Ensuring delivery of our population's NHS Constitutional rights.

During the year we have also worked closely with GP leads from the Clinical Commissioning Group (CCG) to manage the transition to April 2013 and to involve them in the process of contract management and reviewing services commissioned.

Clinical Commissioners are regular members of the Finance and Performance Committee.

Key performance information is also reported to the CCG Governing Body.

We also began to prepare and consider the key indicators associated with the *NHS Outcomes Framework for 2013-14*, the *CCG Outcomes Indicator Set for 2013-14* and *Everyone Counts: Planning for Patients 2013-14*.

We are continuing to work hard to meet increasingly challenging targets. This will continue in 2013-14 with focus on the main risk areas of Referral to Treatment, Cancer Waits, A&E standards and Infection Control. The tables below summarise 2012-13 performance on key indicators and compare performance to 2011-12.

Access to Emergency Care in 2012-13

Figures here relate to Ambulance responses (East of England Ambulance Service) and maximum waiting times at Accident & Emergency (A&E).

Performance Target	11-12 Actual	12-13 Actual	12-13 Target
All ambulance trusts to respond to 75% of Category A calls (immediately life threatening) within 8 minutes	75.4%	74.2%	75%
All ambulance trusts to respond to 95% of Category A calls (immediately life threatening) within 19 minutes	94.9%	93.5%	95%

Ambulance underperformance has been contributed to, across the region, by ambulances being delayed at hospitals whilst trying to hand patients over. This mainly affected the rural areas, as when the East of England Ambulance Service Trust (EEAST) vehicle resources are responding to/conveying a patient, the resource is no longer available for dispatch. There are certain parts of the region where the rurality and the resource required to respond conspire to make the 8 minute target challenging to achieve. The Trust has been pushing forward with plans to increase unit hour production, for staffing of shifts.

EEAST is working with commissioners and all acute trusts to try and limit the impact hospital delays have on their ability to respond. Delays are being monitored on a 30 minute basis, with acute trusts, rather than the previous 60 minutes to ensure maximum number of vehicles being released on time. EEAST have been undertaking rota reviews to ensure that their workforce planning is as effective as possible, considering the match of demand against supply of responders. This is part of a wider unit hour production review. Recovery plans are being monitored by NHS England.

Four-hour Maximum wait in A&E from arrival to admission, transfer or discharge in 2012-13

A&E performance is monitored through the local urgent care networks which centre around providers. For each provider, A&E is a key service performance element in the contract and

as such contract queries are raised for under performance and remedial action plans requested by commissioners to address on-going under performance.

NHS Peterborough's A&E performance was affected by underperformance at PSHFT as outlined in the table below.

Provider	11-12 Actual	12-13 Actual	12-13 Target
Peterborough & Stamford Hospitals Foundation Trust	93.4%	93.1%	95%
Cambridge Community Services*	99.9%	99.8%	95%

*CCS included in NHS Peterborough figures as 72% of their activity is at Peterborough Walk in Centre.

PSHFT failed to meet the standard for 8 months out of 12. The primary reasons for the delays were (a) incomplete embedding of actions recommended through the Intensive Support Team review in 2011/12; (b) patient flow through the Trust and the local system; both exacerbated by (c) winter pressures.

PSHFT is focusing on delayed transfers of care as the primary issue, causing a bottleneck in A&E. Twice in February the Trust was on black alert with long trolley waits arising. Community and social care colleagues are involved on a daily basis with the PSHFT discharge team and in March senior management attended daily capacity meetings, working with the discharge team for a two week period. During this time observations and recommendations for improvement were made, including installation of a senior discharge coordinator to pull everything together in a timely, proactive and robust way. Contractual consequences have been applied as appropriate and the Trust are developing their assurance plans to include trajectories for performance improvement.

Access to Planned Care in 2012-13

Figures here relate to patients receiving care within the NHS system starting from your GP to receiving treatment at your local hospital.

Performance Target	11-12 Actual	12-13 Actual	12-13 Target
Percentage of patients seen within 18 weeks for admitted pathways	91.3%	90.5%	90%
Percentage of patients seen within 18 weeks for non-admitted pathways	97.4%	97.5%	95%
Percentage of patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 18 weeks from referral	95.6%	97%	92%

Access to Cancer Services in 2012-13

Figures here relate to how long patients have to wait for treatment.

Performance Target	11-12 Actual	12-13 Actual	12-13 Target
Patients seen within two weeks from an urgent GP referral for suspected cancer to date first seen	96.4%	96.9%	93%
Patients seen within two weeks from a referral for evaluation of "breast	98.6%	97.6%	93%

symptoms" by a primary care professional to date first seen			
Patients receiving their first definitive treatment for cancer within one month (31 days) of a decision to treat	98.9%	99%	96%
Patients receiving their subsequent Chemotherapy treatment for cancer within one month (31 days) of a decision to treat	99.2%	99.1%	98%
Patients receiving their subsequent Surgical treatment for cancer within one month (31 days) of a decision to treat	92.7%	97.1%	94%
Patients receiving their subsequent Radiotherapy treatment for cancer within one month (31 days) of a decision to treat	99.2%	94.5%	94%
Patients receiving their first definitive treatment for cancer within two months (62 days) of GP or dentist urgent referral	88.5%	87.2%	85%
Patients receiving their first definitive treatment for cancer within two months (62 days) of a National Screening referral	94.5%	96.8%	90%

Access to Cardiovascular Services in 2012-13

Figures here relate to how long patients have to wait for treatment.

Performance Target	11-12 Actual	12-13 Actual	12-13 Target
Percentage of people having transient ischaemic attack (TIA) Scanned & Treated within 24 hours	51%	59.5%	60%
Percentage of stroke patients who spend at least 90% of their time on a specialist stroke unit	78.7%	80.3%	80%

NHS Peterborough met the TIA standards in all Quarters apart from Q3 and as a result, missed meeting the annual target by 0.5%.

PSHFT's performance fell significantly in July (31%), and September (38.5%), recovered in October (68.8%), fell again in November (50%) but then performance was maintained for the rest of the year above the required standard. An issue identified in breach reports was around delays from a patient leaving their GP to arriving at the hospital in a number of cases meaning the Trust could not have delivered the target.

The improvement in October performance was due to the introduction of additional Doppler capacity and availability from Monday to Friday. With regard to the delays in patients arriving at hospitals, it was identified that this was an issue in the referral process rather than an issue with Trust performance. These matters were reported back to the GPs concerned in order to facilitate learning to reduce such issues in the future.

Patient Safety 2012-13

Figures here relate to the number of incidences of Clostridium Difficile and MRSA applicable to NHS Peterborough.

Performance Target	11-12 Actual	12-13 Actual	12-13 Ceiling
Number of incidences of Clostridium Difficile	40	44	29
Number of incidences of MRSA in patients aged 2 or over	4	1	2

All of our providers exceeded the C Difficile ceilings confirmed in the 2012/13 Trust plans and contractual consequences have been applied as appropriate. Remedial action plans are in place which are monitored monthly through Clinical Quality Review meetings.

Examples of actions being taken to improve performance are as follows:

- Undertake one-off focused antibiotic audits on areas where cases have been identified
- Deep clean programmes for clinical areas, to assure continued high standards of environmental cleanliness
- Root cause analysis (RCA) of all patients admitted with or diagnosed with Clostridium difficile during their admission to be completed by the clinical team
- Scrutiny panels with Clinical Business Units (CBU) to review RCAs and agree actions to be implemented. CBU membership to include nursing and medical staff, including junior doctors.
- Formal monthly review of all Clostridium difficile cases between providers and NHS Peterborough (to include root cause analysis)

There is no single change which will improve performance however the key issues identified have been around communication across and between all services and the need to have a fuller understanding of the disease burden.

Who's who?

Our Members – NHS Cambridgeshire and NHS Peterborough Cluster Board and Shadow Clinical Commissioning Group (CCG) Governing Body

Non-Executive Directors/Lay Members		
Name	**Title**	**Attends Board Sub Committee**
Maureen Donnelly (To July 2012)	PCT Cluster Chair (to July 2012) *CCG Lay Chair (from July 2012)*	Finance & Performance Committee, Quality & Patient Safety Committee Shadow CCG Governing Body
John Barratt	Audit Committee Chair & Non-Executive Director (to July 2012) PCT Cluster Chair	Audit Committee Chair (To July 2012), Finance & Performance Committee, Quality & Patient Safety Committee

	(from July 2012)	
Malcolm Burch	Non-Executive Director	Remuneration & Terms of Service Committee, Quality and Patient Safety Committee
Glen Clark	Non-Executive Director (to August 2012) CCG Lay Member Representative (from August 2012) – Speaking rights only	Finance & Performance Committee, Quality & Patient Safety Committee, Remuneration & Terms of Service Committee (To August 2012) Governance & Compliance Committee
Prof Colin Coulson-Thomas	Non-Executive Director	Audit Committee, Finance & Performance, Committee Remuneration & Terms of Service Committee (From August 2012)
Robert Kynnersley	Non-Executive Director	Remuneration & Terms of Service Chair, Governance & Compliance Chair
Edward Libbey (From July 2012)	Non-Executive Director	Audit Committee (Chair), Finance & Performance Committee
Peter Southwick (To December 2012)	Non-Executive Director (to August 2012) CCG Lay Member Representative (from August to December 2012) – Speaking Rights only	Finance & Performance, Audit Committee, Remuneration & Terms of Service (August 2012), Quality & Patient Safety
Sally Williams	Non-Executive Director	Quality & Patient Safety (Chair to December 2012), Audit Committee, Finance & Performance Committee, Shadow CCG Governing Body (to July 2012)
Executive/Other (Voting):		
Dr Sushil Jathanna (Until September 2012)	Chief Executive	Finance & Performance Committee, Shadow CCG Governing Body
Sheila Bremner (From October 2012)	Chief Executive (Accountable Officer – Local Area Team Director)	PCT Cluster Board
Dr Simon Hambling (To June 2012)	Chair of Shadow Clinical Commissioning Group (Until June 2012)	Shadow CCG Governing Body

Dr Neil Modha (From June 2012)	CCG Accountable Officer Designate (from June to January 2013: Chief Clinical Officer from January 2013: Shared vote with Medical Director	Quality & Performance Committee, Finance & Performance Committee, Shadow CCG Governing Body
Dr Liz Robin	Director of Public Health – Cambridgeshire: Shared Vote	Quality & Patient Safety Committee, Governance & Compliance Committee, Shadow CCG Governing Body
Dr Andy Liggins	Director of Public Health – Peterborough: Shared Vote	Quality & Patient Safety Committee, Shadow CCG Governing Body
John Leslie (Until January 2013)	Director of Finance	Finance & Performance Committee, Audit Committee, Governance & Compliance Committee
Adrian Marr (from January 2013)	Director of Finance	Finance & Performance Committee, Audit Committee
Alan Mack	Director of Corporate Development and Performance/Deputy Chief Executive: Shared vote with Medical Director	Finance & Performance Committee, Governance & Compliance Committee, Quality & Patient Safety Committee, Shadow CCG Governing Body
Dr Christine Macleod	Medical Director: Shared vote with Deputy Chief Executive	Quality & Patient Safety, Governance & Compliance Committee, Shadow CCG Governing Body
Andy Vowles	Chief Operating Officer – NHS Cambridgeshire	Finance & Performance Committee, Quality & Patient Safety Committee, Shadow CCG Governing Body
In Attendance with Speaking Rights (Non-Voting):		
Jessica Bawden (From May 2012)	Director of Communications & Engagement	Quality & Patient Safety, Shadow CCG Governing Body
Dr Geraldine Linehan	Vice-Chair Shadow CCG Governing Body	Finance & Performance Committee, Shadow CCG Governing Body
Russ Platt (Until August	Chief Operating Officer -	Finance & Performance Committee

2012)	Peterborough	
Jill Houghton	Director of Nursing and Quality	Quality & Patient Safety Committee, Governance & Compliance Committee, Shadow CCG Governing Body
Peter Wightman	Interim Director of Primary Care	PCT Cluster Board
Mike Hewins	Cambridgeshire LINk	PCT Cluster Board
Gordon Lacey	Peterborough LINk	PCT Cluster Board

Other Shadow Clinical Commissioning Group Governing Body Members Not Included Above
Name
Dr Arnold Fertig, GP Member, Cam Health LCG
Dr Geraldine Linehan, GP Member, CATCH LCG
Dr David Roberts, GP Member, Hunts Health LCG
Dr John Jones, GP Member, Isle of Ely LCG
Dr David Irwin, GP Member, Hunts Care Partners LCG
Dr Tim Webster, GP Member, Wisbech LCG (from February 2013)
Dr Richard Withers, GP Member, Borderline LCG
Dr Andrew Wordsworth, GP Member, Wisbech LCG (To November 2012)
Harper Brown, Director of Commissioning & Contracting
Victoria Corbishley, Director of Performance & Delivery
Tim Woods, Chief Finance Officer
Rebecca Stephens, CCG Lay Member
Dr Christopher Scrase, Secondary Care (Hospital) Doctor

Declarations of Interest

A register of Interests for NHS Peterborough was maintained.

Board Members and other Sub-Committee members who hold a Company Directorship with companies who are likely to do business or seek (or may seek) to do business with the NHS, plus any other relevant interests are set out below.

The list below also includes the GP Members of the Shadow CCG Governing Body.

Name	**Title**	**Declaration of Interest**
Non-Executive Directors		
John Barratt	Non-Executive Director PCT Cluster Chair	Cambridge Business Ventures Ltd, Spouse employed by Alconbury & Brampton Surgery

	(From July 2012)	
Malcolm Burch	Non-Executive Director	Director of Malcolm Burch Associates
Glen Clark	Non-Executive Director (to August 2012) CCG Lay Member Representative (from August 2012)	Marshall of Cambridge Aerospace Ltd, Marshall of Cambridge (Engineering), Aeropeople Ltd, Marshal Aerospace US Inc, Marshall Aerospace Netherlands BV, Marshall Aerospace Canada Inc, Marshall Aerospace Australia Pty Ltd, AeroAcademy Ltd, Slingsby Aerospace Ltd, Slingsby Aviation Ltd, Slingsby Ltd, Slingsby Advanced Composites Ltd, Slingsby Holdings Ltd, Marshall Specialist Vehicles Ltd, Marshall Vehicle Engineering Ltd, Marshall SDG Ltd, LifTow Ltd; and Marshall Land Systems Ltd.
Prof Colin Coulson-Thomas	Non-Executive Director	Chairman, Director and Shareholder Adaptation Ltd, Chairman, Director and Shareholder Policy Publications Ltd, Chairman, Director and Shareholder Cotoco Ltd, Chairman, Director and Shareholder Bryok Systems Ltd, Partner Governor Peterborough and Stamford Hospitals NHS Foundation Trust Adjunct Visiting Professor Manipal University, Professor, Business School, University of Greenwich
Robert Kynnersley	Non-Executive Director	Chair of Anglia Support Partnership (to April 2012)
Peter Southwick (To December 2012)	Non-Executive Director (to August 2012): CCG Lay Member (From August 2012 to December 2012)	Member of the corporation (Governor) Hills Road Sixth form College Trustee of the BAS Breakwell Charitable Trust Company Ltd Spouse is a Trustee of the BAS Breakwell Charitable Trust Co. Ltd.
Sally Williams	Non-Executive Director	Intermittently works for an individual who provides organisational development input to CCG and LCGs. Independent Adjudicator with Independent Sector Complaints

		Adjudication Service (ISCAS)
Other PCT Cluster Board Members (Voting and Non Voting Members)		
Dr Michael Caskey (To September 2012)	GP Representative	GP Principal and Senior Partner in Park Medical Centre, GP with Special Interest in Neurology, Member of Sutton Parish Council, Director Peterborough Doctors Commissioners Ltd.
Dr Simon Hambling (To June 2012)	Chair of Shadow CCG (To June 2013)	Senior Partner Doddington Medical Centre, UCC Occasional Sessional work.
Mike Hewins,	Cambridgeshire LINk	President of Cambridgeshire LINk, Treasurer & Trustee of Inspire – Wellbeing Through Arts
Dr Sushil Jathanna (To September 2012)	Chief Executive	Wife is a GP in Colchester
Gordon Lacey	Peterborough Local Involvement Network	Vice Chair, Peterborough LINk
Dr Andy Liggins	Director of Public Health, joint appointment with Peterborough City Council	Company Member of Peterborough Environment City Trust
Dr Geraldine Linehan,	Vice-Chair of CCG Governing Body	Member of Steering Group of Research Application Board. PCT, Cambs University and CATCH, member of Cambridgeshire Local Medical Committee
Dr Neil Modha	CCG Accountable Officer (From June 2013) & Shadow CCG Governing Body Member	General Practitioner Thistlemoor Healthcare & Managing Secretary Graham Young Limited Secretary
Andy Vowles	Director of Strategy and Delivery	Spouse is an employee of Cambridgeshire University Hospitals NHS Foundation Trust
CCG Governing Body (GP Members and Lay Members (if not included above))		
Dr Arnold Fertig	Shadow CCG Governing Body Member	Locum work – Nuffield Road Medical Centre Initial set-up of Propdoc
Dr David Irwin	Shadow CCG Governing Body Member	General Practice senior partner of Buckden and Little Paxton surgeries Partner of Dermatology Clinic Community Service Ltd (DCCSL)

Dr John Jones	Shadow CCG Governing Body Member	Partner, Staploe Medical Centre (PMS, Dispensing, Clinical Trials, Teaching Practice) Director Eagletie Ltd Director Eaglebond Ltd Director Staploe Medical Services Ltd Director Protix Ltd Shareholder and Director in Holding Company (Eagletie Ltd) that owns the pharmacy operating from Staploe Medical Centre
Dr David Roberts	Shadow CCG Governing Body Member	GP Senior Partner (Primary Care NHS Contract) Director Aquarius Systems Ltd
Dr Tim Webster (From February 2013)	Shadow CCG Governing Body Member	Partner North Brink Practice Director North Brink Pharmacy
Dr Richard Withers	Shadow CCG Governing Body Member	Partner at GP Yaxley Group Practice. Member of Cambridgeshire Local Medical Committee.
Dr Andrew Wordsworth (To November 2012)	Shadow CCG Governing Body Member	Partner at Trinity Surgery, Wisbech
Rebecca Stephens	Shadow CCG Governing Body Lay Member	Owner/Director - Syntax Communications Ltd Member – Cambridgeshire and Peterborough NHS Foundation Trust Member of Peterborough & Stamford Hospitals NHS Foundation Trust Currently contracted by Greater Peterborough Partnership on CSR Workstream

Annual governance statement

1. Scope of responsibility

As Accountable Officer, and Chief Executive of the Board of NHS Peterborough, 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.

NHS Cambridgeshire and NHS Peterborough became a Cluster PCT in December 2011. The PCT Cluster Board arrangements were approved by

each PCT Board and are described in an Establishment Agreement which was approved by the PCT Cluster Board in December 2011. This is in line with the guidance from the Department of Health in relation to clustering of Primary Care Trusts. NHS Peterborough remains a statutory organisation in its own right.

This Annual Governance Statement reflects arrangements from 1 April 2012 to 31 March 2013.

NHS Peterborough has worked closely with other organisations throughout the year through a variety of relationships such as:

- Service level agreements and contracts with other NHS organisations to deliver health services to agreed specifications;
- Legal agreements with Peterborough City Council including the operation of the Partnership Governance Group which oversees the Section 75 Agreements;
- Performance management arrangements with the NHS Midlands and the East Strategic Health Authority;
- With patients through the Peterborough Local Involvement Network;
- With partners such as social care, GPs and with specialised commissioning groups carrying out joint needs assessments, strategic planning and joint commissioning;
- Accountability to the Secretary of State and to parliament for the performance of functions and meeting statutory duties;
- With local partners to promote the objectives of our local health plans and Local Area Agreement through partnership working, formal Partnership Boards and pooled funding arrangements;
- With wider communities through public engagement, through our Board meetings in public, publication of various corporate documents and plans, and production of the Annual Report and Annual Accounts; and
- Through clustering arrangements with NHS Cambridgeshire in line with the Establishment Agreement set out above.

2. The Governance Framework of the Organisation

The PCT Cluster Board met bi-monthly in public. There was good attendance from all Board members at each meeting and attendance is recorded within the minutes of each meeting.

The Board was served by the following Committees:

- Joint Audit Committee;
- Joint Finance & Performance Committee;
- Joint Governance & Compliance Committee;
- Joint Quality & Patient Safety Committee ;
- Shadow CCG Governing Body; and
- Joint Remuneration and Terms of Service Committee.

There was good attendance at Sub-Committee meetings and this is recorded within the minutes of each meeting.

The Joint Audit Committee is chaired by the Audit Committee Chair (Non-Executive Director, and is responsible for overseeing compliance with the development of systems and providing assurance to the Board of compliance with approved internal control mechanisms. GP attendance was included in the Committee to reflect the role of the Shadow CCG Governing Body and the future role of the CCG following authorisation.

The Joint Finance & Performance Committee is chaired by a Non-Executive Director, and is responsible for providing assurance on the overall financial wellbeing and performance of the PCT. GP attendance was included in the Committee to reflect the role of the Shadow CCG Governing Body and the future role of the CCG following authorisation.

The Joint Governance and Compliance Committee is chaired by a Non-Executive Director, and has overall responsibility for ensuring effective implementation of the PCT's Risk Management Strategy and associated policies. GP attendance was included in the Committee to reflect the role of the Shadow CCG Governing Body and the future role of the CCG following authorisation

The Joint Quality and Patient Safety Committee, chaired by a Non-Executive Director, oversees all areas related to the three cornerstones of clinical activity, namely clinical effectiveness, patient safety and patient experience. The Committee supports NHS Cambridgeshire and NHS Peterborough to ensure that patient safety and quality is at the top of the agenda for providers as their highest priority. GP membership was strengthened to reflect the role of the Shadow CCG and the future role of the CCG following authorisation.

The Shadow CCG Governing Body has responsibility for Clinical Commissioning during the shadow year, in line with the scheme of delegation approved by the PCT Cluster Board.

The Joint Remuneration and Terms of Service Committee, chaired by a Non-Executive Director, is responsible, on behalf of the Board, for agreeing Very Senior Managers' Pay and for overseeing Executive Directors' performance.

The Board met in public on a bi-monthly basis. The Board Agenda was divided into four key areas – General Issues, Quality and Governance, Finance and Performance and Strategy and Delivery. The Board receives reports on the activities of all its Sub-Committees on a regular basis.

The Board also receives detailed overview reports on the work of the Joint Audit Committee which includes progress against External Audit progress reports, internal audit and counter fraud and the Board Assurance Framework. The Joint Audit Committee reviews its Audit Committee Self-Assessment Check-List regularly.

The PCT has met throughout the year with the NHS Midlands and East SHA cluster and its predecessor, to review the PCT's performance against key national and local targets, with a particular focus on performance, including financial performance and progress against the PCT's Financial Recovery Plan. In addition, the PCT has an Annual Accountability Review meeting with representatives of the SHA Board to formally review and record the PCT's performance.

The Board is committed to ensuring that it complies with all aspects of Corporate Governance. This is maintained through the Code of Conduct and Accountability, Register of Interests, Register of Gifts and Hospitality, Whistleblowing Policy and the Complaints Policy.

The Board holds regular Board Development Sessions. Board to Board meetings with our main providers are also conducted.

The Board conducted a formal review of its effectiveness. An annual self-assessment was undertaken against the Corporate Governance Code took place during May to July 2012. The outcomes of the self- assessment were reported and discussed at the Board Development Session in August 2012.

3. PCT Transition and Close Down

In line with guidance received from the Department of Health on 22 February 2013, Peterborough PCT transferred functions to the relevant body on 1 April 2013 in line with the Health and Social Care Act 2012. Technically, functions are conferred by legislation and so do not transfer from one body to another. Instead Peterborough PCT ceases to be responsible and either another body (for example, the Cambridgeshire & Peterborough CCG, NHS England, Peterborough City Council, NHS Property Services) is made responsible for it in the future or the function ceases to exist.

A Transition and Closedown process was established with three key programmes:-

Changing the Architecture;
Leadership, Support and Relationship Management; and
Managing the Business

An Action Plan was developed covering three key areas and was reported through the Cluster Executive Team, Governance & Compliance Committee and Audit Committee to provide assurance to the PCT Cluster Board.

Risks around the Transition and Close Down process were included on the Board Assurance Framework, with gaps in assurance identified and managed via Action Plans.

The PCT assured itself through the Audit Committee and Board that they had transferred staff, property, and all other assets and liabilities associated with these functions to the appropriate receiving organisation via transfer schemes. This process was managed by a Task and Finish Group led by the Trust Board Secretary. The PCT engaged with receivers to complete full handover and knowledge transfer for those functions, through receiving of assets and liabilities and through three key documents approved by the PCT Board, namely the Handover Document, Quality Handover Document and Public Health Handover Document.

At the demise of the PCT, the draft Transfer Scheme had been reviewed and returned to the Department of Health for finalisation. In line with Guidance, the PCT Board signed off, via delegated approval to the Audit Committee the draft scheme as returned to Department of Health. A process to finalise the Transfer Schemes is now being overseen by the Midlands and East Legacy Team. A process for identifying “Discovered Assets and Liabilities” has been implemented.

The PCT Staff Transfer Scheme, which transfers all of the PCT’s staff that are not made redundant to nominated receivers, was completed in line with national guidance. Extensive consultations were conducted with Staff in relation to the Staff Transfer Scheme.

Provision of formal notification to each member of staff currently employed by each PCT, confirming their destination in the new system, or alternatively notification of redundancy arrangements has taken place. PCTs have been asked to reflect their predicted 31 March 2013 staffing position in their returns to the People Transition Programme. Those employees made redundant as at 31 March 2013 received redundancy payments from Cambridgeshire PCT. Redundancy payments have been approved by the PCT Cluster’s Remuneration and Terms of Service Committee. Where staff have not transferred and there are potentially on-going employee relations issues then these have been notified to the DH as potentially “residual employment liabilities”.

Financial liabilities around the Local Government Pension Scheme were included on the Transfer Scheme to transfer to the Department of Health. Subsequently, it has been identified that Admission Agreements should also have transferred to the CCG. This has now been addressed via the Discovered Assets and Liabilities Log process established by the Department of Health.

4. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and

objectives. It can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to:

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

The system of Internal Control has been in place in NHS Peterborough for the year ended 31 March 2013 and up to the date of approval of the Annual Report and Annual Accounts.

5. Capacity to handle risk

The PCT Board provides leadership to ensure that risk management is embedded within the organisation. This includes development of the Integrated Plan which identifies the key objectives and related risks.

As Accountable Officer, I ensure that sufficient resources are invested in managing risk, and I am supported in this task by the Medical Director (Caldicott Guardian) who holds Board-level responsibility for clinical risk and the Director of Corporate Development and Performance (Senior Information Risk Owner) who also holds Board-level responsibility for non-clinical risks.

In preparation for the authorisation of the CCG, the Director of Nursing, Quality and Patient Experience has been appointed as the Caldicott Guardian and the Director of Performance & Delivery has been appointed as the CCG's Senior Information Risk Owner.

Leadership is given to the risk management process through Executive and Non-Executive Directors via the Joint Audit Committee, Joint Quality and Patient Safety Committee and Joint Governance and Compliance Committee.

Staff are trained and equipped to manage risk in a way that is appropriate to their authority and duties and this is done through a documented system of risk assessment, formal and ad hoc training and from meetings with them to identify and manage risk. Guidance is provided to staff by the Governance Team who provide templates on how to undertake risk assessments, produce risk registers and business continuity plans and embed risk management in the activity of the organisation.

The PCT is supported by Risk Management resources within SERCO which provides support in terms of advice, development and training to Peterborough and Cambridgeshire PCTs and Cambridgeshire and Peterborough NHS Foundation Trust. This aims to provide a consistent approach across the organisations.

6. The risk and control framework

Risk management is demonstrated by:

- adopting an integrated approach to risk management, whether the risk relates to clinical, organisational, health and safety or financial risk, through the processes and structures detailed in the PCT's Risk Management Strategy

- managing risk as part of the routine line management responsibilities and consideration of funding to address 'risk' issues (based on a risk assessment) as part of the normal business planning process

- undertaking risk assessments on both existing, new and proposed activities to ensure that:

  i) significant risks are identified in accordance with the Risk Management Strategy which provides full details on what constitutes a hazard or risk, how it should be identified and assessed;
  ii) assessments are made of their potential frequency and severity;
  iii) control measures are implemented in accordance with the Risk Management Strategy;
  iv) risks are always minimised;
  v) Strategic risks are recorded on the Board Assurance Framework as appropriate.
  risks are recorded on the CCG Assurance Framework and LCG Risk Registers and escalated as appropriate

  Staff at all levels of the organisation contribute to the identification and assessment of risk through Directorates and at our Main Provider Performance Management Days. The Risk Management actions that have been taken this year include:

  - Strengthening of LCG Risk Registers and the development of the CCG Assurance Framework;
  - Maintenance of governance policies and the Risk Management Strategy;
  - Testing of our emergency planning and business continuity planning arrangements;
  - Development of our information governance arrangements and Information Governance Toolkit scores for both PCT Cluster and CCG.

The control environment is supported by regular review of Standing Orders, Scheme of Delegation and Standing Financial Instructions, directions on fraud, programme of Internal Audit, budgetary control systems and information to support performance and risk monitoring processes.

The BAF identifies the PCT's strategic objectives and risks, the controls that are currently in place to minimise the risk and the sources of assurance to those controls. The system of regular review of the BAF by the Board

provides evidence to the Annual Governance Statement. The Board has reviewed gaps in key controls and assurance and progress on management actions to address the gaps.

The BAF assesses the likelihood of an event occurring combined with the possible consequences to provide a standard approach to the assessment of risk. Calculating the risk supports the prioritisation of action plans and the reduction of risks is therefore managed through this process.

The Internal Audit review of the BAF provided substantial assurance. The BAF is regularly reviewed by the Cluster Executive Team and input is also provided by the Joint Quality & Patient Safety Committee and Joint Finance and Performance Committees as required. It is scrutinised at each Joint Audit Committee and is presented at each Board meeting in public through the Chief Executive's Report.

Recommendations arising from the Internal Audit review that were designed to further develop and strengthen the BAF will be taken forward during 2013-2014 by successor organisations.

The BAF identified a number of High Risks which are being managed through robust action plans to mitigate these risks. These are as follows:-

- Risk to delivery of the QIPP and System Reform Plan
- Risk to delivering financial balance in 2012/13
- Risk to contract negotiation process for 2013/14 due to transition process
- Failure to achieve key performance targets
- Insufficient capacity and capability to deliver all goals – linked to the Health and Social Care Bill and transition to CCG
- Risk of skilled workforce not available within commissioned services when needed
- Risk of potential poor governance in services which the PCT commissions
- Failure to safeguard children and adults
- Risk to maintaining the quality of community services
- Risk around retrospective review of Continuing Healthcare cases
- Risk around failure to implement NHS 111 Service

From the above High Risks, the BAF identifies a number of gaps in controls. The Management Action Plans to address these are as follows:-

- Each strategic risk listed above has been included in the CCG Assurance Framework and will continue to be reported and monitored through the robust governance structures that have been established for the new organisation,

- Improved QIPP monitoring and reporting processes have been implemented in the latter part of the year to provide the PCT, through the Joint Finance and Performance Committee, with a clearer picture of QIPP savings that could realistically be delivered for 2012/13. Early and significant focus has also been given to QIPP Planning for 2013/14, which will continue to be taken forward by the CCG and the Local Commissioning Groups (LCGs) next year.

- Appointment of staff to the CCG commenced in June 2012 and is almost complete.

- The Shadow CCG Governing Body has been responsible for progressing the 2013/14 contract negotiations.

- As a core provider for the PCT, the financial position of Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT) and other related issues has been actively monitored during the last twelve months and will continue to be done so by the CCG next year.

NHS Peterborough continues its commitment to ensuring that Information Governance is an integral part of the PCT's Risk Management Strategy and operational planning. The Joint Information Governance and IM&T Steering Group prioritises its work programme and has provided exception reporting to the Audit and Governance Committee (Joint Governance and Compliance Committee from 1 December 2011).

NHS Cambridgeshire and NHS Peterborough (as a Cluster PCT) submitted and published a GREEN 'satisfactory' rating for its self-assessment on the Information Governance Tool-kit during 2012-2013. An Action Plan is in place to improve this score which will be implemented for the CCG to take forward and will be monitored by the CCG Information Governance and IM&T Steering Group.

NHS Peterborough is required to publish all Serious Incidents (SIs) relating to loss of personal data involving confidentiality breaches in its Annual Report. There were three serious breaches reported during 2012-2013 and of these one was categorised as level 3.

SUMMARY OF SERIOUS UNTOWARD INCIDENTS INVOLVING PERSONAL DATA AS REPORTED TO THE INFORMATION COMMISSIONER'S OFFICE IN 2012/13				
Date of Incident	**Nature of Incident**	**Nature of Data Involved**	**Number of People Potentially Affected**	**Notification of Steps**
July 2012	During a planned transfer of ESR records for a group of staff from one NHS Trust to	Electronic staff record detail including pay, training, sickness and	90+	Affected staff were identified and notified

	another an additional set of records was transferred at the same time. Access to the data was restricted to a very small number of staff who were part of the project team who had been granted access to carry out this work. DH Level 3	absence		
Further action on information risk	Recommendations and lessons learned were reported and shared with members of the project team to mitigate risk of this happening again.			

NHSP SUMMARY OF OTHER PERSONAL DATA RELATED INCIDENTS IN 2011-12		
Category	**Nature of incident**	**Total**
I	Loss/theft of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	2
II	Loss/theft of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	-
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	-
IV	Unauthorised disclosure	-
V	Other – Categorised at Level 1	2

NHS Peterborough has developed processes to align to the guidance set out in “Managing the Transition – Sharing Legacy Information” and “Maintaining and improving quality during the transition: safety, effectiveness, experience”. The final cut of the Handover Document was presented to the NHS Midlands and East SHA at the end of March 2013.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with.

Members of the public are reminded about managing their own risks through warning signs and notices as appropriate throughout the PCT’s premises and through their participation as patients in the consent process.

In addition, the PCT complies with its statutory duties under the Civil Contingencies Act 2004. A Joint Major Incident Plan is in place and is reviewed annually, with formal endorsement received by the PCT Board. A Business Continuity Policy is in place and is reviewed annually, with formal endorsement received by the PCT Board. Emergency Planning and Business Continuity Planning is overseen by the Emergency Planning Sub-Group which reports to the Joint Governance and Compliance Committee.

Responsibility for carbon reduction and sustainability falls within the portfolio of the Director of Finance who acts as the Board lead. The PCT has an approved Sustainability Strategy and the Sustainability Strategy Delivery Plan is monitored by the Board on a bi-annual basis.

The PCT has undertaken a climate change risk assessment and developed an Adaption Plan, to support its emergency preparedness and civil contingency requirements, as based on the UK Climate Projections 2009 (UKCP09), to ensure that this organisation's obligations under the Climate Change Act are met.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. As Accountable Officer, I am assured by the relevant aspects of the NHS Constitution that the Board (through the Finance and Performance Committee receives assurance on and regular monitoring of workforce performance. A mechanism is also in place for undertaking and reviewing equality impact assessments. An Equality and Delivery System is now in place.

7. Review of the effectiveness of Risk Management and 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 BAF and on the controls reviewed as part of the Internal Audit work. Executive Directors within the organisation who have responsibility for the development and maintenance of the system of internal control provides me with assurance.

The BAF itself provides me with the evidence that the effectiveness of controls that manage the risks to the organisation achieving its corporate objectives have been reviewed. My review is also informed by Internal and External Audit. I have been advised of the implications of the result of my review of the effectiveness of the system of internal control by the Board and the Joint Audit Committee as described in Section 1. A plan to address weaknesses and ensure continuous improvements of the system of internal control will be put in place. The Board and its associated Committees, together with Internal Audit, maintain a regular review of the effectiveness of the process of internal control.

My review is also informed by:

- The Information Governance Toolkit Assessment;
- Our Research Governance Framework;
- Any external reviews;
- Review of key governance meetings;
- Reports from Internal Audit and the Head of Internal Audit Opinion;
- NHSLA Membership and Risk Management Assessment; and
- External Audit's assessment of the PCT's arrangements for economy, efficiency and effectiveness in the use of its resources.

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

- The Board, which has responsibility for setting the overall direction, agreeing the PCT's corporate objectives, assessing and managing strategic risks to the delivery of those objectives and monitoring progress through regular performance monitoring reports
- The Joint Audit Committee which works to a well-developed audit plan and provides assurance to the Board
- The Joint Finance & Performance Committee) meets monthly and is responsible for reviewing financial risk and performance of providers commissioned to provide services to the patients of NHS Peterborough
- The Joint Governance & Compliance Committee which meets bi-monthly and is responsible for overall implementation of the Risk Management Strategy which includes reviewing Information Governance and IT Security Risks
- The Joint Quality & Patient Safety Committee which is responsible for ensuring clinical risk is managed. The Committee meets monthly
- The Joint Remuneration and Terms of Service Committee, which is responsible for agreeing Very Senior Managers Pay and monitoring Executive Director performance
- The Cluster Executive Team which meets regularly to support the achievement of the Operational Plan and deals with day to day risk
- Executive Directors and Assistant Directors
- Internal Audit, which has reviewed the effectiveness of the design and operation of the controls in the areas covered by its risk-based Operational Plan.

Internal Audit's overall opinion for the year ended 31 March 2013 is that **significant assurance** can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. Progress against implementation of all Internal Audit recommendations is regularly reviewed by Audit Committee (Joint Committee from 1 December 2011). Management Actions taken are confirmed by specific, formal follow-up by Internal Audit and this is independently reported to the Audit Committee.

The PCT met its statutory financial duty to break even in 2012-2013, and has ended the year with a surplus of £790k.

With the exception of the internal control issues that I have outlined in this Annual Governance Statement, my review confirms that NHS Peterborough has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives. The control issues have been or are being assessed.

8. Significant Issues

In respect of the PCT Close down and completion of the Peterborough PCT Transfer Scheme I am assured that the organisation has carried out due diligence to identify all property, rights and liabilities currently held and up to 31st March 2013 in relation to the Peterborough PCT. The organisation has assigned all property, rights and liabilities according to function, to the best of its ability and understanding, to the most appropriate permitted receiver in the new NHS system architecture. Sign-off of this process was approved on the basis of assurance from the Deputy Chief Executive that the Governance Team and Legal Task and Finish Group had completed the documentation to the best standard possible and had completed due diligence required in line with the Guidance from the Department of Health.

The PCT achieved £20.7m of efficiencies through a range of savings schemes including contribution from QIPP (quality, innovation, productivity and prevention) initiatives. Nevertheless, this was insufficient in regards to the total saving needed and therefore the PCT was reliant on the use of non-recurrent savings to achieve a break-even position for 2012/13. Although a significant improvement in the management, control and robustness of reporting on QIPP programme delivery was identified in the latter part of 2012/13, the auditors were required to consider the PCT's performance over the full-year. In doing so they identified that savings plans had not been entirely fit for purpose, supported by effective delivery plans or consistently and effectively monitored for the full 12 months For this reason the external auditors have been unable to conclude that the PCT's arrangements satisfy the Audit Commission's specified criteria for securing financial resilience and challenging how it secures economy, efficiency and effectiveness in the use of its resources, and their value for money conclusion for 2012/13 has been qualified in this respect. In making this judgement the auditors were also required to take into account the PCT's previous track record for delivering QIPP Programme savings.

I am however assured that the ownership and robustness of the detailed QIPP plans together with the reporting processes now in place, which were demonstrated in the final months before the demise of the PCT, will be taken forward by the Cambridgeshire and Peterborough Clinical Commissioning Group for the purpose of achieving the cost savings targets identified for 2013/14.

9. Annual Accounts Closedown and Sign Off Arrangements

A detailed financial closedown report was developed in line with the Department of Health Checklist. The closedown process was monitored through the Finance & Performance Sub-Committee and assurance sought through the PCT Cluster's Audit Committee.

Staff have been retained under RETS to manage the Annual Accounts process until the 30 June 2013. Audit Committee membership to continue this process has been agreed and three existing Non-Executive Directors have been appointed by the Department of Health to form the basis of this

Committee to approve the Annual Report and Annual Accounts for 2012-2013 for the PCT.

The Accountable Officer for sign off of the Annual Accounts will be the NHS England East Area Team Area Director in line with guidance issued by the Department of Health

Accountable Officer: Andrew Reed
Organisation: Director of Area Team
Signature:
Date: 7 June 2013

NHS Peterborough Annual Report 2012-13

Operating and Financial Review

NHS Peterborough, as with all PCTs, had three main financial duties:

- Remaining within an agreed revenue and capital resource limit
- Managing within an annual cash limit
- Achieving operating financial balance (or better)

In summary, NHS Peterborough made an operating surplus of £0.790m in 2012-13 compared to a surplus of £4.110m for 2011-12. The PCT also achieved its capital resource limit (underspend of £0.353m in 2011/12). Details of the summary positions are outlined below.

NHS Peterborough continued to invest additional funding in a range of service areas to achieve the national and local performance targets and in developing services for the local population.

Operating environment
Nature of the business

We were responsible for commissioning a range of hospital, community and mental health services, and also for improving primary care and the general health of the local population.

The main organisations from which NHS Peterborough commissioned services include:

Organisation	What services are commissioned	SLA Expenditure value 2012-13

		(£000)
Peterborough and Stamford Hospitals NHS Foundation Trust	Specialist, general, acute	87,669
Cambridge University Hospitals NHS Foundation Trust	General and acute	5,414
Cambridge and Peterborough NHS Foundation Trust	Mental Health	27,329
Cambridgeshire Community services NHS Trust	Community services	19,046
East of England Ambulance Service NHS Trust	Emergency ambulance service	7,592
South East Essex PCT	Specialist commissioning	21,657

Our three main functions are to:

- work with our local population to improve their health and well-being
- commission a comprehensive and equitable range of effective services within our resources
- provide high quality responsive and efficient services where this gives best value.

Once again the 2012-13 financial year was a challenging one for the PCT which included the delivery of £21.1m of the PCT's savings programme. This was essential to ensure the PCT created the platform necessary to meet the service and clinical challenges.

One of NHS Peterborough's statutory financial duties is to remain within its Revenue Resource Limit. For the financial year 2012-13 NHS Peterborough ended with a surplus of £0.790m (2011-12 surplus of £4.110m) against an available resource limit of £289m (2011-12 £286m). During the year, the PCT has repaid £6.4m of support from previous years to the East of England Strategic Health Authority.

A summary of the position is outlined below:

	2012-13	**2011-12**
	£000	**£000**
Total net operating cost for the financial year	288,314	281,889
Revenue Resource Limit	289,104	285,999
Under spend against revenue resource limit	**790**	**4,110**

Capital Resource Limit

Another key financial measure is the requirement to remain within its Capital Resource Limit. For the year 2012-13 NHS Peterborough reported achievement of this target (2011-12 £0.353m underspend).

Capital Resource Limit	2012-13	2011-12
	£000's	£000's
Gross capital Expenditure	200	129
Less: Net book Value of assets disposed of	0	(148)
Charge against the Capital Resource Limit	**200**	**(19)**
Capital Resource Limit	200	334
Under spend against Capital Resource Limit	**0**	**353**

External Audit
PricewaterhouseCoopers LLP (PwC) are NHS Peterborough's external auditors. Their statutory work includes the audit of our financial statements and other performance work required by the Audit Commission Code of Audit Practice. Our Audit and Governance Committee considers matters that concern the independence of the external auditors. The PCT incurred audit fees within 2012-13 of £139,539 (exc VAT). Of this, the 2012-13 statutory audit totalled £96,140 exc. VAT (2011-12 £203,000) and the remainder related to additional work for 2011-12 not included in the reported year end figure of £203,000.

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

Public Sector Payment Policy (Confederation of British industry's Better Payment Practice Code)

NHS Peterborough has a requirement to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice whichever is later. Details of compliance with the code are detailed here.

Better Payment Practice Code – measure of compliance - Non NHS Creditors	2012-13 Number	2012-13 £000's	2011-12 Number	2011-12 £000's
Total Bills paid in year	9,545	54,277	11,862	44,650
Total bills paid within target	8,882	51,689	10854	41,956
Percentage of bills paid within target	**93.1%**	**95.2%**	**91.5%**	**94.0%**
NHS Creditors				
Total Bills paid in year	2,500	188,074	2,446	174,132
Total bills paid within target	2,321	186,465	2,376	173,264
Percentage of bills paid within target	**92.8%**	**99.1%**	**96.4%**	**99.5%**

Future View

The PCT continued its strategy identified over the last few years to take account of the impact of the economic downturn. For the future this strategy will be renewed and taken forward in the new commissioning architecture of the NHS.

These commissioning arrangements were introduced by the NHS Health and Social Care Act 2012 and a new Clinical Commissioning Group (CCG) covering the geographic areas of Cambridgeshire and Peterborough has been created; this was approved in January and formally became a legal entity on 1st April 2013.

The CCG has been created with a specific focus on local decision making and accountability and has eight locality commissioning groups ensuring a local focus on commissioning. The process of transition has been successful, with the CCG, assuming the statutory duty to commission services from 2013-14 onwards. This will be supported by services commissioned through NHS England and Local Authorities.

The majority of the PCT's assets will be transferred upon demise of the PCT to the newly created NHS Property Services Ltd which has assumed the responsibility for residual NHS estate.

Going Concern

As the PCT's functions, assets and liabilities transfer to other public sector organisations, Government accounting requires that the accounts are prepared on a "going concern" basis. The financial position reported has therefore been drawn up on the same basis as previous years and as if the organisation was continuing.

Conclusion

Overall NHS Peterborough has delivered a good performance during the course of 2012-13 meeting of its key performance targets as mentioned above (see page 23 for more information on these). The PCT ceased as a legal entity after the 31st March and these accounts are the final ones for Peterborough PCT. Its functions in the future will be adopted by NHS England, the Cambridgeshire and Peterborough CCG, NHS Property Services Ltd and Peterborough City Council.

The full financial statements are presented in the following pages.

Statement of Comprehensive Net Expenditure for year ended

31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure			
Gross employee benefits	7.1	**14,414**	11,398
Other costs	5.1	**283,443**	277,962
Income	4	**(11,926)**	(9,603)
Net operating costs before interest		**285,931**	279,757
Finance costs	11	**2,383**	2,132
Net operating costs for the financial year		**288,314**	281,889
Of which:			
Administration Costs			
Gross employee benefits	7.1	**12,118**	8,887
Other costs	5.1	**5,509**	3,599
Income	4	**(3,291)**	(1,080)
Net administration costs for the financial year		**14,336**	**11,406**
Programme Expenditure			
Gross employee benefits	7.1	**2,296**	2,511
Other costs	5.1	**277,934**	274,363
Income	4	**(8,635)**	(8,523)
Net programme expenditure before interest		**271,595**	**268,351**
Finance costs	11	2,383	2,132
Net programme expenditure for the financial year		**273,978**	**270,483**

Other Comprehensive Net Expenditure		**2012-13 £000**	**2011-12 £000**
Impairments and reversals put to the Revaluation Reserve	12.1,12.2	**58**	**2**
Net gain on revaluation of property, plant & equipment	12.1,12.2	**(50)**	**(2,367)**
Adjustment for movements relating to merger accounting		**0**	**10,018**
Net actuarial (gain)/loss on pension schemes	7.4.1	**956**	(301)
Total comprehensive net expenditure for the year		**289,278**	**289,241**

The notes from page 56 onwards 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	**27,678**	28,860
Intangible assets	13	**1**	2
Total non-current assets		**27,679**	28,862
Current assets:			
Inventories	18	**0**	27
Trade and other receivables	19	**3,829**	13,022
Cash and cash equivalents	22	**57**	11
Total current assets		**3,886**	13,060
Total assets		**31,565**	41,922
Current liabilities			
Trade and other payables	24	**(16,410)**	(22,547)
Provisions	30	**(3,335)**	(1,820)
Borrowings	26	**(418)**	(390)
Total current liabilities		**(20,163)**	(24,757)
Non-current assets plus/less net current assets/liabilities		**11,402**	17,165
Non-current liabilities			
Other Liabilities	25	(10,820)	(9,328)
Provisions	30	(504)	(744)
Borrowings	26	(22,175)	(22,593)
Total non-current liabilities		**(33,499)**	(32,665)
Total Assets Employed:		**(22,097)**	(15,500)
Financed by taxpayers' equity:			
General fund		(27,925)	(21,826)
Revaluation reserve		5,828	6,326
Merger reserve		0	0
Total taxpayers' equity:		**(22,097)**	(15,500)

The notes from page 56 onwards form part of this account.

The financial statements on pages 51 to 55 were approved by the Audit Sub Committee of the Department of Health Audit and Risk Committee on 7th June 2013 and signed on its behalf by:

Andrew Reed
Designated Accountable Officer:
(On Behalf of Department of Health)

Date: **7th June 2013**

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

	General fund	Revaluation reserve	Merger reserve	Total reserves
	£000	£000	£000	£000
Balance at 1 April 2012	**(21,826)**	**6,326**	**0**	**(15,500)**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(288,314)	0	0	**(288,314)**
Net gain on revaluation of property, plant, equipment	0	50	0	**50**
Impairments and reversals	0	(58)	0	**(58)**
Transfers between reserves	490	(490)	0	**0**
Net actuarial gain/(loss) on pensions	(956)	0	0	**(956)**
Total recognised income and expense for 2012-13	**(288,780)**	**(498)**	**0**	**(289,278)**
Net Parliamentary funding	282,681	0	0	**282,681**
Balance at 31 March 2013	**(27,925)**	**5,828**	**0**	**(22,097)**
Balance at 1 April 2011	**(17,195)**	**4,184**	**0**	**(13,011)**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(281,889)	0	0	(281,889)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment	0	2,367	0	2,367
Impairments and Reversals	0	(2)	0	(2)
Transfers between reserves	(9,795)	(223)	10,018	0
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	67	67
Merger Accounting Adjustment with Non-TCS Body	0	0	(10,085)	(10,085)
Net actuarial gain/(loss) on pensions	301		0	301
Total recognised income and expense for 2011-12	(291,383)	2,142	0	(289,241)
Net Parliamentary funding	286,752	0	0	286,752
Balance at 31 March 2012	**(21,826)**	**6,326**	**0**	**(15,500)**

The General fund reflects the cumulative underspend incurred by the PCT as the balance from the Statement of Comprehensive Net Expenditure is transferred to this fund each year. The PCT's Parliamentary funding is accounted for in this reserve.

The balance cannot be released back to the Statement of Comprehensive Net Expenditure.

The reported actuarial gains attributable to the PCT in relation to the Local Government Pension Scheme are separately disclosed in the General Fund.

The revaluation reserve reflects movements in the value of property, plant and equipment and intangible assets as set out in the PCT's accounting policy (see note 1.6). The revaluation reserve balance relating to each asset is released to the General Fund on disposal of that asset.

The merger reserve in 2011-12 represented the value of net liabilities retained by the PCT in respect of Adult Social Care on the date that the pooled funding agreement came to an end at 31st March 2012. This balance was immediately transferred to the General Fund.

The transfer to other bodies within the Resource Accounting Boundary represents the value of the net liabilities transferred to Cambridgeshire Community Services NHS Trust on the date that services transferred to them under the transforming Community Services initiative.

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		**(285,931)**	(279,757)
Depreciation and Amortisation	12.1,13.1	**1,087**	1,222
Impairments and Reversals	12.1	**288**	23
Interest Paid		**(1,946)**	(2,127)
(Increase)/Decrease in Inventories		**27**	(27)
(Increase)/Decrease in Trade and Other Receivables		**9,193**	(9,010)
Increase/(Decrease) in Trade and Other Payables		**(6,124)**	1,928
Increase in Other Current Liabilities		**110**	5,650
Provisions Utilised	30	**(842)**	(558)
Increase in Provisions		**2,106**	1,891
Net Cash Outflow from Operating Activities		**(282,032)**	**(280,765)**
Cash flows from investing activities			
Payments for Property, Plant and Equipment		**(213)**	(116)
Proceeds of disposal of assets held for sale (PPE)		**0**	125
Net Cash Inflow/(Outflow) from Investing Activities		**(213)**	**9**
Net cash outflow before financing		**(282,245)**	**(280,756)**
Cash flows from financing activities			
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**(390)**	(356)
Net Parliamentary Funding		**282,681**	286,752
Adjustment for non cash movements relating to merger accounting		**0**	(10,018)
Net Cash Inflow from Financing Activities		**282,291**	**276,378**
Net increase/(decrease) in cash and cash equivalents		**46**	**(4,378)**
Cash and Cash Equivalents at Beginning of the Period		**11**	**4,389**
Cash and Cash Equivalents at year end		**57**	**11**

The adjustment for non cash movements relating to merger accounting in 2011-12 represented the nominal value of the balance relating to Adult Social Care on the date of the ending of the pooled funding arrangement and the subsequent transfer of services to Peterborough City Council.

1. Accounting policies

Under the provisions of The Health and Social Care Act 2012 (Commencement No.4.Transitional, Savings and Transitory Provisions) Order 2013, Peterborough PCT was dissolved on 1st April 2013. The PCT's functions, assets and liabilities transferred to other public sector entities as outlined in note 38. Where reconfigurations of this nature take place within the public sector, Government accounting requires that the activities concerned are to be considered as continuing operations, and so the closing entity prepares accounts on a "going concern" basis.
The Statement of Financial Position has therefore been drawn up at 31 March 2013 on the same basis as in previous years, reporting balances on the same basis as would a continuing entity. The estate has been revalued but this was required as part of the routine cycle of revaluation. No other assets and liabilities have been revalued and no disclosures have been made under IFRS 5 Non-current Assets Held for Sale and Discontinued Operation.

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

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

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

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

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

Critical accounting judgements and key sources of estimation uncertainty

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

affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

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

In considering the amounts to be accounted for under provisions and contingent liabilities the PCT makes a judgement on the values and likelihood of liabilities arising in respect of claims under continuing care. This is detailed in Note 30.

The PCT also considers that all assets will continue in use following the dissolution of the PCT at 1st April 2013 and subsequently transferred onto the successor organisations, as such there are no impairments to report (other than those identified in the revaluation of the estate). Liabilities and provisions have been assessed for the demise of the PCT, and only one provision deemed necessary for an onerous contract. This is further detailed in note 1.19 and 30 respectively.

For the purpose of these accounts, the liability relating to the Local Government Pension scheme is judged to have crystallised at 1st April 2013 upon its transfer to the Department of Health. It has been accounted for as a continuing operation as at 31st March 2013 in line with the FReM requirements to prepare accounts on a going concern basis.

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.

Property valuation - the PCT's estate has been revalued as at 31st March 2013 (see note 12).

Property, plant and equipment (see note 12) are depreciated over estimated useful lives, details of which are given in note 1.8.

Provisions - Details of estimating provisions required at the Statement of Financial position date, and of provisions made, are given in notes 1.24 and 30 respectively. The Continuing Healthcare provision was an area of particular uncertainty and this has been described fully including sensitivity analysis in note 30.

The PCT includes in full the liability relating to the Cambridgeshire Local Government Pension Scheme at the Statement of Financial Position date as valued by its actuary. In deriving the value of this liability a number of assumptions and estimates are made. The estimates and assumptions are based on historical experience and other factors considered reasonable at the time but actual results may differ from those estimates. Revisions to these estimates are made in the period in which they are recognised. The main assumptions and judgements made are disclosed in note 7.4 to these accounts.

1.2 Revenue and Funding

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

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

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

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

1.3 Pooled budgets

The PCT does not have any pooled budgets

1.4 Taxation

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

1.5 Administration and Programme Costs

Treasury has set performance targets in respect of non-frontline expenditure (administration expenditure).
From 2011-12, PCTs therefore analyse and report revenue income and expenditure by "admin and programme"
For PCTs, the Department has defined "admin and programme" in terms of running costs.
The broad definition of running costs includes any cost incurred that is not a direct payment for the provision of healthcare or healthcare related services.

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

1.6 Property, Plant & Equipment

Recognition

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

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

Valuation

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

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

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

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

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

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

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

Peterborough PCT had a full revaluation of its estate as at 31st March 2013. This valuation was carried out by the District Valuer, DVS Property Specialists, Norwich Valuation Office in accordance with Royal Institute of Chartered Surveyors (RICS). This valuation is reflected in the financial statements. The previous full valuation was also carried out by the District Valuer, DVS Property Specialists and was applied on 31st March 2009. A desk top valuation is performed in each year that a full valuation is not carried out.

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

1.7 Intangible Assets

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

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

● how the intangible asset will generate probable future economic benefits or service potential
● the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
● the ability to measure reliably the expenditure attributable to the intangible asset during its development

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 amortised historic cost to reflect the opposing effects of increases in development costs and technological advances.

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

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

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

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

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

1.9 Donated assets

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

1.10 Government grants

The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.11 Non-current assets held for sale

The PCT does not hold any non- current assets for sale.

1.12 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula.

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 PCT'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 PCTs 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 PCTs.

The NHSLA operates a risk pooling scheme under which the PCT pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure in the year that it is due. The total value of clinical negligence provisions carried by the NHSLA on behalf of the PCT is disclosed at Note 30.

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. 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.

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

Some employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the PCT’s accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. Actuarial gains and losses during the year are recognised in the General Fund and reported on the Statement of Changes in Taxpayers' Equity.

With the transfer of services in 2011-12, many staff, originally in the Local Government Superannuation Scheme, transferred employment to either Peterborough City Council or Cambridgeshire Community Services on 29th February 2012. These staff were transferred on a 'fully funded' basis and an equal value of gross pension assets and gross pension liabilities transferred with them.

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 Contingencies

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

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

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

1.20 Leases

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

The PCT as lessee

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

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

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

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

The PCT as lessor

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

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.

1.21 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.

1.22 Provisions

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

estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.35%.

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

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

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

The PCT will continue to incur costs post 31st March 2013 in relation to its closure and accounts completion. Specific guidance has been received from the Department of Health that these costs are not to be provided for by the PCT but are to be borne by the Department of Health.

1.23 Financial Instruments

Financial assets

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

Financial assets are initially recognised at fair value.

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

The PCT only holds financial assets classed as loans and receivables.

Loans and receivables

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

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

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

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

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

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

Financial liabilities are initially recognised at fair value.

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

1.24 Private Finance Initiative (PFI) transactions

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

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

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

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

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

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

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

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

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

c) Lifecycle replacement
Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the PCT's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.
The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.
Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

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

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

1.25 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, except in the circumstances listed:
Standards applicable from 2013/14:
IAS 1 Presentation of financial statements (amendment).
IAS 12 Income Taxes (amendment).
IAS 19 (Revised) Employee Benefits
For NHS bodies that recognise defined benefit pension liabilities e.g. where they have staff who are members of the Local Government pension scheme, the standard may have a significant impact for 2013/14 due to the changes in measurement of the net finance cost.
IFRS 7 Financial Instruments: Disclosures (amendment)
IFRS 13 Fair Value Measurement – this standard should be applicable for 2013/14, however, HM Treasury has delayed its adoption by government bodies while it finalises some adaptions. The impact on the financial statements is unknown until these adaptions are finalised.
IAS 27 Consolidated and separate financial statements – removal of dispensation from consolidating NHS charitable funds.
Annual Improvements to IFRS 2011. This standard is potentially applicable to 2013/14 but has not yet been endorsed by the EU and therefore by HM Treasury policy is not available for NHS bodies to apply.

Standards applicable from 2014/15:
IFRS 10 Consolidated Financial Statements (see IAS27 above)
IFRS 11 Joint Arrangements
IFRS 12 Disclosure of Interests in Other Entities
IAS 27 Separate Financial Statements (amendment)
IAS 28 Investments in Associates and Joint Ventures (amendment)
IAS 32 Financial instruments: Presentation (amendment)

Other standards in issue:
IFRS 9 Financial Instruments – this standard will eventually replace IAS 39. It is applicable for periods beginning on or after 1 January 2015, but the standard has not yet been EU endorsed and therefore by HM Treasury policy is not available or NHS bodies to apply.
IPSAS 32 - Service Concession Arrangement

2 Operating segments

Segmental reporting is required to reflect the content and form of information that is reported to the PCT's Chief Operating Decision Maker (CODM). The PCT considers the Board to be the CODM as the Board is responsible for reporting the PCT's budget and for allocating resources to operating segments and assessing their performance. Financial management information presented to the Board is designed to report on the PCT's performance against its annual Revenue Resource Limit (as determined each year by the Department of Health) and does not analyse the PCT's net assets by segment. The segment information provided to the Board for the year is summarised below.

	Original	Audit adjustments	Final position
	£'000	**£'000**	**£'000**
Acute Commissioning	109,176	0	109,176
Other Commissioning	77,723	(491)	77,232
NCB Specialist Commissioning	21,657	(169)	21,488
NCB Primary Care other	41,388	(55)	41,333
NCB Primary Care Prescribing	22,912	357	23,269
Running Costs	15,532	75	15,607
Other Budget Areas	209	0	209
Total Net Expenditure	**288,597**	**(283)**	**288,314**
Underspend against Revenue Resource Limit	**518**		**790**

The internal reporting of the organisation has changed and therefore direct comparators for 2011/12 expenditure are unavailable. The 2011/12 reported figures were:

	2011-12			
	Commissioning - unadjusted expenditure £000	Adjustments £000	Final Commissioning £000	Primary Care Contracting £000
Main SLAs	172,616	(989)	171,627	0
Other Commissioning Budgets	31,153	(784)	30,369	0
Primary Care Prescribing	31,075	(84)	30,991	0
Primary Care	27,537	(588)	26,949	0
Dental	8,853	(1,268)	7,585	0
Other	5,922	383	6,305	4,181
Employee Benefits	11,758	(437)	11,321	0
Total Expenditure	**288,914**	**(3,767)**	**285,147**	**4,181**
Underspend against Revenue Resource Limit			**4,108**	**2**

The PCT's income is largely in the form of Parliamentary funding allocated by the Department of Health which is accounted for in the PCT's General Fund. Income is not allocated to operating segments in the financial information reported to the Board.

3. Financial Performance Targets

3.1 Revenue Resource Limit

	2012-13 £000	2011-12 £000
The PCT's performance for the year ended 31 March 2013 is as follows:		
Total Net Operating Cost for the Financial Year	**288,314**	281,889
Revenue Resource Limit	**289,104**	285,999
Under/(Over)spend Against Revenue Resource Limit (RRL)	**790**	4,110

3.2 Capital Resource Limit

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

	2012-13 £000	2011-12 £000
Capital Resource Limit	**200**	334
Charge to Capital Resource Limit	**200**	(19)
Underspend Against CRL	**0**	**353**

3.3 Performance against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**282,681**	286,752
Cash Limit	**282,681**	286,752
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)	245,370
Less: Trade Income from DH	(145)
Plus: movement in DH working balances	8
Sub total: net advances	**245,233**

Plus: cost of Dentistry Schemes (central charge to cash limits)	8,204
Plus: drugs reimbursement (central charge to cash limits)	29,244
Parliamentary funding credited to General Fund	**282,681**

4 Miscellaneous Revenue

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Dental Charge income from Contractor-Led GDS & PDS	**1,167**	0	1,167	1,089
Dental Charge income from Trust-Led GDS & PDS	**1**	0	1	0
Prescription Charge income	**1,569**	0	1,569	1,479
Strategic Health Authorities	**572**	0	572	478
NHS Trusts	**0**	0	0	0
NHS Foundation Trusts	**218**	214	4	3
Primary Care Trusts - Other	**301**	47	254	136
English RAB Special Health Authorities	**13**	13	0	0
Department of Health - Other	**145**	145	0	63
Recoveries in respect of employee benefits	**301**	125	176	650
Local Authorities	**350**	299	51	237
Rental revenue from operating leases	**4,607**	50	4,557	4,484
Other revenue	**2,682**	2,398	284	984
Total miscellaneous revenue	**11,926**	**3,291**	**8,635**	**9,603**

Other revenue includes £2,013k income from the Primary Care Commissioning Community Interest Company for work carried out within the NHS hosted element of Primary Care Commissioning (11-12 - £880k).

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	**21,665**	0	21,665	16,500
Non-Healthcare	**123**	123	0	105
Total	**21,788**	**123**	**21,665**	**16,605**
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	**28,259**	1,304	26,955	28,600
Goods and services (other, excl Trusts, FT and PCT))	**5**	0	5	9
Total	**28,264**	**1,304**	**26,960**	**28,609**
Goods and Services from Foundation Trusts	**124,090**	0	124,090	125,355
Purchase of Healthcare from Non-NHS bodies	**27,681**	0	27,681	29,102
Social Care from Independent Providers	**477**	0	477	301
Contractor Led GDS & PDS (excluding employee benefits)	**9,594**	0	9,594	7,537
Salaried Trust-Led PDS & PCT DS (excluding employee benefits)	**5**	0	5	48
Chair, Non-executive Directors & PEC remuneration	**64**	64	0	81
Executive committee members costs	**298**	298	0	0
Consultancy Services	**393**	290	103	1,333
Prescribing Costs	**24,232**	0	24,232	23,977
G/PMS, APMS and PCTMS (excluding employee benefits)	**27,258**	92	27,166	26,949
Pharmaceutical Services	**110**	0	110	131
New Pharmacy Contract	**7,080**	0	7,080	6,883
General Ophthalmic Services	**2,160**	0	2,160	2,127
Supplies and Services - Clinical	**1,107**	72	1,035	389
Supplies and Services - General	**1,297**	187	1,110	1,229
Establishment	**863**	626	237	905
Transport	**0**	0	0	5
Premises	**3,488**	1,689	1,799	3,386
Impairments & Reversals of Property, plant and equipment	**288**	0	288	23
Depreciation	**1,086**	150	936	1,221
Amortisation	**1**	0	1	1

Movement in Impairment of Receivables	**(78)**	(78)	0	(9)
Audit Fees	**110**	110	0	203
Other Auditors Remuneration	**58**	58	0	20
Education and Training	**131**	93	38	475
Grants for capital purposes	**0**	0	0	63
Other	**1,598**	431	1,167	1,013
Total Operating costs charged to Statement of Comprehensive Net Expenditure	**283,443**	**5,509**	**277,934**	**277,962**

The statutory audit fee for 2012/13 was £91k exclusive of VAT (2011-12: £169k).

Employee Benefits (excluding capitalised costs)				
Employee Benefits associated with PCTMS	**45**	0	45	68
PCT Officer Board Members	**544**	544	0	573
Other Employee Benefits	**13,825**	11,574	2,251	10,757
Total Employee Benefits charged to SOCNE	**14,414**	**12,118**	**2,296**	**11,398**
Total Operating Costs	**297,857**	**17,627**	**280,230**	**289,360**

Analysis of grants reported in total operating costs				
For capital purposes				
Grants to Fund Capital Projects - Dental	**0**	0	0	14
Grants to Fund Capital Projects - Other	**0**	0	0	49
Total Capital Grants	**0**	**0**	**0**	**63**
Grants to fund revenue expenditure				
To Private Sector	**0**	0	0	0
To Other	**0**	0	0	0
Total Revenue Grants	**0**	**0**	**0**	**0**
Total Grants	**0**	**0**	**0**	**63**

	Total	**Commissioning Services**	**Public Health**
PCT Running Costs 2012-13			

Running costs (£000s)	**14,336**	13,619	717
Weighted population (number in units)*	**158,095**	158,095	158,095
Running costs per head of population (£ per head)	**91**	**86**	**5**
PCT Running Costs 2011-12			
Running costs (£000s)	**10,551**	10,031	520
Weighted population (number in units)	**158,095**	158,095	158,095
Running costs per head of population (£ per head)	**66**	**63**	**3**

* Weighted population figures are not available for 2012-13 as the weighted capitation formula for PCT allocations was not updated for 2012-13. This was because it was decided to give all PCTs the same percentage growth in their allocations in this transitional year rather than differential growth based on a weighted capitation formula

Therefore, 2011-12 weighted populations have been used when calculating the Running Costs per head of population in 2012-13

The PCT commissioning services running costs for 2012-13 include a sum of £7,291k for Hosted Services running costs.

5.2 Analysis of operating expenditure by expenditure classification

	2012-13	2011-12
	£000	£000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	27,303	26,949
Prescribing costs	24,232	23,977
Contractor led GDS & PDS	9,594	7,537
Trust led GDS & PDS	5	48
General Ophthalmic Services	2,160	2,127
Pharmaceutical services	110	131
New Pharmacy Contract	7,080	6,883
Total Primary Healthcare purchased	**70,484**	67,652
Purchase of Secondary Healthcare		
Learning Difficulties	3,127	3,078
Mental Illness	34,990	35,584
Maternity	9,825	9,532
General and Acute	105,671	65,843
Accident and emergency	11,940	11,587
Community Health Services	35,610	73,724
Other Contractual	724	323
Total Secondary Healthcare Purchased	**201,887**	199,671
Grant Funding		
Grants for capital purposes	0	63
Grants for revenue purposes	0	0
Total Healthcare Purchased by PCT	**272,371**	**267,386**
Included above:		
Secondary healthcare commissioned by PCT	0	0
Social Care from Independent Providers	477	301
Healthcare from NHS FTs	124,090	122,788

6. Operating Leases

The PCT holds a number of operating leases for properties and also for vehicles. None of the operating lease agreements contain contingent rent clauses. None of the operating lease agreements contain renewal or purchase options. The leases may be renewed when due.

6.1 PCT as lessee

	Buildings	Other	2012-13 Total	2011-12
	£000	£000	£000	£000
Payments recognised as an expense				
Minimum lease payments	**1,258**	**15**	**1,273**	1,504
Total	**1,258**	**15**	**1,273**	**1,504**
Payable:				
No later than one year	**1,062**	**5**	**1,067**	1,041
Between one and five years	**2,716**	**3**	**2,719**	3,025
After five years	**4,687**	**0**	**4,687**	4,640
Total	**8,465**	**8**	**8,473**	**8,706**
Total future sublease payments expected to be received			0	0

The General Medical Services contract entered into by Peterborough PCT includes conditions relating to the use of GP premises. Under IFRIC 4, 'Determining whether an arrangement contains a lease,' the PCT has determined that those conditions are operating leases.

As the GMS contract does not have a defined term, it is not possible to analyse the financial impact of the arrangements over future financial years. The premises cost included in the GMS payments in the Statement of Comprehensive Net Expenditure for 2012-13 is £861k (2011-12: £1,392k).

6.2 PCT as lessor

The PCT has one PFI scheme operating under the name of the City Care Centre (CCC) and has tenants who occupy part of the building. The tenants are actively running services from the CCC and have occupied the building at all or some point during the year 2012-13.

Rental income is charged to seek to recover all costs associated with the building on a proportionate occupancy basis, however there are no formal sub-leases in place and as such the arrangements have been regarded as short-term operating leases in this financial year. Without formal agreements there is no guarantee of future income and it is difficult to affirm with any certainty the lease term, and levels of rental income until this has been reconciled with the tenants. As such the PCT does not have non-cancellable agreements in place at 31 March 2013.

	2012-13 £000	2011-12 £000
Recognised as income		
Rental Revenue	**4,607**	4,484
Total	**4607**	4,484
Receivable:		
No later than one year	**3,893**	3,633
Total	**3,893**	3,633

Due to changes within the local health service economy, the full income is not expected to be received in 2013-14, therefore an onerous contract provision has been included within provisions for £824k (2011-12 £851k)

7. Employee benefits and staff numbers

7.1 Employee benefits

				Permanently employed			Other		
	Total	Admin	Programme	Total	Admin	Programme	Total	Admin	Programme
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Employee Benefits 2012-13- Gross Expenditure									
Salaries and wages	**12,807**	11,399	1,408	**4,169**	3,461	708	**8,638**	7,938	700
Social security costs	**322**	268	54	**322**	268	54	**0**	0	0
Employer Contributions to NHS BSA - Pensions Division	**503**	418	85	**503**	418	85	**0**	0	0
Other pension costs	**40**	33	7	**40**	33	7	**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	**742**	0	742	**742**	0	742	**0**	0	0
Total employee benefits	**14,414**	**12,118**	**2,296**	**5,776**	**4,180**	**1,596**	**8,638**	**7,938**	**700**
Less recoveries in respect of employee benefits (table below)	**(301)**	(125)	(176)	**(301)**	**(125)**	**(176)**	**0**	**0**	**0**
Total - Net Employee Benefits including capitalised costs	**14,113**	**11,993**	**2,120**	**5,475**	**4,055**	**1,420**	**8,638**	**7,938**	**700**
Employee costs capitalised	**0**	0	0	**0**	0	0	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**14,414**	**12,118**	**2,296**	**5,776**	**4,180**	**1,596**	**8,638**	**7,938**	**700**
Recognised as:									
Commissioning employee benefits	**14,414**			**5,776**			**8,638**		
Provider employee benefits	**0**			**0**			**0**		
Gross Employee Benefits excluding capitalised costs	**14,414**			**5,776**			**8,638**		

				Permanently employed			Other		
	Total	Admin	Programme	Total	Admin	Programme	Total	Admin	Programme
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Employee Benefits 2012-13 - Revenue									
Salaries and wages	**149**	100	49	**149**	100	49	**0**	0	0
Social Security costs	**15**	10	5	**15**	10	5	**0**	0	0
Employer Contributions to NHS BSA - Pensions Division	**22**	15	7	**22**	15	7	**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	**115**	0	115	**115**	0	115	**0**	0	0
TOTAL excluding capitalised costs	**301**	**125**	**176**	**301**	**125**	**176**	**0**	**0**	**0**

Employee Benefits - Prior- year

	Total	Permanently employed	Other
	£000	£000	£000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	**9,889**	6,880	3,009
Social security costs	**416**	290	126
Employer Contributions to NHS BSA - Pensions Division	**658**	459	199
Other pension costs	**57**	57	0
Other post-employment benefits	**0**	0	0
Other employment benefits	**0**	0	0
Termination benefits	**378**	378	0
Total gross employee benefits	**11,398**	**8,064**	**3,334**
Less recoveries in respect of employee benefits	**(650)**	(650)	0
Total - Net Employee Benefits including capitalised costs	**10,748**	**7,414**	**3,334**
Employee costs capitalised	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**11,398**	**8,064**	**3,334**
Recognised as:			
Commissioning employee benefits	**11,398**		
Provider employee benefits	**0**		
Gross Employee Benefits excluding capitalised costs	**11,398**		

7.2 Staff Numbers

	2012-13			2011-12		
	Total	**Permanently employed**	**Other**	**Total**	**Permanently employed**	**Other**
	Number	**Number**	**Number**	**Number**	**Number**	**Number**
Average Staff Numbers						
Medical and dental	**3**	2	1	**2**	2	0
Administration and estates	**118**	96	22	**132**	113	19
Nursing, midwifery and health visiting staff	**1**	1	0	**1**	1	0
Scientific, therapeutic and technical staff	**4**	4	0	**9**	9	0
Other	**3**	3	0	**8**	8	0
TOTAL	**129**	**106**	**23**	**152**	**133**	**19**
Of the above - staff engaged on capital projects	**0**	0	0	**0**	0	0

7.3 Exit Packages agreed during 2012-13

Exit package cost band (including any special payment element)	2012-13 Number of compulsory redundancies	2012-13 Number of other departures agreed	2012-13 Total number of exit packages by cost band	2011-12 Number of compulsory redundancies	2011-12 Number of other departures agreed	2011-12 Total number of exit packages by cost band
	Number	Number	Number	Number	Number	Number
Less than £10,000	**1**	**1**	**2**	0	1	**1**
£10,001-£25,000	**2**	**1**	**3**	0	1	**1**
£25,001-£50,000	**1**	**2**	**3**	0	4	**4**
£50,001-£100,000	**4**	**1**	**5**	0	1	**1**
£100,001 - £150,000	**0**	**0**	**0**	0	1	**1**
£150,001 - £200,000	**0**	**0**	**0**	0	0	**0**
>£200,000	**0**	**1**	**1**	0	0	**0**
Total number of exit packages by type	**8**	**6**	**14**	**0**	**8**	**8**
	£	**£**	**£**	**£**	**£**	**£**
Total resource cost	376,146	366,109	**742,255**	0	378,000	**378,000**

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Agenda for Change Handbook Section 16. 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.

The termination benefits of other departures agreed relate to payments made to staff who successfully applied for Voluntary Redundancy under a scheme run in line with the NHS Agenda for Change terms and conditions. The scheme was time limited and had HM Treasury approval.

Peterborough City Council contributed £115k towards the costs of departure for the Public Health Director which is not reflected in the costs shown above. This was because, historically, Peterborough PCT and the City Council worked in partnership on Public Health issues and there was an informal agreement that the City Council would pay a share of the departure costs of the Public Health Director.

This disclosure reports the number and value of exit packages agreed with staff leaving in the year.

7.4 Pension costs

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

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM required 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 the valuation data as at 31 March 2012, updated to 31 March 2013 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.
The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.
The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.
The next formal valuation to be used for funding purposes will be carried out as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions
The NHS Pension Scheme provides 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 AVCs run by the Scheme’s approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

7.4.1 Cambridgeshire Local Government Pension Scheme

Peterborough City Council Adult Social services former staff that transferred to the PCT under TUPE arrangements have remained part of the Cambridgeshire Local Government Pension Fund (CLGPF) unless they exercised the option to transfer to the NHS Superannuation Scheme. The transferred staff continue to contribute to the CLGPF with the PCT continuing to pay employer's contribution into the scheme.

On 29th February 2012 the PCT transferred staff under TUPE arrangements to Cambridgeshire Community Services and Peterborough City Council. Some of these staff were members of the CLGPF. The terms of the transfer were such that the liabilities associated with these staff were fully funded by the PCT in that assets equal to the value of the liabilities, calculated by the projected unit credit method of valuation as required by IAS19, have been allocated and transferred to the successor organisations. The PCT has therefore retained the liabilities of staff who remain employees of the PCT and those who have already retired or deferred their pension rights. The assets available to cover those liabilities are those remaining after funding the liabilities of the transferred staff.

The liability arising from the CLGPF is believed to have crystallised as at 1st April 2013 following the transfer to the Department of Health. The liability as at 31st March 2013 has however been accounted for on a going concern basis. The financial impact of crystallisation will be recognised by the Department of Health.

The fund provides defined benefits relating to pay and service and the contribution rate is determined by the Fund's actuary based on triennial actuarial valuations. The last review took place as at 31 March 2010 and concluded the fund was in deficit and that increased contribution rates would be required to meet the cost of further benefit accrual.

For 2012-13 the employer's contribution rate was 14% and the employer's contribution to the fund was £64k (2011-12: £52k).
The proposed contribution rate put forward by the actuaries is 14% for 2013-14.

The inflation assumption has been derived by considering the difference in gross redemption yields of traditional and index-linked gilt-edged securities as at 31 March 2013. Salary increases are assumed to be 1% in line with the assumption used in the latest formal valuation of the fund. The discount rate employed for the 2012-13 financial year is the yield available on long-dates, high quality corporate bonds (as measured by the yield on Iboxx Sterling Corporate Index, AA over 15 years), at the IAS19 valuation date.

For the purposes of calculating the IAS19 disclosures at 31 March 2013, the actuary (Hymans Robertson) has included an assumption for the effect of 25% of future retirement members electing to exchange up to HMRC limits of their LGPS pension for additional tax free cash at retirement, as permitted by the change in LGPS regulations effective from April 2006 and also for life expectancy improvements based on the PMA/PFA92 table projected to calendar year 2017.

An allowance is included for future retirements to elect to take 25% of the maximum additional tax -free cash up to HMRC limits for pre-April 2008 service and 63% of the maximum tax-free cash for post-April 2008 service.

7.4 Pension Costs (continued)

7.4.1 Cambridgeshire Local Government Pension Scheme (continued)

The assets of the scheme have been calculated at market value and the liabilities calculated using the following principal actuarial assumptions. These are included in the IAS 19 actuarial report as at 31 March 2012.

	31 March 2013	31 March 2012
	% pa	% pa
Inflation / Pension Increase rate	2.8	2.5
Salary Increases	5.1	4.8
Expected Return on assets	4.5	5.5
Discount rate	4.5	4.8

Under IAS 19 the rate used to discount scheme liabilities is based on corporate bond yields.

Mortality

Life expectancy is based on the SAPs year of birth tables with improvements from 2007 in line with the Medium cohort and a 1% p.a. underpin.
The mortality assumptions at 31 March 2013 imply the following life expectancies at age 65:

	Males	**Females**
Current pensioners	21	23.8
Future pensioners	22.9	25.7

The assets in the scheme and the expected rate of return were:

	At 31 March 2013		At 31 March 2012	
	Long-term rate of return	**Value**	Long-term rate of return	Value
	%	**£000**	%	£000
Equities	**4.5**	**2,839**	6.3	2,546
Bonds	**4.5**	**561**	3.3	480
Property	**4.5**	**262**	4.4	295
Cash	**4.5**	**75**	3.5	369
Total		**3,737**		3,690

Investment Returns

The return on the Fund in market value terms for the year to 31 March 2013 is estimated based on actual fund returns as provided by the Administering Authority and index returns where necessary. Details are given below:

Actual return for the period from 1 April 2012 to 31 December 2012	5.40%
Estimated return for the year from 1 April 2012 to 31 March 2013	15.00%

Reconciliation of opening and closing balances of present value of scheme liabilities

	31 March 2013 £000	31 March 2012 £000
Scheme liabilities at start of the year	**13,018**	15,872
Merger adjustment	**0**	(2,152)
Restated liabilities	**13,018**	13,720
Current Service Cost	**30**	50
Interest Cost	**616**	744
Contributions by scheme participants	**10**	17
Actuarial losses/(gains)	**1,279**	(604)
Losses on curtailments	**144**	0
Liabilities extinguished on settlement	**0**	0
Benefits paid	**(540)**	(943)
Curtailments	**0**	26
Past service gain	**0**	8
Scheme liabilities at the end of the year	**14,557**	13,018

Reconciliation of opening and closing balances of fair value of scheme assets

	31 March 2013 £000	31 March 2012 £000

Scheme assets at start of the year	**3,690**	11,296
Merger adjustment	**0**	(1,555)
Restated assets as at 1 April 2011	**3,690**	9,741
Expected return on scheme assets	**190**	503
Actuarial gains / (losses)	**323**	(303)
Employer contributions	**64**	52
Contributions by scheme participants	**10**	16
Assets distributed on settlement	**0**	(5,375)
Benefits paid to members	**(540)**	(944)
Scheme assets at the end of the year	**3,737**	3,690
Net Pension Scheme Liability	**(10,820)**	**(9,328)**

Amounts Recognised

	31 March 2013 £000	31 March 2012 £000
Other Costs		
Past Service gain/(cost)	**0**	8
Current Service Cost	**30**	50
Finance Costs		
Interest Cost	**616**	744
Expected return on plan assets	**(190)**	(503)
	426	241

For the purposes of reporting under IAS19, the liabilities of the PCT have been valued using the prevailing IAS 19 financial assumptions as at 31 March 2013.

The net Actuarial (Loss) Gain of (£956k) (2011-12: £301k) is recognised in the general fund and presented as an item of Other Comprehensive Net Expenditure.

IAS 19 requires a five year history to be shown disclosing the present value of the scheme liabilities, the fair value of the scheme assets and the surplus or deficit in the scheme. As noted above, the IAS 19 accounting entries have been restated where appropriate in accordance with merger accounting requirements. It is not considered practicable to determine a five year history on this basis. A three year history is given as follows:

Amounts for the Current and Previous Accounting Periods

	31 March 2013	**31 March 2012**	31 March 2011
	£000	**£000**	£000
Fair Value of Plan Assets	**3,737**	**3,690**	11,296
Present Value of Defined Benefit Obligation	**(14,557)**	**(13,018)**	(15,872)
Deficit	**(10,820)**	**(9,328)**	(4,576)
Experience Gains / (Losses) on Assets	**323**	**(303)**	(1,829)
Experience (Losses) / Gains on Liabilities	**(1,279)**	**604**	3,575

The cumulative net actuarial loss recognised in the General Fund is (£5,359k), (2011-12: (£4,403k)).

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	**9,545**	**54,277**	11,862	44,650
Total Non-NHS Trade Invoices Paid Within Target	**8,882**	**51,689**	10,854	41,956
Percentage of NHS Trade Invoices Paid Within Target	93.05%	95.23%	91.50%	93.97%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,500**	**188,074**	2,466	174,132
Total NHS Trade Invoices Paid Within Target	**2,321**	**186,465**	2,376	173,264
Percentage of NHS Trade Invoices Paid Within Target	92.84%	99.14%	96.35%	99.50%

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

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

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

9. Investment Income

The PCT has no investment income (2011-12: none).

10. Other Gains and Losses

The PCT has no Other Gains and Losses (2011-12: none).

11. Finance Costs

	2012-13	**2012-13**	**2012-13**	2011-12
	Total	**Admin**	**Programme**	
	£000	**£000**	**£000**	£000
Interest				
Interest on obligations under PFI contracts:				
- main finance cost	**1,577**	**0**	**1,577**	1,615
- contingent finance cost	**369**	**0**	**369**	271
Total interest expense	**1,946**	**0**	**1,946**	**1,886**
Other finance costs	**426**	**0**	**426**	241
Provisions - unwinding of discount	**11**		**11**	5
Total	**2,383**	**0**	**2,383**	**2,132**

Interest obligations under PFI contracts of £1,946k (2011-12: £1,886k) are cash payments and no accruals have been made.

12.1 Property, plant and equipment

2012-13	Land	Buildings excluding dwellings	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000
Cost or valuation:						
At 1 April 2012	**4,335**	**33,210**	**848**	**2,484**	**1,408**	**42,285**
Additions Purchased	0	0	0	200	0	**200**
Upward revaluation/positive indexation	0	50	0	0	0	**50**
Impairments/negative indexation	0	(58)	0	0	0	**(58)**
At 31 March 2013	**4,335**	**33,202**	**848**	**2,684**	**1,408**	**42,477**
Depreciation						
At 1 April 2012	**1,280**	**8,769**	**659**	**2,076**	**641**	**13,425**
Impairments - charged to operating expenses	145	35	51	57	0	**288**
Charged During the Year	0	709	41	215	121	**1,086**
At 31 March 2013	**1,425**	**9,513**	**751**	**2,348**	**762**	**14,799**
Net Book Value at 31 March 2013	**2,910**	**23,689**	**97**	**336**	**646**	**27,678**
Purchased	2,910	23,689	97	336	646	**27,678**
Total at 31 March 2013	**2,910**	**23,689**	**97**	**336**	**646**	**27,678**
Asset financing:						
Owned	910	2,949	57	261	69	**4,246**
On-SOFP PFI contracts	2,000	20,740	40	75	577	**23,432**
Total at 31 March 2013	**2,910**	**23,689**	**97**	**336**	**646**	**27,678**

Within Buildings the PCT holds a PFI asset, the City Care Centre, at a value of £20,740k (2011-12: £21,240k). The PCT has legal title to the asset, but the asset is not used by the PCT, but rather, it is let out to Provider Organisations for the provision of healthcare services.

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Plant & machinery	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	**692**	**4,989**	**(20)**	**0**	**665**	**6,326**
Reclassifications/transfers	(253)	898	20	0	(665)	**0**
In year revaluation	0	(8)	0	0	0	**(8)**
Review of balances	(121)	(369)	0	0	0	**(490)**
At 31 March 2013	**318**	**5,510**	**0**	**0**	**0**	**5,828**

A review of the revaluation reserve in 2012/13 identified some historic misclassifications within the revaluation reserve and also some balances relating to assets no longer owned by the PCT. The relevant balances have been transferred to the I and E reserve (£490K) as shown on the Statement of Changes in Taxpayers Equity.

12.2 Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	**£000**
Cost or valuation:						
At 1 April 2011	**4,361**	**30,947**	**835**	**2,421**	**1,383**	**39,947**
Additions - purchased	0	28	13	63	25	**129**
Disposals sold	(26)	(130)	0	0	0	**(156)**
Upward Revaluation/positive indexation	0	2,367	0	0	0	**2,367**
Impairments/negative indexation	0	(2)	0	0	0	**(2)**
At 31 March 2012	**4,335**	**33,210**	**848**	**2,484**	**1,408**	**42,285**
Depreciation						
At 1 April 2011	**1,280**	**7,978**	**600**	**1,862**	**492**	**12,212**
Disposals sold	0	(31)	0	0	0	**(31)**
Impairments charged to operating expenses	0	0	0	0	23	**23**
Charged During the Year	0	822	59	214	126	**1,221**
At 31 March 2012	**1,280**	**8,769**	**659**	**2,076**	**641**	**13,425**
Net Book Value at 31 March 2012	**3,055**	**24,441**	**189**	**408**	**767**	**28,860**
Purchased	3,055	24,441	189	408	767	**28,860**
At 31 March 2012	**3,055**	**24,441**	**189**	**408**	**767**	**28,860**
Asset financing:						
Owned	3,055	3,201	189	408	767	**7,620**
On-SOFP PFI contracts	0	21,240	0	0	0	**21,240**
At 31 March 2012	**3,055**	**24,441**	**189**	**408**	**767**	**28,860**

12.3 Property, plant and equipment

Donated Assets
The PCT has not received any donated assets in the financial year ending 31 March 2013 (2011-12: none).

Revaluation of Property Plant and Equipment

The PCT commissioned a full valuation as at 31 March 2013, carried out by the District Valuer. This valuation included a full inspection of assets. The PCT's policy is to undertake a full independent inspection and valuation every five years and desktop valuations are performed in intervening years.

The valuation has been undertaken having regard to the International Financial Reporting Standards (IFRS) as applied to the United Kingdom public sector and in accordance with HM Treasury guidance, International Valuation Standards and the requirements of the Royal Institution of Chartered Surveyors (RICS) Valuation Standards.

Specialised assets were valued using Modern Equivalent Asset Value (MEA) in accordance with directives from the Department of Health. MEA is a measure of depreciated replacement cost (DRC) which in turn is a measure of fair value under IAS 16 for specialised assets. DRC is 'the current cost of replacing an asset with its modern equivalent asset less deductions for physical deterioration and all relevant forms of obsolescence and optimisation'.

The basis of valuation formed by the District Valuer are:

Specialised operational assets, if there is no market-based evidence of fair value because of the specialised nature of the property and the item is rarely sold, except as part of a continuing business, fair value is estimated using a depreciated replacement cost approach subject to the assumption of continuing use.

Non-specialised operational assets, this equates in practice to Existing Use Value (EUV),Non-operational assets, including surplus land, are valued on the basis of Market Value, making the assumption that the property is no longer required for existing operations, which have ceased. The basis used for the valuation of non-specialised operational owner-occupied property for financial accounting purposes under IAS 16 is fair value, which is the market value subject to the assumption that the property is sold as part of the continuing enterprise in occupation.

Effect of Assets Revalued in Year

	Full Valuation	Full Valuation		**Total**
	Upwards revaluation	Downwards revaluation	Impairment	
	£000	£000	£000	**£000**
Specialised Operational Assets	50	(58)	(145)	**(153)**
Non Specialised Operational Assets		0	0	**0**
	50	**(58)**	**(145)**	**(153)**

Economic Lives of Property, Plant and Equipment

The PCT has assessed the useful economic lives of its property, plant and equipment to be as follows:

	Min Life (Years) 2012-13	**Max Life (Years) 2012-13**
Property, Plant and Equipment		
Buildings exc Dwellings	**5**	**65**
Plant and Machinery	**5**	**15**
Information Technology	**5**	**10**
Furniture and Fittings	**5**	**10**

Change to Asset Lives

The PCT has made no changes to the asset lives of Leasehold Assets in the financial year to 31 March 2013 (2011-12: none).

Compensation from Third parties

The PCT has received an increase of £288,000 in its resource limit for assets impaired in the financial year to 31 March 2013 (2011-12: none).

13.1 Intangible assets

2012-13	Software purchased	Total
	£000	£000
Cost or Valuation:		
At 1 April 2012	**48**	**48**
At 31 March 2013	**48**	**48**
Amortisation		
At 1 April 2012	**46**	**46**
Charged during the year	1	**1**
At 31 March 2013	**47**	**47**
Net Book Value at 31 March 2013	**1**	**1**
Net Book Value at 31 March 2013 comprises		
Purchased	1	**1**
Total at 31 March 2013	**1**	**1**

2011-12	Software purchased	Total
	£000	£000
Cost or Valuation:		
At 1 April 2011	48	**48**
At 31 March 2012	**48**	**48**
Amortisation		
At 1 April 2011	45	**45**
Charged during the year	1	**1**
At 31 March 2012	**46**	**46**
Net Book Value at 31 March 2012	**2**	**2**
Net Book Value at 31 March 2012 comprises		
Purchased	2	**2**
Total at 31 March 2012	**2**	**2**

13.2 Intangible assets

The PCT has assessed the useful economic lives of its Intangible Assets to be as follows:

Intangible Assets	Min Life (Years)	Max Life (Years)
Software Licences	1	5
Licences and Trademarks	5	5

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

	2012-13 Total	**2012-13 Admin**	**2012-13 Programme**
	£000	**£000**	**£000**
Property, Plant and Equipment impairments and reversals taken to SoCNE			
Assets previously disposed of	143	0	143
Changes in market price	145	0	145
Total charged to Annually Managed Expenditure	**288**	**0**	**288**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Assets previously disposed of	51	0	51
Changes in market price	7	0	7
Total impairments for PPE charged to reserves	**58**	**0**	**58**
Total Impairments of Property, Plant and Equipment	**346**	**0**	**346**
Total Impairments charged to Revaluation Reserve	58	0	58
Total Impairments charged to SoCNE - DEL	0	0	0
Total Impairments charged to SoCNE - AME	288	0	288
Overall Total Impairments	**346**	**0**	**346**

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.

15 Investment property

The PCT does not hold any investment properties (2011-12: none).

16 Capital Commitments

The PCT does not have any capital commitments at the Statement of Financial Position date (2011-12: none).

17 Intra-Government and other balances

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with other Central Government Bodies	589	0	2,308	0
Balances with Local Authorities	1,308	0	147	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	1,277	0	2,223	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	655	0	11,732	0
At 31 March 2013	**3,829**	**0**	**16,410**	**0**
prior period:				
Balances with other Central Government Bodies	855	0	2,327	0
Balances with Local Authorities	0	0	397	0
Balances with NHS Trusts and Foundation Trusts	1,319	0	3,296	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	10,848	0	16,527	0
At 31 March 2012	**13,022**	**0**	**22,547**	**0**

Peterborough PCT - Annual Accounts 2012-13

18 Inventories	**Other**	**Total**
	£000	**£000**
Balance at 1 April 2012	**27**	**27**
Additions	**0**	**0**
Inventories recognised as an expense in the period	**(27)**	**(27)**
Balance at 31 March 2013	**0**	**0**

19.1 Trade and other receivables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
NHS receivables - revenue	**1,633**	2,173	**0**	0
NHS prepayments and accrued income	**0**	1	**0**	0
Non-NHS receivables - revenue	**1,465**	7,369	**0**	0
Non-NHS prepayments and accrued income	**560**	912	**0**	0
Provision for the impairment of receivables	**(38)**	(335)	**0**	0
VAT	**209**	295	**0**	0
Other receivables	**0**	2,607	**0**	0
Total	**3,829**	13,022	**0**	0
Total current and non-current	**3,829**	13,022		
Included above:				
Prepaid pensions contributions	**0**	0		

The majority of the PCT's business is with other Primary Care Trusts, NHS Trusts and central and local government organisations. As these are public sector organisations funded to a large extent by Government, no credit scoring of them is considered necessary.
£209,000 (2011-12: £295,000) of the balance relates to VAT due from HM Revenue and Customs for which a credit scoring is not considered necessary.

19.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	**1,399**	297
By three to six months	**3**	0
By more than six months	**0**	5
Total	**1,402**	302

19.3 Provision for impairment of receivables

	2012-13 £000	**2011-12 £000**
Balance at 1 April 2012	**(335)**	(1,855)
Amount written off during the year	**219**	1,511
Amount recovered during the year	**116**	0
(Increase)/decrease in receivables impaired	**(38)**	9
Balance at 31 March 2013	**(38)**	(335)

20 Other financial assets

The PCT does not hold any other financial assets (2011-12: none).

21 Other current assets

The PCT does not hold any other current assets (2011-12: none).

22 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**11**	4,389
Net change in year	**46**	(4,378)
Closing balance	**57**	11
Made up of		
Cash with Government Banking Service	**29**	8
Commercial banks	**0**	0
Cash in hand	**28**	3
Cash and cash equivalents as in statement of cash flows	**57**	11
Patients' money held by the PCT, not included above	**0**	859

The stewardship of patients' monies transferred to Peterborough City Council during 2012-13. This followed the transfer of the Adult Social Care service in 2011-12.

23 Non-current assets held for sale

The PCT does not hold any non-current assets for sale (2011-12: none).

24 Trade and other payables

	Current	
	31 March 2013	31 March 2012
	£000	£000
NHS payables - revenue	**4,499**	5,623
Non-NHS payables - revenue	**1,045**	3,803
Non-NHS payables - capital	**0**	13
Non-NHS accruals and deferred income	**10,827**	11,018
Social security costs	**2**	56
Tax	**2**	66
Other	**35**	1,968
Total	**16,410**	22,547
Total payables	**16,410**	**22,547**

There are no non-current payables (2011-12: none).
Other payables includes £19k (2011-12: £715k) in respect of outstanding pension contributions at 31 March 2013.
Non-NHS accruals and deferred income includes £388k for liabilities for early retirements (2011-12: none).

25 Other liabilities

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Pension Liability	**0**	0	**10,820**	9,328
Total	**0**	0	**10,820**	9,328

Total other liabilities (current and non-current)	**10,820**	9,328

The amount disclosed as non-current above relates to the liability due to the Local Government Pension Scheme, details of which are set out in note 7.4. This will transfer to the Department of Health on 1st April 2013 and at the time of preparing these accounts it is unknown if this amount may become payable within one year.

26 Borrowings

	Current		Non-current	
	31 March	31 March	**31 March**	31 March

	2013	2012	2013	2012
	£000	£000	£000	£000
PFI liabilities:				
Main liability	418	390	22,175	22,593
Total	**418**	390	**22,175**	22,593
Total borrowings (current and non-current)	**22,593**	22,983		

27 Other financial liabilities

The PCT does not have any other financial liabilities.

28 Deferred income

The PCT does not have any deferred income (2011-12: none).

29 Finance lease obligations

The PCT has only one finance lease obligation which relates to the City Care Centre under the PFI scheme of which more details are provided in note 32. The lease is for a period of 34 years and will cease in 2043.

The PCT has no other Finance Lease obligations other than disclosed in Note 32.

The obligation relating to the City Care Centre finance lease will transfer on 1 April 2013 to NHS Property Company Ltd.

30 Provisions

	Total £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Restructurin g £000s	Continuing Care £000s	Other £000s
Balance at 1 April 2012	**2,564**	0	119	851	527	1,067
Arising During the Year	**2,954**	22	16	567	2,329	20
Utilised During the Year	**(842)**	(3)	(43)	(594)	(188)	(14)
Reversed Unused	**(878)**	0	(62)	0	(339)	(477)
Unwinding of Discount	**11**	0	0	0	0	11
Change in Discount Rate	**30**	0	0	0	0	30
Balance at 31 March 2013	**3,839**	**19**	**30**	**824**	**2,329**	**637**
Expected Timing of Cash Flows:						
No Later than One Year	**3,335**	**3**	**30**	**824**	**2,329**	**149**
Later than One Year and not later than Five Years	**165**	**15**	**0**	**0**	**0**	**150**
Later than Five Years	**339**	**1**	**0**	**0**	**0**	**338**

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at 31 March 2013	3,416
As at 31 March 2012	352

Pensions Relating to Other Staff

There is a provision for the capitalisation of early retirements of £19k (2011-12 none) for one employee who retired before 6 March 1995.
The provision decreases on a yearly basis by the amount paid out to the former employee.

Legal Claims

The PCT has made provision of £30k (2011-12: £80k) for three (2011-12: eight) employee liability claims as notified by the NHS Litigation Authority (NHSLA).
In 2011-12 the PCT also made provision of £39k for other legal claims which were not covered by the NHSLA scheme.

Restructuring

A provision of £824k (2011-12:£851k) has been made for onerous contracts relating to rental income contracts for the City Care Centre.

In assessing assets and liabilities the PCT have concluded that due to temporary vacancies within the City Care Centre, the costs of the PFI contract are not fully recoverable over the next two years and therefore this represents an onerous contract.

Continuing Care

On 15th March 2012 the Department of Health announced the introduction of deadlines for individuals to request an assessment of eligibility for NHS Continuing Healthcare funding for cases during the period 1 April 2004 - 31 March 2012. The PCT invited requests from individuals or their representatives to notify NHS Peterborough in respect of previously un-assessed periods of time where there is evidence that they should have been assessed for eligibility for NHS Continuing Healthcare funding.

The time periods for notifying Peterborough PCT were as follows:

Period	Deadline
1 April 2004-31 March 2011	30 September 2012
1 April 2011- 31 March 2012	31 March 2013

For the period April 2004 to March 2011 Peterborough PCT received 148 notifications of intention to make a claim. In the majority of instances the PCT has not been able to perform a full assessment and make an accurate estimate of the likely outcome of claims on an individual basis due to insufficient information and time constraints. The PCT has made a best estimate based on the information available and has employed a range of assumptions in order to calculate the provision at 31 March 2013.

After 28 weeks 75 of the potential claimants have failed to produce sufficient information to progress the claim further and make an accurate assessment of the potential liability. The PCT has assessed the likelihood of these claims becoming payable to be between 5% and 15% based on historical knowledge within the Continuing Healthcare (CHC) team and the length of time that has elapsed since the original claim was made without further information being provided. Assumed probability rates and the average cost of similar settled cases over a 2 year period has been considered in calculating a provision for the accounts. On this basis a provision of £405,447 has been included for these claimants.

73 of the claimants have produced sufficient information to progress claims and the PCT is currently accessing data such as medical and care home records in order to fully assess these claims. On the basis of historical knowledge within the Continuing Healthcare (CHC) team of the likely success of claimants the PCT has assumed a 65% success rate for residential home claims and 75% for nursing home claims. Assumed probability rates and the average cost of similar settled cases over a 2 year period has been considered in calculating a provision for the accounts. On this basis a provision has been included in the accounts for £1,839,362 for these claimants

For the period April 2011 to March 2012 14 claims were received. As the closing date for notification of claims was 31 March 2013 it has not been possible to assess any claims received. Based on the likelihood of previous claims above and the maximum total claim possible a provision has been included for £84,175.

Continuing Care Sensitivity

The eventual outturn on claims could vary from that estimated due to either variance in the average cost of successful claims, or in the proportion of claims that are successfully upheld. In order to show the possible impact of this we have included sensitivity analysis below of a range of possible outcomes due to a combination of the areas of uncertainty above.

	Provision per accounts	10% Decrease	20% Decrease	10% Increase	20% Increase
	£'000	£'000	£'000	£'000	£'000
Total	£2,329	£2,096	£1,863	£2,562	£2,795
Movement	-	(£233)	(£466)	£233	£466

Other Provisions
Provision has been made for the Injury Benefit of two employees totalling £513k (2011-12: £521k).
£124k (2011-12: £272k) has been provided for the loss of profit for the premature ending of a GP contract resulting from a change in service provision.
The PCT has a responsibility to reimburse the GP for these costs.
In 2011-12 the PCT also made provision of £216k for the dilapidation of properties and a provision of £58k in relation to a claim against the PCT by an employee.

31 Contingencies

Contingent Liability

Continuing Care

As explained in Note 30, requests for assessments of Continuing Care liabilities have been received by the PCT and this is a key area of uncertainty. Due to the inherent limitations in assessing the outcome of claims it is deemed necessary to disclose a contingent liability in regards to the potential cost that may be incurred over and above the provision that cannot be quantified.

32 PFI - additional information

The PCT has one PFI scheme operating under the name of the City Care Centre (CCC) and is part of a £335m Greater Peterborough Health Investment Project (GPHIP) managed by Peterborough (Progress Health) plc (Project Company).

The CCC is built on the Fenland Wing at Peterborough District Hospital and opened in April 2009.

The PCT runs the CCC although a number of organisations provide services from the building. The services include:

- Walk-in Centre and Out of Hours service
- Outpatient Clinics:

  (pain management, musculo-skeletal assessment and treatment, audiology, neurology, dermatology)
- Intermediate Care
- Children's services

The PFI scheme is for a period of 34 years and the centre provides world class health care facilities fit for the 21st century. The PCT is contracted to pay an annual service payment that is adjusted for Retail Prices Indices and Return on Equity that may be adjusted from time to time. The annual service payment is also subject to market and value testing following a market test for the services or a benchmarking exercise.

Both the Project Company and the PCT has rights and obligations to indemnify each other for such things as death or personal injuries, physical damage to any assets or property. Full details are available in the project agreement dated 4 July 2007 including:

· Rights to use specified assets

· Obligations to provide or rights to expect provision of services

· Obligations to acquire or build items of property, plant and equipment

· Obligations to deliver or rights to receive specified assets at the end of the contract period

· Renewal and termination options

- Other rights and obligations

32.1 Charges to operating expenditure and future commitments in respect of on SOFP PFI

The total charged in the year to expenditure in respect of on Statement of Financial Position PFI contracts and the service element of on Statement of Financial Position PFI contracts was £1,243k (2011-12: £1,307k). This includes £5k for lifecycle maintenance costs (2011-12: £15k).

	31 March 2013	31 March 2012
	£000	£000
Service element of on SOFP PFI charged to operating expenses in year	**1,243**	1,307
Total	**1,243**	**1,307**
Payments committed to in respect of on SOFP PFI and the service element of on SOFP PFI		
No Later than One Year	**1,334**	1,292
Later than One Year, No Later than Five Years	**5,676**	5,500
Later than Five Years	**50,852**	51,963
Total	**57,862**	58,755

The annual payment increases by the rate of Retail Prices Indices.

32.2 Imputed "finance lease" obligations for on SOFP PFI contracts due		
Analysed by when PFI payments are due		
No Later than One Year	**1,967**	1,966
Later than One Year, No Later than Five Years	**7,585**	7,699
Later than Five Years	**42,453**	44,306
Subtotal	**52,005**	53,971
Less: Interest Element	**(29,412)**	(30,988)
Total	**22,593**	22,983

Contingent rents recognised as an expense £356k (2011-12: £271k).

The total future minimum lease payments are £52.005m (2011-12: £53.971m) which reconciles to the total outstanding payable of £22.593m (2011-12: £22.983m) and the future interest charges of £29.412m (2011-12: £30.988m)

Future sublease payments expected to be received total £3,893k (2011-12: £3,633k). These leases are cancellable in their current form.

33 Impact of IFRS treatment - 2012-13

	Total £000	Admin £000	Programme £000
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (PFI)			
Depreciation charges	**499**	0	499
Interest Expense	**1,932**	0	1,932
Impairment charge - AME	**0**		0
Impairment charge - DEL	**0**	0	0
Other Expenditure	**1,257**	0	1,257
Revenue Receivable from subleasing	**(3,404)**	0	(3,404)
Total IFRS Expenditure (IFRIC12)	**284**	**0**	**284**
Revenue consequences of PFI schemes under UK GAAP / ESA95 (net of any sublease income)	**(174)**	0	(174)
Net IFRS change (IFRIC12)	**110**	**0**	**110**
Capital Consequences of IFRS : PFI and other items under IFRIC12			
Capital expenditure 2012-13	0		
UK GAAP capital expenditure 2012-13 (Reversionary Interest)	0		

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 than 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.
The PCT is effectively exposed to interest rate risk on its PFI liabilities insofar as the Unitary Payment is subject to annual indexation and the part of this uplift allocated to the lease element is accounted for as a contingent finance cost.

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.

The PCT's main long term liability is its PFI obligation, with the contract ending in 2043. Further information on the commitments under this contract are provided in note 32.

34.1 Financial Assets

	Loans and receivables £000	Total £000
Receivables - NHS	1,633	**1,633**
Receivables - non-NHS	2,196	**2,196**
Cash at bank and in hand	57	**57**
Total at 31 March 2013	**3,886**	**3,886**
Receivables - NHS	2,173	**2,173**
Receivables - non-NHS	10,849	**10,849**
Cash at bank and in hand	11	**11**
Total at 31 March 2012	13,033	13,033

34.2 Financial Liabilities

	Other £000	Total £000
NHS payables	4,499	**4,499**
Non-NHS payables	11,911	**11,911**
PFI & finance lease obligations	22,593	**22,593**
Other financial liabilities	10,820	**10,820**
Total at 31 March 2013	**49,823**	**49,823**
NHS payables	5,623	5,623
Non-NHS payables	16,924	16,924
PFI & finance lease obligations	22,983	22,983
Other financial liabilities	9,328	9,328
Total at 31 March 2012	54,858	54,858

35 Related party transactions

NHS Peterborough is a body corporate established by order of the Secretary of State for Health.

During the year the Board Members or members of the key management staff or parties related to them has undertaken material transactions with Peterborough Primary Care Trust as follows

Certain local GPs sit on Peterborough PCT's Shadow CCG Leadership Group (from 1st September 2012, CCG Governing Body). During the year payments were made to those General Practitioners practices, in line with the practices' role as independent contractors. The payments below were made to the practices and not to the doctors personally for services provided by those practices. In addition, there have been transactions in the ordinary course of the PCT's business with a number of provider Trusts with which Directors of the PCT are connected. Details of directors' and senior managers' remuneration are given in the Remuneration Report included in the PCT's Annual Report.

Details of related party transactions with individuals are as follows:

	2012-13			
	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party at year end	Amounts due from Related Party at year end
	£	£	£	£
Dr Richard Withers, Yaxley Group Practice	9,647	0	0	0
Dr Modha - Thistlemoor Practice	1,216,110	0	121,679	0
Total	1,225,757	0	121,679	0

	2011-12			
	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party at year end	Amounts due from Related Party at year end
	£	£	£	£
Dr Caskey - Park Medical Centre	1,072,510	7,858	99,103	0
Dr Van den Bent - North Street Medical Practice	1,757,948	0	197,901	0
Dr. Bishop - Thorpe Road Surgery	607,569	0	49,159	0

Dr. Mistry - The Thomas Walker Surgery	**956,469**	**0**	**84,285**	**0**
Dr. Panday - Lincoln Road Surgery	**1,283,503**	**0**	**130,347**	**0**
Dr Sanders - Westgate Surgery	**905,871**	**0**	**98,998**	**0**
Dr Laliwala - Ailsworth Practice	**314,800**	**0**	**26,265**	**0**
Dr Modha - Thistlemoor Practice	**1,239,870**	**0**	**109,581**	**0**
Dr Withers - Yaxley Group Practice	**45,701**	**0**	**0**	**0**
Total	**8,184,241**	**7,858**	**795,639**	**0**

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

	2012-13				
	Payments to Related Party	**Receipts from Related Party**	**Amounts owed to Related Party at year end**	**Amounts due from Related Party at year end**	**Amount due provided as doubtful at year end**
	£000	**£000**	**£000**	**£000**	**£000**
Department of Health	**1**	**137**	**0**	**24**	0
East of England Strategic Health Authority	**148**	**340**	**0**	**86**	0
West Midlands Strategic Health Authority	**0**	**143**	**0**	**23**	**0**
South Central Strategic Health Authority	**41**	**0**	**17**	**0**	**0**
Cambridgeshire PCT	**1,008**	**25**	**1,998**	**244**	**0**
Lincolnshire Teaching PCT	**0**	**40**	**0**	**1**	**0**
South East Essex PCT	**21,645**	**760**	**145**	**0**	**0**
Cambridgeshire Community Services NHS Trust	**18,641**	**1,972**	**370**	**554**	**0**
East Of England Ambulance Service NHS Trust	**7,745**	**0**	**60**	**0**	**0**
Hinchingbrooke Healthcare NHS Trust	**551**	**60**	**0**	**4**	**0**
Nottingham University Hospitals NHS Trust	**701**	**0**	**25**	**0**	**0**
The Royal National Orthopaedic Hospital NHS Trust	**175**	**0**	**50**	**0**	**0**
University Hospitals Of Leicester NHS Trust	**1,143**	**0**	**57**	**0**	**0**
Cambridge Univ Hosp NHS Foundation Trust	**5,244**	**55**	**139**	**0**	**0**
Cambridgeshire And Peterborough NHS Foundation Trust	**28,502**	**1,957**	**96**	**90**	**317**
Peterborough and Stamford Hospitals NHS Foundation Trust	**89,278**	**708**	**640**	**566**	**0**

174,823	**6,197**	**3,597**	**1,592**	**317**

	2011-12			
	Payments to Related Party	**Receipts from Related Party**	**Amounts owed to Related Party at year end**	**Amounts due from Related Party at year end**
	£000	**£000**	**£000**	**£000**
Department of Health	**4**	**63**	**9**	**16**
East of England Strategic Health Authority	**7**	**294**	**0**	**1**
West Midlands Strategic Health Authority	**0**	**184**	**0**	**19**
Cambridgeshire PCT	**692**	**43**	**2,243**	**3**
South East Essex PCT	**16,365**	**760**	**0**	**0**
Cambridgeshire Community Services NHS Trust	**19,784**	**158**	**350**	**41**
East Of England Ambulance Service NHS Trust	**7,176**	**0**	**138**	**0**
Hinchingbrooke Healthcare NHS Trust	**546**	**9**	**0**	**60**
Nottingham University Hospitals NHS Trust	**677**	**0**	**86**	**0**
University Hospitals Of Leicester NHS Trust	**1,934**	**0**	**61**	**0**
Cambridge Univ Hosp NHS Foundation Trust	**4,882**	**0**	**178**	**54**
Cambridgeshire And Peterborough NHS Foundation Trust	**29,413**	**2,413**	**538**	**510**
Papworth Hospital NHS Foundation Trust	**1,986**	**0**	**14**	**0**
Peterborough and Stamford Hospitals NHS Foundation Trust	**88,145**	**647**	**1,230**	**654**
	171,611	**4,571**	**4,847**	**1,358**

In addition, the Primary Care Trust has had a significant number of material transactions with other Government Departments and other central and local Government bodies. Most of these transactions have been with Peterborough City Council in relation to providing health support to social care.

	2012-13			
	Payments to Related Party	**Receipts from Related Party**	**Amounts owed to Related Party**	**Amounts due from Related Party**
	£000	**£000**	**£000**	**£000**
Peterborough City Council	**9,261**	**4,066**	**116**	**1,308**

Cambridgeshire County Council (Local Government Pension Scheme)	**62**	**0**	**3**	**0**

	2011-12			
	Payments to Related Party	**Receipts from Related Party**	**Amounts owed to Related Party**	**Amounts due from Related Party**
	£000	**£000**	**£000**	**£000**
Peterborough City Council	**264**	**237**	**397**	**0**
Cambridgeshire County Council	**1,160**	**0**	**89**	**0**

In conjunction with neighbouring Primary Care Trusts and other consortia Peterborough Primary Care Trust operates a system of "lead commissioning". Under this, organisations take lead responsibility for negotiating and agreeing service arrangements for a number of county wide service agreements.

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	10,739	22
Total losses	10,739	22
Total special payments	0	0
Total losses and special payments	10,739	22

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	10,671	4
Total losses	10,671	4
Total special payments	0	0
Total losses and special payments	10,671	4

Details of cases individually over £250,000
There were no cases over £250,000.

37 Third party assets

The PCT holds no third party assets at 31 March 2013. At 31 March 2012, the PCT held £859k cash and cash equivalents on behalf of patients. These transferred to Peterborough City Council during 2012-13.

38 Events after the end of the reporting period

Per Note 1, under the provisions of The Health and Social Care Act 2012 (Commencement No.4.Transitional, Savings and Transitory Provisions) Order 2013, Peterborough PCT was dissolved on 1st April 2013. The PCT's functions, assets and liabilities transferred to successor bodies as at 1st April 2013.

The commissioning of healthcare for Cambridgeshire and Peterborough patients, that was carried out by Peterborough PCT in 2012-13 are to be carried out by the following successor organisations for 2013-14:

Service	Successor organisation
General Acute	Cambridgeshire and Peterborough Clinical Commissioning Group
Community Services	Cambridgeshire and Peterborough Clinical Commissioning Group
Mental Health	Cambridgeshire and Peterborough Clinical Commissioning Group
Learning Disability services	Cambridgeshire and Peterborough Clinical Commissioning Group
Ambulance Services	Cambridgeshire and Peterborough Clinical Commissioning Group
Public Health Services	Peterborough City Council
Sexual Health	Peterborough City Council
Specialised Commissioning	NHS England
Primary Care Services	NHS England

The balance sheet entries for Peterborough PCT will transfer to the following organisations:

Asset/Liability	Successor organisation

Non-current assets - IT related	Cambridgeshire and Peterborough Clinical Commissioning Group
Non-current assets - other	NHS Property Company Ltd and Cambridgeshire Community Services NHS Trust
PFI scheme (borrowings)	NHS Property Company Ltd
Local Government Pension Scheme Deferred Liabilities	Department of Health
Cash	Department of Health
Provisions relating to former staff	Department of Health
Provisions relating to transferred services	Cambridgeshire and Peterborough Clinical Commissioning Group
Short term debtors and creditors	Department of Health - (who it is expected will devolve responsibility to the appropriate receiving bodies.)
Revaluation reserve	NHS Property Company Ltd and Cambridgeshire Community Services NHS Trust
General Fund	The appropriate receiving body

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.

As disclosed in the Annual Governance Statement, the auditors have identified matters to report in forming their conclusion on the PCT's arrangements for securing economy, efficiency and effectiveness in the use of resources. The auditors' conclusion concerns the two criteria specified by the Audit Commission as to whether the PCT has proper arrangements for securing financial resilience and for challenging how it secures economy, efficiency and effectiveness. The ownership and robustness of the detailed QIPP plans together with the reporting processes now in place will be taken forward by the Cambridgeshire and Peterborough Clinical Commissioning Group for the purpose of achieving the cost savings targets identified for 2013/14.

Taking into account the matter set out above, 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: **Andrew Reed**

Date **7 June 2013**

STATEMENT OF RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

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

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

7 June 2013......Date...Signing Officer

7 June 2013......Date...Finance Signing Officer

REMUNERATION REPORT

Membership of Remuneration Committee

Name	Position
Robert Kynnersley (NED)	Chairman
Glen Clark	Non-Executive Director
Malcolm Burch	Non-Executive Director
Prof.Colin Coulson-Thomas	Non-Executive Director (from August 2012)
Peter Southwick	Non-Executive Director (to August 2012)

The Remuneration Committee is a joint committee with NHS Cambridgeshire.

Policy on the remuneration of senior managers

Remuneration payments made to the Non-Executive directors and Professional Executive Committee members are set nationally by the Secretary of State. The remuneration for Officer Directors is set by the Remuneration Committee, having regard to comparative salary data and the labour market. No remuneration was waived by members and no compensation was paid for loss of office outside of standard NHS terms and conditions. No payments were made to co-opted members and no payments were made for golden hellos.

Where individual national review bodies govern salaries, then the national rates of increase have been applied. Where national review bodies do not cover staff, then increases have been in line with the percentage notified by the NHS Chief Executive and approved by the Remuneration Committee. For 2012/13 this was 0.0% (2011/12 0.0%). Any increases above that limit have been on the basis of increased responsibilities or promotion.

Policy on Performance Conditions

The PCT's Remuneration Committee set standards in conjunction with the Chief Executive, who has held regular appraisals and 1:1 supervision sessions with the individuals concerned. The Chair sets individual targets for the Chief Executive based on the performance of the PCT in relation to national and local targets set out in the PCT service plans. The Remuneration Committee takes the financial circumstances of the organisation into consideration in making pay awards, as well as Advance letters advice from the Department of Health. All uplifts were discussed with and decided by the Chair and Non Executives at the Remuneration Committee, which is supported by a Human Resource (HR) professional. Middle managers receive their targets through cascade of organisational objectives with advice and support from HR. The annual cost of living uplift is decided by the Remuneration Committee.

Policy on duration of contracts, notice periods and termination payments

Senior manager contracts are subject to 3 - 6 months' contractual notice due to the time it takes to replace a senior manager. Termination payments are in accordance with NHS policy and negotiated with trades unions. Contracts, where possible, are permanent except for project work, due to the legislation giving fixed term contracts similar employment rights. During times of change the organisation resorts to fixed term contracts and secondments, but this is becoming increasingly regulated.

There was only one Senior Manager on Peterborough PCT's payroll in March 2013 as shown below:

Name	Position	Date of Contract	Unexpired term (if applicable)	Early termination terms
Andy Liggins	Director of Public Health	01/08/1994	N/A	N/A

Salary and Pension entitlements of Senior Managers (audited information)

Remuneration			2012-13			2011-12			
NHS Peterborough									
APPOINTED CLUSTER BOARD									
Name		Period	Salary (bands of £5,000)	Other Remuneration (bands of £5,000) £000	Benefits in kind (bands of £100) £00	Percentage of full cost in 11/12	Salary (bands of £5,000) £000	Other remuneration (bands of £5,000) £000	Benefits in kind (bands of £100) £00
Non-Executive Directors									
Maureen Donnelly	Chair (13%)	01/04/12 to 30/06/12	0 to 5	0	0	17%	0 to 5	0	0
John Barratt	Non-Executive Director (50%), Chair from 01/07/12	01/04/12 to 31/03/13	15 to 20	0	0	17%	0 to 5	0	0
Malcolm Burch	Non-Executive Director (50%)	01/04/12 to 31/03/13	0 to 5	0	0	83%	5 to 10	0	0
Glen Clark	Non-Executive Director (50%)	01/04/12 to 31/03/13	5 to 10	0	0	17%	0 to 5	0	0
Prof.Colin Coulson-Thomas	Non-Executive Director (50%)	01/04/12 to 31/03/13	0 to 5	0	0	83%	10 to 15	0	0
Robert Kynnersley	Non-Executive Director (50%)	01/04/12 to 31/03/13	0 to 5	0	0	17%	0 to 5	0	0
Peter Southwick	Non-Executive Director (50%)	01/04/12 to 30/11/12	0 to 5	0	0	17%	0 to 5	0	0
Sally Williams	Non-Executive Director (50%)	01/04/12 to 31/03/13	0 to 5	0	0	17%	0 to 5	0	0
Edward Libbey	Non-Executive Director (50%)	01/07/12 to 31/03/13	0 to 5	0	0	n/a	0	0	0
Rebecca Stephens	Non-Executive Director (50%)	01/08/12 to 31/03/13	0 to 5	0	0	n/a	0	0	0
Officer Members/Directors									
Dr Sushil Jathanna	Joint Chief Executive (50%)	01/04/12 to 30/09/12	55 to 60	0	0	50%	70 to 75	0	0
Sheila Bremner*	Joint Chief Executive	01/10/12 to 31/03/13	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Dr. Andy Liggins	Director of Public Health (100%)	01/04/12 to 31/03/13	85 to 90	0	14 to 15	100%	85 to 90	0	20 to 21
John Leslie	Joint Director of Finance (40%)	01/04/12 to 31/01/13	30 to 35	0	0	40%	40 to 45	0	0
Adrian Marr*	Joint Director of Finance	01/02/13 to 31/03/13	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Alan Mack	Joint Deputy Chief Executive (40%)	01/04/12 to 31/03/13	45 to 50	0	0	40%	45 to 50	0	0
Dr Liz Robin	Director of Public Health - NHSC funded	01/04/12 to 31/03/13	0	0	0	0%	0	0	0
Andy Vowles	Chief Operating Officer - NHSC funded	01/04/12 to 31/03/13	0	0	0	0%	0	0	0
Jessica Bawden	Joint Director of Communications & Public Engagement, Joint Director of Corporate Affairs w.e.f. 21.12.12 (40%)	01/04/12 to 31/03/13	30 to 35	0	0	26%	30 to 35	0	0
Dr. Christine Macleod	Joint Medical Director (40%)	01/04/12 to 31/03/13	55 to 60	0	0	40%	30 to 35	0	0
Russ Platt	Chief Operating Officer (100%)	01/04/12 to 31/08/12	45 to 50	0	0	100%	35 to 40	0	0
Jill Houghton	Joint Director of Nursing & Quality (40%)	01/04/12 to 31/03/13	40 to 45	0	0	26%	5 to 10	0	0
Sarah Shuttlewood	Director of Acute Commissioning (100%)	01/04/12 to 31/08/12	30 to 35	0	0	100%	75 to 80	0	7 to 8
		Highest paid	85 to 90				85 to 90		
		Median	£30,957				£32,014		
		Ratio	2.83				2.73		

1.0 From 1 December 2011, the NHS Peterborough and NHS Cambridgeshire Cluster Board was established to carry out the business of both Peterborough and Cambridge PCTs.

1.1 The percentages shown against individuals represent the percentage of the total cost of employing that senior member in 2012/13 that is attributable to NHS Peterborough and the values represent the cost to NHS Peterborough.

1.2 Where recharges have occurred, the cost of individuals is based upon the percentage value of time allocated to each PCT.

1.3 * in accordance with national guidance, the salary costs of the Local Area Office staff have continued to be met in full by their employer, rather than be accounted for in part by Peterborough PCT, so they are not disclosed in table 1 of this remuneration report.

1.4 The Appointed Executive Directors and Non-Executive directors for the Cluster Board are shown in the table below with the full cost of each shared individual.

1.5 Dr. Andy Liggins departure costs are not included in other remuneration because he took early retirement and as such received no other remuneration from the PCT.

			2012-13			2011-12		
		Period of shared post	Annual Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in kind (Bands of £100)	Annual Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in kind (Bands of £100)
			£000	£000	£000	£000	£000	£000
Maureen Donnelly	Chair /CCG Lay Chair from 01/07/12	01/04/12 to 31/03/13	35 to 40	0	0	35 to 40	0	0
John Barratt	Non-Executive Director, Chair from 01/07/12	01/04/12 to 31/03/13	30 to 35	0	0	10 to 15	0	0
Malcolm Burch	Non-Executive Director	01/04/12 to 31/03/13	5 to 10	0	0	5 to 10	0	0
Glen Clark	Non-Executive Director /CCG Lay Member from 01/08/12	01/04/12 to 31/03/13	10 to 15	0	0	5 to 10	0	0
Prof.Colin Coulson-Thomas	Non-Executive Director	01/04/12 to 31/03/13	5 to 10	0	0	10 to 15	0	0
Robert Kynnersley	Non-Executive Director	01/04/12 to 31/03/13	5 to 10	0	0	5 to 10	0	0
Peter Southwick	Non-Executive Director	01/04/12 to 30/11/12	5 to 10	0	0	5 to 10	0	0
Sally Williams	Non-Executive Director	01/04/12 to 31/03/13	5 to 10	0	0	5 to 10	0	0
Edward Libbey	Non-Executive Director /CCG Lay Member from 01/08/12	01/07/12 to 31/03/13	5 to 10	0	0	0	0	0
Rebecca Stephens	Non-Executive Director /CCG Lay Member from 01/08/12	01/08/12 to 31/03/13	5 to 10	0	0	0	0	0
Dr Sushil Jathanna	Joint Chief Executive	01/04/12 to 30/09/12	110 to 115	60 to 65	0	140 to 145	0	0
Sheila Bremner	Joint Chief Executive	01/10/12 to 31/03/13	0	0	0	0	0	0
John Leslie	Joint Director of Finance	01/04/12 to 31/01/13	55 to 60	75 to 80	0	105 to 110	0	0
Adrian Marr	Joint Director of Finance	01/02/13 to 31/03/13	0	0	0	0	0	0
Alan Mack	Joint Director of Corporate Development & Performance	01/04/12 to 31/03/13	90 to 95	125 to 130	0	110 to 115	0	0

Jessica Bawden	Joint Director of Communications & Engagement /CCG Director Designate from 01/07/2012	01/04/12 to 31/03/13	75 to 80	0	0	75 to 80	0	0
Dr. Christine Macleod	Joint Medical Director	01/04/12 to 31/03/13	140 to 145	0	0	75 to 80	0	0
Jill Houghton	Director of Nursing & Quality /CCG Director Designate from 01/07/12	01/04/12 to 31/03/13	115 to 120	0	0 to 1	20 to 25	0	0
Dr Liz Robin	Director of Public Health - NHSC funded	01/04/12 to 31/03/13	100 to 105	0	0	100 to 105	0	0
Andy Vowles	Chief Operating Officer - NHSC funded	01/04/12 to 31/03/13	125 to 130	0	0	100 to 105	0	0

The other remuneration included above relates to exit packages. For Dr S Juthana this is still under negotiation.

A shadow CCG was created during the year with the view to taking responsibility from 2013/14 and during the transition period some individuals had dual roles.

The total cost of the individuals on the shadow CCG board is shown below (there are no prior year figures as the Board was only established in 2012/13):

Members of the Shadow CCG Board (not included above)				
Dr Simon Hambling	CCG Shadow Accountable Officer - NHSC funded	01/04/12 to 30/05/12	0 to 5	10 to 15
Dr Neil Modha	CCG Chief Clinical Officer - NHSC funded	30/05/12 to 31/03/13	70 to 75	0
Tim Woods	CCG Chief Finance Officer - NHSC funded	01/09/12 to 31/03/13	55 to 60	0
Victoria Corbishley	CCG Director of Performance and Delivery - NHSC funded	01/09/12 to 31/03/13	60 to 65	0
Harper Brown	CCG Director of Commissioning and contracting - NHSC funded	01/08/12 to 31/03/13	60 to 65	0
Dr Mike Caskey	CCG Gov Body GP Member	01/04/12 to 31/03/13	50 to 55	0
Dr Geraldine Linehan	CCG Gov Body GP Member	01/04/12 to 31/03/13	5 to 10	70 to 75
Dr Richard Withers	CCG Gov Body GP Member	01/04/12 to 31/03/13	5 to 10	25 to 30
Dr John Jones	CCG Gov Body GP Member	01/04/12 to 31/03/13	5 to 10	5 to 10
Dr David Roberts	CCG Gov Body GP Member	01/04/12 to 31/03/13	5 to 10	60 to 65
Dr David Irwin	CCG Gov Body GP Member	01/04/12 to 31/03/13	5 to 10	25 to 30
Dr Arnold Fertig	CCG Gov Body GP Member	01/04/12 to 31/03/13	5 to 10	60 to 65
Dr Andrew Wordsworth	CCG Gov Body GP Member	01/04/12 to 31/10/12	0	0
Dr Christopher Scrace	CCG Gov Body Secondary Care Member	01/12/12 to 31/03/13	5 to 10	0

Other remuneration for members of the shadow CCG Board are for attending meetings other than in their capacity on this Board.

3. 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 organisations workforce.
3.1 The banded remuneration of the highest paid director in NHS Peterborough in the financial year 2012-13 was £85k to £90k. (2011-12 £85k - £90k).
3.2 This was 2.83 times (2011-12, 2.73) the median remuneration of the workforce, which was £30,957 (2011-12, £32,014)
3.3 In 2012-13, no employees (2011-12, 3) received remuneration in excess of the highest paid director. Remuneration ranged from £5,673 to £85,113. (2011/12 - £5,673 to £114,714)
3.4 There is no significant change in the median ratio
3.5 The number of the general workforce has reduced from 122 to 99
3.6 There has been no change in the highest paid director
3.7 There is nothing to report impacting on the ratio
3.8 Total remuneration includes salary, nonconsolidated performance-related pay, benefits in kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.
3.9 The highest paid director is based on the element paid by PCT, not the employee's full salary.
4. The PCT has not waived any remuneration or paid allowances in lieu during the financial year to 31 March 2013.

Pension entitlements (audited information)	**Real increase**		**Real increase**		**Total accrued**		**Lump sum at**		**Cash**		**Cash**		**Real increase**	
Name and title	**in pension at**		**in lump sum**		**pension at age**		**age 60 related**		**Equivalent**		**Equivalent**		**in Cash**	
	age 60		**at age 60**		**60 at 31 March**		**to accrued**		**Transfer**		**Transfer**		**Equivalent**	
					2013		**pension at**		**Value at**		**Value at**		**Transfer**	
							31 March 2013		**31 March**		**31 March**		**Value**	
	(bands of		**(bands of**		**(bands of**		**(bands of**		**2013**		**2012**		**2013**	
	£2,500)		**£2,500)**		**£5,000)**		**£5,000)**							
	£000		**£000**		**£000**		**£000**		**£000**		**£000**		**£000**	

A Liggins - Director of Public Health	5 to 7.5	20 to 22.5	35 to 40	115 to 120	778	586	161
R Platt - Interim Chief Operating Officer	0 to 2.5	0 to 2.5	5 to 10	20 to 25	125	106	13
*S Shuttlewood - Director of Acute Commissioning	-0 to -2.5	-0 to -2.5	25 to 30	80 to 85	494	459	11
The following employees are employed by NHS Cambridgeshire and form part of the Cluster Board. As such their pension liabilities have been included below for completeness, but the liability is with their substantive employer and will also be disclosed in the Accounting Statements of NHS Cambridgeshire							
*Dr. S Jathanna - Joint Chief Executive	0 to 2.5	-2.5 to -5	25 to 30	60 to 65	695	621	42
Sheila Bremner - Chief Executive					0	0	0
J Leslie - Joint Director of Finance	0 to 2.5	0 to 2.5	15 to 20	50 to 55	292	265	13
Adrian Marr - Director of Finance							
Tim Woods - CCG Chief Financial Officer	0 to 2.5	0 to 2.5	45 to 50	135 to 140	897	825	29
*A Mack - Joint Director of Corporate Development & Performance	-2.5 to -5	-7.5 to -10	50 to 55	160 to 165	1205	1168	(23)
J Bawden - Joint Director of Communications & Engagement	0 to 2.5	0 to 2.5	5 to 10	15 to 20	83	67	12
*Dr. C Macleod - Joint Medical Director	-0 to -2.5	-2.5 to -5	60 to 65	180 to185	1321	1247	9
Dr Liz Robin - Director of Public Health	0 to 2.5	0 to 2.5	20 to 25	65 to 70	432	397	15
Andy Vowles - Chief Operating Officer	0 to 2.5	0 to 2.5	20 to 25	60 to 65	320	293	12
*Jill Houghton - Director of Nursing & Quality	-7.5 to -10	-20 to -22.5	35 to 40	85 to 90	706	790	(126)
Victoria Corbishley - CCG Director of Performance & Delivery			5 to 10		51	0	0
Harper Brown - CCG Director of Commissioning & Contracting	0 to 2.5	0 to 2.5	20 to 25	70 to 75	548	498	24

Figures for total pension entitlement are shown even where the Director was not in post for the whole year
*Values for real increase in pension and lump sum are negative because directors' pensionable pay is less than 2011-12.
Sheila Bremner and Adrian Marr, in their roles within the Local Area Office of the NHS Commissioning Board, were confirmed in director roles for Cambridgeshire and Peterborough PCT Cluster. In accordance with national guidance the salary costs of the Local Area Office staff have continued to be met in full by their employer, rather than accounted for in part by Peterborough PCT, so there are no pension values disclosed in the remuneration report.
Victoria Corbishley has no amounts disclosed for the real increase in pension at age 60 or against either column relating to lump sums because she is new to the pension scheme. Therefore the real increase cannot be circulated and she is not currently entitled to a lump sum.

Cash Equivalent Transfer Values
A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accumulated benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefit accrued in the former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figure

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

Real Increase in CETV

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

Independent Auditors' Report to the officer responsible for preparing the accounts of Peterborough Primary Care Trust

We have audited the financial statements of Peterborough Primary Care Trust ("the PCT") for the year ended 31 March 2013 which 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 the accounting policies directed by the Secretary of State for Health with the consent of the Treasury as relevant to the National Health Service in England set out therein.

Respective responsibilities of the officer responsible for preparing the accounts and auditors

As explained more fully in the Directors' Responsibilities Statement of set out on page 120 the officer responsible for preparing the accounts is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view in accordance with accounting policies directed by the Secretary of State, with the consent of the Treasury, as being relevant to the National Health Service in England. Our responsibility is to audit and express an opinion on the financial statements in accordance with Part II of the Audit Commission Act 1998, the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission and International Standards on Auditing (ISAs) (UK and Ireland).Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the officer responsible for preparing the accounts of Peterborough Primary Care Trust in accordance with Part II of the Audit Commission Act 1998 as set out in paragraph 45 of the Statement of Responsibilities of Auditors and of Audited Bodies (Local NHS Bodies) published by the Audit Commission in March 2010 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Scope of the audit of the financial statements

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

material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

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

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion

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

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Code of Audit Practice issued by the Audit Commission requires us to report to you if:

- in our opinion, the Governance Statement does not comply with the Department of Health's requirements set out in "2012/13 Governance Statements – Guidance " issued on 31 January 2013 or is misleading or inconsistent with information of which we are aware from our audit; or
- we refer a matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because 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.

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

Respective responsibilities of the PCT and auditors

The PCT is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the PCT has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

We report if significant matters have come to our attention which prevent us from concluding that the PCT has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the PCT's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the review of the arrangements for securing economy, efficiency and effectiveness in the use of resources

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

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

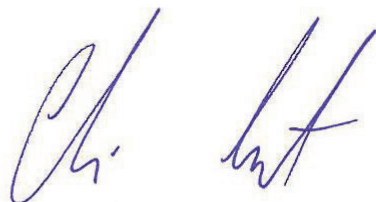
- our review of the Governance Statement;
- the work of other relevant regulatory bodies or inspectorates, to the extent that the results of this work impact on our responsibilities at the Trust; and
- our locally determined risk-based work on the PCT's governance arrangements for the demise of the PCT and review of the achievement of the PCT's savings plans and in year reporting mechanisms.

As a result, we have concluded that there are the following matters to report:

- In 2012/13 the PCT has underperformed in regards to achieving savings targets and has been reliant on the use of non-recurrent savings as well as the cancellation of £6.4 million of legacy loan to support the achievement of breakeven. The underperformance of savings targets has been a consistent theme over the past three years.
- Savings plans have not been fit for purpose and supported by robust delivery plans and have not been consistently and effectively monitored throughout the financial year.

Certificate

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



Clive Everest, Engagement Lead

For and on behalf of PricewaterhouseCoopers LLP

Appointed Auditors

Cambridge

Date: 9 June 2013

The maintenance and integrity of the Peterborough Primary Care Trust website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.

Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.