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North West Strategic Health Authority

2012-13 Annual Report and Accounts

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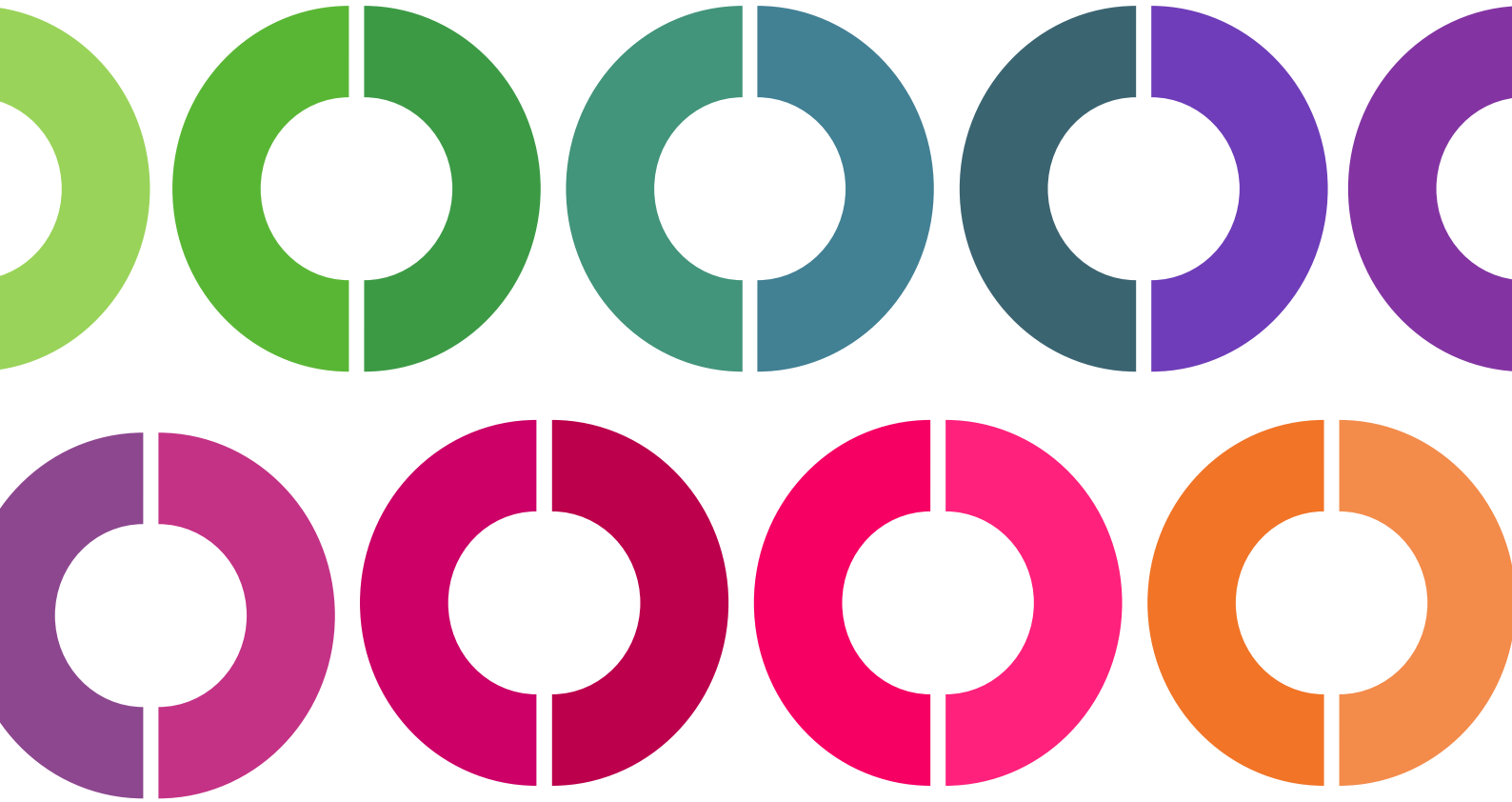
North West Strategic Health Authority

2012-13 Annual Report

NHS North West



ANNUAL REPORT
AND FINANCIAL STATEMENTS

2012/ 2013

North West Strategic Health Authority
Part of NHS North of England

2. Joint foreword from the Chair and Chief Executive

This final annual report of the three strategic health authorities (SHAs) that make up NHS North of England is an opportunity to reflect – not just over the past year, but over the whole period of the SHAs – and acknowledge the contribution we have made towards improving health and healthcare for people who live in the North of England.

NHS North East, NHS North West and NHS Yorkshire and the Humber came into being in 2006 as a result of mergers of eight smaller SHAs established in 2002. During this time we have taken the NHS through a period of growth and development in the earlier years, but also through more financial and service pressures in the last three years.

Our stewardship of the NHS through the years of our tenure has hopefully lived up to the expectations of a good farmer – another generation of caring for land! Our land was the NHS and we weathered most of the storms and tried not to let the thistles grow under our feet. We have worked it hard and sought to get the best value we could. We have also grown ideas, encouraged innovation and introduced new technology to increase productivity and efficiency. We have overseen the governance and professional standards that continuously improved the environment for our patients and endeavour to protect them from avoidable harm.

Now we hand over to the new organisations that will manage the future NHS.

Our successor bodies will continue to face the challenges of ensuring the NHS stays relevant and trusted so it is able to serve an ageing population against the rising costs of treatments and constant increases in the number of people with long-term conditions.

We hand over during the most radical period of transition the NHS has seen since its inception in 1948. A transition to a new NHS that will be ever more patient-focused and clinically-led, with its success measured by outcomes.

We feel we have achieved so much it would be invidious to pick out too many examples. Put simply, what we have done is put the people first and work with the resources given to us to create as much health and as many good health services as we could:

- We have supported the development of our providers to be amongst the best hospitals, mental health services, community teams and general practices in the country.
- We have driven health improvement and tackled health inequalities – including world class innovations like Fresh, the North East Office for Tobacco Control, the Our Life public engagement social enterprise in the North West and the award-winning Altogether Better community health champions model in Yorkshire and the Humber.
- We have encouraged the research and delivery of technical innovations across the North from telemedicine in prisons to early adoption of new cancer drugs…

…and so much more.

All this success is due to the hard work and commitment of our staff. We are genuinely grateful to everyone who has worked in the SHAs and in the NHS organisation across the North in a particularly challenging time. Staff who, despite great uncertainties in their own futures, have unfailingly shown their dedication to delivering excellence to patients and health improvements for our population.

This year has very much been a year of transition, preparing to move from old structures to the new organisations that will continue to implement the changes to the NHS set out in the Health and Social Care bill 2010.

We wish our successors all the best for the future and pass the baton to them to take the NHS in the North of England forward for the benefit of those who use it.

Kathryn Riddle
Chair
NHS North of England

Professor Stephen Singleton OBE
Interim Chief Executive
NHS North of England

About us

NHS North of England

On 3 October 2011, the three strategic health authorities (SHAs) across the north of England – NHS North East, NHS North West and NHS Yorkshire and the Humber – were placed under a single management framework and began to work together as NHS North of England – one of four SHA 'clusters' across England.

As a whole, NHS services in the North of England:

NHS North of England's area covers 126 NHS organisations and 50 local authorities, with over 380,000 NHS staff providing health and social care to over 14.7 million people, and a NHS budget of £26 billion.

Our collective aim is to ensure the delivery of safe, high quality services, providing excellent patient experience and with strong clinical outcomes during organisational changes within the NHS.

As part of NHS North of England, the three statutory SHA bodies will remain in place until the end of March 2013 and will continue to be responsible for the performance and development of the NHS across the region.

NHS North of England is led by one single executive management team:

- Professor Stephen Singleton OBE – Interim Chief Executive and Medical Director
- Jane Tomkinson – Director of Finance
- Gill Harris – Chief Nurse
- Richard Barker – Chief Operating Officer
- Tim Gilpin – Director of Workforce and Education
- Professor Paul Johnstone – Cluster Director of Public Health

This annual report outlines the progress of the North West Strategic Health Authority, as part of NHS North of England, during 2012/2013.

NHS changes under the Health and Social Care Act 2012

The strategic health authority has continued to lead a huge amount of work under the transition programme, which began in March 2011, to coordinate the implementation of NHS changes taking place under the Health and Social Care Bill 2010.

Working together with chief executives from primary care trusts, NHS trust and NHS foundation trusts, local authorities, clinical commissioning groups and the NHS Commissioning Board, a lot of our work this year has focussed on a detailed transition plan for the north east, to ensure smooth and effective handover of functions and work to successor organisations.

This work has covered the functions below, as well as the corporate transition of the strategic health authority and primary care trust clusters:

- Maintaining and improving the quality of health outcomes
- Developing the NHS workforce
- Provider development
- Public health services
- Commissioning arrangements
- Support for local authorities to establish health and wellbeing boards

Governance of the transition programme – which was a shared programme across the three strategic health authorities in the NHS North of England cluster - was through the transition programme board, which provided on going assurance to the NHS North of England chief executive that transition was on track, with all risks and issues actively managed.

The transition programme board

The detailed work of the transition programme was to ensure that functions, information and assets which were the responsibility of the three strategic health authorities (SHAs) making up NHS North of England, were either transferred successfully to the appropriate new organisation, or brought to satisfactory conclusion by the 31 March 2013. The transition board coordinated and oversaw, on behalf of NHS North of England, the development and implementation of transition and closedown plans, to ensure the appropriate systems, processes and assurances were in place to support the SHA cluster through the final year of its operation to successful organisational closure.

The SHAs also continued to exercise oversight and assurance over the handover and closure programmes of PCTs across the North of England up until the 31 March 2013.

The transition programme board which oversaw this work consisted of senior representatives from eleven specialist work streams:

- Workforce, education and training
- Corporate affairs
- Operations and performance
- Estates
- Human resources
- Chief Nurse and quality and safety
- Informatics
- Finance
- Public health
- Commissioning development
- Provider development

Programme assurance was provided through completion of a monthly report, completed by PCT transition leads and SHA cluster work stream leads and reviewed by the programme board. This allowed the programme board to identify emerging risks and issues and plan mitigating actions at a regional and local level. The transition director reported on the overall progress of the programme to the SHA cluster board.

1. Equality and diversity in the North West

We at NHS North West recognise the fundamental importance of embracing the diversity of people from all groups in society, regardless of age, disability, gender, gender reassignment, race, religion and belief, sexual orientation or responsibilities as a carer.

As leader of the region's health economy NHS North West has had a legal and moral responsibilities to ensure that the Board and all staff promoted equality, fair treatment and social inclusion in everything the organisation did. We have supported the elimination of unlawful discrimination by ensuring that the values underpinning equality, diversity and human rights were central to our policymaking, employment practices and community involvement.

The Public Sector Equality Duty (part of the Equality Act 2010)

Like all public sector bodies, NHS North West has had to comply with the Public Sector Equality Duty (PSED) which came into force in April 2011. This has meant that, as an employer and also as the leader of the NHS in the region, we have taken into account the need to:

- Eliminate unlawful discrimination, harassment and victimisation and any other conduct prohibited by the Equality Act.
- Advance equality of opportunity between people who share a protected characteristic and people who do not share it.
- Foster good relations between people who share a protected characteristic and people who do not share it.

For full details of the protected groups and our work to implement the PSED, please visit:

http://www.northwest.nhs.uk/whatwedo/improvingservices/equalityanddiversity/

2. Public health

Transition Alliance

Since July 2011, the Transition Alliance has worked hard to deliver a programme of support to Local Government, the NHS and the voluntary and community sector during a difficult period of transition and upheaval. The take-up of its activities and programmes and the trust built through strong relationships is testament to the quality of the service provided by the Alliance.

Health and Wellbeing Boards and commissioning development

This work stream has supported Health and Wellbeing Boards, Clinical Commissioning Groups and Local Health Watch Groups to develop robust arrangements and to build strong relationships, including work on membership, governance, accountability and scrutiny.

Achievements include the development of a number of networks, case studies and workshops on topics ranging from: the engagement of children and young people with Local Healthwatch; to the prioritisation of evidence; and asset-based approaches to Joint Health and Wellbeing Strategies. We have also provided bespoke reviews and tailored support to partnerships and stakeholders across the North West.

Delivering the new system for the health of the public

In terms of Public Health, our focus has been on the development of the new Public Health system across the region, by encouraging innovation and the rapid adoption of good practice.

A North West Academy for large scale change (LSC) has been developed and the current cohort is developing a group of 'agents'. These agents will be able to share learning and practice across sectors and develop their large scale projects and skills.

We have also held a series of social media masterclasses for Public Health workers, taking delegates from the basics through to the implementation of a successful social media campaign.

Leadership and workforce development

A package of support, programmes, networks and masterclasses has been delivered to elected members, NHS and local government leaders. These have been designed to help them understand their new roles and develop a coherent approach to HR and workforce issues. Also included were a series of two-day Health Champions Programmes for elected Members and a number of leadership masterclasses, focused on key challenges for public sector leaders in the 21st century. We have also produced a series of health and wellbeing quick guides and policy briefings.

Personalisation

We have worked with local authorities to help them make improvements in relation to process, managed personal budgets and workforce. In addition to bespoke support, we have brought together people from statutory and voluntary sector organisations to share nationally-developed tools and knowledge. We have looked at best practice in commissioning for personalised services and the ways in which provider organisations are grappling with customs and practices that limit choice and control for disabled people. We have also looked at the way to ensure that third sector providers are considered, including the identification of barriers to entry to the market.

Holding the ring

This work stream has supported some key policy areas that cross local government and health boundaries, including safeguarding for both children and adults and work around dementia, Carers and autism. Achievements include rolling out the Dementia Commissioning Toolkit across the region and actively supporting the call to reduce antipsychotic prescribing. A network of Carers Leads has been established to develop a work programme in support of the Carers strategy. We also held a large conference on autism, which resulted in the development of an action plan to deliver North West priorities**.**

Health inequalities

Addressing health inequalities remains a priority in the North West. A regionally commissioned report on the evidence and experience of addressing health inequalities has been welcomed by local authorities. The rates for life expectancy and mortality have been actively monitored. The effect of the economic slowdown is also being demonstrated in a slowing of progress on reducing mortality. However, we have seen the gap in mortality and infant mortality closing in many areas, demonstrating the progress on health inequalities.

Children and families

The transfer of commissioning responsibilities for children, young people and maternity from PCTs to clinical commissioning groups, the NHS Commissioning Board, and the transfer of Public Health to local authorities has been an important feature of our work this year. We have collaborated with the shadow NHS Commissioning Board and Public Health England to identify the risks and opportunities of the NHS reforms, and have held regional events to help shape support within local areas. The NW Director for Child and Maternal Health Dr Ann Hoskins was a member of the Children and Young People's Health Outcomes Forum, which is reporting to Government on a new strategy for improving care for children and young people. She also co-chaired the work stream on Public Health.

Safeguarding children remains critical to the work undertaken by the SHA with PCTs, Trusts and local authorities. The regional network of Executive and Designated Safeguarding Health Professionals has been important in developing improvement work including:

- The improvement of information sharing between the NW Ambulance Service and local Lead Nurses, so that any potential risks to a child's welfare can be identified as early as possible. A pilot period has demonstrated the effectiveness of this work and is being extended for further development.
- Sharing models for safeguarding networks, which will support CCGs.
- The provision of two leadership programmes: one for designated and named safeguarding professionals, now in its fourth wave; and another programme specifically for Executive and Board level leads in the CCGs.

In addition, the SHA has supported PCTs and Trusts on an individual basis on improvement work, and shared the learning through networks.

The national launch of the new School Nursing Model in 2012 was quickly followed in the region by the SHA setting up an implementation group, with more than 150 people attending a regional conference. The group, consisting of professional leads, PCTs/CCGs, providers, schools, local authorities and young people's representatives, has established local networks to accelerate roll-out of the new model.

The SHA has supported the work undertaken by AQuA in the North West to improve outcomes for children with long term conditions – in particular asthma, diabetes and epilepsy. The aim of the programme is to reduce unnecessary admissions to Accident & Emergency and improve self-care.

Our work with the regional office of the Child and Maternal Health Observatory (ChiMat) continued to progress well. Local workshops were held across the region to train and support PCT analysts and commissioners in the use of online data and information tools, improving local capacity and intelligence. ChiMat maintains production and publication of local area profiles which are well used by PCTs and local authorities; in 2012/2013 the organisation published new reports on long term conditions of children and young people, as well as on accidents of under-19 year olds.

The SHA's work on reducing alcohol harm continued with the publication of promotional material for PCTs and local authorities on the five point charter – this captures the views of children and young people, as well as the evidence base for effective interventions. This also provides local areas with a framework to reduce underage alcohol consumption. Nineteen organisations across the region now formally support the charter.

Finally, in 2011/2012 the region was one of only four areas to host the Improving Access to Psychological Therapies Programme for young people; this has now been firmly established as an important catalyst for raising skills levels and improving access to psychological services. Further expansion of the programme was planned in 2012/2013.

Achieving better outcomes for pregnant women and newborns

The improvements seen during 2011/2012 in enabling women early access to maternity care have been sustained into 2012/2013, meeting the 90 per cent requirement for early professional assessment and care planning by the end of the twelfth week of pregnancy.

The prevalence of breastfeeding until 6-8 weeks continues to improve slowly across the North West, but the proportion of women who choose to breastfeed their infant appears to have levelled off.

Supporting commissioning of early years and maternity services

Providing support and guidance to early years and maternity commissioners remained a key priority as transition to reformed commissioning systems continued.

Work continues with the Workforce directorate to ensure the Call to Action for Health Visiting is realised in the North West. In 2012/2013 this included an increase in the availability of Family Nurse Partnership places to support the most vulnerable first-time teenage parents.

An early years discussion kit has been commissioned, and training provided to support North West health visiting services in carrying out their community engagement role; it has also been shared with Early Implementer Sites of the Health Visiting Implementation Plan across England.

Improving the quality and experience of maternity services

Monitoring of the quality and safety of maternity services in Greater Manchester has remained in place during the final stages of reconfiguration and has given assurance that services continued to be safe and of high quality as the closures and transfers of services took place.

North West maternity services have continued to be involved in national initiatives and testing such as the development of the Payment by Results Pathway Tariff, the Friends and Family Test, workforce modelling and planning reviews.

Screening programmes

Screening programmes must be commissioned and provided in a coherent way, with clear adherence to pathways, standards and protocols, in order that they may be delivered in a safe and effective manner.

The North West screening team has worked closely with other SHA screening leads, PCT leads, providers and regional quality assurance teams to ensure that transition risks to all 11 programmes are clearly documented and addressed, where possible, prior to the transfer of accountability and commissioning responsibilities to new organisations.

3. The year in numbers

Revenue funding and expenditure

In 2012/2013, the 24 PCTs in the North West received a recurrent allocation of £12.8 billion (equivalent to £1,827 per person), and a total in-year allocation of £13.8 billion to provide healthcare services on behalf of people in our region. Growth funding in 2012/2013 to North West PCTs was £370 million, which on average represented an increase in allocations of 3 per cent (England 3 per cent).

There were 14 NHS Trusts and 28 Foundation Trusts in the North West at year end. The NHS Trusts in aggregate generated revenue income of £3.1 billion for the year.
A breakdown of the analysis of healthcare is shown in the table below:

Analysis of purchase of healthcare

	2012/2013 £'m	2011/2012 £'m	Increase
Primary healthcare purchased			
Prescribing	1,215	1,280	-5%
Primary Care medical services	1,033	1,028	0%
Dental services	439	436	1%
Pharmaceutical services	346	342	1%
Ophthalmic services	76	73	4%
Secondary health services from GPs	20	17	18%
Other	15	18	-17%
Total primary healthcare purchased	**3,144**	**3,194**	**-2%**
Secondary healthcare purchased			
General & acute	5,965	5,694	5%
Community health services	1,479	1,423	4%
Mental illness	1,204	1,171	3%
Maternity	341	345	-1%
Learning difficulties	149	152	-2%
Accident & emergency	386	357	8%
Other contracts	530	473	12%
Total secondary healthcare purchased	**10,054**	**9,615**	**5%**
Grants	44	35	26%
Grand total	**13,242**	**12,844**	**3%**

4. Spotlight on success

Fighting infections

MRSA and C.difficile (CDI) are at their lowest levels in the North West since records began. The number of MRSA cases has continued to fall; there has been a reduction of three-quarters over the past four years.

The rate of reduction has improved, with 9.5 per cent fewer cases reported during 2012/2013, compared with the year 2010/2011. In particular, many of our hospitals have reduced the number of cases reported in the year; seven hospitals had only one patient who acquired MRSA during the year and four hospitals reported none at all.

All organisations are undertaking screening programmes for patients, either in preparation for a hospital admission or, in the case of an emergency admission, when they are seen in hospital.

Across health communities any patient identified as carrying MRSA is provided with an opportunity to have decolonisation treatments as necessary. This increase in collaborative working between infection prevention teams in this way continues to support reductions in identified infections.

The number of reported cases of CDI also fell significantly in the past year. Cases reported by hospitals decreased by a larger percentage than in previous years. There were 84.3 cases per month on average in 2012/2013, compared with 107 in 2011/2012. The number reported by PCTs in 2012/2013 also fell notably, by 17 per cent – an average of 195.6 per month from 235.7 per month.

An increased emphasis on identifying patients at risk of CDI by examining risk factors (such as high prescribing of certain antibiotics and a history of a previous episode of CDI) has provided valuable information to teams in both hospitals and the community.

Root cause analysis is now performed on all cases and used to identify areas where learning can be identified.

The increased involvement of the whole health economy in areas such as reducing the prescribing of high-risk antibiotics and increasing the information given to patients has been instrumental in reducing the number of incidences of infection and improving outcomes for our patients.

Improving access

In the year April 2012 to February 2013, 97.5 per cent of all outpatients in the North West were seen and treated within 18 weeks. The national standard is for 95 per cent of patients to be seen within 18 weeks following referral from their GP for non-admitted patient pathways. Half of these patients waited less than four and a half weeks, an improvement on the previous year. In the same period, over 461,000 patients were admitted to hospital in the North West for planned treatment. Over 90 per cent of them started their treatment within 18 weeks of referral from their GP.

Half of all these patients waited less than nine weeks for their admission for treatment – this is in line with the rest of England.

The number of patients having diagnostic tests is around 156,000 a month. In February 2013 only 0.4 per cent of patients waited longer than six weeks for a diagnostic test; the majority, some 73.5 per cent, waited less than four weeks.

Over 96.1 per cent of patients with symptoms of cancer are seen by a specialist within two weeks of urgent referral from their GP. Over 95.9 per cent of patients with breast symptoms are also seen by a specialist within two weeks of referral. Over 98.5 per cent of patients with a diagnosis of cancer receive treatment within 31 days of agreeing a course of treatment. Some 3.3 million patients visited an A&E department or walk-in centre during 2012/2013; 96.1 per cent of them waited no longer than four hours to be seen and admitted, referred or discharged.

The on-going deployment of UK armed forces means it is now more important than ever that PCTs and the SHA work closely with military services to ensure that we meet the needs of this community appropriately. As part of the Military Health Programme, the North West has developed a closer relationship with the NHS and the Ministry of Defence through the North West Armed Forces Network. The aim of the network is to develop the best ways of delivering appropriate care to the armed forces in the North West, as well as to their dependants, reservists and veterans. The network will also help ensure the smooth transition of military casualties and priority treatment for veterans with conditions related to their service.

‘The collaborative approach taken by Inspiration NW in utilising distributed networks to support innovation and improvement has contributed to the ongoing success of the work programmes.’

Improving major trauma care in the North West

Since April 2012 hospitals across the North West have been working together and improving the care of patients with very serious injuries.

Small groups of hospitals, known as Major Trauma Centre Collaboratives (MTCC), provide specialist and urgent care for patients with life-threatening injuries. They also lead a network of local hospitals each accredited as providing 'trauma unit' level care.

Three major trauma networks for the care of adults with severe injuries have been implemented. These serve the populations of: Cheshire and Merseyside; Greater Manchester; and Lancashire and South Cumbria. A fourth network, serving all of the North West, is now in place to care for children with major trauma injuries.

Ambulance staff assess and transfer people with severe injuries to the nearest MTCC for urgent treatment. Other patients are taken to their local trauma unit or, if their injuries are not severe, they are taken to a nearby A & E department.

The North West MTCCs are already showing that Consultant-led teams are assessing and treating people more quickly and many patients have a plan for their rehabilitation within a few days of their admission to hospital.

Immunisation

Ensuring that children are vaccinated against infectious diseases has been a key priority for the Public Health Directorate, the Health Protection Agency and local Public Health teams in the North West for a number of years.

The teams have been working together to share good practice and spread innovation, through local forums and the annual North West Best Practice event. Work is underway to plan how these programmes will transfer safely into the new system and to hand over commissioning responsibilities to the NHSCB.

Improving patient experience

The Service Experience Directorate continues to support a vibrant network for improving patient and staff experience. From its start in the North West, the work of the Directorate (through its work programme known as Inspiration NW) now has an impact both locally and nationally.

Inspiration NW has led a range of larger and smaller commissions supported by the INSPIRE training and development call-off framework.

The scope of the Directorate's improvement work is in the areas of:

- building knowledge and insight
- strategy and planning
- living values and behaviours every day experience-based design services.

One example of work is the development of the Inspiration NW Care Cards for adults and children. The Care Cards support health professionals in fostering meaningful conversations about the emotional aspects of care. They utilise new and innovative techniques to capture, and take action on, feedback from patients and the public.

Listening to the Voice of Families and Their Health Visitors utilised: crowd sourcing techniques known as 'echo' to capture feedback from Health Visitors; SMS texting to capture qualitative and quantitative feedback from families: and the Inspiration NW Children's Care Cards to encourage feedback from children.

In addition, the Service Experience Directorate is delivering the patient experience policy programme, a commission from the Department of Health which will complete in March 2012, delivering:

- An Excellence Framework for Patient Experience. To be available online and in journal-style hard copy from early summer 2012. Articles have been written by thought leaders and reviewed and debated by those interested in the area of patient experience. The Framework will continue to be a live document and new debate and articles encouraged from those who are interested to contribute,
- Strategic options for the future of the national patient experience feedback architecture. The development of this product has included extensive engagement with policy teams, the NHS and suppliers of feedback expertise and technology,
- Recommendations for the NHS Outcomes Framework Domain 4 indicators – "ensuring people have a positive experience of care".

5. Quality, nursing and safety

Improving quality

Advancing Quality Alliance (AQuA)

The improvements which AQuA members across the North West of England secured for patients continued to be impressive during 2012.

AQuA's flagship Advancing Quality (AQ) programme continued to bring about improvements with its member organisations. In November 2012, AQ published its year four results (April 2011 to March 2012) which showed the region's NHS Trusts achieved improvements of more than 30 per cent in key quality measures designed to drive up standards. The figures followed a November 2012 entry in the *New England Journal of Medicine* of an independent evaluation by a team of economists and health experts from the Universities of Manchester, Nottingham, Birmingham and Cambridge, who found there has been a "significant" fall in mortality rates since the introduction of Advancing Quality.

Partnerships between organisations have been further strengthened to deliver better care through AQuA's Long Term Conditions and Mental Health Programme; and its work on Integration. During 2012, AQuA worked with its members on these and other programmes, which included work on urgent care and an AQuA-led national engagement programme on shared decision making. AQuA also worked with its Commissioning Members in a variety of ways, including working together on a Commissioning Outcomes programme.

Patient safety and patient outcomes

There has been very good progress in achieving two objectives: ensuring patient safety during transition and the continued improvement of patient outcomes and experience. The DH/SHA Assurance Review in November 2011 confirmed that the legacy handover process to the cluster PCTs and SHAs had been robust. The new SHA quality dashboard provides early warning of patient safety risks, incident reporting is improving and action is being taken in response to concerns. The National VTE and regional Advancing Quality Commissioning for Quality and Innovation (CQUINs) demonstrate improvement across the North West. In total 27 Trusts are achieving the national CQUIN VTE assessments and the remaining Trust has made significant improvement.

Quality assurance audit

Following the Winterbourne Inquiry, the PCT commissioners undertook a quality assurance audit of placements for people with learning disabilities. The outcomes informed the DH national assurance framework, the learning has been shared and all reported concerns are now closely monitored. There are well-attended adult and children's safeguarding networks and joint work has resulted in a number of additional safeguards, including: improved communications between the North West Ambulance Service and Trusts when children are at risk; and the well-attended leadership programmes and master classes for adult safeguarding leads developed in collaboration with Salford University.

Wider successful quality improvement programmes include:

- the Self Care Aware e-learning programme by the Royal College of General Practitioners (RCGP) for primary care practitioners
- the shared decision making pathfinder project to explore what "no decision about me without me" means in reality to our patients, public and staff
- a pilot project to reduce re-admission rates for people with long-term conditions involving Aintree University Hospitals NHS Foundation Trust and University Hospital of South Manchester NHS Foundation Trust, targeting 1,000 patients in 12 months
- 11 Acute Trusts have joined the Improving End of Life in Acute Hospitals programme.

Energise for Excellence (E4E)

The Energise for Excellence national interactive website was launched in February. North West nurses and midwives who have joined the call to action can now share challenges and celebrate success on line. Eight North West Trusts took a significant step and participated in the E4E transparency call to action to be open and transparent, publishing monthly information on patient harms and patient and staff experience.

Publication of data drives improvement and builds public confidence; the eight Trusts developed comparable indicators, which measure what matters to patients, and published their first results in February 2012. The pilot is now entering its second phase; involving more Trusts, improving the information and working with the Patients' Association and the Information Centre.

6. Workforce and Education directorate

The Workforce and Education Directorate has begun the implementation of Developing the Healthcare Workforce from Design to Delivery.

This has involved setting up three geographical, provider-led networks and stakeholder forums. This will support the move to Health Education England and the Local Education and Training Boards during 2012/2013.

Developing the Healthcare Workforce from Design to Delivery

The delivery of *Developing the Healthcare Workforce: From Design to Delivery* (DH, 2012) is well underway, with the introduction of three sub-regional Local Workforce and Education Groups (LWEGs) and wider Stakeholder Engagement Framework. These underpin the establishment of the regional NW Local Education and Training Board (NW LETB) as a statutory committee of Health Education England (HEE).

The NW LETB will both provide and co-ordinate high quality education, training and development and deliver innovation on behalf of service users and constituent partner members across the footprints of:

- Cheshire & Merseyside
- Cumbria & Lancashire and
- Greater Manchester

Mersey Deanery

The Mersey Deanery has continued to flourish and has been an active partner in the development of the North West LETB and the Local Workforce and Education Group (LWEG).

The Deanery has also had another successful year with the GMC UK Trainee Survey. The Deanery has been an important part of the Mersey & Cheshire HIEC, making a contribution to Innovation, including education relating to QIPP Care Pathways, Primary Care and, recently, App-based learning - the Mersey Burns App.

Quality improvement: quality education is becoming linked to Quality care.

Educator development: trainers across Merseyside & Cheshire are required to be trained to Level 1; with many to Levels 2 and 3, this accreditation system developed in Mersey is being used nationally.

Leadership development: the Deanery has appointed Leadership Fellows, working in specific areas, including Public and Patient involvement and training for Bands 1-4.

Revalidation: the Deanery has made an important contribution to the development of Revalidation for trainees, the system is now live.

Portfolio of activity: core Deanery activity is training of junior doctors; however, the Deanery has broadened its activity to include SAS Doctors, and with the HIEC, developing CPD for Primary Care and supporting Appraisal in General Practice.

Single Lead Employer: Mersey Deanery has a Single Lead Employer, St Helens & Knowsley Hospitals, employing all trainees.

The Deanery Strategic Plan emphasises Medical Education contributing to Patient Safety and Care – **"Quality education ….. Quality care".**

7. Clinical engagement

The team has supported existing clinical networks, alongside developing new forums. The Medical Congress, CCG Chairs and Clinical Leaders Network provide important platforms for clinicians to engage with managers to deliver system improvements. The HICAT (a team of clinicians supporting health informatics improvement) has helped clinicians develop sustainable information strategies.

Lead Scientist

The objective has been to ensure healthcare scientists are recognised in the new architecture.

Projects have included:

- testing the role of HCSs as technology adoption specialists
- Public Involvement Toolkit
- Organisational Lead Scientists network.

Revalidation

For the implementation of revalidation the focus has been on supporting organisations with strengthened appraisal training in the form of top-up training and new appraiser training. This will enable Responsible Officers to be reassured of robust appraisals within their organisation.

Pharmaceutical Advisor

Priorities have included:

- delivery of QIPP targets
- procurement and development of Home Care services
- successful maximisation of benefits of generic anti-psychotic prescribing in Primary Care
- development of the Electronic Prescription Service.

Chronic Obstructive Pulmonary Disease

The team has delivered:

- seven best practice events (involving all North West PCTs and Trusts)
- patient engagement event and report
- respiratory data / best practice repository in collaboration with AQuA
- reduction of home oxygen spend by £300k/quarter.

Dementia

Implementation of the national dementia strategy has been delivered in partnership with the North West Transition Alliance and has included:

- roll-out of the National Dementia Commissioning Pack
- NHS call to action on the reduction of antipsychotic medication
- community of practice approach for dementia and acute care with the Advancing Quality Alliance
- awareness-raising of junior doctors, in collaboration with North West Deanery.

8. Informatics directorate

We have continued to focus on our aims of supporting the NHS in improving productivity, increasing efficiency, improving the patient experience and achieving better outcomes.

Workforce development

In November 2011 we launched the North West Informatics Skills Development Network. Two successful annual conferences have been held since then and the aim is to profile the workforce annually and deliver a range of opportunities – from Masters-level learning to half-day networking events.

Quality, Innovation, Productivity and Prevention (QIPP)

We have continued to roll-out Informatics innovations across the patch. In the last 12 months we have focused on new innovations such as multi-Trust projects for disseminating and sharing clinical documentation and the emergence of multi-organisation clinical portals for clinical staff.

Supporting transition

We have continued to work with local health communities in both the development of IT shared services to support the new NHS models of care and in working through the IT implications of Transforming Community Services.

Improving the patient experience and achieving better outcomes

We have continued working to ensure that information and intelligence are delivered effectively to Commissioners. Work has included a collaborative approach to data management at scale, including supporting the set-up of a North West Data Management and Integration Centre. Dashboards are used to deliver information more effectively, and business intelligence tools under development include the validation of new algorithms for risk stratification tools. Work has also supported the deployment of tools such as the Urgent Care Clinical Dashboard.

Some 57 per cent of first out-patient hospital appointments are now booked through the Choose and Book system. There are also increasing numbers of referrals to diagnostics and therapies, enabling practices and patients to choose services appropriate to their needs. Increasing numbers of General Practitioners (GPs) are providing patients with access to their electronic records. As of September 2012, 27.2 per cent of GP practices had enabled some part of this functionality, with work being done to promote further provision.

9. Capital and investment

During 2012/2013 the total capital expenditure for the North West was £158.2 million. NHS Trusts (excluding FTs) capital expenditure was £121.7 million and PCT expenditure £36.5 million. NHS Trusts invested over £121.7 million in secondary care premises which included addressing a range of backlog maintenance issues and a number of new developments.

PCTs invested £36.5 million of public capital in the primary care estate in 2012/2013, which included significant investment to address backlog maintenance issues in PCT, GP and General Dental Practitioner's premises. During 2012/2013 some examples of the new facilities opened included:

- Warrington Town Centre (Warrington)
- Orford Park Primary Care Resource Centre (Warrington)
- Mere Lane Neighbourhood Health Centre (Liverpool)
- Princes Park Health Centre (Liverpool)
- Kensington Neighbourhood Health Centre (Liverpool)
- Kirby Health Centre (Knowsley)
- Castlefields Health Centre (Halton & St Helens)
- Women and Children's "Super Centre (Royal Oldham)

The NHS estate in the North West is valued at £2.5 billion. A QIPP estates savings target of £169 million has been established in the North West and in 2012/2013 organisations continued to made excellent progress on identifying in-year savings following on from the successful delivery of the second year's savings targets. Successful initiatives included the setting up of economy-wide accommodation bureaus, energy efficiency schemes, building utilisation reviews and the sale of surplus assets. Many of these schemes were supported through continued partnership working with local authorities and other public sector organisations.

10. Support for healthcare in less developed countries and the armed forces

Developing partnerships with hospitals in developing countries

Despite increased pressure on the NHS from structural change and tighter budgets many volunteers and organisations still find significant benefit in releasing staff to share their knowledge and skills and learn from working in very low resource settings. Organisations have been successful in gaining grants from the Department for International Development for these purposes and are co-ordinating their work in partnership with other parts of the NHS.

The North West Armed Forces

The North West Armed Forces Network has built on its work to ensure the smooth transition of the military casualties into NHS care from the Armed Forces.

Clinical commissioning groups (CCGs) have been engaged and have observed the significant benefits offered by the two bespoke services collaboratively commissioned across the North West by the 24 PCTs (and the professional recognition that they have received from peer reviews). The 33 CCGs in the North West have agreed to an extension of the two pilots in. Therefore the Military Veterans' IAPT service will continue as before but the reforms will mean that the wraparound service commissioning will now be divided between local authority, Public Health and CCG commissioning. Therefore, the latter service will operate at reduced capacity focussing primarily on mental health issues.

NHS bodies have joined local authorities and the Armed Forces to agree the signing of local Community Covenants. They have the potential to bid for significant sums of money to improve Community/Armed Forces relationships.

The North West Armed Forces Network has also launched the first searchable geographical database (with maps) enabling professionals and the public to navigate the large numbers of statutory bodies and charities providing services to veterans. The Network has also commissioned Joint Strategic Needs Assessments into the needs of servicing personnel, Reserve Forces and Veterans and their families in the region and had these over to the new commissioners. The Network is also working with the Armed Forces to ensure the smooth transition of service personnel from service life back into the civilian world at the end of their service, or after being made redundant.

11. Transition

Commissioning Development

The Commissioning Development team has three key objectives:

- to ensure all Clinical Commissioning Groups (CCGs) are ready and able to be authorised by the end of March 2013
- to ensure delivery of viable Commissioning Support Organisations (CSOs) capable of meeting the national assurance tests and being fully functional and available to support the Authorised CCGs
- to ensure the smooth transition of all NHS Commissioning Board (NHS CB) direct commissioning responsibilities.

Progress against each of these objectives during 2012/2013:

Clinical Commissioning Groups

- The regional team has actively worked with the NHSCB Authorisation team to support the authorisation process from all CCGs across the North of England in association with our other SHA cluster regional teams.
- 33 CCGs in the North West have progressed through the authorisation process, which will see the CCGs prepared to take on their full statutory duties from April 2013.
- All CCGs have been working in partnership with their PCT cluster colleagues leading this year's commissioning/contracting round.
- To support CCGs, the North West team ran the Dry Run process as part of the 2011/2012 contracting round. This allowed all CCGs to identify their development needs in a live environment. We have continued to work with the Leadership Academy and the Advancing Quality Alliance (AQuA) to actively provide support in line with the identified development needs which emerged during the Dry Run process.

Commissioning Support Organisations

- The North West team, working in partnership with the PCT clusters, developed a Commissioning Support Network with the sole aim of supporting the delivery of viable Commissioning Support offers. This group has developed a number of focused learning opportunities for the Commissioning Support leaders using expertise from both inside and outside the NHS.
- There has been some regrouping as the Commissioning Support offers matured and developed. Five Commissioning Support Organisations have progressed through to Checkpoint 3, from which point the responsibility transferred to the Business Development Unit (BDU).
- The Commissioning Support Network has continued independently, following the transfer of responsibility from the SHA to the BDU.

NHS Commissioning Board – Direct Commissioning

- The SHA has continued to work in partnership with PCT clusters to undertake a full baseline of the current contractual arrangements and working practices. This has subsequently enabled the clusters to bring local commissioning (specifically of Primary Care services) into single, cluster-based teams ready for transition to the new single operating model which has been shared by the NHS Commissioning Board. The final details of the single operating model are yet to be published.
- The regional team initiated the development of a cluster-wide Offender Health network. This network has: supported the shared understanding of the issues the transition will have on this area; had an input into the national work on creating a single operating model; and which continues to look for opportunities to streamline the current working arrangements ready for transfer into the NHSCB Area Teams.

Provider development

As part of the overall reform programme for the NHS, the delivery of the Foundation Trust (FT) pipeline by April 2014 continues to be a vital component of modernisation.
In the North West of England there are a number of Trusts still to achieve FT status. Accountability for delivering the FT pipeline remains with SHAs until 2013, when it will move to the NHS Trust Development Authority, which is already involved in FT applications.

Programme Directors have been allocated to support more challenged Trusts and the remaining Trusts have Relationship Managers, which is consistent with the approach adopted by Monitor, the FT regulator. They work with Trusts to support them in achieving their goals and monitoring their progress against identified milestones and timelines.

Tripartite Formal Agreements (TFAs) have been signed by all NHS Trusts, which include agreed milestones. To support the performance management arrangements, a stringent risk register is in place.

Aspirant Trusts	Monitor Submission Date
Manchester Mental Health & Social Care Trust	Awaiting authorisation by Monitor
North West Ambulance Service NHS Trust	Awaiting authorisation by Monitor
Royal Liverpool & Broadgreen University Hospitals NHS Trust	Awaiting Authorisation by Monitor

Aspirant Trusts	DH Submission Date
East Lancashire Hospitals NHS Trust	Submitted October 2012
Bridgewater Community Healthcare NHS Trust	Submitted November 2012
Wirral Community NHS Trust	Submitted January 2013
Liverpool Community Health NHS Trust	Submitted January 2013
Southport & Ormskirk Hospital NHS Trust	October 2012 (revised date to be agreed)
Mersey Care NHS Trust	April 2013
St Helens & Knowsley Teaching Hospitals NHS Trust	April 2013 (revised date to be agreed)
East Cheshire NHS Trust	October 2012 (revised date to be agreed)
Pennine Acute Hospitals NHS Trust	December 2012 (revised date to be agreed)

For some Trusts an alternative solution may be required, which may include the Trust deciding that an acquisition is preferable.

Aspirant Trust	Acquisition Date
North Cumbria University Hospitals NHS Trust	31 March 2013 (revised date to be agreed)

12. Research and development

Due to changes within the SHA some team members have moved on to new opportunities. Research and development (R&D) has managed to maintain and in some instances increase the work momentum by recruiting agency staff and working closely with contractors to ensure continuation of all work programmes and maintenance of high standards of delivery.

Communications

Good communication underpins all the R&D work programmes and is pivotal to future success. An external communications strategy has been designed to ensure that R&D information is disseminated in an appropriate and timely manner to a targeted audience. This year:

- An R&D rebranding exercise has been completed creating a new logo and establishing a more engaging image for the future.
- An evaluation of the existing communication strategy and communication tools is on-going with development of a specification for a new website.
- Twitter and Linked–in profiles have been established and used to disseminate key R&D facts and figures to stakeholders
- 4 animated films have been commissioned to describe and promote R&D work in facilitating new health research ideas (Catalyst) and accessing research funding through the EU. **http://youtu.be/4vEBcr_YkHUT** **http://youtu.be/PwpQMtTSi5c**
- R&D have hosted a number of regional events over the last 12 months details of which are included under the individual programme updates.

The EU information

R&D EU programme is part of ensuring that the North of England is perceived to be the place of choice to undertake high quality health research and our high quality research strengths are nationally and internationally recognized & acknowledged. R&D works closely with the senior EU health officer for the North of England and over the last 12 months the EU programme has included:

- Information on all the latest calls from FP7 listed on our EU health researcher website and information on Horizon 20/20.
- Two animated films providing information on the EU and how to access EU funding as described above.
- Facilitating an inter-regional agreement between Cataluña and NHS North of England.
- Supporting the Catalan health care leaders two day visit to NHS Greater Manchester In December 2012.
- Providing informal support to smaller academic institutions around EU funding.
- Small events held to support health researchers' access EU funding for cancer and palliative care projects in July 2012.
- Mapping of EU funded health research projects across the North of England.

Catalyst

Catalyst events were developed and designed to promote engagement and collaboration between a range of researchers, health professionals and social development agencies to facilitate different ways of thinking and develop new research questions on specific subjects.

This year:

- A catalyst event on adolescent health was held at the Reebok stadium in July 2012
- A catalyst event on veterans' health was held in December 2012
- Two new animations were commissioned to promote Catalyst and Open Space facilitation technique as listed above.
- A new catalyst toolkit has been developed to facilitate the roll out of catalyst events across the region.

Workforce development

- A high-level Advisory Group for Research Workforce Development has been established to inform the commissioning of a detailed programme of regional and local activity flowing from the Department of Health's strategy as set out in *Developing the Role of the Clinical Academic Researcher in the Nursing, Midwifery and Allied Health Professions (DH, March 2012).* Preliminary research to inform the group, focusing on the experiences of National Institute for Health Research senior investigators and fellows, has been completed.
- NHS North West R&D are engaged in advanced discussions with the Department of Health about undertaking a major project resulting in a comprehensive written report to their Clinical Academic Training Pathway (CATP) Programme Board by September 2013 of a national review of the size and shape of the clinical academic workforce of the nursing, midwifery and allied health professions in England that will inform UK-wide evidence-based modelling of the future NHS workforce.
- A leadership development programme - *Releasing Potential* - devised and commissioned by NHS North West R&D, has been delivered to NHS Trust R&D managers in the region to enable them to better support research outputs and innovations to increase evidence based, high quality and cost effective interventions and service delivery. The programme is also key to enabling R&D managers to lead the requisite culture change to embed R&D as core NHS business ensuring maximum return on the Government's investment in research and to encourage the take up of new innovations. Preliminary evaluation data supports further commissioning in this area, with planning for a further programme now in progression.

Knowledge Exchange

- A scoping exercise to identify the future activity of NHS North West R&D in relation to the region's Knowledge Exchange agenda has been commissioned and a detailed final report produced. The content of a future work plan based on the report's recommendations is currently being considered, with a view to making a series of recommendations to key KE partners, including the region's Academic Health Science Networks.
- A blue print for an effective KE web resource has been developed which incorporates best industry practices, drawing upon regional case studies such as NHS Education for Scotland (NES) and E-health Ontario (Canada). These are benchmarked for creating an implementation plan that can be shared with key stakeholders as they refine their KE agendas within the new NHS infrastructure.
- The foundation work for identifying and developing a community of KE champions to support the work programme in the region, drawn from NHS and academic institutions, is underway.

Creative learning academy

- A manifesto for creative learning within the NHS has been developed, with the intention of trialling innovative solutions to workforce development challenges which, if successful, can be rolled out to the wider R&D community. The manifesto draws upon a powerful evidence base for creative learning in the public and private sectors and builds upon the team's foundation work in this area which gave rise, for example, to the *Releasing Potential* programme (see above).
- NHS North West R&D is working with a range of experts, skilled in using techniques from creative writing, music and theatre to construct a series of workshops focused on dealing with complexity and uncertainty in the NHS, enhancing individual and team performance and strategic planning at a time of transition. The workshops have been designed as interventions to support personal and professional development whilst also producing tangible materials for use in future communication, branding and engagement activities.

Additional activities

- Initial plans to develop a Research Intelligence Observatory (RIO) are currently being drawn up. It is intended that RIO will draw together the regional and local intelligence which NHS North West R&D has ready access to, in order to inform and support the collaborative activities of the region's wider R&D community. As a starting point for establishing observatory resources, the existing intelligence on regional HEI research excellence and infrastructure will be updated, augmented by a major mapping exercise to capture the key clinical-, biomedical-, health service- and related research strengths of the region.

13. Service reconfiguration

The North West has again this year seen the reconfiguration of a significant number of NHS services. All proposals for major service change continue to be subject to the Secretary of State for Health's four service tests, which require proposals to demonstrate:

- support from clinical commissioners
- evidence of strong public, patient and local authority engagement
- clarity on the clinical evidence base
- consistency with patient choice.

Public consultations have taken place this year in relation to changes to vascular services in Cheshire and Merseyside, services at Trafford General Hospital and community Mental Health services provided by Cheshire & Wirral Partnership NHS Foundation Trust. The NHS in the Fylde Coast is consulting on the future configuration of rehabilitation services for older people and a consultation is planned about the provision on in-patient services for people with dementia in Lancashire.

The on-going implementation of existing schemes has included: changes to in-patient older adult services in the west of Greater Manchester; Making It Better (Maternity and Children's Services in Greater Manchester); Liverpool Out of Hospital scheme; and Healthy Futures (acute hospital services in North East Greater Manchester).

Proposals for the relocation of Walk-In Centres in Manchester were referred to the Secretary of State by the Manchester Health and Wellbeing Overview and Scrutiny Committee for a second time. Following a further review by the Independent Reconfiguration Panel, the Secretary of State has said that he expects implementation of these proposals to be completed in the interest of patient care. Halton, St Helens and Warrington Joint Health Overview and Scrutiny Committee and Wirral Overview and Scrutiny Committee referred proposed changes to vascular services in South Mersey to the Secretary of State and the outcome of an initial review by the Independent Reconfiguration Panel is awaited.

14. QIPP directorate

The Quality, Innovation, Productivity and Prevention (QIPP) programme has reached its second year of delivery. The programme seeks to deliver whole-system transformation of NHS services, ensuring the sustainability and delivery of high quality, safe and affordable care into 2015 and beyond.

The target

The QIPP challenge for the NHS North West in 2012/2013 is £704 million. In line with expectations, so far QIPP initiatives across the North of England have yielded the required levels.

In the North West, transformational change is being achieved through a range of initiatives, most significantly those relating to shifting settings of care and urgent care, and improving planned care pathways. In general terms, the transformational programmes aim to:

- better manage demand through earlier and more effective intervention for patients (eg better management of long term conditions through risk stratification and enabling patients to manage their own condition through technology telehealth and telemedicine enabling clinicians to treat patients remotely from a specialised clinical unit.
- provide a wider range of care settings, including through integrated care
- improve existing planned care pathways

QIPP delivery in 2012/13

North West	Four-year QIPP challenge
Cheshire, Warrington & Wirral	420,308
Cumbria	157,863
Greater Manchester	1,286,956
Lancashire	595,653
Merseyside	457,295
Total	**2,918,075**

These transformational initiatives share the goal of reducing urgent care admissions through enhanced provision of planned and community care. They include a range of demand management work, pathway improvements, ambulatory care services, integrated health and social care schemes, community diagnostic services, risk stratification roll-out in Primary Care, support services for people with long term conditions and GP-fronted A&E departments.

In addition the health economies have worked collaboratively to realise benefits in estates rationalisation, procurement, medicines management, workforce innovation, provider productivity and informatics. A number of case studies can be found on our website at: **http://nww.northwest.nhs.uk/qipp/**

Appendix A

Board membership

North of England SHA Cluster Board

From 3 October 2011, Yorkshire and the Humber Strategic Health Authority, North East Strategic Health Authority, and North West Strategic Health Authority came together under a single management framework, working together as NHS North of England.

This section introduces the members of the North of England SHA Cluster Board and lists their declared interests.

From 1 April 2012 to 31 March 2013, the North of England SHA Cluster Board met on six occasions in both public and private sessions. Private board sessions ensure information of a confidential nature, within the terms of the exemptions permitted by the Freedom of Information Act 2000, can be discussed without compromising the proper and effective operation of the organisation.

Agendas and minutes of the public sessions of the board meetings can be found on our website **www.northwest.nhs.uk**.

Non-executive directors

Kathryn Riddle - Chairman
Kathryn is Pro Vice Chancellor and Chairman of the Council of the University of Sheffield. She is also a Justice of the Peace, a Deputy Lieutenant of South Yorkshire and an Honorary Colonel.

Sir Peter Carr CBE – Vice Chairman (to 31 May 2012)
Sir Peter is the Chair and Director of Premier Waste Management Ltd, Company Secretary and Director of Corchester Towers Ltd and, until early 2012, was Chair and Director of Durham County Waste Management Ltd.

Sally Cheshire – Vice Chairman
Sally is an Authority member and Audit Chair of the Human Fertilisation and Embryology Authority (HFEA, a non-departmental body of the DH). She is also the Audit Chair of the Health Research Authority (from July 2012).

Prof. Peter Fidler CBE
Prof. Fidler is a Non-Executive Director of Codeworks and Chief Executive / Vice Chancellor of the University of Sunderland.

Alan Foster
Alan has no declared interests.

Sarah Harkness
Sarah is Chair of the SHA's Independent Investigations Committee (a standing committee of the SHA Board) and is a member of the Council and Audit Committee of the University of Sheffield. She is also a Non-Executive Director and Chair of the Audit Committee of the NHS Trust Development Authority (from 28 September 2012)

Prof. Oliver James
Prof. James is a Non-Executive Chair of e-Therapeutics PLC and Chair of Samoures Investment Trust, Jersey. He is also Chair of the Sir James Knott Trust.

Ian Walker
Ian is the Managing Director of Rotary Electrical Services and Chairman of Rotary Engineering UK Ltd. He is also a member of the Court of the University of Sheffield and is Chairman of the SHA's Audit Committee.

Executive directors

Ian Dalton CBE – Chief Executive (to September 2012)
Ian has no declared interests.

Richard Barker – Chief Operating Officer
Richard has no declared interests.

Jane Cummings – Director of Nursing/ Chief Nurse (to May 2012)
Jane is a Trustee of 'Over the Wall' charity.

Gill Harris – Chief Nurse (from May 2012)
Gill has no declared interests.

Mark Ogden – Deputy Chief Executive / Director of Finance (to June 2012)
Mark is a member of The Financial Skills Partnership Advisory Group.

Jane Tomkinson – Director of Finance (from June 2012)
Jane has no declared interests.

Prof. Stephen Singleton OBE – Medical Director and Interim Chief Executive (from October 2012)
Professor Singleton is the Chair of Trustees, Children's Foundation and a group member of Slaters' Bridge Group

Directors

Elaine Darbyshire – Director of Communications and Corporate Affairs
Elaine is a Trustee of St. Ann's Hospice, Manchester and Trustee of 'Greatsport', Manchester. She is also Director of Our Life.

Tim Gilpin – Director of Workforce and Education
Tim is a Non-Executive Director of After Adoption Yorkshire

Prof. Paul Johnstone – Cluster Director of Public Health
Paul's post is a joint position spanning the Department of Health and Strategic Health Authority. He is a trustee of a charity called North-to-North Partnership. Paul's wife is a part-time partner for a small consultancy which provides management and leadership support for GPs and primary care professionals.

Committees of the board

Audit Committee

The Audit Committee was responsible for making sure that the SHA ran in a clear and open way and that we identified and managed significant risks across the NHS. It also made sure that the SHA acted in line with relevant regulations, codes of conduct or any other relevant guidance.

The committee members were:

Chairman

- Mr Ian Walker

Non-executive directors

- Prof. Peter Fidler CBE
- Mr Alan Foster
- Mrs Sarah Harkness

Remuneration Committee

Details of this committee are contained in the remuneration report.

Provider Development Board

On behalf of the SHA Board, the Provider Development Board was established to ensure that NHS trusts yet to achieve authorisation as a foundation trust (FT) do so, or reach an appropriate alternative solution, and was charged with providing the board with assurance on aspirant FT applicants and other provider development proposals as required until March 2013.

The Provider Development Board oversaw the transition of this work to the National Trust Development Authority which becomes operational on 1 April 2013.

Patient Safety Committee

The Patient Safety Committee had oversight of the SHA's functions in relation to patient safety, with specific reference to:

- The commissioning and publication of independent investigations under HSG(94)27
- Oversight of other serious incidents
- Section 12 accountabilities
- Local Supervising Authority for Midwives

Local Education and Training Board (LETBE)

The purpose of the North West LETB is to:

- Identify and agree local priorities for education and training to ensure security of supply of the skills and people providing health and public health services across the North West
- Plan and commission education and training on behalf of the North West in the interests of sustainable, high-quality provision and health improvement
- Improve the quality of education and training for the future and current NHS workforce
- Develop effective partnerships and facilitate collaboration between key stakeholders
- Be a forum for developing the whole health and public health workforce
- Implement local financial governance assurance and delegated responsibility for the LETB Multi-Professional Education and Training (MPET) budget within the agreed HEE financial framework
- Drive improvements in service quality and safety

Director of Finance Report

2012-13 was the final year of the NHS North West Strategic Health Authority ("NHSNW".) Since October 2011 NHS North West, NHS North East and NHS Yorkshire & the Humber - the three strategic health authorities in the North of England – have been working together under a single management framework as NHS North of England.

2012-13 was therefore a year with focus on financial transition. I am grateful to colleague Finance Directors and the SHA Finance Team for ensuring that the NHS NW health economy as a whole, and NHSNW in particular delivered its financial targets, during a time of significant change. The NHS North of England Board was able to be assured about the operation of controls to manage risks: and hence to have confidence in governance and reporting arrangements.
The final accounts of NHSNW are set out in the pages that follow. All assets and liabilities have been fully identified, and all balances have an identified destination. Balance sheet disaggregation and transfer of balances will be actioned through the Department of Health's legacy management team in liaison with successor bodies in the 2013-14 financial year

Appendix B

Summary financial statements for 2012/13
Statement of comprehensive net expenditure for the year ended 31 March 2013

This is a summary of the audited annual accounts for 2012/2013.

	2012-13 £000	2011-12 £000
Employee benefits		
Staff costs	25,566	24,836
Redundancy provision	(3,353)	7,269
Other costs	688,788	688,639
Income	(4,402)	(3,098)
Net operating costs for the financial year	**706,599**	**717,646**
Of which:		
Administration costs		
Employee benefits	19,300	19,993
Other costs	15,204	19,164
Income	(1,963)	(948)
Net administration costs for the financial year	**32,541**	**38,209**
Programme expenditure		
Employee benefits	2,913	12,112
Other costs	673,584	669,475
Income	(2,439)	(2,150)
Net programme expenditure for the financial year	**674,058**	**679,437**
Total comprehensive net expenditure for the financial year	**706,599**	**717,646**

Summary of financial statements for 2012/2013
Statement of financial position as at 31 March 2013

	31 March 2013 £000	31 March 2012 £000
Non-current assets		
Property, plant and equipment	0	0
Total non-current assets	**0**	**0**
Current assets		
Trade and other receivables	2,636	3,338
Cash and cash equivalents	0	0
Total	**2,636**	**3,338**
Total current assets	**2,636**	**3,338**
Total assets	**2,636**	**3,338**
Current liabilities		
Trade and other payables	(2,172)	(8,239)
Provisions	(1,296)	(8,361)
Borrowings	0	0
Total current liabilities	**(3,468)**	**(16,600)**
Non-current assets plus/ less current assets/ liabilities	**(832)**	**(13,262)**
Non-current liabilities		
Provisions	0	0
Borrowings	0	0
Total non-current liabilities	**0**	**0**
Total assets employed	**(832)**	**(13,262)**
Financed by:		
Taxpayers' equity		
General fund	(832)	(13,262)
Revaluation reserve	0	0
Total taxpayers' equity	**(832)**	**(13,262)**

Summary of financial statements for 2012/ 2013
Statement of changes in taxpayers' equity for the year ended 31 March 2013

	General fund £000
Balance at 1 April 2012	**(13,262)**
Changes in taxpayers' equity for 2012-13	
Net operating costs for the year	(706,599)
Total recognised income and expense for 2012-2013	**(719,861)**
Net parliamentary funding	719,029
Balance at 31 March 2013	**(832)**

Statement of changes in taxpayers' equity for the year ended 31 March 2012

	General fund £000
Balance at 1 April 2011	**(8,678)**
Changes in taxpayers' equity for 2011-12	
Net operating costs for the year	(717,646)
Total recognised income and expense for 2011-2012	**(726,324)**
Net parliamentary funding	713,062
Balance at 31 March 2012	**(13,262)**

Note: the SHA does not hold any other reserves other than the general fund disclosed above.

Summary financial statements for 2012/ 2013
Statement of cash flows for the year ended 31 March 2013

	2012-2013 £000	2011-2012 £000
Cash flows from operating activities		
Net operating costs	(706,599)	(717,646)
(Increase)/ decrease in trade and other receivables	702	(1,361)
(Increase)/ decrease in trade and other payables	(6,067)	(1,983)
Provisions utilised	(3,759)	(81)
(Increase)/ decrease in provisions	(3,306)	8,009
Net cash (outflow) from operating activities	**(719,029**	**(713,062)**
Cash flows from investing activities		
Net cash inflow/ (outflow) from investing activities	0	0
Net cash inflow/ (outflow) before financing	**(719,029)**	**(713,062)**
Cash flows from financing activities		
Net parliamentary funding	719,029	713,062
Capital element of payments in respect of finance leases	0	0
Cash transferred (to)/ from other NHS bodies	0	0
Net cash inflow/ (outflow) from financing	**719,029**	**713,062**
Net increase/ (decrease) in cash and cash equivalents	0	0
Cash equivalents at the beginning of the period	0	0
Effect of exchange rate changes on the balance of cash held in foreign currencies	0	0
Cash equivalents at year end	**0**	**0**

Summary financial statements for 2012/ 2013
Key performance indicators

Revenue resource limit and operational financial balance	2012-2013 £000	2011-2012 £000
Net operating cost for the financial year	706,599	717,646
Revenue resource limit	946,270	932,770
Underspend	**239,671**	**215,124**
Unplanned resource brokerage received	0	0
Operational financial balance	**239,671**	**215,124**

Remaining within the revenue resource limit (RRL)

The Revenue Resource Limit (RRL) is the agreed level of funding provided by the Department of Health to North West SHA. For 2012/13 the final RRL for North West SHA was £946.3 million. North West SHA underspent against its maximum RRL by £239.7 million. This underspend was generated by the management of PCT resources and the return of resources which were previously managed by the Department of Health; North West SHA also had an underspend of £68.9 million on its own management of resources.

Capital resource limit (CRL)

At the year end the North West SHA held no Capital Resource Limit.

Remaining within the cash limit

The Cash Limit is the agreed level of cash provided by the Department of Health for North West SHA. For 2012/13 the final figure for North West SHA was £719.029 million. North West SHA achieved its target and underdrew against its cash limit by £4.8 million.

Better payment practice code – measure of compliance

North West SHA is required to pay its non-NHS creditors in accordance with the Better Payment Practice Code (BPPC). The target is to pay 95 per cent of non-NHS creditors within 30 days of receipt of goods or receipt of a valid invoice (whichever is later) unless other payment terms have been agreed with the supplier. The same target applies to NHS bodies.

	£000	Number
Total non-NHS invoices paid in the year	175,454	12,850
Total non-NHS invoices paid within target	175,001	12,473
Percentage of non-NHS invoices paid within target	**99.7%**	**97.1%**
Total NHS invoices paid in the year	533,697	3,278
Total NHS invoices paid within target	532,094	3,225
Percentage of NHS invoices paid within target	**99.7**	**98.4%**

Prompt Payment Code

North West SHA has signed up to the Prompt Payment Code. Further information on the Prompt Payment Code can be found at **www.promptpaymentcode.org.uk**

Strategic health authority running costs

	2012/2013 £000	2011/2012 £000
Running costs (in £000)	32,122	37,511
Weighted population (in units)	7,702,578	7,702,578
Running costs per head of population (£ per head)	4.2	4.9

Pay multiples

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

The midpoint of the remuneration band of the highest paid director in North West SHA in the financial year 2012/13 was £157,859 (2011/12 £150,167) This was the net charged to North West SHA following cluster arrangement recharges with North East SHA and Yorkshire and Humber SHA This was 4.89 times (2011/12 5.26) the median remuneration of the workforce, which was £32,263 (2011/12 £28,571).

In 2012/13 two employees (2011/12 two employee) received remuneration in excess of the highest paid director. Remuneration ranged from £177,516 to £182,986 (2011/12 Remuneration ranged from £172,828 to £178,362). The employees hold senior posts in the organisation, which is not shared with other organisations under clustering arrangements. Therefore the full salary cost is charged to the North West SHA.

Total remuneration includes salary, non consolidated performance-related pay, benefits in kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. Termination benefits must be excluded from the calculation of the highest-paid Director's salary to avoid distorting the ratio.

Review of Tax Arrangements of Public Sector Appointees

The SHA has employed one person on an off payroll engagement during 12-13 at a cost of over £58,200 per annum. The SHA confirms that contractual clauses were in place at the beginning of the contract providing the employing department with the assurance as to the individual's tax obligations.

Appendix C

Remuneration report

Membership of the remuneration and terms of service committee

For the period 1 April 2012 to 31 March 2013 membership of the committee comprised three non-executive directors. The Chief Executive and the Director of Workforce and Education also usually attend.

Policy on the remuneration of senior managers for current and future financial years

Since January 2006, Her Majesty's Treasury (HM Treasury) has required that all public sector pay proposals must be subject to approval through the new HM Treasury/Cabinet Office gateway, the Public Sector Pay Committee (PSPC). The Department of Health (DH) and HM Treasury have therefore produced a framework for senior managers in the NHS – very senior managers pay framework (VSM).

The framework is based on setting "spot rates" for Chief Executive (CE) salaries of strategic health authorities (SHAs) and primary care trusts (PCTs) within four bands determined by the size of the weighted population of the SHA. North West SHA is categorised as band 2. In addition to the spot rate, there is local discretion to increase salaries to reflect either additional duties and/or to aid recruitment and retention, the latter being called recruitment and retention premia (RRPs). Salaries under this framework are first approved by the SHA's remuneration committee and subject to final approval by the Department of Health.

Performance assessment and performance related pay

North West SHA has agreed to follow the national pay framework for VSM which includes the possibility for an annual non-pensionable, non-consolidated one-off payment, dependant on performance.

Contract duration, notice periods and termination payments.

All directors of the SHA are on a permanent contract with either the SHA or their substantive employer. All directors with the exception of the Regional Director of Public Health are subject to the terms and conditions of service set out in the very senior managers pay policy. The Regional Director of Public Health is subject to arrangements determined by the Department of Health. There are no specific conditions relating to termination payments except that any decisions about termination payments are reserved to the Remuneration and Terms of Service Committee.

Service contracts

Details of the service contract for each senior manager who has served NHS North of England from 1 April 2012 to 31 March 2013:

Name	Start date	Notice period
Executive directors		
Ian Dalton CBE	28/08/2007	6 months
Richard Barker	01/05/2009	6 months
Jane Cummings	01/11/2007	6 months
Mark Ogden	01/07/2006	6 months
Prof. Stephen Singleton OBE	01/07/2006	6 months
Tim Gilpin	02/10/2006	6 months
Prof. Paul Johnstone	Joint appointment with DH 01/07/2006	6 months
Elaine Darbyshire	02/03/2009	6 months
Jane Tomkinson	11/05/2011	6 Months
Gill Harris	01/05/2012	6 Months
Non-executive directors		
Kathryn Riddle*	01/07/2006	31/03/2013
Sir Peter Carr CBE*	01/07/2006	31/03/2013
Sally Cheshire*	01/09/2006	31/03/2013
Prof. Peter Fidler CBE*	01/07/2006	31/03/2013
Sarah Harkness*	01/12/2007	31/03/2013
Alan Foster*	01/07/2006	31/03/2013
Prof. Oliver James*	01/08/2007	31/03/2013
Ian Walker*	01/10/2006	31/03/2013

Notes:

* Appointed by the Appointments Commission

Provision of compensation for early termination

Not applicable.

Other details sufficient to determine the entity's liability in the event of early termination

Not applicable.

Any other significant awards made to past senior managers

Not applicable.

Salary and pension entitlements of senior managers

Salaries and allowances 1 April 2012 – 31 March 2013

	2012/2013 (share of cluster costs to North West SHA)			Gross costs for 2012/2013			Gross costs for 2011/2012		
	Salary (bands of £5,000)	Other remuneration (bands of £5K)	Benefits in kind (rounded to the nearest £00)	Salary (bands of £5,000)	Other remuneration (bands of £5K)	Benefits in kind (rounded to the nearest £00)	Salary (bands of £5,000)	Other remuneration (bands of £5K)	Benefits in kind (rounded to the nearest £00)
Name and title	**£000**	**£000**	**£00**	**£000**	**£000**	**£00**	**£000**	**£000**	**£00**
Executive members of NHS North of England									
Ian Dalton CBE[1] Chief Executive	20-25	5-10	0	60-65	15-20	0	75-80	0	0
Richard Barker Chief Operating Officer	45-50	0-5	0	140-145	10-15	0	140-145	5-10	0
Mark Ogden[2] Deputy Chief Exec/ Director of Finance	15-20	0-5	10	45-50	5-10	20	175-180	5-10	60
Jane Cummings[3] Director of Nursing/ Chief Nurse	0-5	0	0	10-15	0	0	135-140	5-10	0
Prof. Stephen Singleton OBE[4] Medical Director/ Interim Chief Executive	45-50	0	0	140-145	360-365	15-20	190-195	0	40

Notes

[1] Ian Dalton was part-time in the role of Chief Executive at NHS North of England and on a part-time IMAS placement at the NHS Commissioning Board. He left NHS North of England in September 2012.

[2] Mark Ogden left NHS North of England in June 2012

[3] Jane Cummings left NHS North of England in May 2012

[4] Prof. Stephen Singleton became Interim Chief Executive at NHS North of England in September 2012 in addition to his role as Cluster Medical Director. His other remuneration includes the redundancy payment £300 - £305k.

Salaries and allowances 1 April 2012 – 31 March 2013 contd.

	2012/2013 (share of cluster costs to North West SHA)			Gross costs for 2012/2013			Gross costs for 2011/2012		
	Salary (bands of £5,000)	Other remuneration (bands of £5K)	Benefits in kind (rounded to the nearest £00)	Salary (bands of £5,000)	Other remuneration (bands of £5K)	Benefits in kind (rounded to the nearest £00)	Salary (bands of £5,000)	Other remuneration (bands of £5K)	Benefits in kind (rounded to the nearest £00)
Name and title	£000	£000	£00	£000	£000	£00	£000	£000	£00
Executive members of NHS North of England contd.									
Tim Gilpin Director of Workforce and Education	45-50	0	0	145-150	280-285	86	130-135	0	84
Prof. Paul Johnstone Cluster Director of Public Health	30-35	25-30	0	90-95	80-85	0	85-90	80-85	0
Elaine Darbyshire Director of Communications and Corporate Affairs	35-40	0	10	115-120	0	20	115-120	0	20
Jane Tomkinson[5] Director of Finance	45-50	0	20	145-150	0	50	N/A	N/A	N/A
Gill Harris[6] Director of Nursing/ Chief Nurse	45-50	0	0	140-145	0	0	N/A	N/A	N/A

Notes:

[5] Jane Tomkinson joined NHS North of England in June 2012

[6] Gill Harris joined NHS North of England in May 2012

Salaries and allowances 1 April 2012 – 31 March 2013 contd.

	2012/2013 (share of cluster costs to North West SHA)			Gross costs for 2012/2013			Gross costs for 2011/2012		
	Salary (bands of £5,000)	Other remuneration (bands of £5K)	Benefits in kind (rounded to the nearest £00)	Salary (bands of £5,000)	Other remuneration (bands of £5K)	Benefits in kind (rounded to the nearest £00)	Salary (bands of £5,000)	Other remuneration (bands of £5K)	Benefits in kind (rounded to the nearest £00)
Name and title	£000	£000	£00	£000	£000	£00	£000	£000	£00
Non-executive members of NHS North of England									
Kathryn Riddle Chair	20-25	0	0	60-65	0	0	55-60	0	0
Sir Peter Carr CBE[7] Vice Chair	5-10	0	0	25-30	0	0	40-45	0	0
Sally Cheshire Vice Chair	15-20	0	0	50-55	0	0	40-45	0	0
Prof. Peter Fidler CBE Non-executive director	0-5	0	0	5-10	0	0	10-15	0	0
Alan Foster Non-executive director	0-5	0	0	5-10	0	0	10-15	0	0
Sarah Harkness Non-executive director	0-5	0	0	5-10	0	0	5-10	0	0
Prof. Oliver James Non-executive director	0-5	0	0	5-10	0	0	5-10	0	0
Ian Walker Non-executive director	0-5	0	0	10-15	0	0	10-15	0	0

Notes

7 Sir Peter Carr left NHS North of England in May 2012

NHS pension benefits 2012/13 – executive members of NHS North of England[1]

Name and title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in lump sum at age 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2013 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000) £000	Cash equivalent transfer value at 31 March 2013 £000	Cash equivalent transfer value at 31 March 2012 £000	Real increase in cash equivalent transfer value £000
Ian Dalton CBE Chief Executive	2.5-5	7.5-10	20-25	60-65	362	293	54
Richard Barker Chief Operating Officer	0-2.5	2.5-5	50-55	155-160	961	866	50
Mark Ogden Deputy Chief Executive/ Director of Finance	0.2.5	2.5-5	40-45	120-125	814	685	23
Jane Cummings Director of Nursing/ Chief Nurse	0-2.5	2.5-5	65.70	205-210	1,260	965	20
Prof Stephen Singleton OBE Medical Director/ Interim Chief Executive	0-2.5	2.5-5	65-70	200-205	142	1,326	-1253
Tim Gilpin Director of Workforce and Education	2.5-5	10-12.5	55-60	175-180	1,274	1,107	77
Paul Johnstone[2] Cluster Director of Public Health	N/A refer to note 1						
Elaine Darbyshire Director of Communications and Corporate Affairs	0-2.5	0	5-10	0	95	70	22

Notes

[1] Non-executive members do not receive pensionable remuneration, therefore their names are not listed

[2] Prof. Paul Johnstone is a member of the senior civil service pension scheme

NHS pension benefits 2012/13 – executive members of NHS North of England contd.

	Real increase in pension at age 60	Real increase in lump sum at age 60	Total accrued pension at age 60 at 31 March 2013	Lump sum at age 60 related to accrued pension at 31 March 2013	Cash equivalent transfer value at 31 March 2013	Cash equivalent transfer value at 31 March 2012	Real increase in cash equivalent transfer value
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)			
Name and title	£000	£000	£000	£000	£000	£000	£000
Jane Tomkinson Director of Finance	2.5-5	7.5-10	50-55	150-155	929	812	75
Gill Harris Director of Nursing/ Chief Nurse	(2.5)-0	(5)-(2.5)	55-60	165-170	1013	966	(3)

Salary and pension entitlements of senior managers of NHS North of England

The executive directors are members of the NHS pension scheme. The employer's contribution to the scheme was equivalent to 14% of their salary.

From 1 April 2012 Prof. Paul Johnstone was appointed as the cluster director for Public Health and is employed by the Department of Health. This is a joint appointment between NHS North of England and the Department of Health.

The benefits in kind for the senior managers relate to their lease cars and it is calculated on the taxable benefit of the lease car.

Contrary to the definition of the real increase in CETVs set out in the Manual for Accounts, common market valuation factors have not been used for the start and end of the period (as the most recent set of actuarial valuation factors, produced by the Government Actuary's Department (GAD) with effect from 8 December 2011, have been applied as at 31 March 2013).

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

Total cost of exit packages agreed 2012 - 2013

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departure agreed	Total number of exit packages by cost band
Less than £10,000	7	0	7
£10,001 - £25,000	3	0	3
£25,001 - £50,000	3	0	3
£50,001 - £100,000	8	0	8
£100,001 - £150,000	7	0	7
£150,001 - £200,000	4	0	4
> £200,001	4	0	4
Total number of exit packages by type (total cost)	**36**	**0**	**36**

Appendix D

Statement of the Accounting Officer's responsibilities

North of England SHA Cluster Board

The Secretary of State has directed that the Chief Executive should be the Accountable Officer to the Authority.

The relevant responsibilities of the Accountable Officers are set out in the Accountable Officers Memorandum issued by the Department of Health. These include ensuring that:

There are effective management systems in place to safeguard public funds and assets and assist in the implantation of corporate governance

Value for money is achieved from the resources available to the Authority

The expenditure and income of the Authority has been applied to the purposes intended by Parliament and conform to the authorities which govern them

Effective and sound financial management systems are in place

Annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the net operating cost, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Professor Stephen Singleton
Chief Executive
May 2013

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NHS North West Annual Governance Statement 2012/13

1. Scope of responsibility

This section broadly describes my responsibilities as Accountable Officer of the Authority, including maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives, whilst safeguarding public funds.

1.1 During 2012/13 North West Strategic Health Authority continued to operate as a statutory body within the NHS North of England cluster, which included North East and Yorkshire and the Humber SHAs under a single management structure. This was the final year of `clustering` prior to the structural changes in the NHS becoming operational on 1 April 2013, at which time North West SHA will cease to exist. As Interim Chief Executive, appointed from October 2012, I have responsibility for the accounting and governance arrangements across the cluster including North West SHA during this final year.

1.2 The accounting and governance arrangements in operation across the cluster have been in operation since the creation of the NHS North of England Board in October 2011. These arrangements were put in place to reflect the need for continuity and stability during a period of significant change, and also to reflect the continuing statutory nature and responsibilities of the three SHAs, whilst operating within a single common set of objectives and priorities.

1.3 The Board is accountable for internal control and as Accountable Officer and Interim Chief Executive of the SHA, 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 public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum with the Department of Health.

1.4 In addition to my responsibility for the Strategic Health Authority, I am accountable for the performance of PCTs and non-Foundation NHS Trusts in the North West, including providing strategic leadership to the health community, ensuring that all parts of the NHS work together and with partner organisations such as Local Authorities, and driving the achievement of agreed targets for health improvement and service delivery.

1.5 During this period of significant change in the NHS, I am also responsible for ensuring that arrangements are in place to identify and manage risks associated with the transition of services and organisations within NHS North of England to their new successor bodies. 2012/13 has been a particularly challenging year as final arrangements have been put in place to ensure the smooth closedown of existing organisations, whilst ensuring the development of new organisations and their operational readiness from 1 April 2013. This included taking forward the structural changes to deliver Clinical Commissioning Groups (CCGs) which will succeed PCTs, together with their Commissioning Support Units (CSUs), and also supporting the development of new national bodies including the NHS Commissioning Board, Public Health England and Health Education England.

1.6 As Interim Chief Executive, I have overall responsibility for risk management arrangements and I am supported in this role by a Senior Management Team made up of Executive and other Directors. The structure of the Senior Management Team means that all directors have a responsibility for risk management in their respective areas. These responsibilities are set out in the Authority's Risk Management Strategy and Responsibilities Statement.

1.7 Relationships with Chief Executives in all local health organisations in the North West are maintained via a forum which meets on a regular basis and this is mirrored by other directors with their professional counterparts. The SHA performance manages Primary Care Trusts and NHS Trusts (but not Foundation Trusts) and in this context it seeks assurance that these organisations have also developed frameworks for the management of risk and board assurance.

The governance framework of the organisation

This section sets out the governance arrangements in place within the Authority and reflects the fact that the SHA continued to operate within a single management structure following the `clustering` of Strategic Health Authorities in 2011.

2.1 The non statutory NHS North of England cluster brings together the three Strategic Health Authorities of NHS North East, NHS North West and NHS Yorkshire and the Humber under a single Board and management structure, whilst recognising the three SHAs continued to function as statutory bodies to 31 March 2013.

2.2 There is a single committee structure across the three SHAs, including an Audit Committee which is the principal committee charged with governance arrangements. Other committees of the Board include Remuneration and Terms of Reference; Provider Development; Education and Training; and Patient Safety. Membership of these committees is drawn from the non-Executive Directors of the Board of NHS North of England. During the year there were several changes to Board membership, some of which were as a result of the structural changes taking place in the NHS.

2.3 The Board`s 2012/13 Business Plan includes the key deliverables set out in the NHS Operating Framework and these were reflected as strategic objectives in the Board`s Risk and Assurance Framework, which is the main vehicle for monitoring and reporting progress and associated risks. During the year the Board received quarterly updates on progress toward achieving its strategic objectives in a `traffic light` risk rated format. During the first half of the year a number of objectives turned from green to amber, largely due to uncertainties around the transition programme and the emergence of financial pressures in some NHS organisations. However, as the year progressed and guidance and clarification regarding processes and procedures became clearer, this allowed these issues to be managed more effectively. In addition, regular performance reports and updates from relevant Directors on key business areas within its broader strategic objectives were reported to each meeting of the Board, highlighting performance, risks and actions in managing the effective implementation of the business agenda. These reporting mechanisms provided the Board with assurance on the progress and performance in achieving its key objectives

2.4 The key risks associated with the achievement of the Board`s strategic objectives are set out in the Risk and Assurance Framework, which continued to be reviewed and updated during the year to ensure it continued to meet operational needs and was being effectively implemented during this final year of transition. The risk and control framework associated with the Transition programme is referred to in sections 3 and 4 below.

2.5 The Board has ultimate responsibility for ensuring that effective governance arrangements are in place across all three SHAs and assures itself through a range of sources that effective governance, internal control and risk management arrangements are in place and operating effectively. The Board also has a responsibility to ensure compliance with its **statutory functions** and receives regular compliance report. The Board`s development session in January 2013 considered the latest report.

2.6 The Board operates within the Code of Conduct for NHS Boards which sets out the public service values that are at the heart of the National Health Service, and also the Code of Accountability for NHS Boards which sets out the basis on which NHS organisations should seek to fulfil the duties and responsibilities conferred upon them by the Secretary of State for Health. These Codes, together with the Department of Health requirement for all NHS organisations to have a Board Risk and Assurance Framework setting out strategic objectives and risks, form the code of governance within which the SHA conducts its business.

2.7 The **Audit Committee** plays a key role in ensuring the establishment and maintenance of an effective integrated system of governance, risk management and internal control that supports the achievement of the organisation`s objectives. The minutes of the Audit Committee are reported to the Board at which the Committee Chair highlights any significant issues.

The Audit Committee is supported in its work by internal and external auditors, who provide independent review of the systems and procedures and report regularly to Committee. In addition, each SHA has a Local Counter Fraud Specialist who undertakes an annual programme of work approved by Committee, which supports a zero tolerance approach to fraud and corruption.

The normal processes for **scrutinising and signing off the statutory accounts** which would normally be carried out by the Audit Committee of the SHA in May/June 2013 following the conclusion of work by the auditors, cannot be carried out by the existing Committee as the SHA will cease to be a statutory body on 31 March 2013. Alternative arrangements have therefore been put in place which include the continued responsibility of myself and the Director of Finance beyond 31 March 2013 to bring this process to a conclusion, together with the establishment of an Audit Committee which will meet (probably in June) specifically for this purpose as a sub-committee of the Department of Health`s Audit Committee, with membership drawn from the Non Executive Directors of the Board of NHS North of England to provide continuity.

As part of the closedown process, arrangements are in place for identifying financial balances to appropriate receiver organisations in accordance with Department of Health guidance and details of these will be included in the annual accounts.
There is also a formal **Transfer Scheme** in place which is a legal process coordinated by the Department of Health, which identifies everything (e.g. existing staff, assets, contracts, data etc) that is transferring to new receiving organisations.

Any ongoing risks or actions associated with functions transferring to new organisations are being identified and documented, and arrangements made for discussion and **handover** to successor bodies. An example of this is a Quality handover event held in February 2013, with attendees from SHAs and PCTs across the North of England meeting with Public Health England and the NHS Commissioning Board to discuss the handover of Quality issues and risks.

3. Risk assessment

This section describes the arrangements for assessing risk and how this is monitored and managed within the Authority.

3.1 The Board is engaged in the development and review of the risks associated with the Authority`s strategic objectives included in the Risk and Assurance Framework and the relevant controls in place to manage those risks. Risks are initially formulated by the relevant lead Director and considered and approved by the Board.

3.2 All staff are encouraged to participate in risk management and familiarise themselves with the various policies, processes, procedures and training materials available through shared electronic files, including arrangements for raising risks on the risk register. Anti-fraud and corruption work is carried out by a dedicated Local Counter Fraud Specialist who reports regularly to the Audit Committee and communicates with all staff.

3.3 The Authority operates a `traffic light` risk assessment process whereby risks are rated green (low), amber (medium) or red (high). Risk rating is the combined result of scoring for probability and impact and the value of risk scores is amended during the year as a consequence of actions taken to mitigate or manage risks. Strategic risks and their ratings are reviewed regularly by the Board through the review of the Risk and Assurance Framework.

3.4 A particular risk has been **staff capacity/capability** during the latter part of the year as staff began to be appointed to new NHS organisations. Close attention has been paid to this with plans in place to manage the situation. Both old and new organisations recognised the importance of ensuring an accurate and timely financial closedown and handover and have cooperated on staffing issues to deliver a satisfactory outcome.

3.5 **Information governance** and data security continued to be an important area for the SHA during this final year of transition. The main focus of work during 2012/13 has been on preparing SHA information for appropriate handover and supporting the business needs of emerging organisations, ensuring capability and capacity to take on Information Governance functions moving forward, whilst minimising risk and maintaining data security. This focus has meant that less work has been able to be done on pursuing the Department of Health Information Governance Toolkit indicators, an approach which was agreed by both the Senior Management Team and Audit Committee.

There have been no reported serious lapses in data security during the year.

4. The risk and control framework

This section describes how the various risk control mechanisms work within the Authority and how these provide assurance to the Board that risks are being addressed and managed.

4.1 In accordance with the principles of good governance, the key focus for managing risk and assuring the Board that effective arrangements are in place, is the **Board Risk and Assurance Framework**, which identifies the strategic objectives of the Board, together with the associated risks to achieving those objectives and the control mechanisms in place to manage risk.

4.2 This is the main vehicle for managing risk associated with the delivery of the Board`s strategic objectives. This is a strategic management tool and is not designed to reflect every potential risk, but rather to focus on those risks which are most significant and could threaten the achievement of the Authority`s strategic objectives. In addition, a further element of the risk and assurance process are departmental **Operational Risk Registers**, which capture those lesser, transient or operational risks which, although not likely to impact on the achievement of the organisations` objectives, need to be addressed and managed as part of the ongoing evaluation and improvement of the risk and control environment.

The Framework continued to be reviewed and updated during the year to ensure it continued to reflect the key strategic objectives of the Board, and that actions were identified and agreed with the appropriate Directors to address any gaps in control or assurance processes. Strategic and operational risk registers operate a `traffic light` risk rating system which readily identifies the risk status and these ratings are reviewed regularly and amended as appropriate.

4.3 There has been particular focus in 2012/13 on the systems and risks surrounding the **Transition Programme,** including the financial closure programme in this final year, to ensure a smooth handover to successor organisations when the three cluster SHAs are abolished on 31 March 2013. The key governance and risk mechanisms associated with this are set out below.

The NHS North of England Board has a number of processes in place across the three cluster SHAs to successfully manage the Transition into the new NHS landscape.

A cluster **Transition Board** was established at the beginning of the year and has continued to provide leadership and management of the overall transition programme throughout the year, across the main business areas of the cluster SHAs. This reports to the NHS North of England Board on a regular basis and is supported by a number of **work stream groups,** dealing with key business areas, which link to both local and national mechanisms for identifying risks, seeking guidance and reporting actions. A North of England **transition risk register** has been developed which captures the key local risks identified through these various mechanisms, together with actions to manage these, and is monitored by the Transition Board.

The Transition Board is also supported through the **financial transition assurance framework** which links to one of the work stream groups. This is a `traffic light` risk rated system which is both a local and national financial reporting mechanism. It captures the key financial work areas which need to be addressed, together with milestones, timeframes and risks, and provides monthly local intelligence on progress. The framework is monitored by the Transition Board and is reported at national level to the Department of Health. All North of England PCTs are also involved in this process.

In addition, to support financial closedown and the production of the annual accounts and effective handover to successor organisations, the three cluster SHAs have detailed local financial **closedown plans** which are embedded within the broader transition assurance framework and provide a check list of the detailed tasks, responsible persons and timeframes for successful closedown.

4.4 The various mechanisms set out above with regard to the management of the Transition process and associated risks are embedded within NHS North of England risk management arrangements. The importance of the Transition process to the successful delivery of the structural changes in the NHS is reflected in the well defined and documented processes for identifying, monitoring, reporting and managing risk in this regard. The reporting mechanisms include the cluster Transition Board, the NHS North of England Board and the Department of Health.

The NHS North of England Board received monthly reports on the progress of transition arrangements, which provided assurance that appropriate systems were in place to manage the process.

4.5 The practice of inviting Directors to attend Audit Committee during the year to discuss the key risks associated with their objectives has been continued during 2012/13 and helped to inform the overall risk management process and provide assurance.

4.6 Risks are operationally managed through the **Senior Management Team** and the **Assurance Group** and monitored by the Audit Committee. The Assurance Group, which comprised senior managers across the broad spread of business of the three cluster SHA`s in the North of England, supported the Senior Management Team and Audit Committee in monitoring risk management arrangements, providing regular review and monitoring of the risk environment, including development, monitoring and review of the Risk and Assurance Framework and Operational Risk Registers.

4.7 Risks are identified in a number of ways, including: -

- Risk assessment of policies and procedures
- Risk assessment of operational procedures
- Risk scanning by the Senior Management Team
- Board reports
- Strategic risk register
- Operational risk registers
- Assurance Group (with cross cutting membership on Transition and IT groups)
- Internal and External Audit reports.
- Information issued by the Department of Health on risks affecting the whole NHS.
- Local Counter Fraud Specialist reports.
- Plans and processes supporting the Transition programme including the risk register.

4.8 The prevention of risk is addressed through policies, procedures, guidance documents and manuals which are designed to assist and support staff and which govern the routine operational business processes of the SHA. These together form the internal control environment within which risks are managed.

4.9 **Internal and External Audit** also play a key role in reviewing risk, assurance and control systems and reporting on their effectiveness to Audit Committee on a regular basis. The Audit Committee is involved in determining the SHA`s internal audit plan, based on a risk assessment which reflects the key objectives set out in the Risk and Assurance Framework and aimed at providing the Board with assurance on various aspects of the risk and control environment. For 2012/13, Committee agreed that the plan should remain flexible, based on a rolling assessment of the SHA`s core processes, to reflect the increased potential for risk arising during this final year of transition. The SHA also had an **anti-fraud** plan in place throughout the year to detect and deter fraud.

The plan was based on criteria set by NHS Protect (the national counter fraud service) plus a local risk based assessment and was approved and monitored by the Audit Committee.

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

This section talks about the effectiveness of the risk management processes in place within the Authority and the sources which provide evidence that the various mechanisms are operating effectively.

5.1 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.

5.2 The Head of Internal Audit provides me with a year-end `Opinion` statement on the overall arrangements for gaining assurance through the Board Risk and Assurance Framework and on the systems of internal control which are reviewed as part of the internal audit work programme. For 2012/13 the audit Opinion gave the Authority 'significant assurance' that there was a sound system of internal control in operation throughout the year.

5.3 External Auditors appointed by the Audit Commission also provide an independent review of the Authority`s Financial Statements and overall control environment. Their Annual Audit Letter to the Board in respect of North West SHA provided an `Unqualified Opinion` (clear) for 2011/12. Their Opinion for the current year will be reported after the year-end accounts have been audited and is expected in June 2013. The auditors also provide a statutory Value for Money Conclusion on the SHA`s arrangements for securing economy, efficiency and effectiveness and for 2011/12 the SHA received an `Unqualified Conclusion` (clear) opinion. The Auditor`s report for 2012/13 will be reported after the financial year end.

5.4 The Department of Health carried out a 2012 mid-yearTransition Assurance Review of all SHA clusters to assess preparedness to manage the transition programme through to its final conclusion. The outcome was very positive and provided the Board and the Department of Health with assurance that NHS North of England had appropriate arrangements in place which were being managed effectively.

5.5 Executive managers and Directors within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance, through monitoring and review of the risks and associated actions in respect of their areas of responsibility. Senior managers also represent their respective Directors on the Assurance Group which is responsible for the operational effectiveness of the risk and control environment.

The Risk and Assurance Framework itself, which is subject to regular review, provides me with evidence of the effectiveness of the control mechanisms that manage the risks to the organisation of achieving its principal objectives.

5.6 My review is also informed by:

(i) other sources of assurance as set out in the Risk and Assurance Framework.

(ii) Board agenda papers which are linked to the appropriate Board objective/s and carry a risk assessment and other control statements completed by the author provide the Board with assurance.

(iii) The Transition programme assurance processes that were in place.

(iv) The system of internal control within the SHA comprising a range of policies, procedures, codes of conduct, scheme of delegation etc. The key procedures are set out in the SHA cluster Corporate Governance Manual which was reviewed and amendments approved by the Board during the year and communicated to all staff. Other guidance is communicated to budget holders on a regular basis and a finance training programme was rolled out designed to direct and guide staff in operational matters and improve internal control and risk arrangements.

(v) The Audit Committee has a key role in the oversight of the Authority`s risk and control environment which is reflected in the Committee`s Terms of Reference agreed by the Board.

(vi) NHS Protect (which leads nationally on work to identify and tackle fraud and corruption across the health service) provides the Authority with assurance regarding its anti-fraud and corruption arrangements. A Qualitative Assessment of all NHS bodies is carried out annually and for 2011/12 (the latest available) this showed that the North West SHA received a score of 2.

(vii) The cross directorate Assurance Group which supports the Senior Management Team and Audit Committee.

Professor Stephen Singleton
North West SHA
NHS North of England

6. Significant issues

There were no significant control issues to report in NHS North West.

Independent Auditor's statement

Independent Auditor's report to the directors of NHS North West

We have examined the summary financial statement 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 associated notes.

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

Respective responsibilities of accountable officer and auditor

The accountable officer is responsible for preparing the Annual Report.

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

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

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

Opinion

In our opinion the summary financial statement is consistent with the statutory financial statements of the North West Strategic Health Authority for the year ended 31 March 2013.

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

29 May 2013

Appendix E

Sustainability reporting & environmental issues

NHS North West leads by example in the field of carbon reduction and sustainability action planning as a responsible employer and provider of premises. NHS North West has been working closely with the building owner (Carillion) to reduce its organisational carbon footprint; this year carbon emissions have been reduced and significant cost savings made through the application of green principles, more efficient utilisation of estate, robust waste and energy management and cost-effective procurement.

Targeting culture change through Board engagement and the launch of a new network of staff and community, Green Champions, NHS North West has continued to actively promote the core principles of sustainability to NHS organisations in the region, working with NHS North East and NHS Yorkshire and Humber to support organisations across NHS North of England to deliver the NHS Carbon Reduction Strategy; improve performance against national targets; and meet the requirements of the Carbon Reduction Commitment (CRC).

3 Piccadilly Place & BREEAM-In-Use Award

Three Piccadilly Place (3PP) is now amongst the top 14 per cent of BREEAM-In-Use Asset assessed buildings in the UK. Measures such as the environmentally conscientious operation of the lift, waste segregation and efforts to reduce energy and water consumption have all been factors that have taken 3PP into the Premier League of sustainable buildings, not just in their construction with a BREEAM Excellent certificate but how they're operated when occupied with a BREEAMIn-Use Very Good certificate.

The Building Research Establishment Environmental Assessment Method (BREEAM) is the world's most widely-used environmental assessment methodology for construction. Approximately 400 BREEAM-In-Use assessments have taken place across 16 countries.

There are three different elements that can be assessed; we opted for an Asset assessment which concentrates on the building's common systems and plant, energy use, and the environmentally-compatible use of land in the immediate vicinity.

The initial assessment gave us a BREEAM-In-Use certification of 'Good'.

3PP also won the Green Build Awards 2012 category for 'Celebrating sustainability in buildings'.

Piccadilly Estates – sustainability improvement plan

The improvement plan included, amongst other things; aerating flow restrictors in the tap outlets; flow restrictors in the showers; species enhancement measures for biodiversity; and a small rainwater harvesting system.

The aerators in the taps reduce the water flow by 30-50 per cent, but by aerating the water it helps the water go further.

The rainwater harvesting system collects the rainwater from the roof of the bin store (located at the rear of 3PP) and stores the water in a 1,300 litre tank. This water is now used in the machine that scrubs clean the piazza and the other outside areas. During warmer weather it will be used for planters and the green roof too. This simple concept reduces mains water consumption, reduces the mains water bill and reduces the environmental impact.

The out of hours lighting in the reception area at 3PP was reviewed by Carillion and now uses 90% less lighting during these hours.

In pursuance of sustainability excellence, over the last year the estates team has worked side by side with the environmental business service arm of the not-for-profit organisation, Groundwork Trust.

The estates team recently received a very encouraging letter from Groundworks accompanied by two certificates indicating the annual savings the Estate should expect over a 12 month period; 740 tonnes of CO2 equivalent emissions and 650,000 litres of water.

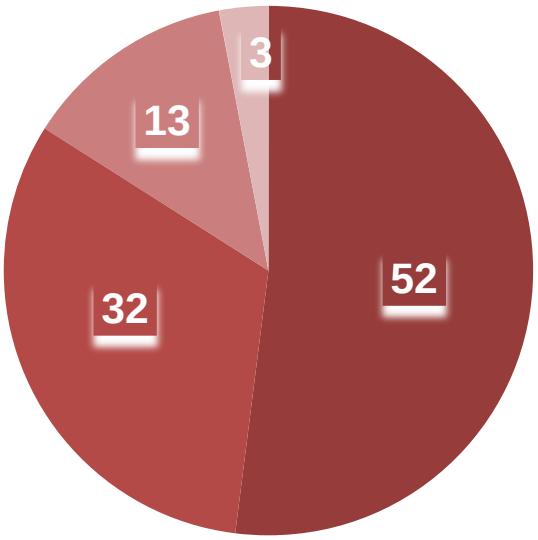
Waste management at NHS North West

NHS North West has a strict waste disposal and management policy and the tables below demonstrate the organisation's commitment to recycle waste in order to help the environment and reduce the omission of green gases into the atmosphere.

Waste management	2012/2013 Tonnes	2011/2012 Tonnes
Total waste	28704.79	24000
Total recycled	18308.23	
Recycled waste (%)	63.78%	96%
Total cost (£000s)	**£11**	**£11**

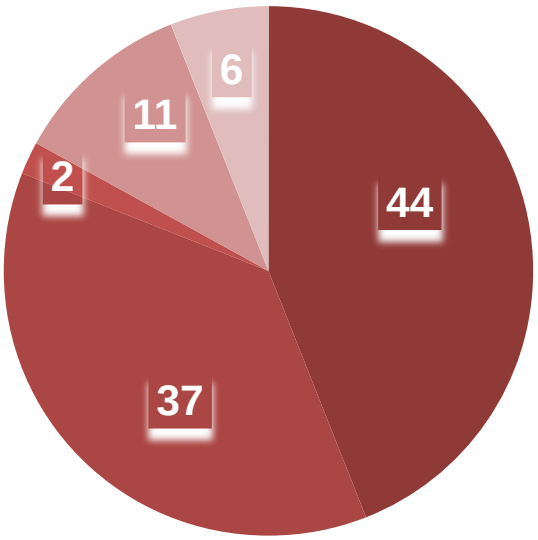
The NHS generated waste for 2012/2013 has been weighed separately to give a more accurate result. Earlier figures were based on a percentage of the total building waste which was calculated on the building occupancy figures.

The charts below show types of recycled waste in the two years under review.



2011/2012 waste type

- Shred it (confidential waste)
- Landfill waste
- Plastics
- Paper – non-confidential



2012/2013 waste type

- Shred it (confidential waste)
- Landfill waste
- Plastics
- Paper – non-confidential
- Recycled – other

Use of finite energy resources at NHS North West

NHS North West is committed to reduce the use of finite resources to build on its commitment towards sustainability. The increase in NHS electricity usage for 2012/2013 can be attributed to the NHS server room consumption being recorded incorrectly prior to this as part of the total building consumption.

Use of finite energy resources at NHS North West

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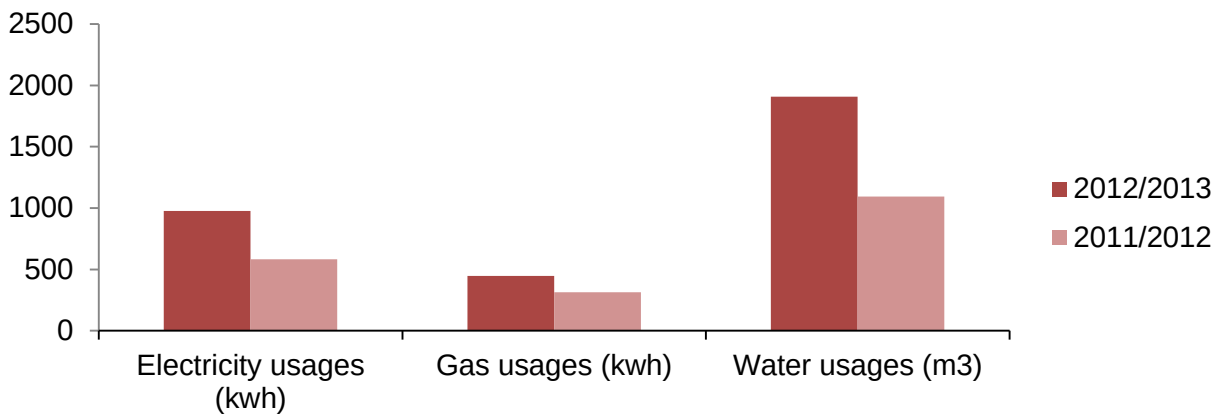
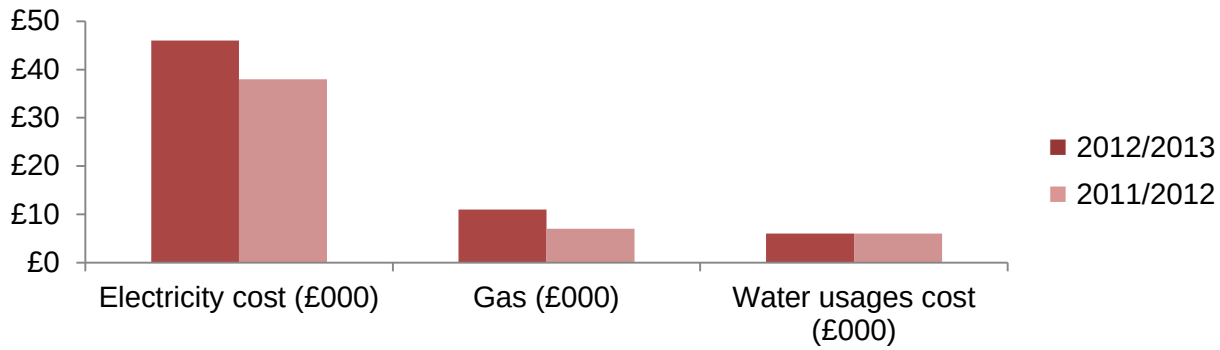
	2012/2013	2011/2012
Finite resources management		
Electricity usage (kwh)	977	584
Gas usage (kwh)	446	313
Water usage (m3)	1908	1094
Total cost (£000s)		
Electricity cost	46	38
Gas cost	11	7
Water cost	6	6

Finite resources management – usage



Finite resources management – cost



Leading the North West on sustainability

NHS North West has carried out an organisational audit of sustainability leads across all NHS organisations this year. This is to ensure that during transition and beyond, SD leadership is consolidated and NHS organisations are: supported in meeting the requirements of the new Sustainability Reporting Framework for NHS organisations; and are able to access networking, support and technical advice in order to meet their responsibilities with regard to socially responsible corporate leadership, CRC compliance and carbon reduction.

A priority action for NHS North West has been transition-proofing existing sustainability support arrangements to ensure that sustainability principles are embedded into the key processes, priorities and governance arrangements of the developing organisations and service structures during the transition period through to April 2013.

Development areas have included: embedding sustainability in cluster arrangements and provider development planning and performance regimes; and amalgamating existing SD health practitioner networks within a North West pan-sectoral network of sustainability leads to ensure that sustainability leads in North West NHS organisations are signposted to practice-led – sharing opportunities and pertinent information around mandatory reporting, Sustainable Development Management Plans (SDMPs) Carbon Reduction Delivery Plans (CRDPs) and Good Corporate Citizen Action Plans.

NHS North West has taken on the lead across NHS North of England in articulating and promoting the public health and sustainability agenda, supporting clinicians, NHS staff and service users to better understand and articulate the direct links between health, well-being and low carbon, healthy lifestyles.

This year, a priority focus has been placed upon the creation of a sustainable healthcare system in the region and beyond, embedding sustainability as a core component of the delivery of modern, efficient and effective health and social care.

Appendix F

Planning for emergencies

The SHA has continued to lead work to ensure the North West region's NHS is fully prepared and has the ability to respond to major incidents and any other pressures in the system.

During the year, work commenced on the transition of the SHA and PCTs towards the new operational framework for emergency preparedness being developed by the Department of Health. This significant piece of work will be completed by March 2013.

The North West Winter Plan continues to be used by all providers in the region, ensuring consistency in responding to a range of pressures affecting the local NHS and particularly when managing winter pressures.

During 2012/ 2013, an emergency preparedness exercise was undertaken to explore the North West's response to community services following the move of primary care services to a new host. The exercise included representatives from all the new hosts who are providing community services.

Working together as NHS North of England, efforts have been focused on sharing best practice and further testing and refining preparedness plans in light of both changing threats and the changing healthcare landscape. Preparing for the Olympics has required the NHS to work with partners and the DH to ensure that all NHS organisations have reviewed their business continuity plans and are able to mitigate any effects of the coming year 2012.

Appendix G

Our workforce

As at 31 March 2013, NHS North West SHA employed XXX (headcount) people. The whole-time equivalent figure is XXX full-time employees.

Some XX per cent (XXX) members of staff are female and XX per cent (XXX) male. Staff turnover for the period of April 12 to March 13 was X per cent.

North West SHA staff breakdown by ethnic origin

Ethnic origin		FTE	Head-count	Head-count %
A	White – British	0	0	0
B	White – Irish	0	0	0
C	White – any other White background	0	0	0
CK	White – Italian	0	0	0
E	Mixed – White & Black African	0	0	0
F	Mixed – White & Asian	0	0	0
H	Asian or Asian British – Indian	0	0	0
J	Asian or Asian British – Pakistani	0	0	0
L	Asian or Asian British – any other Asian background	0	0	0
M	Black or Black British – Caribbean	0	0	0
N	Black or Black British – African	0	0	0
R	Chinese	0	0	0
S	Any other ethnic group	0	0	0
Z	Not stated	0	0	0

Awaiting access to final information requested from Department of Health via HR Legacy team.

Health & Safety

NHS North West is committed to improving the health, safety, welfare and security of its staff and other persons who may be affected by its activities. We acknowledge that the contribution of staff is fundamental to achieving this and we will take steps to ensure that our statutory duties are met at all times. All our staff are required to complete basic Health & Safety training on an annual basis.

We will promote an open and supportive management culture. We will also help our staff to discharge their individual responsibilities and encourage them to take personal responsibility for identifying issues relating to health, safety, welfare and security and to take action to prevent or minimise those issues. We will use the management of health, safety, welfare and security as an opportunity for learning and improvement. All our policies and procedures relating to these areas will be freely available to all staff at all times.

Staff engagement and involvement

Over the last year the organisation has been faced with a tremendous amount of change: the merger of the North West SHA with the other two Northern SHAs; a reduction in management costs; and the requirements of the government White Paper Equality and Excellence at NHS North West. It is therefore vitally important the organisation continues to communicate effectively with staff, keeping them informed and motivated in both delivering now and preparing for the future.

We are replacing the staff survey with an internal regular ‘pulse’ survey to gauge staff views on engagement.

We sought views from staff about training. This resulted in career coaching, CV training and interview skills training sessions amongst others.

A number of staff briefing events gave all staff the opportunity to hear from the senior team about organisational changes and challenges and to feed any queries or concerns back to the senior team.

Formal monthly Joint Partnership Forums continued to take place, enabling management and staff to discuss people-related issues with regards to policies and processes. The weekly newsletter, Interaction, has been re-launched with a fresh new look.

HR has held a number of confidential drop-in sessions for staff, allowing them the time and confidentiality of a private room to seek ad-hoc advice and guidance. HR has also continued to provide both informal support.

The policy in relation to disabled employees

The organisation invites new joiners to confidentially disclose any disabilities they may have and to suggest any reasonable adjustments within the workplace which may be necessary. Further to this, HR has actively promoted the Occupational Health Service for existing staff who may feel that they would like further information or advice about a disability they may have.

HR actively encourages staff to speak to Managers with regards to any disability and to suggest reasonable adjustments. A separate flexible working policy has been developed which advocates, where possible and practical, flexible working options for staff.

The policy on equal opportunities

www.northwest.nhs.uk

Appendix H

Equality and diversity and Human Resources

The Strategic HR team works in partnership with the HR community in the NHS in North West to develop and enhance HR capability and capacity.

In 2012/2013 this has included:

- delivery of two regional conferences for HR professionals
- design and delivery of a number of development programmes
- professional leadership to the profession
- leadership on the implementation of the transition process for PCTs
- guidance and advice on the implementation of national and statutory HR policy and best practice
- management of a bespoke training programme for graduates wanting a profession in HR
- management of regional social partnership arrangements working alongside national trade unions, which has resulted in a regional programme to increase mediation skills across the North West
- provision of a comprehensive programme to enhance staff engagement and wellbeing
- supporting the development of shared HR services within the North West.

Appendix I

Complaints procedure

The NHS (complaints) regulations outline the process for complaints about NHS services. There are two stages to the complaints procedure; local resolution, followed by an independent review.

Complaints should first be made to the complaints manager at the hospital, GP or dental practice where the care or treatment took place. The complaint will be investigated and a full written response provided. If the complaint cannot be resolved locally, it can be taken to the second stage by contacting the Parliamentary and Health Service Ombudsman on 0345 015 4033.

When looking into complaints raised by individuals, NHS organisations should be committed to the P*rinciples of Good Complaint Handling* published by the Parliamentary and Health Service Ombudsman.

A full set of the principles, together with supporting information, can be accessed via the following link:

http://www.ombudsman.org.uk/improving-public-service/ombudsmansprinciples/principles-of-good-complaint-handling-full

Free, independent help, advice and support, including interpreter services are available from the Independent Complaints Advocacy Service (ICAS) on 0808 802 3000 (for ICAS in Yorkshire) or by visiting their website at **www.carersfederation.co.uk**.

In 2012/2013 the SHA received 1 formal complaints:

Nature of Complaint SHA Process Local Supervising Authority Function Number **2**

Appendix J

Freedom of information requests

We have introduced policies and procedures for responding to requests for information under the Freedom of Information Act 2000 and we fully comply with the Treasury's guidance on setting charges for such information.

For the period 1 April 2012 –1 December 2012 we received 267 requests, the breakdown of which is as follows:

- politicians - 6 per cent
- voluntary organisations - 15 per cent
- NHS organisations/personnel - 2 per cent
- journalists - 28 per cent
- public - 12 per cent
- marketing requests - 37 per cent.

Further information can be obtained from:

Kieran Lamb, FOI Officer
Fade Evidence Knowledge Centre
Bevan House
65 Stephenson Way
Wavertree Technology Park
Wavertree
Liverpool
L13 1HE

Email: **kieran.lamb@fade.nhs.uk**

Appendix K

Reporting of personal data-related incidents

During the year 2012/2013 there had been one breach of personal data which was immediately reported to the Information Commissioner and to the individuals concerned.

The Information Commissioner confirmed that the incident in question was not regarded as a serious breach or one which required further action. The SHA notified the individuals concerned and provided them with a copy of the Commissioner's decision. A review of internal processes was carried out and guidance provided for staff.

Appendix L

Feedback and comments

Department of Health
79 Whitehall
London
SW1A 2NS

Department of Health

NHS

North West Strategic Health Authority

2012-13 Accounts

October 2013

Published to gov.uk, in PDF format only.

www.gov.uk/dh

North West Strategic Health Authority

2012-13 Accounts

NATIONAL HEALTH SERVICE

ANNUAL ACCOUNTS 2012/2013

The Accounts of the North West SHA

FOREWORD

These accounts have been prepared by the North West Strategic Health Authority (NHS North West) under section 98(2) of the National Health Service Act 1977 (as amended) in the form which the Secretary of State has, with the approval of the Treasury, directed.

Statutory background

The North West SHA is a public body and part of the National Health Service. It is a statutory body governed by Acts of Parliament and came into existence on the 1st July 2006 under Statutory Instrument 2006 No 1408. As a statutory body, the North West SHA has specific powers to act as a regulator, to contract in its own name, act as a corporate trustee, to fund projects jointly planned with and to make payments and grants to local authorities, voluntary organisations and other bodies.

On the 2nd October 2011 SHAs were organised under a clustering arrangement, where the North West SHA was clustered with the Yorkshire and the Humber SHA and the North East SHA and have been placed under a single management framework and work together as NHS North of England. Each SHA maintains its separate statutory responsibilities and reports on its own activities and resources.

Main functions of the Strategic Health Authority

The North West SHA secures the improvement in the physical and mental health of people in the North West through resources available to it.

This is done by:

- Creating a strategic framework to deliver the NHS Plan in their area.
- Securing annual performance agreements and performance management of Primary Care Trusts and NHS Trust.
- Building capacity and supporting performance improvement across all their local health agencies.

Review of activities and performance against targets

The North West SHA, in line with other NHS bodies, operates resource based accounting. This expenditure is measured against a Resource Limit set by the Department of Health. The North West SHA has a statutory duty to contain expenditure within the Resource Limit and an administrative duty to achieve "Operating Financial Balance".

Better Payment Practice Code

The North West SHA is required to pay its non-NHS creditors in accordance with the Better Payments Practice Code. The target is to pay 95% of non-NHS creditors within 30 days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed with the supplier. Of the total relevant non-NHS bills, 97.1% of bills, representing 99.7% by value, were paid within the target. The same target applies to NHS bodies. Of the total relevant NHS bills, 98.4% of bills representing 99.7% by value, were paid within target.

Names of Board Members
NHS North of England

CHAIRMAN:
Kathryn Riddle

VICE CHAIRMAN:
Sir Peter Carr, C.B.E, DL (to 30.6.12)
Sally Cheshire (From 1.7.12 to 31.3.13)

NON EXECUTIVE DIRECTORS:
Professor Peter Fidler, M.B.E, DL, DipTP, DipSoc, MRTPI
Alan Foster
Sarah Harkness
Professor Oliver James BA, MA, BM, BCh, FRCP, F.Acad.Med.Sci
Ian Walker

CHIEF EXECUTIVE:
Ian Dalton (1.3.12-30.9.12)
Professor Stephen Singleton (from 1.10.12)

EXECUTIVE DIRECTORS:

Richard Barker	Chief Operating Officer
Jane Cummings (1.4.12 - 30.04.12)	Chief Nurse
Gill Harris (1.5.12 - 31.03.13)	Chief Nurse
Mark Ogden (1.3.12 - 30.6.12)	Cluster Director of Finance / Deputy Chief Executive
Jane Tomkinson (1.7.12 - 31.03.13)	Cluster Director of Finance
Professor Stephen Singleton (30.09.12 - 31.03.13)	Cluster Medical Director / Deputy Chief Executive (from 1.07.12 - 30.09.12)

OTHER DIRECTORS

Tim Gilpin	Cluster Director of Workforce and Education
Professor Paul Johnstone	Cluster Director of Public Health
Elaine Darbyshire	Director of Communications & Corporate Affairs

Details of salaries, allowances and pension benefits relating to the Non - Executive Directors are contained in the governance and finance section of the Strategic Health Authority's 2012/13 Annual Report

Policy in respect of employees with disabilities

The North West SHA is committed to challenging discrimination, promoting equality and diversity, and respecting human rights in all we do. The NHS North West is committed to employing people with disabilities and to retaining existing employees if they become disabled. The NHS North West has once again been re-accredited for the Job Centre Plus, Department of Work and Pensions "two ticks" disability symbol, which is proof of the authority's commitment to employing people with disabilities.

Policy in respect of equality and diversity

The North West SHA is committed to meet the Public Sector Equality Duty in the Equality Act 2010, by treating all its employees, applicants for employment, service users, patients and sub-contractors equally regardless of their gender, marriage or civil partnership status, sexual orientation, colour, race, nationality, ethnic origin, religion or belief, including lack of belief, age, disability, gender re-assignment, sex, pregnancy and maternity, part time work status or carers' responsibilities.

Name of the auditor and the cost of work performed during the year split by audit work, further assurance and other services.

The audit service is provided by Grant Thornton in 2012/13, who was awarded the North West contract on behalf of the Audit Commission

The auditor is Mr M Waite from Grant Thornton. The summary of the auditors' remuneration is shown below:

	2012/13	2011/12
	£000	£000
Audit fees	104	173
efficiency reduction	(8)	(14)
Total	96	159

Signed:  **Date:** 29/5/2013

Signing Officer JANET PERRY

Statement of Comprehensive Net Expenditure for year ended 31 March 2013

	NOTE		2012/13 £000		2011/12 £000
Administration Costs and Programme Expenditure					
Employee Benefits					
Staff Costs		25,566		24,836	
Redundancy Provision 11/12				7,269	
Redundancy Provision Release 12/13		(3,353)			
		22,213		32,105	
Gross employee benefits	7.1		**22,213**		32,105
Other costs	5.1		**688,788**		688,639
Income	4		**(4,402)**		(3,098)
Net operating costs before interest			**706,599**		717,646
Net operating costs for the financial year			**706,599**		717,646
Net operating costs and transfer gains/losses for the financial year			**706,599**		717,646
Of which:					
Administration Costs					
Gross employee benefits	7.1		**19,300**		19,993
Other costs	5.1		**15,204**		19,164
Income	4		**(1,963)**		(948)
Net administration costs before interest			**32,541**		**38,209**
Net administration costs for the financial year			**32,541**		**38,209**
Programme Expenditure					
Gross employee benefits	7.1		**2,913**		12,112
Other costs	5.1		**673,584**		669,475
Income	4		**(2,439)**		(2,150)
Net programme expenditure before interest			**674,058**		679,437
Net programme expenditure for the financial year			**674,058**		679,437
Total comprehensive net expenditure for the year*			**706,599**		**717,646**

*This is the sum of the rows above plus net operating costs for the financial year after absorption accounting adjustments.
The notes on pages 7 to 32 form part of this account.

Statement of financial position at 31 March 2013

	NOTE	**31 March 2013** £000	31 March 2012 £000
Current assets:			
Trade and other receivables	19	**2,636**	3,338
Sub Total current assets		**2,636**	3,338
Total current assets		**2,636**	3,338
Total assets		**2,636**	3,338
Current liabilities			
Trade and other payables	25	**(2,172)**	(8,239)
Provisions	32	**(1,296)**	(8,361)
Total current liabilities		**(3,468)**	(16,600)
Non-current assets plus/less net current assets/liabilities		**(832)**	(13,262)
Total Assets Employed:		**(832)**	(13,262)
Financed by taxpayers' equity:			
General fund		(832)	(13,262)
Total taxpayers' equity:		**(832)**	(13,262)

The notes on pages 7 to 22 form part of this account.

The financial statements on pages 3 to 6 were approved by the Board on *[date]* and signed on its behalf by

Signing Officer: Date: 29.5.2013

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY
For the year ended 31 March 2013

	General fund £000	Total reserves £000
Balance at 1 April 2012	(13,262)	**(13,262)**
Changes in taxpayers' equity for 2012/13		
Net operating cost plus (gain)/loss on transfers by absorption	(706,599)	**(706,599)**
Total recognised income and expense for 2012/13	(706,599)	**(706,599)**
Net Parliamentary funding	719,029	**719,029**
Balance at 31 March 2013	**(832)**	**(832)**
Changes in taxpayers' equity for 2011/12		
Balance at 1 April 2011	**(8,678)**	(8,678)
Restated balance at 1 April 2011	(8,678)	**(8,678)**
Net operating cost for the year	(717,646)	(717,646)
Total recognised income and expense for 2011/12	**(717,646)**	**(717,646)**
Net Parliamentary funding	**713,062**	713,062
Balance at 31 March 2012	**(13,262)**	**(13,262)**

Statement of cash flows for the year ended 31 March 2013

	2012/13 £000	2011/12 £000
Cash Flows from Operating Activities		
Net Operating Cost Before Interest	**(706,599)**	(717,646)
(Increase)/Decrease in Trade and Other Receivables	**702**	(1,361)
Increase/(Decrease) in Trade and Other Payables	**(6,067)**	(1,983)
Provisions Utilised	**(3,759)**	(81)
Increase/(Decrease) in Provisions	**(3,306)**	8,009
Net Cash Inflow/(Outflow) from Operating Activities	**(719,029)**	(713,062)
Cash flows from investing activities		
Net Cash Inflow/(Outflow) from Investing Activities	**0**	0
Net cash inflow/(outflow) before financing	**(719,029)**	(713,062)
Cash flows from financing activities		
Net Parliamentary Funding	719,029	713,062
Net Cash Inflow/(Outflow) from Financing Activities	**719,029**	713,062
Net increase/(decrease) in cash and cash equivalents	**0**	**0**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**0**	**0**
Cash and Cash Equivalents (and Bank Overdraft) at year end	**0**	0

1. Accounting policies

Under the provisions of the Health and Social Care Act 2012, North West SHA was dissolved on 31 March 2013. The SHA's functions, assets and liabilities transferred to other public sector entities as outlined in Note 40 Events after the Reporting Period. Where reconfigurations of this nature take place within the public sector, Government accounting requires that the activities concerned are to be considered as continuing operations, and so the closing entity prepares accounts on a "going concern" basis.

The SOFP has therefore been drawn up at 31 March 2013 on the same basis as in previous years, reporting balances on the same basis as would a continuing entity. In particular, there has been no general revaluation of assets or liabilities, and no disclosures have been made under IFRS 5 Non-current Assets Held for Sale and Discontinued Operation.

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

The SHA 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 SHA 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

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 SHA'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 North West SHA entered into a lease agreement for its headquarters at 3 Piccadilly Place during 2009/10. The lease does not transfer substantially all of the risks and rewards incidental to ownership. An assessment of this lease was undertaken in 2009/10 and it was judged an operating lease under IAS 17.

Key sources of estimation uncertainty

The North West SHA has used estimation techniques in calculating provisions within the accounts. No key assumptions concerning the future or any other sources of estimation are considered to be a significant risk that would cause a material adjustment to the carrying amount of assets and liabilities within the next financial year.

1. Accounting policies (continued)

1.2 Revenue and Funding

The main source of funding for the North West SHA is allocations (Parliamentary Funding) from the Department of Health within an approved cash limit, which is credited to the General Fund of the SHA. 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 SHA. 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 Taxation

The North West SHA 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.

1.4 Administration and Programme Costs

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

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

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

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

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

1. Accounting policies (continued)

1.5 Property, Plant & Equipment

Recognition

The North West SHA fully depreciates all assets within the year of acquisition and as such is not required to account for any capitalisation costs or valuation issues. Any impact on revenue expenditure of this accounting policy is disclosed in note 5. This policy is a departure from the NHS Manual for Accounts and IAS 16.

1.6 Intangible Assets

North West SHA does not hold any intangible assets.

1.7 Depreciation, amortisation and impairments

The North West SHA does not capitalise any assets and as such is not normally required to account for depreciation, amortisation and impairments.

1.8 Non-current assets held for sale

The North West SHA does not hold any non-current assets for sale.

1.9 Inventories

The North West SHA does not hold any inventories.

1.10 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 SHAs not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.11 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

The NHSLA operates a risk pooling scheme under which the SHA pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The total value of clinical negligence provisions carried by the NHSLA on behalf of the SHA is disclosed at Note 31.

1. Accounting policies (continued)

1.12 Employee benefits
Short-term employee benefits

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

Retirement benefit costs

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

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

1.13 Research and Development
The North West SHA has no research and development activity.

1.14 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.

1.15 Grant making

Under section 256 of the National Health Service Act 2006, the SHA has the power to make grants to local authorities, voluntary bodies and registered social landlords to finance capital or revenue schemes. A liability in respect of these grants is recognised when the SHA has a present legal or constructive obligation which occurs when all of the conditions attached to the payment have been met.

1.16 EU Emissions Trading Scheme

EU Emission Trading Scheme allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amount are valued at fair value at the end of the reporting period.

1. Accounting policies (continued)

1.17 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 SHA, 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.

1.18 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 SHA 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 SHA'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. This is a change in accounting policy from previous years where leased land was always treated as an operating lease.

The SHA as lessor

The North West SHA is not the lessor for any leases.

1.19 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.

1.20 Provisions

Provisions are recognised when the SHA has a present legal or constructive obligation as a result of a past event, it is probable that the SHA 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 2.2% in real terms (2.8% for employee early departure obligations)..

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

1. Accounting policies (continued)

1.21 Financial Instruments

Financial assets

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

Financial assets are initially recognised at fair value.

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

Financial assets at fair value through profit and loss

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

Held to maturity investments

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

Available for sale financial assets

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

Loans and receivables

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

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

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

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

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

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

1. Accounting policies (continued)

Financial liabilities

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

Financial liabilities are initially recognised at fair value.

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

Financial liabilities at fair value through profit and loss

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

Other financial liabilities

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

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

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

IAS 27 Separate Financial Statements - subject to consultation
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IFRS 9 Financial Instruments - subject to consultation - subject to consultation
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IPSAS 32 - Service Concession Arrangement - subject to consultation

2 Operating segments

Within the overall resource allocation issued by the Department of Health, the North West SHA receives a separate allocation for Multi-Professional Education & Training (MPET) for its activities in relation to planning and commissioning training and education on behalf of the NHS organisations in the region. The relative size and nature of this allocation means that expenditure relating to the MPET allocation is monitored separately from the North West SHA's other budgets. The North West SHA acts also as a Statutory host body to a wide range of National and Regional programmes. These hosted budgets have also been reported separately from its Core allocation. The North West SHA has not previously separated its assets and liabilities into each segment, but for 2012/13 they can be reported by receiver organisations for allocation in 2013/14.

In line with the Operating Framework, The North West SHA has maintained a strategic reserve for transfers to/from PCTs. In aggregate, PCTs revenue resource limits have been reduced by £130.203 million in 2012/13 (£113.907 million in 2011/12) and this amount is included in the North West SHA surplus, together with SHA sector reserves is reflected as Sector in the table below. This amount will be returned to receiver organisations in 2013/14.

	Sector		Core Activities		Hosted Activities		MPET		Total	
	2012/13	2011/12	**2012/13**	2011/12	**2012/13**	2011/12	**2012/13**	2011/12	**2012/13**	2011/12
	£000	£000	**£000**	£000	**£000**	£000	**£000**	£000	**£000**	£000
Expenditure	**0**	**0**	**7,931**	15,167	**11,740**	19,629	**686,928**	682,850	**706,599**	717,646
Surplus/(Deficit)										
Segment surplus/(deficit)	**170,728**	144,483	**3,898**	484	**2,272**	11,401	**62,773**	58,756	**239,671**	215,124
Common costs	**0**	0	**0**	0	**0**	0	**0**	0	**0**	0
Surplus/(deficit) before interest	**170,728**	144,483	**3,898**	484	**2,272**	11,401	**62,773**	58,756	**239,671**	215,124
Net Assets:										
Segment net assets	**0**	**0**	**(832)**	(13,262)	**0**	0	**0**	0	**(832)**	(13,262)

3. Financial Performance Targets

3.1 Revenue Resource Limit

	2012/13 £000	2011/12 £000
The SHAs' performance for the year ended 2012/13 is as follows:		
Total Net Operating Cost for the Financial Year	**706,599**	717,646
Revenue Resource Limit	**946,270**	932,770
Under/(Over)spend Against Revenue Resource Limit (RRL)	**239,671**	215,124

Prior period adjustments in respect of errors
The North West SHA had no prior period adjustments in respect of errors.

3.2 Capital Resource Limit

	2012/13 £000	2011/12 £000
The SHA is required to keep within its Capital Resource Limit.		
Total Gross Capital Expenditure	**0**	0
Capital Resource Limit (CRL)	**0**	80
(Over)/Underspend Against CRL	**0**	**80**

3.3 Underspend against cash limit

	2012/13 £000	2011/12 £000
Total Charge to Cash Limit	**719,029**	713,062
Cash Limit	**723,829**	719,062
Underspend against Cash Limit	**4,800**	**6,000**

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

	2012/13 £000
Total cash received from DH (Gross)	719,029
Sub total: net advances	**719,029**
Parliamentary funding credited to General Fund	**719,029**

4 Operating Revenue

	2012/13 Total £000	2012/13 Admin £000	2012/13 Programme £000	2011/12 £000
Fees & Charges	**492**	1	491	338
Rental Income from Finance Leases	**0**	0	0	0
Rental Income from Operating Leases	**0**	0	0	0
Recoveries in respect employee benefits	**1,544**	1,264	280	0
Other	**2,366**	698	1,668	2,760
Total operating revenue	**4,402**	1,963	2,439	3,098
Investment Revenue	0	0	0	0
Total Operating and Investment Revenue	**4,402**	**1,963**	**2,439**	3,098

5.1 Operating costs (excluding employee benefits)

	2012/13 Total £000	2012/13 Admin £000	2012/13 Programme £000	2011/12 £000
Chair and Non-executive directors remuneration	**67**	67	0	86
Consultancy Services	**1,775**	1,471	304	3,524
External contractors	**2,052**	721	1,331	774
Establishment expenses	**4,954**	4,175	779	6,297
Premises	**3,370**	3,370	0	3,464
Auditors remuneration - audit fee*	**96**	96	0	159
MPET	**670,194**	242	669,952	662,973
Provisions	**0**	0	0	415
Reasearch & Development	**266**	266	0	0
AQUA	**0**	0	0	177
Cancer Screening	**1,437**	1,437	0	1,244
Chief Information and Knowledge Office (CIKO) Support Cost	**1,591**	1,591	0	547
Commissioning Development	**0**	0	0	542
Communications	**274**	274	0	0
Health Innovation and Education Cluster (HIEC)	**849**	849	0	326
Improving Access to Psychological Therapies (IAPT)	**417**	0	417	519
Innovation	**0**	0	0	492
National Institute of Health Research (NIHR)	**0**	0	0	4,105
NHS Leadership	**331**	331	0	0
Other	**1,115**	314	801	2,995
Total Operating Costs excl. Employee benefits	**688,788**	15,204	673,584	688,639

* Includes Audit Commission efficiency rebate of £8K

5.2 Gross Employee Benefits - excluding capitalised costs and income in respect of staff costs

	2012/13 Total £000	2012/13 Admin £000	2012/13 Programme £000	2011/12 £000
Employee Benefits (excluding officer board members)	**21,462**	18,549	2,913	30,931
SHA Officer Board members	**751**	751	0	1,174
Total Employee Benefits	**22,213**	19,300	2,913	32,105
TOTAL OPERATING COSTS	**711,001**	34,504	676,497	720,744

Training (Multi Professional Education and Training)

	2012/13 £000	2011/12 £000
NHS Bodies	**509,908**	510,774
Educational Insititutions	**148,596**	147,526
Other	**11,690**	4,673
Total Training	**670,194**	662,973

Note 5 Continued ...

Expenditure with Educational Institutions

	2012/13	2011/12
	£000	£000
The University of Manchester	26,425	26,452
University of Salford	25,394	25,455
University of Central Lancashire	20,234	19,713
University of Liverpool	15,357	15,234
Edge Hill University	13,248	13,041
University of Chester	12,389	12,661
University of Cumbria	11,895	11,495
Liverpool John Moores University	10,423	10,647
Manchester Metropolitan University	9,371	9,134
Lancaster University	1,756	1,745
University of Bolton	1,371	1,277
York St John University	644	655
Other Educational Bodies	88	17
Total Educational	148,596	147,526

5.3 Running costs and public health expenditure

Running Costs 2012/13	SHA & MPET	Public Health	Total
	£000	£000	£000
Running costs (£000s)	29,738	2,384	32,122
Weighted population (number in units)	7,702,578	7,702,578	7,702,578
Running costs per head of population (£ per head)	3.9	0.3	4.2

Running Costs 2011/12	SHA & MPET	Public Health	Total
	£000	£000	£000
Running costs (£000s)	34,699	2,812	37,511
Weighted population (number in units)	7,702,578	7,702,578	7,702,578
Running costs per head of population (£ per head)	4.5	0.4	4.9

Public Health		
Of the above:	**2012/13**	2011/12
	£000	£000
Public Health running costs	**2,384**	2,812
Total operating costs excluding employee benefits	**2,545**	2,406
Employee Benefits	**1,875**	2,252
Total Public Health expenditure	**4,420**	4,658
Of Operating Revenue: amount relating to Public Health Income from Outside the NHS/DH	**(147)**	(48)

6. Operating Leases

6.1 SHA as lessee	Land	Buildings	Other	2012/13 Total	2011/12
	£000	£000	£000	£000	£000
Payments recognised as an expense					
Minimum lease payments				812	842
Total				812	842
Payable:					
No later than one year	0	780	32	812	812
Between one and five years	0	0	0	0	1,218
Total	0	780	32	812	2,030

The lease obligation will transfer to NHS Property Services Ltd on the 1st April 2013

6.2 SHA as lessor

The North West SHA is not the lessor for any leases.

7. Employee benefits and staff numbers

7.1 Employee benefits

				Permanently employed			Other		
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Employee Benefits 2012/13 - gross expenditure									
Salaries and wages	**18,744**	15,831	2,913	**14,505**	11,592	2,913	**4,230**	4,230	0
Social security costs	**1,524**	1,524	0	**1,524**	1,524	0	**0**	0	0
Employer Contributions to NHS BSA - Pensions Division	**1,945**	1,945	0	**1,945**	1,945	0	**0**	0	0
Termination benefits *	**0**	0	0	**0**	0	0	**0**	0	0
Total employee benefits	**22,213**	**19,300**	**2,913**	**17,974**	**15,061**	**2,913**	**4,230**	**4,230**	**0**
Less recoveries in respect of employee benefits (table below)	**(1,544)**	(1,264)	(280)	**(1,544)**	(1,264)	(280)	**0**	0	0
Total - Net Employee Benefits including capitalised costs	**20,669**	18,036	2,633	**16,430**	13,797	2,633	**4,230**	4,230	0
Employee costs capitalised	**0**	0	0	**0**	0	0	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**22,213**	19,300	2,913	**17,974**	15,061	2,913	**4,230**	4,230	0

*** Please note that although there is £0 termination benefit reported , there was expenditure for termination costs in 2012/13 which were offset against the redundancy provision shown in the 2011/12 accounts. The full cost of this is reported within note 7.4 Exit Packages**

Employee Benefits 2012/13 - income				Permanently employed			Other		
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Salaries and wages	**1,544**	1,264	280	**1,544**	1,264	280	**0**	0	0
TOTAL excluding capitalised costs	**1544**	**1,264**	**280**	**1,544**	**1,264**	**280**	**0**	**0**	**0**

Employee Benefits Prior Year

	Total	Permanently employed	Other
Employee Benefits Gross expenditure 2011/12	**£000**	**£000**	**£000**
Salaries and wages	**28,324**	25,811	2,513
Social security costs	**1,520**	1,520	0
Employer Contributions to NHS BSA - Pensions Division	**2,056**	2,056	0
Other employment benefits	**11**	11	0
Termination benefits	**194**	194	0
Total employee benefits	**32,105**	29,592	2,513
Less recoveries in respect of employee benefits	**0**	0	0
Total - Net Employee Benefits including capitalised costs	**32,105**	29,592	2,513
Employee costs capitalised	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**32,105**	29,592	2,513

7.2 Staff Numbers

	2012/13			2011/12		
Average Staff Numbers	**Total Number**	**Permanently employed Number**	**Other Number**	**Total Number**	**Permanently employed Number**	**Other Number**
Other	374	334	40	397	369	28
TOTAL	374	334	40	397	369	28
Of the above - staff engaged on capital projects	0	0	0	0	0	0

7.3 Staff Sickness absence and ill health retirements

	2012/13 Number	2011/12 Number
Total Days Lost	**2,692**	1,850
Total Staff Years	**345**	355
Average working Days Lost	**7.80**	5.21

The North West SHA did not have any persons retired early on ill health grounds in 2012-13 or in 2011-12.

The North West SHA did not have any additional pensions liabilities accrued in 2012-13 or in 2011-12.

7.4 Exit Packages agreed during 2012/13

	2012/13			2011/12		
Exit package cost band (including any special payment element)	*Number of compulsory redundancies Number	*Number of other departures agreed Number	Total number of exit packages by cost band Number	*Number of compulsory redundancies Number	*Number of other departures agreed Number	Total number of exit packages by cost band Number
Lees than £10,000	**7**	0	**7**	1	0	**1**
£10,001-£25,000	**3**	0	**3**	0	0	**0**
£25,001-£50,000	**3**	0	**3**	0	0	**0**
£50,001-£100,000	**8**	0	**8**	0	0	**0**
£100,001 - £150,000	**7**	0	**7**	0	0	**0**
£150,001 - £200,000	**4**	0	**4**	1	0	**1**
>£200,000	**4**	0	**4**	0	0	**0**
Total number of exit packages by type (total cost	**36**	**0**	**36**	**2**	**0**	**2**
	£	**£**	**£**	**£**	**£**	**£**
Total resource cost	3,374,000	0	**3,374,000**	193,000	0	193,000

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

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

7.5 Pension costs

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

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

a) Accounting valuation

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

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

b) Full actuarial (funding) valuation

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

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

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

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

c) Scheme provisions

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

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.
With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

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

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

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

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

8. Better Payment Practice Code

8.1 Measure of compliance	2012/13 Number	2012/13 £000	2011/12 Number	2011/12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**12,850**	**175,454**	12,067	173,709
Total Non-NHS Trade Invoices Paid Within Target	**12,473**	**175,001**	11,966	173,319
Percentage of NHS Trade Invoices Paid Within Target	97.07%	99.74%	99.16%	99.78%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3,278**	**533,697**	3,211	537,804
Total NHS Trade Invoices Paid Within Target	**3,225**	**532,094**	3,180	537,379
Percentage of NHS Trade Invoices Paid Within Target	98.38%	99.70%	99.03%	99.92%

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

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

There were no late payment interest charges in 2012/13 (2011/12: nil).

9. Investment Income

The North West SHA had no investment income in 2012/13 (2011/12: nil).

10. Other Gains and Losses

The North West SHA had no other gains or losses in 2012/13 (2011/12: nil).

11. Finance Costs

The North West SHA had no Finance Costs in 2012/13 (2011/12: nil)

12.1 Property, plant and equipment

2012/13	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:									
At 1 April 2012	0	0	0	0	0	0	361	214	575
At 31 March 2013	0	0	0	0	0	0	361	214	575
Depreciation									
At 1 April 2012		0	0	0	0	0	361	214	575
At 31 March 2013	0	0	0	0	0	0	361	214	575
Net Book Value at 31 March 2013	0	0	0	0	0	0	0	0	0
Asset financing:									
Owned	0	0	0	0	0	0	0	0	0
Held on finance lease	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	0	0	0	0	0	0	0	0	0

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	0	0	0	0	0	0	0	0	0
At 31 March 2013	0	0	0	0	0	0	0	0	0

12.2 Property, plant and equipment

2011/12	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:									
At 1 April 2011	0	0	0	0	0	0	361	214	575
At 31 March 2012	0	0	0	0	0	0	361	214	575
Depreciation									
At 1 April 2011	0	0	0	0	0	0	361	214	575
At 31 March 2012	0	0	0	0	0	0	361	214	575
Net book value	0	0	0	0	0	0	0	0	0

12.3 Property, plant and equipment

North West SHA holds no property, plant or equipment as at 31 March 2013 that is not fully depreciated.

13.1 Intangible non-current assets

2012/13	Software internally generated £000	Software purchased £000	Licences & trademarks £000	Patents £000	Development expenditure £000	Total £000
At 1 April 2012	0	73	0	0	0	73
At 31 March 2013	0	73	0	0	0	73
Amortisation						
At 1 April 2012	0	73	0	0	0	73
At 31 March 2013	0	73	0	0	0	73
Net Book Value at 31 March 2013	0	0	0	0	0	0

Revaluation reserve balance for intangible non-current assets

	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	0	0	0	0	0	0
At 31 March 2013	0	0	0	0	0	0

13.2 Intangible non-current assets

2011/12	Software internally generated	Software purchased	Licences & trademarks	Patents	Development expenditure	Total
	£000	£000	£000	£000	£000	£000
Cost or valuation:						
At 1 April 2011	0	73	0	0	0	**73**
At 31 March 2012	**0**	**73**	**0**	**0**	**0**	**73**
Amortisation						
At 1 April 2011	0	73	0	0	0	**73**
At 31 March 2012	**0**	**73**	**0**	**0**	**0**	**73**
Net book value at 31 March 2012	**0**	**0**	**0**	**0**	**0**	**0**

13.3 Intangible non-current assets

North West SHA holds no Intangible non-current assets as at 31 March 2013 that is not fully depreciated.

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

The North West SHA had no impairments or reversals in 2012/13

15 Investment property

The North West SHA had no investment property as at 31 March 2013

16 Commitments

16.1 Capital commitments

The North West SHA had no capital commitments as at 31 March 2013.

16.2 Other financial commitments

The North West SHA had no other financial commitments at 31 March 2013.

17 Intra-Government and other balances	Current receivables	Non-current receivables	Current payables	Non-current payables
	£000s	£000s	£000s	£000s
Balances with other Central Government Bodies	1,377	0	738	0
Balances with Local Authorities	0	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	116	0	305	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	1,143	0	1,129	0
At 31 March 2013	**2,636**	**0**	**2,172**	**0**
prior period:				
Balances with other Central Government Bodies	1,767	0	2,440	0
Balances with Local Authorities	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	677	0	891	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	894	0	4,908	0
At 31 March 2012	**3,338**	**0**	**8,239**	**0**

18 Inventories

The North West SHA held no inventories at 31 March 2013.

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	**971**	2,229	**0**	0
NHS Receivables - Capital	**0**	0	**0**	0
NHS Prepayments and Accrued Income	**0**	0	**0**	0
Non NHS Trade Receivables - Revenue	**219**	324	**0**	0
Non NHS Trade Receivables - Capital	**0**	0	**0**	0
Non-NHS Prepayments and Accrued Income	**922**	570	**0**	0
Provision for Impairments of Receivables	**0**	0	**0**	0
VAT	**522**	215	**0**	0
Interest receivables	**0**	0	**0**	0
Finance lease receivables	**0**	0	**0**	0
Operating lease receivables	**0**	0	**0**	0
Other receivables	**2**	0	**0**	0
Total	**2,636**	3,338	**0**	0
Total current and non current	**2,636**	3,338		

19.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	**2,626**	3,183
By three to six months	**9**	17
By more than six months	**1**	138
Total	**2,636**	3,338

19.3 Provision for impairment of receivables

The North West SHA had no provision for impairment of receivables in 2012/13. (2011/12 Nil)

20 Other financial assets

The North West SHA had no other financial assets.

21 Other current assets

The North West SHA had no other current assets.

22 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**0**	0
Closing balance	**0**	0

23 Non-current assets held for sale

The North West SHA held no current assets held for sale at 31 March 2013.

24 Trade and other payables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Interest Payable	**0**	0	**0**	0
NHS Payables - Revenue	**1,043**	2,342	**0**	0
NHS Payables - Capital	**0**	0	**0**	0
NHS Accruals and Deferred Income	**0**	0	**0**	0
Non-NHS Trade Payables - Revenue	**239**	2,505	**0**	0
Non-NHS Trade Payables - Capital	**0**	0	**0**	0
Non-NHS Accruals and Deferred Income	**890**	2,412	**0**	0
Social Security Costs	**0**	206	**0**	0
VAT	**0**	0	**0**	0
Tax	**0**	263	**0**	0
Payments received on account	**0**	0	**0**	0
Other	**0**	511	**0**	0
Total	**2,172**	8,239	**0**	0
Total payables (current and non-current)	**2,172**	**8,239**		

25 Other liabilities

The North West SHA had no other liabilities at 31 March 2013 (31 March 2012: nil).

26 Borrowings

The North West SHA had no borrowings in 2012/13 (2011/12: nil)

27 Other financial liabilities

North West SHA had no other financial liabilities at 31 March 2013.

28 Deferred income

North West SHA had no deferred income at 31 March 2013.

29 Finance lease obligations

North West SHA had no finance leases at 31 March 2013.

30 Finance lease receivables as lessor

The North West SHA had no finance lease receivables during 2012/13

31 Provisions

		Comprising:								
	Total	Pensions to Former Directors	Pensions Relating to Other Staff	Legal Claims	Restructuring	Continuing Care	Equal Pay	Agenda for Change	Other	Redundancy
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2012	**8,361**	0	0	235	0	0	0	0	857	7,269
Arising During the Year	**265**	0	0	0	0	0	0	0	265	0
Utilised During the Year	**(3,759)**	0	0	0	0	0	0	0	(439)	(3,320)
Reversed Unused	**(3,571)**	0	0	0	0	0	0	0	(218)	(3,353)
Balance at 31 March 2013	**1,296**	**0**	**0**	**235**	**0**	**0**	**0**	**0**	**465**	**596**
Expected Timing of Cash Flows:										
No Later than One Year	**1,296**	0	0	235	0	0	0	0	465	596

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

As at 31 March 2013	244,459
As at 31 March 2012	244,636

32 Contingencies

The North West SHA had no contingencies at 31 March 2013.

33 Impact of IFRS treatment 2012/13

The North West SHA had no IFRS impacts in 2012/13

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 North West SHA are met through Parliamentary Funding, financial instruments play a more limited role in creating risk that would apply to a non-public sector body of a similar size. The majority of financial instruments relate to contracts for non-financial items in line with the North West SHA's expected purchase and usage requirements and the North West SHA is therefore exposed to little credit, liquidity or market risk.

Currency risk

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

Interest rate risk

SHAs are not permitted to borrow. The North West SHA therefore has low exposure to interest-rate fluctuations

Credit Risk

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

Liquidity Risk

The North West SHA 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 North West SHA is not, therefore, exposed to significant liquidity risks.

34.1 Financial Assets	Loans and receivables £000	Total £000
Receivables - NHS	971	**971**
Receivables - non-NHS	220	**220**
Cash at bank and in hand	0	**0**
Other financial assets	0	**0**
Total at 31 March 2013	**1,191**	**1,191**
Receivables - NHS	2,229	2,229
Receivables - non-NHS	265	265
Cash at bank and in hand	0	0
Other financial assets	56	56
Total at 31 March 2012	2,550	2,550

34.2 Financial Liabilities	Other £000	Total £000
NHS payables	1,043	**1,043**
Non-NHS payables	675	**675**
Other borrowings	0	**0**
PFI & finance lease obligations	0	**0**
Other financial liabilities	1,027	**1,027**
Total at 31 March 2013	**2,745**	**2,745**
NHS payables	2,591	**2,591**
Non-NHS payables	4,897	**4,897**
Other borrowings	0	**0**
PFI & finance lease obligations	0	**0**
Other financial liabilities	8,361	**8,361**
Total at 31 March 2012	**15,849**	**15,849**

35 Related party transactions

The North West SHA receives financial services from East Lancashire Financial Services (ELFS). ELFS has been established to provide organisations in the North West with financial shared services and is hosted by Calderstones Partnership Foundation Trust. In previous years the SHA has held a risk share agreement with 7 other partner organisations, which has now ended and a standard contractual arrangement is now in place.

Details of related party transactions with individuals are as follows:

Relationship	Organisation role	Organisation name	Description of Payment	Payments to related party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
				£000's	£000's	£000's	£000's
Elaine Darbyshire	Trustee	St Ann's Hospice	GP salaries, Salary contributions, capibility funding	135			
Kathryn Riddle	Pro Chancellor / Chairman of the council	University of Sheffield	Foundation Training	0			
Sarah Harkeness	Chair	University of Sheffield's Audit Committee	Foundation Training	0			
Sarah Harkeness	Member of the Council	University of Sheffield	Foundation Training	0			
Sarah Harkeness	Non - Executive Director	NHS Trust Development Authority and Chair of Audit Committee	L Burgess Salary recharge		36		
Denis Lidstone	Board member	The Furness Action Board supporting Furness Enterprise	Dental Cadet	1			
Denis Lidstone	Associate	AMTEC Consulting plc	Consultancy Fees	190			

Note: Values shown as 0 represent a balance of less than £500

The Department of Health is regarded as a related party. During the year 2012/13, the North West SHA 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. For example :

Strategic health Authorities
NHS Foundation Trusts
NHS Trusts
NHS Litigation Authority
NHS Business Services Authority

36 Losses and special payments

The North West SHA had no losses cases in 2012/13. (2011/12: nil).

The North West SHA had no special payment in 2012/13. (2011/12: one case of £7k).

37 Third party assets

The North West SHA held no third party assets at 31 March 2013.

38 Pooled budget

The North West SHA has no pooled budget arrangements.

39 Cashflows relating to exceptional items

The North West SHA had no exceptional items in 2012/13.

Note 40 Events after the Reporting Period

Following the Heath and Social Care Act (2012), the North West SHA was dissolved on the 31 March 2013. The main functions carried out by the North West SHA in 2012/13 are to be carried out in 2013/14 by the following public sector bodies:

- Health Education England
- NHS England
- NHS Trust Development Authority
- Public Health England
- Health & Social Care Information Centre

The SHA has put processes in place throughout 2012/13 to ensure the safe discharge of services and ensure a smooth transition. This will ensure that the SHAs duty to commission high quality education services across the NHS, provide support and leadership to Trust which have yet to obtain Foundation status and all other statutory duties will continue to be discharged by the successor organisations.

The SHA has been actively involved in the national process in arranging the transfer of balances post 31 March 2013. All short term balances will be discharged during the first quarter of 2013/14 and any long term balances will adhere to national policy and be transferred to the successor organisation.

In addition to the transfer of functions, the lease for 3 Piccadilly Place, as the principal place of business of the SHA, has transferred to NHS Property Services on 31 March 2013 and any related balance sheet items will also transfer on the same date.

STATEMENT OF THE RESPONSIBILITIES OF THE SIGNING OFFICER OF THE STRATEGIC HEALTH AUTHORITY 2012-13 ACCOUNTS

The Department of Health's Accounting Officer has designated the role of Signing Officer for the final accounts of North West Strategic Health Authority to discharge the following responsibilities for the Department of Health:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

- value for money is achieved from the resources available to the Strategic Health Authority;

- the expenditure and income of the primary care trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;

- effective and sound financial management systems are in place; and

- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the net operating cost, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, and from the assurances provided by the Accountable Officer until 31 March 2013, I am assured that the responsibilities have been properly discharged.

Signed.....

Date.....29.5.2013

NHS North West

2012/13 ACCOUNTS FINANCE CERTIFICATE OF ASSURANCE TO THE DEPARTMENT OF HEALTH DIRECTOR GENERAL, STRATEGY FINANCE AND NHS

I am aware that as Signing Officer designated by the Department of Health Accounting Officer, you are required to sign the accounts and supporting certificates of North West Strategic Health Authority (SHA) in order to comply with the Department's 2012/13 accounts finalisation process.

To assist you in that process, I can confirm that in my role managing the preparation of the annual statutory accounts, the accounts were prepared in the 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 required 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.

Name: JANE TOLLICUSON

Signed: 

Date: 29.5.2013

2012/13 ACCOUNTS CERTIFICATE OF ASSURANCE TO THE DEPARTMENT OF HEALTH DIRECTOR GENERAL, STRATEGY FINANCE AND NHS

I am aware that as Signing Officer designated by the Department of Health Accounting Officer, you are required to sign the accounts and supporting certificates of North West Strategic Health Authority (SHA) in order to comply with the Department's 2012/13 accounts finalisation process.

To assist you in that process, I can confirm that for the year ended 31 March 2013 based on my own knowledge of internal control matters and through experience in my role as Accountable Officer until 31 March 2013, the SHA:

- had in place effective management systems to safeguard public funds and assets and assist in the implementation of corporate governance;
- kept proper accounting records which disclosed with reasonable accuracy at any time the financial position of the SHA;
- took reasonable steps for the prevention and detection of fraud and other irregularities;
- achieved value for money from the resources available to the SHA;
- applied income and expenditure to the purposes intended by Parliament and conformed to the authorities which governed them and
- had effective and sound financial management systems in place.

I also confirm that in my role overseeing the preparation of the annual statutory accounts, the accounts were prepared in the 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 required 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.

Name: STEPHEN SINGLETON

Signed: 

Date: 29.5.2013

INDEPENDENT AUDITOR'S REPORT TO THE ACCOUNTABLE OFFICER OF NORTH WEST STRATEGIC HEALTH AUTHORITY

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

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

- the table of salaries and allowances of senior managers and related narrative notes;
- the table of pension benefits of senior managers and related narrative notes; and
- the table of pay multiples and related narrative notes.

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

Respective responsibilities of the signing officer and auditor

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

Scope of the audit of the financial statements

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

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

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

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

Opinion on other matters

In our opinion:

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

Matters on which we report by exception

We report to you if:

- in our opinion the governance statement does not reflect compliance with the Department of Health's Guidance;
- we refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have a reason to believe that the Authority, or an officer of the Authority, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

We have nothing to report in these respects.

Other matters on which we are required to conclude

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

satisfied that the audited body has put in place such arrangements.

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

· our review of the annual governance statement;

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

· our locally determined risk-based work.

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

Certificate

We certify that we have completed the audit of the financial statements of North West Strategic Health Authority in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Mick Waite
Senior Statutory Auditor, for and on behalf of Grant Thornton UK LLP
4 Hardman Square
Spinningfields
Manchester
M3 3EB

31 May 2013

Grant Thornton

INDEPENDENT AUDITOR'S REPORT TO THE ACCOUNTABLE OFFICER OF NORTH WEST STRATEGIC HEALTH AUTHORITY

We have examined the summary financial statement 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 associated notes.

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

Respective responsibilities of accountable officer and auditor

The accountable officer is responsible for preparing the Annual Report.

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

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

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

Opinion

In our opinion the summary financial statement is consistent with the statutory financial statements of the North West Strategic Health Authority for the year ended 31 March 2013.

Grant Thornton

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

31 May 2013