

Annual Report and Accounts



2005-06

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FOREWORD

We are pleased to write this foreword to the final Annual Report of the Cotswold and Vale Primary Care Trust. The report covers the Trust's performance for 2005-06, but also looks back over the key achievements in the four years of its existence and looks forward to the new Gloucestershire Primary Care Trust.

The report demonstrates the achievement of the PCT and its staff over these four years and, particularly, the successes of the last year. These are the culmination of development work over the last four years and the realisation of the Trust's strategic direction to provide services closer to home.

Any new organisation takes three to five years to mature, and the PCT is now seeing the benefits of the foundations it established in redesigning its local services for local people and their local communities. It has been about work with local clinicians, stakeholders, district councils, Leagues of Friends and the Patient and Public Forums to shape the rural health services in line with national policies and directives.

The PCT produced its strategy on local services – Better Health Closer to Home - in the autumn of 2005-06. In this, it expressed its commitment to ensure services were fit for purpose for the health needs of local people for the next ten to fifteen years.

Partnership has been the hallmark of our work in many areas. This is particularly true in the local and county strategic partnerships, local area agreements and in the area of public health, where, together with our two local district councils, we have achieved Beacon status on health and well-being.

Partnership with the clinical community has been an essential element of many successes. The quality of primary care in the area has been a continuing credit to GPs. Our practices achieved an average of 1,039 points out of a possible 1,050 in the new annual assessment to measure the quality of their care and commitment to patients.

Our local general practices have responded magnificently in supporting the new out of hours service from four centres in the patch. The PCT has been highly successful in providing the most cost effective out of hours service in its cohort of comparative rural PCTs in the county.

The quality of the services provided by the PCT can be measured by the fact it has achieved two star status in every year of its existence and submitted a full compliance with the Healthcare Commission standards in 2005-06. Its returns on the Patient Environment Action Team (PEAT) cleanliness and infection control have been exemplary, as has been its achievement of its Level 1B of the Clinical Negligence Scheme for Trusts (CNST).

The PCT has striven to provide innovative and high quality services for its population. It has therefore welcomed the recent appointment of an independent treatment centre day care service from UK Specialist Hospitals for Cirencester Hospital. This should secure its future from the uncertain position four years ago, when it was seen to be under threat. It has also been very encouraging to receive the Community Hospitals Award for the Multidisciplinary Assessment Unit at Cirencester Hospital as an example of innovative practice.

The disappointment and frustration has been the continuing financial deficit that has absorbed so much time and energy of the Board. The PCT began its life with a deficit and has reduced this from a high of 1.9 percent of income to 1.3 percent, but there remains much work to be done.

GPs have worked hard to reduce their patients' need for care at the district hospitals in Gloucester and Cheltenham, thereby saving money and providing more local services. The establishment of a Foundation Trust and the financial regime that supported it brought significant additional budgetary pressures. This required a new focus on information capture and financial modelling. The foundations are now laid for strong financial control, enabling reduced expenditure and the long march to financial stability.

We have welcomed the community's participation in a number of consultations. The public's input and voice on change has been important to the PCT and we have learnt much through listening to local people. The PCT would wish to express its thanks and admiration for the professional way in which many communities have presented their views on service changes. The voice of the consumer and the public has also been expressed through the Patient and Public Involvement Forum, which has been a source of challenge and support in many areas.


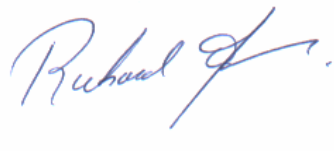
We are aware of the tremendous dedication and effort of all our staff who have had to work in some trying and exacting times over the last four years. They have continued to provide very high quality care to patients with dignity and sensitivity and demonstrated the unique NHS loyalty and ethos. We thank them sincerely for their hard work.

The PCT will be handing over to the new Gloucestershire PCT a legacy of high quality, clinical staff and clinical care, with well-developed plans across our whole geographical area that conform to the vision of a reconfigured NHS, fit for purpose with a patient-led service.



Elizabeth Law

Chair



Richard James

Chief Executive
Committee Chair

Stuart Drysdale

Professional Executive

7 September 2006

ABOUT THE PCT

Cotswold and Vale PCT covers an area of 627 square miles and, in 2005-06, was responsible for healthcare for a population of 197,758. There are 128 GPs in 33 practices, 33 community pharmacists, 76 dentists in 31 practices, and 78 opticians working within the Trust area. The Trust is a relatively large employer, with approaching 2,000 staff.

During 2005-06, we held a budget of £214 million to provide and commission (purchase) healthcare for people in our area. We provide care mainly through our GPs and the six community hospitals we own and manage. We purchase care mainly from other Gloucestershire 'provider' trusts:

- Gloucestershire Hospitals NHS Foundation Trust (owns and manages Gloucestershire Royal and Cheltenham General Hospitals);
- Great Western Ambulance NHS Trust;
- Gloucestershire Partnership NHS Trust (provides services for people with mental health needs).

We also purchase care from hospitals out of county (where more specialised treatment is required), from the voluntary sector and from social services.

Our vision

To deliver a range of high quality local health services around the clock, as close to the patient's home as possible, organised by integrated teams of health and social care staff based within local communities

To make sure our vision becomes reality, we are committed to:

- making sure that we commission services on the basis of patient need and cost effectiveness;
- actively seeking to provide services closer to home and reduce our reliance on acute (hospital) care wherever possible;
- strengthening the role of our community hospitals as vibrant, cost-effective centres that enable our patients to receive care closer to home;
- developing the PCT as an effective organisation and the quality of its partnerships so that it can sustain these changes.

Our localities

To better manage our resources and promote localised decision-making within the large geographical area we cover, our 'locality' forums in Stroud, Berkeley Vale, the north and the south Cotswolds, are made up of local clinicians, managers and patient representatives to identify how best to serve patients in those localities.

The national commissioning strategy promotes more engagement with the public, choice and contestability at local level. Since the PCT came into being in 2002, decision-making has been increasingly devolved to the four localities.

Our objectives are to deliver service change, in particular to increase the volume and range of services that are provided locally. We have worked closely with primary care and community teams, as well as other partners to promote this locality focus.

In the north Cotswolds, we have worked on a whole scale service re-design for an entire locality, involving members of the local community, patients and the voluntary sector. The local community itself identified a need to change the emphasis of how its services are provided, and has developed a business case to support this whole scale change.

In Berkeley Vale and Stroud, we have introduced a specialist nurse for diabetes. Diabetes is a chronic progressive condition, affecting two million people in the UK. It can lead to complications involving the eyes, heart, kidneys, feet and circulation. The service has been designed to offer patient-centred care closer to home.

We regularly run education groups for patients and their supporters in these localities, while training and update sessions for professional staff help to share best practice. Both of these help to reduce referrals to secondary care.

By introducing access to a community outreach night nurse, we have been able to manage more patients at home in Stroud and Berkeley Vale, who would otherwise need to be taken to hospital for treatment.

Across the whole PCT, we have introduced a GP with a special interest in dermatology, and are now able to treat patients with a wide range of skin conditions.

The future

From October this year, Cotswold and Vale PCT will merge with West Gloucestershire and Cheltenham and Tewkesbury PCTs. While the new Gloucestershire PCT will continue to provide as well as commission services (eg from its network of community hospitals), the future of these services in county is likely to look very different.

The government's community health services White Paper - *Our health, our care, our say* – looks to a future where diversity is key to successful provision of health care in our local communities. We are likely

to see, increasingly, hospitals and health centres that are run by the voluntary or independent sectors, working in partnership with their local NHS trusts.

An example of where this is already happening can be seen at Tetbury Hospital. During 2005-06, the PCT worked closely with the independently-run hospital and its local GPs to support its re-development from a mainly inpatient facility to a more broadly focused health care campus, with plans to offer a much wider range of outpatient services and an on-site GP surgery.

RE-DESIGNING HEALTH SERVICES FOR A RURAL POPULATION

This section of the report covers the steps we have taken to commission new types of services to meet the needs of our population in rural areas.

Better healthcare closer to home

During 2005-06, the PCT completed a radical review of its provision, to make sure it develops modern, cost effective health care. The PCT's vision is of local services.

In a dispersed rural population, there is significant merit in increasing local access to outpatient clinics, diagnostic services, day care, therapy, social and home care teams and specialist services to improve the management of patients with long-term conditions.

People currently have to travel many miles for an outpatient appointment. There is a great deal the PCT has done to bring services closer to people. In addition, there are increasing numbers of clinics that will be undertaken locally by GPs with special training.

As a result of the review, our community hospitals are starting to take on a much wider role in the care of local communities. During the year, we involved patients and the public in decisions on the future of Fairford Hospital in a formal public consultation. The beds at both Tetbury and Fairford hospitals have now closed and a range of services such as outpatients, diagnostics, therapy, minor surgery and dental services are starting to take their place.

In Berkeley Vale and the North Cotswolds, proposals to provide an increasing range of services are now being consulted upon.

New ways of caring for patients

In 2005-06, the PCT looked at the potential of a range of new ways of caring for patients. Following these assessments, we started offering dermatology and urology services in different ways. We developed alternatives to secondary care for orthopaedic conditions, including new fracture clinics at Stroud and Cirencester. We also introduced a multi-disciplinary specialist falls clinic in the north Cotswolds, which is supporting older people to live at home.

Across the PCT, we now have a network of 'virtual teams', made up of colleagues from health (including mental health), social care and district council services. The aim of these virtual teams is to support older people to live at home as independently as possible, and to signpost them to appropriate services to meet their needs.

By working as a network, team members are gaining a better understanding of what each other does, and which agency is able to provide the best service to meet the patient's needs.

Rehabilitation in hospital and at home

During 2005-06, the PCT agreed a new protocol for the early transfer of patients with rehabilitation needs from acute hospital beds to community hospitals. The PCT will continue to increase the numbers of patients (particularly elderly patients) who receive their rehabilitation in community hospitals using the multi-disciplinary approach. The PCT has secured specialist consultant input for rehabilitation services, and we are now developing plans to deliver more of this care in patients' own homes.

Shorter stays and increased capacity

We have achieved shorter lengths of stay for patients in Stroud, Berkeley and Cirencester Hospitals with the introduction of rapid assessment teams.

These multi-disciplinary teams are able to assess patients and plan their care - including their estimated discharge date - within 24 hours of admission. This way of working is focusing everyone's attention on treating the patient for a timely discharge and is reducing the length of stay for patients.

The introduction in 2005 of a lead consultant for our minor injuries units is reaping benefits in the form of:

- more capacity to treat fractures (as there are more clinics being held);
- supervision and teaching for Trust doctors;
- an in-house teaching programme for nurses.

And the introduction of a consultant post in elderly care at Cirencester Hospital has meant the rapid assessment of patients, access to appropriate diagnostics and reduction in patients' length of stay.

PATIENT-LED COMMISSIONING

The four PCT locality forums have worked closely with the GP practices in their area this year, to support the transition towards practice-based commissioning (PBC).

Currently, primary care trusts make commissioning, or purchasing, decisions for patients in their care. However, under the new PBC system, due to come into force in [date], GPs will make local decisions on commissioning secondary health care for their patients.

The PCT allocated broad indicative budgets to each GP practice, and 27 out of 33 practices have opted to take on the budget and make local commissioning decisions. The remainder have been active in service planning through their locality forums.

Because of the close working relationships already existing between GP practices in the four localities of Cotswold and Vale, the localities decided to form four sister commissioning units, each with a GP or chair to co-ordinate local planning.

The population of the commissioning units varies from 28,000 in the north Cotswolds, to 75,000 in Stroud. A commissioning team supports PBC, with dedicated support from the PCT's finance and information department.

Practices have been supported to develop action plans to manage demand, and each practice has agreed target levels of activity. Practice facilitators visit each practice to help progress delivery of the plans.

Learning and development across the commissioning units has been promoted through shared learning events.

Quality

Since April 2005, there has been a new performance framework for NHS trusts, driven by the *Standards for Better Health*. These standards represent the first steps toward simplifying and rationalising the expectations on the service and reducing the burden of service requirements.

The standards are divided into seven domains:

- safety
- clinical and cost effectiveness
- governance

- patient focus
- accessible and responsive care
- care and environment amenities
- public health

Within these domains there are two types of standards: core and developmental. The core standards describe a level of service that is acceptable and that must be universal. Meeting the core standards is not optional. The core standards serve as a platform or "bottom rung" for progress against the developmental ladder. They also serve to assure the public that all services, wherever provided, will be safe and of an acceptable quality.

Developmental standards are broad-based and provide a dynamic force for continuous improvement over time. Through the annual review process, they will enable health care organisations, health care professionals and, most importantly, the public to see progress made year-on-year.

The developmental standards are designed for a world in which patients' expectations are increasing. Progress is expected to be made against the developmental standards across much of the NHS as a result of the NHS Improvement Plan and the extra investment in the period to 2008. The Healthcare Commission will, through its criteria for review, assess progress by health care organisations towards achieving the developmental standards.

The final declaration, submitted to the Healthcare Commission in April 2006, indicated that the PCT considered that it had complied with all of the core standards.

The patient experience

During 2005-06, the PCT involved more patients, volunteers, staff and members of the public in decision-making than ever before.

Building on the work of our locality forums, our aim has been to be as open and honest with the public as possible; to set out in clear terms the context for service changes, and to be honest about the parameters for consultation.

During this period, we have involved the public in major decision-making on the future of Fairford Hospital, the government's reconfiguration of PCTs and health authorities, planning for future health services in the north Cotswolds, and our decision to cease commissioning of inpatient beds at the independently-run Tetbury Hospital.

In Berkeley Vale, for example, GPs have worked closely with local hospital staff, the League of Friends and patient representatives to model a future for health services in the area. From initially reviewing the service provision at the existing hospital, the group made the more radical recommendation to relocate hospital services at nearby Dursley; a proposal endorsed by the PCT, but taken by local stakeholders.

In the north Cotswolds, the need to re-provide services in a way that meets the needs of modern patients has stimulated keen debate among professionals, volunteers, local councillors and members of the public. The resulting proposals for our two north Cotswolds hospitals are, at the time of writing, part of the countywide consultation on community change.

Each year, the patient experience in our hospitals is evaluated by Patient Environment Assessment Teams (PEAT).

The PEAT inspections, which take place in the first three months of the year, measure UK hospitals for cleanliness, food choice and quality, privacy and dignity, and the quality of the hospital environment.

Inspection teams also look at how user-friendly a hospital is: for example, its signage and how accessible it is for people with disabilities.

All the community hospitals in Cotswold and Vale scored a mixture of 'good' and 'excellent' grades, with Cirencester Hospital scoring a double 'excellent'.

IMPROVING THE HEALTH OF OUR POPULATION

The Public Health team at Cotswold and Vale has continued to work in partnership with local authorities, the voluntary sector, schools and the wider public to deliver key messages and activities on health and wellbeing.

The team represents the PCT on the Stroud and Cotswold Local Strategic Partnerships and the Gloucestershire Healthy Living Partnership. Through this membership, it has consolidated a shared focus on health and wellbeing and strengthened the role of the local health and wellbeing partnerships.

Active health and wellbeing partnerships exist in both Stroud and Cotswold districts, and include a good representation of statutory and voluntary organisations. The partnerships are funded by the PCT's health inequalities budget, through the Local Strategic Partnership and second homes council tax, and from regional and national grants.

During the year, we have run activities such as Tai Chi for older people, 'active lifestyles' schemes and the development of breast feeding support groups across the PCT area. As successful partnerships, we were instrumental in obtaining funding for Home-Start in the Cotswolds and the achievement of District Council Beacon Status for services for older people.

Obesity prevention

As part of the government's Choosing Health initiative, the PCT was successful in obtaining regional funding for an obesity prevention programme. The 12-week course was aimed at overweight men and women who had already engaged in weight management sessions. The project was led by a practice nurse with a special interest in obesity issues. By the end of the course, participants had experienced a range of physical activities and other interests to encourage them to make healthier lifestyle choices.

Beacon awards

In 2005, Stroud and Cotswold District Councils were successful in obtaining a Beacon award for their wide ranging work with older people. Tewkesbury Borough, Stroud and Forest of Dean district councils worked with the PCTs to achieve a Beacon Award for crime reduction in rural areas. These awards would not have been possible without the close cooperation that exists between partners, including the PCT.

Smoking cessation

The PCT has been successful in reaching, and exceeding, its target for the number of smokers who had quit for four weeks or more. A total of 942 people quit smoking during 2005-06 against a target of 917.

Primary care teams, ably supported by the Gloucestershire Smoking Advice Service, were largely responsible for achieving this.

In addition, the PCT went smoke free in all buildings and grounds on No Smoking Day (8 March) 2006, ahead of the deadline of 31 December 2006 set by the Department of Health.

Physical activity

Exercise referral schemes are now available across the whole of the PCT area. Workers in Stroud Leisure Centre have now been trained to provide the service and this has now filled the 'gap' in provision. Various other activities are available across both districts including a range of organised walks and a 'healthy workplace' initiative in Stroud District Council Offices.

Teenage pregnancy

Cotswold and Vale PCT leads for the county on sexual health activity. We have achieved excellent results against targets for teenage pregnancy in 2005-06.

- The 2004 under-18 conception data (published in February 2006), shows that the conception rate in Gloucestershire has decreased by 17.7% since 1998, which exceeds the reduction in the national rate of 11.1%. This means that Gloucestershire has also exceeded the 2004 national reduction target of 15%.
- Feedback to the Gloucestershire Teenage Pregnancy Partnership Board from the Government Office South West, commends the strong focus on prevention and excellent sexual relationship education (SRE) activity. Some schools have emergency hormonal contraception (EHC) provision through extended school drop-ins provided by school nurses. Local good practice included work with young fathers, and strong links to other work programmes focusing on the most vulnerable children.
- The county has a good record of local organisations working together jointly towards a reduction in the teenage pregnancy rate, including social services, housing and education, Connexions, neighbourhood projects, county youth services and local pharmacies.
- A local scheme of free EHC provision is available amongst several services, including pharmacies, practice nurses within GP surgeries and emergency and accident departments.
- Two GP practices have been providing free instant pregnancy testing and condoms for two years as part of a national collaborative project. Users do not have to be registered with the practice to access this service. The Practices feel it has enhanced the sexual health services offered.
- Pharmacy Pilot Scheme: five pharmacies within the county, all of which have undertaken training in EHC provision, are about to begin offering free instant pregnancy testing, free condoms and direct referral to the pregnancy advisory service.

Prescribing

Last year, our GPs issued an additional 192,636 prescriptions, increasing the total number of prescriptions to 2,875,662. However, this increased number of prescriptions cost the PCT £662,015 less than in the previous year – meaning we provided more medication for the benefit of our population at a lower cost.

The total amount invested in drugs in primary care in 2005-06 was £25,764,314. The significant increases in our prescribing cost effectiveness during this period were the result of both national NHS drug price reductions, and the PCTs own prescribing management strategy.

The largest increases in cost effectiveness were in the prescribing of drugs for the prevention of cardiovascular disease. For example, the number of cholesterol lowering drugs, statins, prescribed with the PCT increased by the national average rate of 22 percent, while the PCT's associated costs reduced by 46 percent: more than twice the national average.

Similarly, there was a 13 percent increase in both the local and national number of drugs prescribed for the reduction of blood pressure, antihypertensives, but an associated increase in the local cost effectiveness of our prescribing of these drugs that was significantly above the national average.

In most key therapeutic areas promoted by the NHS, prescribing for the prevention of disease in the Cotswold and Vale PCT was significantly higher than the similar levels of prescribing in comparator PCTs in 2005-06. The population we serve will benefit from the resultant health gains and preventable deaths achieved.

THE FUTURE OF CHILDREN'S HEALTH

Cotswold and Vale Primary Care Trust has held the lead role on behalf of the three Gloucestershire PCTs in planning and commissioning services for children and young people, working in partnership with the County Council and other partners.

The Children Act 2004 has provided us with a legislative framework within its Every Child Matters: Change for Children Programme. This represents a radical transformation in the way that services for children and young people – including health services - are planned, commissioned and delivered.

The Gloucestershire Children's and Young People's Strategic Partnership brings together the key agencies and other organisations, including those in the voluntary and community sector, that commission and provide services for children and young people. Further information regarding the partnership including its membership can be found at www.gloucestershire.gov.uk/changeforchildren.

Our partnership works to a vision where children and young people have the right to:

- thrive and reach their full potential;
- succeed in school, at college, and through apprenticeships and work based training;
- grow up healthily;
- have every opportunity to grow into successful adults;
- be protected from abuse and neglect and feel safe in their families and communities.

In order to achieve this vision, we are working to develop early, preventative and community based services that:

- break down barriers between agencies;
- give a single point of access;
- are integrated, inclusive and high quality;
- are as locally focused as possible;
- help parents meet their responsibilities.

In April 2006, the partnership produced the first Children's and Young People's Plan for Gloucestershire. Local health services are important contributing partners to the development of this plan, which is, in turn, supported by a business plan that includes targets and indicators for improvement.

In 2007, the development of a local area agreement for Gloucestershire will add to the opportunities for agencies to work more effectively together, with its inclusion of a specific section for children and young people.

Gloucestershire will receive a Joint Area Review (inspection across agencies of services for children and young people) during 2007, with the health service as an important contributor and partner.

There remain areas where partnership working can improve, and it remains important for the Gloucestershire Health Community to continue to work closely in supporting the implementation of this important programme of work.

DEVELOPING SERVICES FOR THE FUTURE

This has been a period of real change and development for Cotswold and Vale PCT. We have embraced the evolving national direction of the NHS (for example, in *Our health, our care, our say*), which has endorsed our own aims to bring more health services closer to where people live.

We have grown and developed our partnership working, making patient and public involvement a reality in many areas of service development, for example, in planning a viable future for our network of community hospitals.

However, we have also been faced with the results of an inherited deficit and a cumulative overspend. Simply put, the excellent quality of services we have provided for patients in the Cotswold and Vale area has cost us more than we could afford.

Together with our neighbouring PCTs and NHS provider trusts, Gloucestershire health community faces a combined deficit of £40million this year.

Chairs and chief executives across the county identified a range of proposals to reduce the deficit and achieve 'run rate' (break even) in day to day spending. At the time of writing, the county has recently completed an extensive public consultation, *The future of healthcare in Gloucestershire*, and is awaiting a decision from the three PCT boards on which of these proposals can be implemented.

Some of the proposals, while driven forward more quickly by the financial imperative, are the result of an evolutionary process of working with local managers, clinicians and partners to plan for the future.

For example, in Cotswold and Vale, the plans to work with independent providers to replace existing community hospitals in the north Cotswolds and Berkeley Vale fall into this category. The new 'health campuses' will reduce the bed base and offer a much wider range of outpatient and diagnostic appointments, reducing the need to travel and making best use of local facilities.

Other proposals, for example, a much tighter criteria for free use of the patient transport service, have been made for purely financial reasons.

LEADERSHIP OF THE PCT

The Trust Board 2005-06

Mrs Elizabeth Law, Chair

Mrs Tracey Barber, Non-Executive Director to 28 Feb 2006

Dr Charles Buckley, Professional Executive Committee clinical governance lead

Dr Hendrik Chapel, Director of Public Health

Mr Jonathan Duckworth, Non-Executive Director

Dr Stuart Drysdale, Chair of the Professional Executive Committee

Mr John Harries, Non-Executive Director, Vice Chair

Mr Richard James, Chief Executive

Mrs Jan Jepps, Professional Executive Committee Nurse member to 27 Jan 2006

Mr Robert Knibbs, Director of Finance

Mr Peter Merson, Non-Executive Director

Mr David Miller, Non-Executive Director

Mr John Pritchard, Non-Executive Director

Professional Executive Committee 2005-06

Dr Stuart Drysdale, General Practitioner - Chair

Dr Charles Buckley, General Practitioner, clinical governance lead

Dr Hendrik Chapel, Director of Public Health

Dr Martin Freeman, General Practitioner – Vice Chair

Mr Richard James, Chief Executive

Mrs Jan Jepps, Nurse member to 27 January 2006

Mr Robert Knibbs, Director of Finance

Dr Paul Sherringham, General Practitioner

Mrs Jane Smith, Nurse member

Mrs Angela Sycamore, Allied Health Professional member from 1 June 2005

Dr Julian Tallon, General Practitioner

Mrs Carey Wallin, Social Services member

Audit Committee - quarterly

Mr John Harries, Non-Executive Director, Chair

Mrs Tracey Barber, Non-Executive Director to 28 February 2006

Mr Jonathan Duckworth, Non-Executive Director

Mr Peter Merson, Non-Executive Director

Mr David Miller, Non-Executive Director

Mr John Pritchard, Non-Executive Director

Charitable Funds Committee – quarterly

Mrs Elizabeth Law, Chair

Dr Stuart Drysdale, Chair of the Professional Executive Committee

Mr Robert Knibbs, Director of Finance

Finance Committee – monthly

Mrs Elizabeth Law, Chair

Mrs Tracey Barber, Non-Executive Director to 28 February 2006

Mr Jonathan Duckworth, Non-Executive Director

Dr Stuart Drysdale, Chair of the Professional Executive Committee

Mr John Harries, Non-Executive Director, Vice Chair

Mr Richard James, Chief Executive

Mr Robert Knibbs, Director of Finance

Mr Peter Merson, Non-Executive Director

Mr David Miller, Non-Executive Director

Mr John Pritchard, Non-Executive Director

Remuneration Committee – as required

Mrs Elizabeth Law, Chair

Mrs Tracey Barber, Non-Executive Director to 28 February 2006

Mr Jonathan Duckworth, Non-Executive Director

Mr John Harries, Non-Executive Director, Vice Chair

Mr Peter Merson, Non-Executive Director

Mr David Miller, Non-Executive Director

Mr John Pritchard, Non-Executive Director

Professional Executive Committee Sub-committees

Clinical Governance Committee – bi-monthly

Health and Safety Committee – bi-monthly

Risk Management Committee - quarterly

Declarations of interest

Declarations of interest for the PCT Board are as follows:

Tracey Barber

- Director, Tracey Barber Consulting Limited

Charles Buckley

- Trustee, Pinching Memorial Trust
- Trustee, John Buckley Memorial Trust
- Member, Royal College of Physicians
- Charity contributor, ASH, BHF, Diabetes UK, RNIB, Scope, Red Cross etc
- Dispensing doctor
- General practitioner
- Sessional employee, out of hours service, Cotswold and Vale PCT
- Appraiser, GP appraisal system

Hendrik Chapel

- Member, British Medical Association

Stuart Drysdale

- Senior partner, Rendcomb Surgery, Cirencester
- Member, Medical Officers for Schools Association
- Sessional employee, out of hours service, Cotswold and Vale PCT

Jonathan Duckworth

- Company secretary, Triple Bottom Line Index Limited
- Technical consultant, Keystone Marketing and Event Management Limited

John Harries

- Chairman, Guinness Trust west region
- Treasurer, Medical Council on Alcohol
- Non-executive, Care and Support

Richard James

- Chair of governors, Crypt School, Gloucester

Peter Merson

- Mediator, clients could include NHS bodies

David Miller

- Governor, Gloucestershire Hospitals NHS Foundation Trust

John Pritchard

- Director, Bergbland Limited

Declarations of interest for the PCT Professional Executive Committee are as follows:

Charles Buckley

- As above

Stuart Drysdale

- As above

Martin Freeman

- Partner, Orchard Medical Centre, Cam

Richard James

- As above

Angela Sycamore

- Physiotherapist, Tetbury Hospital

Julian Tallon

- Partner, The Park Surgery, Cirencester
- Electoral roll, Cirencester Parish Church
- Sessional employee, out of hours service, Cotswold and Vale PCT
- Wife is Chair of governors, Powell's School, Cirencester
- Wife is on Parish Church Council, Cirencester Parish Church
- Wife is on electoral roll, Cirencester Parish Church

EQUALITY AND DIVERSITY STATEMENT

The PCT has in place a Managing Diversity Policy. The purpose of this policy is:

...to provide a framework for all NHS employers within Gloucestershire to develop a culture which enhances contribution from all employees to deliver responsive and quality services to patients and clients ... and to build on the successes already achieved through equal opportunities, making diversity central to each individual and an integral part of the management of staff and services.

Among the key principles of the Managing Diversity Policy are:

- *to build a workforce that is valued and whose diversity reflects the communities it serves, enabling the health community to deliver the best possible healthcare services, and*
- *to develop and implement fair and non-discriminatory systems for recruiting, developing and promoting people irrespective of age, disability, race, nationality, ethnic or national origin, gender, religion, beliefs, sexual orientation, domestic circumstances, social and employment status, HIV status, gender reassignment, trade union membership or political affiliation.*

In support of this policy, the Primary Care Trust has (with Cheltenham and Tewkesbury PCT and West Gloucestershire PCT) obtained funding for a fixed-term Equality and Diversity Project Manager, who has been in place since October 2005. The remit for this role includes:

- to deliver project plans on equality and diversity by promoting awareness, changing attitudes and by embedding good practice throughout the organisation;
- to ensure that the HR / workforce requirements of Race Equality Schemes are met;
- to develop an expert level of understanding of best practice in the field, in order to inform developments, policy and practice on workforce issues;
- to build relationships with local community and special interest groups, representing Trusts and providing a sound channel for dialogue and communication;
- to research and develop employment policies and procedures that will help address employment inequalities and promote diversity in employment.

The Equality and Diversity Manager is currently working towards a Single Equality Scheme, which will encompass all strands of discrimination and ensure compliance with forthcoming legislation, including both Age Discrimination and the statutory duty for Disability Discrimination.

Cotswold and Vale PCT also cross references the Managing Diversity Policy with policies on Promoting Dignity at Work and Harassment and Bullying, as well as Improving Working Lives and KSF Core Dimension 6 – Equality and Diversity.

OUR ACCOUNTS

Operating and financial review

This section is complementary to the content in the rest of the annual report, and in total will fulfil the requirements of the Management Commentary introduced in 2006.

Purpose

The operating and financial review is an integral part of the annual report. It intends to describe the PCT's planning assumptions, the underlying issues affecting its financial performance in 2005-06, and key planning assumptions and risks for 2006-07.

Background

At the beginning of 2005-06, the PCT Board agreed a balanced financial plan for 2005-06. This was approved by Avon, Gloucestershire and Wiltshire Strategic Health Authority. It included a savings requirement of £12,131,000 to deliver a balanced budget. The financial plan provided for additional funding for quality payments to GPs arising from their new contract, higher levels of hospital admissions, and the cost of specialist mental health and learning disability payments

Overview

The PCT had a resource limit of £214,172,000, of which £205,375,000 was recurring. It overspent its resource limit by £6,788,000. The key reasons for the overspend were repayment of the prior year deficit £4,809,000, pressures in respect of private placements, contract activity being higher than planned, and delayed delivery of savings plans.

Details of the key areas where expenditure varied from the financial plan are noted in the paragraphs below.

NHS commissioning activity

The cost of activity from NHS Trusts was £3,978,000 higher than budget. Of this, £3,053,000 related to episodes of care at Gloucestershire Hospitals NHS Foundation Trust and the balance to care commissioned from other trusts.

Gloucestershire Hospitals Trust

The PCT paid £78,019,000 to Gloucestershire Hospitals Trust in 2005-06, in respect of the services that it purchases on behalf of the PCT population. This was £3,053,000 higher than planned. The PCT plan assumed that approximately 11,918 spells of emergency inpatient activity would be required, at a cost of £23,161,000. In the event, 12,680 spells occurred, costing £24,058,000.

The PCT pays for approximately two-thirds of its activity under the national tariff for payment by results (PbR). This creates a common price nationally for specific episodes of care. PCTs receive a funding adjustment (up or down) to accommodate the difference between the local hospital price and the national price.

In 2006-07, the PCT has increased its investment in Gloucestershire Hospitals Trust by £3,814,000, including at least £3,000,000 to fund the change imposed by the national tariff. The remainder will fund the additional activity levels achieved in 2005-06, inflation costs and normal growth levels associated with the population of Cotswold and Vale. This is intended to maintain the current waiting times for accessing inpatient and outpatient care.

In 2006-07, the structure and scope of activity covered by the tariff for payment by results changed. It is designed to encourage NHS Trusts and PCTs to provide care closer to home and limit unnecessarily long hospital stays.

Private sector placements

The PCT has a budget of £3,796,000 for specialist mental health and learning disability placements. This has increased by 120 percent over the last three years, in line with demand. The PCT overspent its budget by £1,160,000 in 2005-06 and has invested significant additional resources in 2006-07 to fund the further increase in demand.

In 2005-06, the three PCTs in Gloucestershire have developed additional arrangements to ensure that all clients receive the most appropriate care for their needs, and are monitored regularly to ensure that care plans are modified to match changing needs. But planning in 2006-07 assumes that this area will continue to experience high levels of growth. The highest area of growth is in the provision of placements for learning disabilities.

Development funding

The PCT deferred all non essential developments as one of several measures to work towards financial balance in 2005-06, thus saving £800,000 non-recurrently. In 2006-07, all developments have been limited to those that are underpinned by a legal requirement or are unavoidable.

Primary care

In 2005-06, the PCT invested an additional £400,000 in primary care to fund the national increase in payments to GPs related to quality provision, as well as an additional £250,000 to fund the newly implemented out of hours service and the GP contracts.

In the event, the PCT spent £724,000 less across a range of services in this area, including GP contracts, the out of hours service and the deferral of developments in primary care.

In 2006-07, there are no significant changes to primary care funding.

Primary care prescribing

Practice prescribing budgets underspent in 2005-06 by £1,158,000, being 4.31 percent of the total prescribing budget. This considerable achievement has been made by the PCT and GP Practices working together to support clinically-based cost effective prescribing.

For 2006-07, each practice within the PCT has received an indicative budget for prescribing based upon the needs of the practice population and its expenditure in 2005-06.

Financial recovery plan

The PCT started 2005-06 with a financial recovery plan of £12,131,000 to enable it to achieve financial balance, including the repayment of its deficit of £4,809,000 from 2004-05. The PCT delivered savings of £9,195,000, leaving a shortfall of £2,936,000. However, the PCT also experienced additional pressures in the number and complexity of procedures undertaken in hospitals, and other areas as noted above.

Capital structure

The PCT has assets valued at £43,431,000 at the end of 2005-06. These primarily consist of health centres and community hospitals within the Cotswold and Vale.

The PCT received a specific allocation of £2,801,000 to fund capital expenditure in 2005-06. The PCT spent £760,000, of which the majority was spent on buildings and IT equipment. The capital underspend of £2,041,000 will be carried forward to 2006-07.

Avon, Gloucestershire and Wiltshire health economy

The overall reported financial position for Avon, Gloucestershire and Wiltshire (AGW) at the end of 2005-06 is subject to audit. The reported position at Month 12 is a deficit of £41.5m. The accumulated deficits,

including that for previous years deferred by the Department of Health, therefore amount to £131.5m at 31 March 2006. (Note: 2003-04, 2004-05 and 2005-06 deficits have been or are due to be repaid.)

In 2005-06, AGW received funding from the NHS Bank totalling £20 million. This was allocated to PCTs and NHS Trusts in Avon and Wiltshire to support the financial position in 2005-06.

2006-07

The PCT has worked collaboratively with Cheltenham and Tewkesbury PCT and West Gloucestershire PCT in preparation for the merger to create one PCT in Gloucestershire from 1 October 2006. The PCTs have jointly developed a financial plan for 2006-07, which, in aggregate, anticipates that the new organisation will achieve financial balance. The Cotswold and Vale plan, which forms part of this, anticipates a deficit of £176,000.

There are a number of key factors that have increased the financial pressure on the three PCTs in 2006-07, and that create differing positions relative to each other.

- Avon, Gloucestershire and Wiltshire Strategic Health Authority (now merged into NHS South West) 'topsliced' 2.1 percent from PCT baselines to create a pool to support organisations deemed nationally to require external support and likely to require more than one year to achieve financial balance. The deduction from Cotswold and Vale is £3,617,000. The total deduction from Gloucestershire PCTs is £13,293,000.
- Cotswold and Vale PCT will receive £6,800,000 from this pool in 2006-07. This is the value of the PCT's overspend in 2005-06.
- As noted in the section on NHS Trusts, PCTs receive funding to meet the gap between national and local prices, where the local price is lower than the national tariff to maintain purchasing power. Nationally, this support has been halved in 2006-07. The three PCTs in Gloucestershire receive £9,566,000 less than they need to retain their purchasing power. West Gloucestershire PCT's shortfall is £2,918,000.
- The PCT is required to repay its 2005-06 deficit in 2006-07, including a premium of 10 percent.

In delivering the plan, the PCT is required to make savings of £13,725,000. Plans have been identified to deliver £10,600,000 and the PCT has been engaging in a consultation process to implement these plans.

Key risks

The PCT, along with its partner PCTs in Gloucestershire, is aware of a number of risks to the delivery of the financial plan in 2006-07. These are:-

- the delivery of the planned savings schemes within the planned timescales;
- the identification of additional savings to meet the gap between planned savings and the full savings requirement;
- the number of episodes of care in hospital settings –particularly emergency activity;
- the volume of complexity of placements required for mental health and learning disability clients with high levels of need;
- the cost of new decisions made by the National Institute for Clinical excellence (NICE).

Conclusion

In 2005-06, the PCT expenditure exceeded its revenue resource limit by £6,788,000, having made significant savings in year and managed unplanned pressures relating to hospital activity and placements for clients with mental health and learning difficulties.

The PCT continues to experience significant financial pressures in 2006-07, but aims to restore financial balance by 2007.

SUMMARY FINANCIAL STATEMENTS

The Summary Financial Statements for Cotswold and Vale Primary Care Trust, for the year ending 2005/2006 is shown below, and is merely a summary of the information in the full accounts, which are available on demand from the Director of Finance, Trust Headquarters, Cirencester Hospital, Tetbury Road, Cirencester, GL7 1UX.

These accounts for the year ended 31 March 2006 have been prepared by the Cotswold and Vale Primary Care Trust under section 98(2) of the National Health Service Act 1977, as amended by section 24(2), schedule 2 of the National Health Service and Community Care Act 1990 in the form which the Secretary of State has, with the approval of the Treasury, directed.

OPERATING COST STATEMENT FOR THE YEAR ENDED 31 March 2006

	2005/06 £000	2004/05 £000
Commissioning		
Gross Operating Costs	199,059	187,083
Less: Miscellaneous Income	<u>(3,828)</u>	<u>(4,327)</u>
Commissioning Net Operating Costs	195,231	182,756
Provider		
Gross Operating Costs	46,578	42,650
Less: miscellaneous income	<u>(19,201)</u>	<u>(16,450)</u>
Provider Net Operating Costs	27,377	26,200
Net Operating Costs before interest	222,608	208,956
Interest Receivable	0	0
Interest Payable	<u>0</u>	<u>0</u>
Net Operating cost for the Financial Year	<u>222,608</u>	<u>208,956</u>

**STATEMENT OF RECOGNISED GAINS AND LOSSES FOR THE YEAR ENDED
31 March 2006**

	2005/06	2004/05
	£000	£000
Fixed asset impairment losses	0	0
Unrealised surplus / (deficit) on fixed asset revaluations/indexation	1,166	4,540
Increase in the donated asset reserve and government grant reserve due to receipt of donated and government granted assets	0	19
Additions / (Reductions) in the General Fund due to the transfer of assets from/(to) NHS bodies and the Department of Health	0	0
Additions / (Reductions) in "other reserves"	0	0
Recognised gains and losses for the financial year	1,166	4,559
Prior period adjustment - other	0	0
Gains and losses recognised in the financial year	1,166	4,559

The figures for 2004/05 have been restated to exclude the deduction in the donated asset reserve due to the depreciation of donated assets of £144k.

BALANCE SHEET AS AT
31 March 2006

	£000	31 March 2006 £000	31 March 2005 £000
FIXED ASSETS			
Intangible assets	0		0
Tangible assets	43,431		42,970
Investments	0		0
		<u>43,431</u>	<u>42,970</u>
CURRENT ASSETS			
Stocks and work in progress	18		14
Debtors	7,274		5,138
Cash at bank and in hand	106		12
TOTAL CURRENT ASSETS		<u>7,398</u>	<u>5,164</u>
CREDITORS : Amounts falling due within one year		<u>(15,159)</u>	<u>(13,695)</u>
NET CURRENT ASSETS / (LIABILITIES)		<u>(7,761)</u>	<u>(8,531)</u>
TOTAL ASSETS LESS CURRENT LIABILITIES		<u>35,670</u>	<u>34,439</u>
Creditors: Amounts falling due after more than one year		0	(165)
Provisions for liabilities and charges		<u>(2,126)</u>	<u>(1,456)</u>
TOTAL ASSETS EMPLOYED		<u>33,544</u>	<u>32,818</u>
FINANCED BY:			
TAXPAYERS EQUITY			
General Fund		18,236	18,541
Revaluation reserve		13,467	12,337
Donated asset reserve		1,841	1,940
Government grant reserve		0	0
Other reserves		0	0
TOTAL TAXPAYERS EQUITY		<u>33,544</u>	<u>32,818</u>

The financial statements were approved by the Board on 11th July 2006 and signed on its behalf by

Chief Executive:



Date: 18-Jul-06

**CASH FLOW STATEMENT FOR THE YEAR ENDED
31 March 2006**

	2005/06	2004/05
	£000	£000
OPERATING ACTIVITIES		
Net cash outflow from operating activities	(220,432)	(205,316)
SERVICING OF FINANCE AND RETURNS ON INVESTMENT:		
Interest paid	0	0
Interest received	0	0
Interest element of finance leases	0	0
Net cash inflow/(outflow) from servicing of finance and returns on investment	0	0
CAPITAL EXPENDITURE		
Payments to acquire intangible assets	0	0
Receipts from sale of intangible assets	0	0
Payments to acquire tangible fixed assets	(683)	(616)
Receipts from sale of tangible fixed assets	0	158
Payments to acquire fixed asset investments	0	0
Receipts from sale of fixed asset investments	0	0
Net cash inflow/(outflow) from capital expenditure	(683)	(458)
Net cash inflow/(outflow) before financing	(221,115)	(205,774)
FINANCING		
Net Parliamentary Funding	221,209	205,749
Other capital receipts surrendered	0	0
Capital grants received	0	0
Capital element of finance lease rental payments	0	0
Cash transfers (to)/from other NHS bodies	0	0
Net cash inflow/(outflow) from financing	221,209	205,749
Increase/(decrease) in cash	94	(25)

Financial Performance Targets**Operational Financial Balance**

The PCTs' performance for 2005/06 is as follows:

	2005/06	2004/05
	£000	£000
Total net operating cost for the financial year	222,608	208,956
Less: Non-discretionary Expenditure	<u>1,648</u>	<u>1,667</u>
Operating Costs less non-discretionary expenditure	220,960	207,289
Revenue Resource Limit	214,172	202,480
Overspend against Revenue Resource Limit	(6,788)	(4,809)
Unplanned support received	<u>0</u>	<u>0</u>
Operational Financial Balance	<u>(6,788)</u>	<u>(4,809)</u>

Financial support included in under /(over) spend against revenue Resource Limit – NHS Bank

0

0

Financial support included in under /(over) spend against revenue Resource Limit – Internally generated

0

0

The PCT made a deficit of £6,788,000 in 2005/6, (2004/2005 deficit £4,809,000). The reasons for this were

Repayment of the prior year deficit £4,809,000, pressures in respect of private placements, contract activity being higher than planned and delayed delivery of savings plans.

Management costs

	2005/06	2004/05
Management costs (£000s)	3,999	3,503
Weighted population (Number)	160,200	160,200
Management cost per head of weighted population (£)	24.96	21.87

The PCT measures its management costs according to the definitions provided by the Department of Health.

Better Payment Practice Code - measure of compliance

	2005/06	2005/06	2004/05	2004/05
Non-NHS Creditors	Number	£000	Number	£000
Total bills paid in the year	16,875	10,108	17,687	17,318
Total bills paid within target	15,748	9,553	15,635	15,584
Percentage of bills paid within target	93.32%	94.51%	88.40%	89.99%

NHS Creditors

Total bills paid in the year	1,995	8,116
Total bills paid within target	1,654	5,878
Percentage of bills paid within target	82.91%	72.42%

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

Salary and Pension entitlements of senior managers

Remuneration

Name and title	2005-6			2004-5		
	Salary (bands of £5,000)	Other remuneration (bands of £5,000)	Benefits in kind (bands of £100)	Salary (bands of £5,000)	Other remuneration (bands of £5,000)	Benefits in kind (bands of £100)
	£000	£000	£00	£000	£000	£00
Richard James Chief Executive	105-110			100 - 105		
Robert Knibbs Director Of Finance	90-95			85 - 90		
Hendrik Chapel Director of Public Health	80 - 85			80 - 85		
Mike Adamson Director of Commissioning	45-50	(left 20.11.05)		70 - 75		
Amanda Fisk Director of Operations	-	(left 3.4.05)		Withheld all information		
Maggie Stubbs Director of Nursing	45-50	(left 3.1.06)		55 - 60		
Sophie Norton Acting Director of Primary Care	20-25	(left 31.8.05)		55 - 60		
Sue Donaldson Director of Human Resources	70-75			45 - 50	(started 1.7.04)	
Martin Hughes Director of Programme Management	Withheld all information	(started 1.4.05)		N/A		
Elizabeth Law Chair	15 - 20			15 - 20		
Peter Merson Non Executive Member	5 - 10			5 - 10		
David Miller Non Executive Member	5 - 10			5 - 10		
Jonathan Duckworth Non Executive Member	5 - 10			Withheld all information		
John Harries Non Executive Member	5 - 10			5 - 10		
Joanna Mitchell Non Executive Member	-			0 - 5	(left 31.12.04)	
John Pritchard Non Executive Member	5 - 10			0 - 5	(started 1.11.04)	
Tracey Barber Non Executive Member	Withheld all information	(1.8.05 - 28.02.06)		N/A		
Dr Stuart Drysdale Chair PEC	30 - 35			30 - 35		
Dr Charles Buckley Executive Committee Member	5 - 10		5 - 10	5 - 10	5 - 10	
Michele Le Mero Executive Committee Member	0 - 5	(left 31.5.05)		5 - 10		
Dr Julian Tallon Executive Committee Member	5 - 10			5 - 10		
Dr Martin Freeman - Executive Committee Member	5 - 10			5 - 10		
Dr Paul Sheringham - Executive Committee Member	5 - 10			Withheld all information		
Jan Jepps - Executive Committee Member	5 - 10	(left 31.1.06)	15 - 20	5 - 10	15 - 20	
Jane Smith - Executive Committee Member	5 - 10		30 - 35	5 - 10	30 - 35	
Angela Sycamore - Executive Committee Member	5 - 10	(started 01.06.05)	10 - 15	N/A		

Remuneration waived by directors and allowances paid in lieu

£Nil (2004-05 £Nil) remuneration was waived by 0 (2004-05 0) directors.

£Nil (2004-05 £Nil) of allowances were paid in lieu to 0 (2004-05 0) directors.

Pension entitlements

Name and title	Real increase in pension at age 60 and related lump sum (bands of £2,500) £000	Total accrued pension at age 60 and related lump sum at 31 March 2005 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2006 £000	Cash Equivalent Transfer Value at 31 March 2005 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension (rounded to nearest £00) £
Richard James - Chief Executive	5 - 7.5	180 - 185	806	743	45	0
Robert Knibbs - Director of Finance	40 - 42.5	50 - 55	228	34	193	0
Hendrik Chapel - Director of Public Health	2.5 - 5	35 - 40	133	111	20	0
Susan Donaldson - Director of Human Resources	2.5 - 5	5 - 10	20	8	12	0
Martin Hughes - Director of Programme Management	75 - 77.5	75 - 80	280	0	280	0
Michael Adamson - Director of Commissioning	0 - 2.5	(left 20.11.05) 10 - 15	33	25	8	0
Amanda Fisk - Director of Operations	0 - 2.5	(left 3.4.05) 55 - 60	191	173	14	0
Maggie Stubbs - Director of Nursing	-2.5 - 0	(left 3.1.06) 75 - 80	345	330	6	0
Sophie Norton - Acting Director of Primary Care	-2.5 - 0	(left 31.8.05) 20 - 25	67	77	-11	0
Janet Jepps - PEC Member	-2.5 - 0	20 - 25	72	72	-1	0
Jane Smith - PEC Member	2.5 - 5	40 - 45	186	161	20	0
Angela Sycamore - PEC Member	2.5 - 5	10 - 15	47	0	47	0

As Non-Executive members do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive members.

Cash Equivalent Transfer Values

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

The CETV figure, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Self-employed GPs who are members of the Professional Executive Committee (PEC) have pension entitlements. However, the proportion of those entitlements that relates to their membership of the PEC is not significant compared to the proportion that relates to their work as practitioners independent of the PCT. It is not, therefore, appropriate to disclose their pension entitlements.

Real Increase in CETV

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

Signed.....  Chief Executive

Dated 18/07/2006.....

Independent auditor's report to the Directors of the Board of Cotswold & Vale Primary Care Trust

I have examined the summary financial statements set out on pages 31 to 36.

This report is made solely to the Board of Cotswold & Vale Primary Care Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 36 of the Statement of Responsibilities of Auditors and of Audited Bodies prepared by the Audit Commission.

Respective responsibilities of directors and auditors

The directors are responsible for preparing the Annual Report. My responsibility is to report to you my opinion on the consistency of the summary financial statements within the Annual Report with the statutory financial statements. I also read the other information contained in the Annual Report and consider the implications for my report if I become aware of any misstatements or material inconsistencies with the summary financial statements.

Basis of opinion

I conducted my work in accordance with Bulletin 1999/6 'The auditors' statement on the summary financial statements' issued by the Auditing Practices Board.

Opinion

In my opinion the summary financial statements are consistent with the statutory financial statements of the PCT for the year ended 31 March 2006.

My opinion on the statutory financial statements is that:

- the financial statements give a true and fair view, in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England, of the state of the PCT's affairs as at 31 March 2006 and of its net operating costs for the year then ended;
- the part of the Remuneration Report to be audited has been properly prepared in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England;

- the PCT exceeded the revenue resource limit specified by the Secretary of State under section 97E of the National Health Service Act 1977 by £6.8 million; and
- except for the incurrence of expenditure in excess of the specified revenue resource limit, in my 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.

Auditor:Stephen Malyn..... Date:25th September 2006.....

Stephen Malyn,
District Auditor
Audit Commission
Westward House
Lime Kiln Close
Stoke Gifford
Bristol
BS34 8SR

Audit Disclosure

The PCT's external Auditor is the Audit Commission and their role is restricted to the Annual Statutory Accounts Audit (£54,175) and Statutory Value for Money – VFM (£29,335) audits together with planning and reporting (£9,278). In 2005/6 VFM audits covered, Workforce, Payment by Results, Practice Based Commissioning, and NPfIT together with review of Auditors Local Evaluation Tool (ALE).

STATEMENT ON INTERNAL CONTROL 2005/06

1. Scope of responsibility

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

The Trust agrees its organisational objectives for each financial year with Avon, Gloucestershire and Wiltshire Strategic Health Authority and the Trust's partners in the Gloucestershire Health Community through the Local Delivery Planning process.

The organisational objectives are set out in the Trust's Local Delivery Plan and Business Plan and these form the basis for the objectives for its directorates and individual members of staff.

An integral part of the process of objective setting in the business plan is the identification of risk. This informs the risk management process and is documented in the Trust's Assurance Framework, which is itself an integral component of the Trust's Business Plan.

2. The purpose of the system of internal control

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

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

The system of internal control has been in place in the Cotswold & Vale Primary Care Trust for the year ended 31 March 2006 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

The Trust's Risk Management Policy sets out the Trust's approach to risk and the risk management process. Cotswold and Vale Primary Care Trust is committed to the development of a holistic approach to risk management which ensures that all areas of risk including organisational, financial and clinical risk are considered in order to support a system of risk management that is fully representative of all areas of the Primary Care Trust's work. In doing so the Primary Care Trust will ensure that risk management plays an integral part in the sound governance of the trust at both a strategic and operational level.

The Risk Management Policy and Strategy sets out the role and responsibilities of the Trust Board and Professional Executive Committee, their Sub-committees, Directors, line managers, individual employees and specialist advisers. The Risk Management Policy and Strategy has been circulated to all senior managers, who are responsible for implementing it within their areas of responsibility.

The Trust's business planning and project management processes incorporates a standardised risk management approach, which is owned by Lead Directors and Lead Managers as an integral part of their role. The PCT has appointed an Assistant Director who oversees this process. Training in the project management approach is provided. In addition, Standards for Better Health and Information Governance self-assessments are carried out. Internal Audit has reviewed the three controls assurance core standards as part of their approach in preparing the Head of Internal Audit Opinion in support of this statement and has reported that these standards have been satisfactorily met. Health and Safety Control Books providing support across a range of risk areas have been circulated to key managers. Training and support are provided to staff through induction and specific training courses.

Good practice is shared through the countywide risk management liaison group.

4. The risk and control framework

The Trust has developed a number of principal risk management mechanisms in order to support good governance and risk management in both clinical and non-clinical areas. These comprise the Assurance Framework, Corporate Governance, Clinical Governance, Research Governance, Information Governance, and Financial Governance.

The Trust's Risk Management Policy and Strategy sets out the framework for defining and distinguishing risk; categorising risk; assessing scales of risk and defining "acceptable" risk; risk analysis, risk treatment and control; and arrangements for risk reporting. Risks can be identified through a range of sources, including work place risk assessments, external and internal audit reports and self-assessments.

The Risk Management Committee is responsible for the ongoing monitoring and review of the risk management strategy and the effectiveness of the risk management processes.

The Trust's Risk Management Policy and Strategy sets out the detailed arrangements, including roles and responsibilities, and structures and accountability, particularly the Audit Committee, Clinical Governance Committee, Risk Management Committee and Health and Safety Committee.

The Trust's business planning and project management processes incorporates a standardised risk management approach, which is owned by Lead Directors and Lead Managers as an integral part of their role, and overseen by the Assistant Director of Planning and Corporate Affairs. In addition self-assessments are carried out through Clinical Governance, Health and Safety and Standards for Better Health.

The Trust has developed an Assurance Framework, which is an integral part of the business planning process in support of the statutory Statement of Internal Control. It is fundamental to providing assurance to the Board that the Trust is managing strategic risks.

The Assurance Framework sets out the Trust's principal objectives (clinical, financial and generic); performance against objectives; the principal risks that threaten the achievement of those objectives; the key controls in place to manage those risks; assurances on the key controls in place; the gaps in control; the gaps in assurance.

This enables the Trust Board to monitor progress against objectives as well as monitor the assurances on the management of its principal risks in a co-ordinated and cohesive way. This is underpinned by the Trust's business planning and project management processes, which incorporate a standardised risk management approach, which is owned by Lead Directors and Lead Managers as an integral part of their role.

Arrangements to address gaps in controls and assurances are in place. All risks scoring 20 or more out of a potential 25 are reported to the Board quarterly. These are accompanied by a full report on the objective, progress towards it and risk management. Gaps in assurance will be reviewed in conjunction with the plans prepared by Audit Committee, Internal Audit and the Counter Fraud Service.

The Trust has identified gaps in controls and assurances, which affect the following principal objectives – improving local health; improving health services; developing effective strategic partnerships; and developing effective support arrangements. Satisfactory assurances were given for all areas covered by Internal Audit, with the exception of the following areas, where limited assurances were given: Dentistry, Community Hospitals, Out of Hours, Income & Debtors-Finance Shared Service and Procurement Shared Services. As part of the programme of follow up Audits, Internal Audit will monitor that all agreed corrective action has been taken. The Trust will be continuously monitoring and reviewing the Business Plan/Assurance Framework through the quarterly Business Plan Performance Reports and Lead Managers will be reviewing risks as part of this process.

Public stakeholders are involved in managing risks which impact on them through the Patient's Forum; the attendance of a Patient's Forum representative at the Trust Board; involvement in reviews of services, through consultation exercises; and project planning.

A significant gap area identified during 2005/2006 related to the achievement of financial balance. With the advent of the Gloucestershire PCT from 1st October 2006 countywide arrangements have been put in place to deliver the required savings. There are significant risks around delivery of these savings and many will not deliver until the second half of the year. Countywide arrangements are in place to ensure robustness of delivery.

5. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by internal sources such as Clinical Governance, Core Standards and Performance Reports and external sources such as Internal Audit, the Audit Commission, the Local Counter Fraud Service, Health and Safety Executive, Improving Working Lives.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, Professional Executive Committee, Audit Committee, Clinical Governance Committee, Risk Management Committee and Health and Safety Committee.

A Plan to address weaknesses and ensure continuous improvement of the system is in place.

The Business Plan Performance Report (monthly and quarterly) is the vehicle for reporting to the Board and includes information on the Assurance Framework.

The Risk Management Committee, with its representation drawn from the Trust Board, Professional Executive Committee, Management Team and Shared Services will monitor the Business Plan/Assurance Framework through the quarterly Plan Performance Reports. High level reports will be presented to the Professional Executive Committee and the Trust Board, which will enable the priority to be given to routinely reporting the top 6-12 risks and the effectiveness of the organisation's system of internal control.

The Assurance Framework risks are continuously reviewed and updated through the monthly/quarterly Business Plan Performance Reports; the Local Delivery Plan; Clinical Governance Reporting Framework; Internal and External Audit; Reports of other external bodies, for example, Healthcare Commission, Health and Safety Executive, NHS Litigation Authority.

The Trust Board recognises the need to continuously monitor the control system in place, which reports on the delivery of the Trust's Financial Recovery Plan. This requires the PCT to deliver £12.192 million of savings in 2006/2007. The Board recognises the significant risk over delivery of the 2006/07 savings and the likelihood that at cessation the PCT will have a deficit for its share of 2006/07.

Dated18/07/2006

Signed



Chief Executive