Department of Health

NHS

Great Yarmouth and Waveney Primary Care Trust

2012-13 Annual Report and Accounts

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Great Yarmouth and Waveney Primary Care Trust

2012-13 Annual Report

NHS
Great Yarmouth and Waveney

Great Yarmouth and Waveney Annual Report and Accounts 2012-2013

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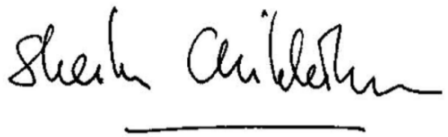
1. Welcome

I am proud to have Chaired the Board of NHS Great Yarmouth and Waveney following our clustering arrangement with NHS Norfolk.

NHS Great Yarmouth and Waveney has a unique identity, it commands loyalty from clinicians and patients alike. It earned its reputation as the fastest improving PCT in the UK. Led by Sushil Jathana and David Edwards, it made immense strides in reducing health inequalities and raising levels of public health. Since 2006 when PCTs were established, Great Yarmouth and Waveney has seen both planned and emergency admissions rise, yet the rates of early deaths from cancer and circulatory diseases have fallen. Life expectancy in the PCT area has risen by as much as two years for men.

We have a robust local health service. As we hand over the baton to our NHS Clinical Commissioning Group we can say the PCT commissioned NHS care with our patients' interests foremost. Our patients have a wide range of GP practices, dentists, opticians, pharmacies, hospitals, community and mental health services to choose from. I hope Primary Care Trusts – NHS Great Yarmouth and Waveney in particular – will be regarded as having laid the foundation for a healthy future for our local NHS.



June 12, 2013

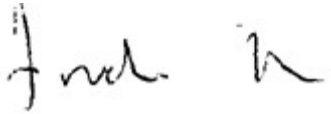
Sheila Childerhouse

Chair

Foreword from the Accountable Officer

This is the last Annual Report of Great Yarmouth and Waveney Primary Care Trust. All PCTs were dissolved on 31 March 2013 and their functions and responsibilities have been distributed within a new NHS commissioning landscape. We have established a vibrant Clinical Commissioning Group which is led by local doctors and nurses, to commission local NHS care for their patients. It has a small team of management staff to drive forward its work. We have also transferred functions to other bodies including NHS England, Public Health and the Norfolk and Waveney Commissioning Support Unit.

This very major transition has been achieved whilst still commissioning high quality care for our patients.



7th June 2013

Andrew Reed
Designated Accountable Officer on behalf of the Department of Health

2. About Us

NHS Great Yarmouth and Waveney was established as a Primary Care Trust in 2006. It served a population of about 230,000 people, covering an area broadly aligned with Great Yarmouth Borough Council and Waveney District Council.

The role of NHS Commissioners is to plan which services are appropriate for the patient population, working closely with key strategic partners such as local councils, patient groups and the Norfolk and Suffolk Local Involvement Networks (LINks). This is done within frameworks set annually by the NHS nationally and regionally.

The right services are then put in place for patients by holding contracts with “providers” - NHS Trusts or independent organisations. We “buy” the care we commission using public funds provided to the NHS.

In addition NHS Great Yarmouth and Waveney was responsible for contracting with Primary Care providers such as GP and dental practices and meeting Public Health targets.

Who provides NHS services?

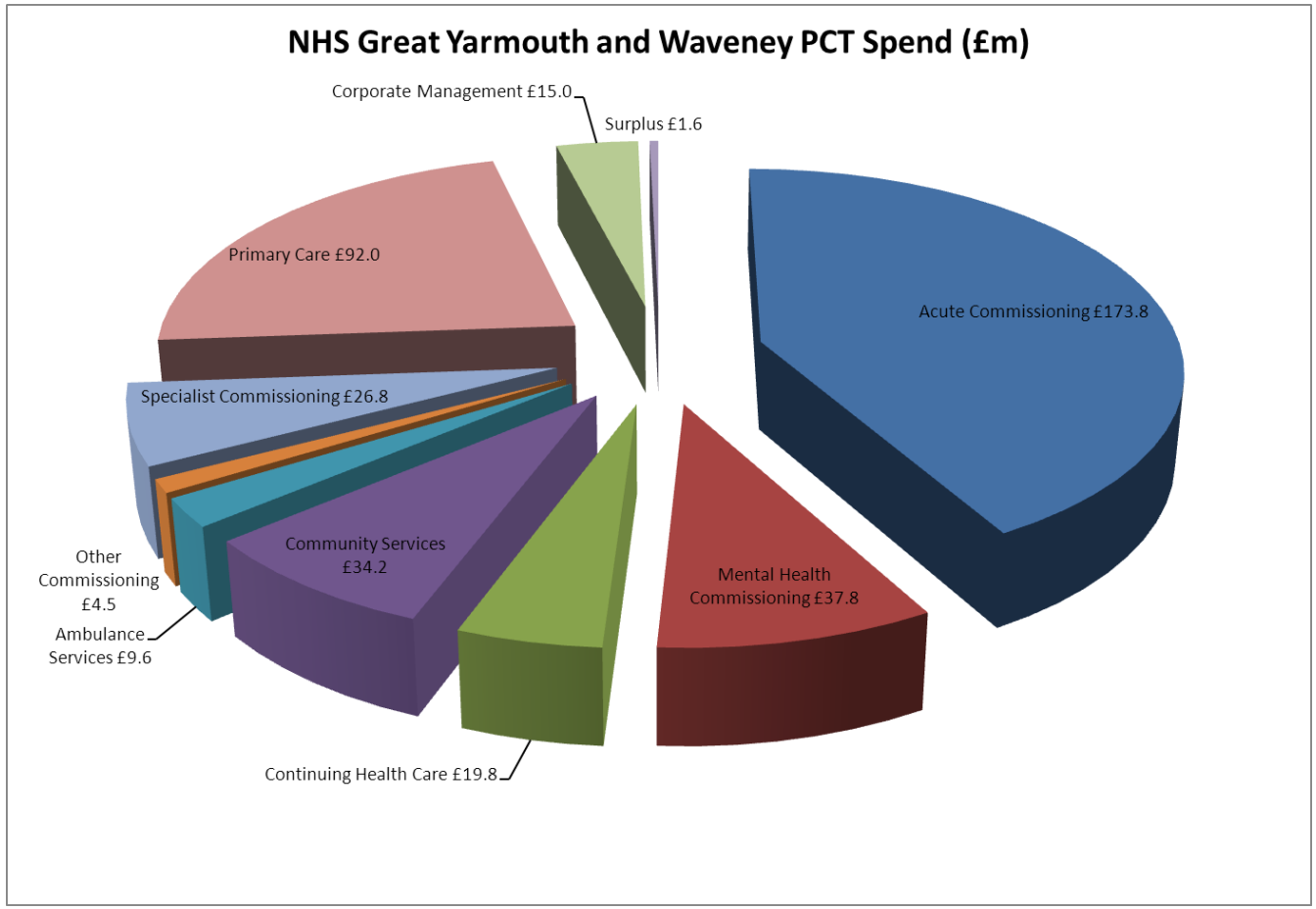
- Patients can choose which hospital they want to be treated at but the majority elect to be treated at the James Paget University Hospital or the Norfolk and Norwich University Hospital. Some patients live closer to the West Suffolk Hospital in Bury St Edmunds or Addenbrooke’s Hospital in Cambridge and choose to have treatment there or further afield.
- Most mental health services in our area are provided by Norfolk and Suffolk NHS Foundation Trust.
- Many community health services are provided by East Coast Community Healthcare
- The East of England Ambulance NHS Trust provides ambulance services for the region

- South East Health provides our Out of Hours GP service and our 111 service.
- Primary care services are provided by GPs, dentists, opticians and pharmacies
- There are also a large number of independent and third-sector organisations which provide NHS care.

How we spent our money

We were provided with a budget by the Department of Health to pay for NHS care within our PCT area. This year the budget was just over £415 million.

The pie chart, below, shows where that money was spent.



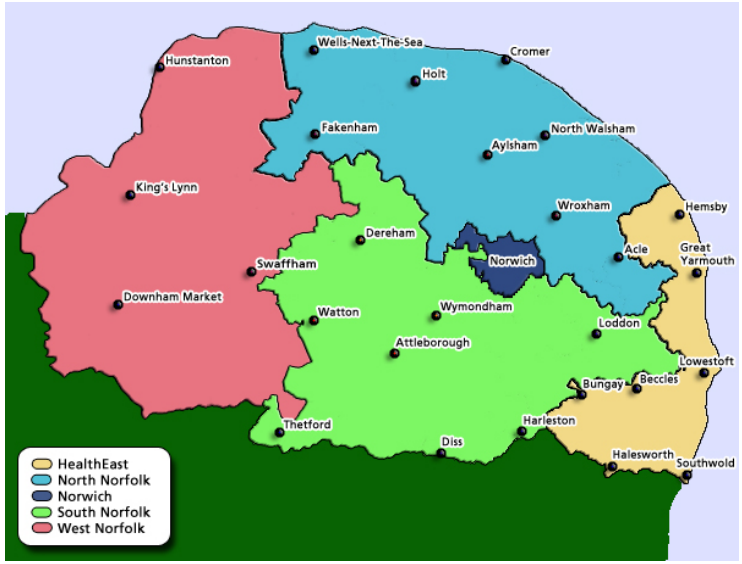
Changes introduced by the Health and Social Care Act 2012

The Health and Social Care Act 2012 set in train the abolition of Primary Care Trusts and the establishment of Clinical Commissioning Groups and NHS England, which have taken over many PCT functions. Public Health responsibilities were transferred to local authorities.

In readiness, we formed a PCT Cluster with NHS Norfolk in 2011 and, whilst remaining a separate statutory body, we have operated with a single Board and Executive Team.

Clinical Commissioning Groups

Family doctors and other local clinicians, together with a highly experienced team of management, established NHS Great Yarmouth and Waveney Clinical Commissioning Group to take over local commissioning of NHS services. The CCG works very closely with those in the former PCT Cluster: North Norfolk, South Norfolk, Norwich and West Norfolk as well as those in Suffolk.



Whilst NHS Great Yarmouth and Waveney Clinical Commissioning Group has a dedicated team of management staff, it can draw upon the **Commissioning Support Unit** which was established to provide support functions for CCGs and other clients. It is based in Norwich.

NHS England. NHS England is accountable for the outcomes achieved by the NHS, and providing leadership for the new commissioning system. Its Local Area Teams are responsible for contracting with primary care providers such as GPs, dentists, pharmacists and opticians, holding CCGs to account and directly commissioning some NHS services.

Public Health transferred to Norfolk County Council.

3. Who's Who

NHS Great Yarmouth and Waveney has been led by a Cluster Board, created on 1 December 1, 2011, consisting of members drawn from both Norfolk and Great Yarmouth and Waveney PCT Boards.

Non-executive directors were recruited from the local community by the Appointments Commission. The Board also consisted of senior officers from NHS Norfolk and Waveney, representatives from Clinical Commissioning Groups and a representative of Norfolk and Suffolk Local Involvement Networks (LINk).

Members of the NHS Norfolk and Waveney Cluster Board

Non-Executive Board Members

Sheila Childerhouse
Chair

Louise Jordan-Hall
Vice Chair

Hilary De Lyon
Non-Executive Director,
Audit Committee Member

John Plaskett
Non-Executive Director,
Audit Committee Member

Dr Edward Libbey
Non-Executive Director,
Audit Committee Chair

Marion Headicar
Non-Exexcutive Director,

Anna Lincoln
Non-Executive Director

Jeff Halliwell
Non-Executive Director

Executive Members

Andrew Morgan
Chief Executive Officer,
until 30th September 2012

Sheila Bremner
Chief Executive Officer,
from 1st October 2012

Alison Taylor
Executive Director of Finance,
until 5th November 2012

Adrian Marr
Interim Director of Finance,
from 5th November 2012

Maureen Carson
Deputy Chief Executive;
Executive Director of
Nursing, Quality and Patient Safety

Dr Alistair Lipp
Medical Director

Dr Jenny Harries
Joint Director of Public Health,
until 30th January 2013

Harper Brown
Executive Director of Integrated
Care Delivery,
until 30th September 2012

Sallie Mills Lewis
Interim Director of
Commissioning,
from 1st November 2012

Also in attendance (non voting)

Jonathan Cook
Company Secretary,
Director of Corporate
Affairs. Resigned through ill
health on 31st jan 2012 and
sadly passed away Feb 2013

Anne Dray
Interim Director of
Corporate Affairs from 1st
April 2012 and Director of
Development from 1st
October 2012

Patrick Thompson
Norfolk LINk

Rob Garner
Interim Managing Director
of CSU

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Clinical Commissioning Group Members of PCT Board (non voting) formally from 1st October 2012

Dr John Stammers, Chair Great Yarmouth and Waveney CCG

Andy Evans, Accountable Officer Designate Great Yarmouth and Waveney CCG

Clinical Commissioning Group Members

Dr John Stammers

Dr Martin Vallis

Dr Andrew McCall

Dr Ian Gibson

Interests of Board members (note these are interests declared at Board meetings. Third party-related transactions which are professional payments made to Board members by the PCT are listed separately in the Remuneration Report.

Sheila Bremner	Chief Executive from 1st October 2012	Chief Executive NHS Suffolk, Chief Executive NHS Cambridge & Peterborough and Local Area Director, NCB LAT, East Anglia
Harper Brown	Executive Director, Integrated Care Delivery	Member UEA Health Economics Steering Group
Dr Jon Bryson	Chair South Norfolk CCG	GP Partner, School Lane Surgery, Thetford
Maureen Carson	Executive Director of Nursing, Quality & Patient Safety	None
Sheila Childerhouse	Chair	Trustee – Keystone Development Trust
Jonathan Cook	Director of Corporate Affairs	None
Hilary De Lyon	Non-Executive Director	Honorary Fellow of the Royal College of General Practitioners Fellow of the Royal College of Medicine Independent Adviser to, and Chair of, the Nominations Committee of The College of Social Work Co-opted member of the executive committee of Labour Women's Network Member of the Labour Party Ordinand sponsored by Norwich Diocese, studying at St Mellitus College, London.
Dr Anoop Dhesi	Chair North Norfolk CCG	GP Staithe Surgery Director, North Norfolk Healthcare CIC; Practice engaged at Level 3 in Research Site Initiative Scheme; Member, Norfolk and Waveney LMC
Ann Donkin	Accountable Officer Designate South Norfolk CCG Board member from 1st November 2012	Director, Adxtra Consulting Ltd
Anne Dray	Interim Director of Corporate Affairs & Director of Development	None
Andy Evans	Accountable Officer Designate Great Yarmouth & Waveney CCG Board member from 1st October 2012	Chief Executive, HealthEast CIC

Jonathon Fagge	Accountable Officer Designate Norwich CCG Board member from 1st October 2012	None
Dr Chris Francis	Chair Clinical Cabinet and Co-Chair Norwich CCG	None
Rob Garner	Interim MD of CSS	None
Jeff Halliwell	Non Executive Director	Chair, Cafedirect PLC
Dr Jenny Harries	Joint Director of Public Health	Company Director Movente Ltd
Marion Headicar	Non-Executive Director Lay Member North Norfolk CCG	Chair Healthwatch, Norfolk Shadow Board
Louise Jordan-Hall	Non Executive Director Lay Member Great Yarmouth & Waveney CCG	Director, Props East Lead Assessor with Institute for Education Business excellence
Edward Libbey	Non-Executive Director	Chair World Energy Solutions, US listed corporation. Audit Chair NHS Cambridgeshire & NHS Peterborough PCT
Anna Lincoln	Non executive Director	None
Dr Alistair Lipp	Medical Director	Honorary Senior Lecturer, University of East Anglia Head of School of Public Health (East of England Multi-professional Deanery) Trustee & Board Member, Faculty of Public Health Member of Programme Advisory Board, Public Health Programme, National Institute of Health Research (advises on research funding).
Dr Ian Mack	Chair, West Norfolk CCG	Partner at Watlington Medical Centre, Director, Watlington Health Shareholder, West Norfolk Health Borough Councillor, Borough Council of King's Lynn and West Suffolk
Adrian Marr	Director of Finance from 5th November 2012	Parent Governor at Holbrook High School, Suffolk, LAT DoF responsibilities + DoF responsibilities for Cambs, & Peterborough PCT Cluster
Sallie Mills-Lewis	Director of Commissioning	Partner 3 Wishes Theatre Company Shareholder in Balkerne Gardens Trust
John Plaskett	Non Executive Director Lay Member Great Yarmouth & Waveney CCG	Director of Norlife Ltd

Dr Cath Robinson	Co-Chair Norwich CCG	GP Partner Oak Street until August 12.

Sue Crossman	Accountable Officer Designate West Norfolk CCG Board member from 1st October 2012	Self Employed consultant
Dr John Stammers	Chair, Great Yarmouth & Waveney CCG	Partner in Southwold Surgery Director of Applicable Ltd
Alison Taylor	Director of Finance to 5th November 2012	None
Mark Taylor	Accountable Officer Designate North Norfolk CCG Board member from 1st October 2012	None
Patrick Thompson	Chairman Norfolk LINk	Chairman National Osteoporosis Society. HCAI Research Core Board Member Trustee TOC-H International, Chairman Health Trainers Gt Yarmouth & Waveney Department of Health (DoH) HCAI SURF (Service Users Research Forum) (DoH) Policy Research Programme Standing Commissioning Panel

4. Our Work

In addition to managing contracts with our hospitals, independent contractors and other major providers of NHS care Great Yarmouth and Waveney:

In the summer of 2012 we launched 111, the new way for patients to find the care they need when it is urgent but not an emergency. The service is provided by South East Health. Patients can call 111 for a range of reasons: if it's a non-life-threatening need for treatment and care, a question about medication, a medical concern about yourself of another person, a query that cannot wait until the following day for your GP or to find your nearest NHS dentist.

We began work on constructing a new state of the art Healthy Living Centre at Reydon, near Southwold.

We also began work on the new Kirkley Mill Health Centre in Economy Road, Lowestoft.

We continued to work with and support the James Paget University Hospital to achieve compliance with CQC standards.

We procured a specialist weight management service, for people with a body mass index (BMI) of over 40 or for people with a BMI of over 35 who also have an obesity-related illness.

We investigated reports circulating nationally that 3.5% of all discharges from hospitals were at night. We confirmed that this figure was heavily affected by anomalies and was certainly not the case in Norfolk and Waveney. We reviewed the discharge policies of the James Paget, Norfolk and Norwich, and Queen Elizabeth hospitals. All these policies avoid overnight discharges.

Our annual flu campaign was focused on reaching pregnant mothers and people who have long term conditions. It included radio advertising, extensive media work and close collaboration by our public health teams with partners in primary and secondary care.

Patient Advice and Liaison Service (PALS)

The Patient Advice and Liaison Service (PALS) provides advice and information to patients, their carers and families about healthcare and NHS services. NHS Great Yarmouth and Waveney highlights the PALS contact details in press releases and patient information, particularly when a new service is introduced or changes are made to an existing policy or procedure.

Principles for remedy

NHS Great Yarmouth & Waveney's Complaints Handling Policy incorporates the Parliamentary and Health Service Ombudsman's Principles of Remedy: Getting it right, being customer focused, being open and accountable, acting fairly and proportionately, putting

things right and seeking continuous improvement. We continue to ensure that these Principles are adhered to by all staff when handling complaints.

Governance

As a public body, it is important that we have strict governance arrangements in place to ensure financial probity, clinical quality and risk management. We have robust arrangements in place for managing person-sensitive information, working with the Information Commissioner's Office and with our auditors. And have followed national guidance and best practice. During 2012/13, NHS Great Yarmouth & Waveney reported no serious incidents regarding data security to the Information Commissioner.

5. Sustainability

Our focus has been on ensuring the effective reallocation of resources to enable commissioning to adapt to the new delivery platform through the Clinical Commissioning Groups and the Commissioning Support Unit. Estate has been reconfigured to enable the effective sharing of resources and optimisation of site use. IT systems infrastructure has been rationalised with a strategic phased approach taken to ensure the higher volume of user entities are supported, and controls and security are retained. Human resource has been prioritised through the transition in terms of ensuring the key skills knowledge and experience are retained to secure effective service delivery in the future.

The commissioning environment has worked to mitigate its impact on the environment in including management of Co2 emissions through proactive resource management and inherent outcomes following the significant rationalisation of services led by the national change programme. A continuation of robust contract performance monitoring has enabled the PCT to achieve Quality, Innovation, Productivity and Prevention (QIPP) and performance targets during the year and specific procurements have resulted in streamlining the provider platform.

NHS Great Yarmouth & Waveney Board implemented the Board-approved Sustainable Development Management Plan (SDMP), which focused on reducing the environmental impact through a series of measures for the PCT as an employer, commissioner and owner of estate to reduce carbon, through the Good Corporate Citizen model.
The Sustainability Transition Framework for handover of responsibilities to successor bodies was included in the NHS Norfolk & Waveney Integrated Plan 2012/13.

Full sustainability data is not available due to the abolition of the PCT, but is held by East Coast Community Healthcare.

6. Emergency Preparedness

Primary Care Trusts responsibilities are carried out in accordance with a variety of statutory requirements and legislation including the Civil Contingencies Act 2004, NHS Emergency Planning Guidance 2005 and Health & Social Care Act 2012.

NHS Norfolk and Waveney combined its Emergency Preparedness, Business Continuity and Out of Hours Director on-call arrangements from June 2012 as part of the Cluster development process. As part of on-going NHS Transitional arrangements senior staff from the Clinical Commissioning Groups have been integrated onto the PCT Cluster on call roster. The emergency planning team continue to provide support to all partners in an effort to ensure continued resilience as we move towards post April 2013 Emergency Planning Resilience & Response (EPRR) arrangements.

A major incident or emergency is usually defined as any event which causes a threat, death or injury, damage to property or the environment, or disruption to the community where the impact cannot be handled within routine service arrangements. NHS Norfolk and Waveney coordinate health emergency preparedness within its geographical boundary in partnership with its health and multi-agency Local Resilience Forum (LRF) partners.

7. Equality and Diversity

Equality and diversity have been fundamental to the achievement of our core vision. We recognise that this has been a huge agenda for the organisation and we have been committed to ensuring that we meet our statutory obligations as a commissioner of healthcare and as an employer; we have policies in place to promote equal opportunities for all, including disabled employees and all protected groups.
As a public authority we have a legal obligation under the Equality Act 2010 to promote equality of opportunity, foster good relations and eliminate discrimination in relation to the protected groups of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion, belief, sex, and sexual orientation. We have strived to move beyond our "legislative requirements" and have developed plans and strategies that are robust, meaningful and can deliver real change for our diverse communities.

During the last 12 months, NHS Norfolk and Waveney developed a legacy for CCGs in order to build on the work achieved, this includes INTRAN interpretation and translation services for our patients, the NHS Equality Delivery System and Public Sector Equality Duties. We have worked closely with Norfolk Community Cohesion Network to take forward county wide initiatives, including those from 'Hidden in Plain Sight' the report by the Equality and Human Rights Commission into Disability Hate Crime. Part of our legacy has been to 'hand over' the findings from the Eradicating Racism in Norfolk NHS (ERINN) 2011 report to CCGs.

8. Our Staff

2012/2013 has been a transitional time for NHS Great Yarmouth & Waveney with the NHS Reforms and transition to Clinical Commissioning Groups (CCGs). This has resulted in developing and supporting our staff for transition to their new receiving organisations.

Supporting Staff Through Transition

A number of initiatives were programmed throughout the year with external consultants. A programme was created to support staff through transition to their new organisations. The format for these sessions included formal one to one career coaching opportunities with a flexible approach to staff needs on how they wanted the meeting to be structured. Workshops included CV writing, interview techniques, coaching and career planning.

Competency based interview techniques were provided during the latter part of the year for members of staff undertaking interviews and secondly for line manager competencies on how to conduct interviews.

Non-Executive and Executive support packages were also available tailored to the need of the individual.

Joint Investment Funds Training for Bands 1-4

A number of our support staff took advantage of Job Investment Funds and used the opportunity to take further qualifications to enhance their roles.

Line Manager Essential Training

Line management training was introduced during the first quarter of the year to 'upskill' line managers and to support their introduction to new human resource policies and procedures. These were launched in-house and well received.

Learning and Development Interventions

Further training was provided on 'Job Evaluation' and 'Job Description' writing to ensure that staff understood the Agenda for Change process and to allow line managers to adapt job descriptions for the needs of the organisation.

Partnership Working

The Cluster has continually enjoyed the positive resource of the Staff Management Council who have supported the organisation through Transition and as well as supporting staff during their difficult periods. Monthly meetings were supplemented with informal interaction and catch up meetings for the final quarter to ensure that information was actioned in a timely manner and shared with staff.

East of England Employment Framework 2012 (V2)

NHS Norfolk and Waveney continued to support the East of England Employment Framework introduced in 2010 by employing their own Redeployment Manager to support other Trusts within Norfolk and Suffolk.

The impact of the Quality, Innovation, Productivity and Prevention (QIPP) plans on workforces and the transactional work created by the NHS Transition as old organisations close and new structures emerge meant that an unprecedented number of staff found themselves at risk of redundancy. The underlying ethos of our Framework was that all NHS organisations would work together to minimise redundancy numbers and to retain valuable skills within the NHS. It was the “One NHS‟ approach that all NHS organisations signed up to in the first edition of this Framework in 2010.

This consistent approach has meant that the Framework was extended regionally and ensured that staff that lived or worked near borders were provided with opportunities to avoid redundancy.

The Framework has been extremely successful and although created for the retention of skilled NHS staff during the Transition, will be continued through HR Directors and networks.

Performance Management

Staff have been supported through appraisal systems and informal one to ones to have clear objectives and an understanding of what acceptable levels of performance look like.

The HR team, together with line managers, manage employee relations with regular evaluations for sickness absence records and assisting with appropriate actions to support staff to return to work. As with other organisations we had a number of long term absences and occupational health and wellbeing support has been invaluable.

	2012-2013
	Number
Full Time Equivalent (FTE) Days Lost to Sickness Absence	2373
Average FTE 2012	368
Average sick days per FTE	6.5

Data from Department of Health

Staff Networks

We continued through 2012/2013 to have active staff networks for staff from Black and Minority Ethnic Groups, staff with disabilities and staff who have identified themselves as Lesbian, Gay, Bisexual and Transsexual. These groups worked within our wider Equality and Diversity arrangements and assisted the organisation to provide policy frameworks for our broader equal opportunities policies.

Staff Communications and Engagements

Weekly all staff briefings were held with summary notes provided on the intranet to provide staff with timely communications of the NHS Reforms and Transition to the CCG's. Board meetings were continued with information made available to the public on the Cluster intranets, and via directorate and team meetings.

With the closure of the PCT and a number of staff transferring to new organisations it has been a priority of the Cluster to support staff through the Transition. Although Transition has been complex with so many receiving organisations there has been a safe and successful transfer of our workforce to approximately 22 receiving organisations providing the 'function' going forward.

9. Performance

The PCT, in conjunction with NHS Norfolk, as NHS Norfolk & Waveney, has demonstrated improvements in key areas of patient care and experience. There are, however, a number of areas such as public health, ambulance response times and reducing unplanned hospitalisations where delivery has fallen short of ambition.

Cancer Waiting Times

Delivery of the nine cancer waiting time standards were consistently met in the majority of months at both the main local provider, James Paget University Hospitals NHS Foundation Trust (JPUH), and across the PCT responsible population.

Health care-acquired Infections

The focus and improvements to infection control introduced last year has resulted in a reduction in the number of health-care acquired infections with cases of MRSA and *Clostridium difficile* both significantly lower than the previous year.

Just two community-acquired MRSA cases were reported across the PCT responsible population against a ceiling target of three. No cases of MRSA attributable to the care at JPUH were reported during the year.

For *Clostridium diffcile*, 34 cases were reported against a ceiling target of 54 in the PCT responsible population. There were 11 cases at JPUH against a ceiling target of 24.

Ambulance Response Times

Ambulance response performance has proved challenging throughout the year with both the regional and local position below plan. New hospital turnaround penalties and a recovery plan are expected to deliver improvements in 2013/14.

A&E Waiting Time

After a challenging year in 2011/12 JPUH delivered strong and sustainable A&E waiting time performance with 97.5% of attendances being seen within the four hour standard.

Referral to Treatment Waiting Time

The start of the year saw a continuation of the significant number of patients waiting over 18 weeks for elective care at JPUH. A specialty-level recovery plan reduced this backlog between April and August but at the expense of achieving the 90% referral standard overall. The Trust met the standard for patients receiving their first treatment in February 2013.

The table below sets out the latest performance status of the key national framework indicators.

12/13 Ref	Indicator	11/12 Actual	12/13 Plan	12/13 YTD	Latest Update
QUALITY 1. Preventing people dying prematurely					
PHQ01	Ambulance Cat A8	78.6	75	73.6	Full Year
PHQ02	Ambulance Cat A19	94.4	95	92.6	Full Year
PHQ03	Cancer 62 day - GP referral	87.5	85	87.4	Full Year
PHQ04	Cancer 62 day - screening	92.8	90	97.3	Full Year
PHQ05	Cancer 62 day - consultant upgrade	96.9	90	100.0	Full Year
PHQ06	Cancer 31 day treatment	98.7	96	98.8	Full Year
PHQ07	Cancer 31 day subsequent treatment - surgery	96.0	94	95.3	Full Year
PHQ08	Cancer 31 day subsequent treatment - drug	100.0	98	99.7	Full Year
PHQ09	Cancer 31 day subsequent treatment - radiotherapy	98.2	94	98.3	Full Year
QUALITY 2. Enhancing quality of life for people with long-term conditions					
PHQ10	New psychosis cases served emergency intervention team	33	73	47	Full Year
PHQ11	Crisis Resolution Home Treatment	344	N/a	657	Full Year
PHQ12	Care Programme Approach 7 day follow up	96.2	95	100.0	Full Year
PHQ13a	Improve access to pyschological therapy: People that enter treatment	2,435	2,992	2,400	Full Year
PHQ13b	Improve access to pyschological therapy: % people complete treatment, moving to recovery	NEW	50.0	46.4	Full Year
PHQ14	% LTC people independent / in control	73.7	increase	N/a	
QUALITY 3. Helping people to recover from episodes of ill health or following injury					
PHQ15	Emergency admissions for chronic ambulatory care sensitive conditions	2,029	Reduction	1,653	Dec-12
PHQ16	Emergency admissions for asthma, diabetes and epilepsy under 19s	133	Reduction	286	Dec-12
PHQ17	Emergency admissions for community-managed conditions	2,557	Reduction	1,890	Dec-12
QUALITY 4. Ensuring that people have a positive experience of care					
PHQ19	% admitted RTT <18wks	90.8	90	83.2	Full Year
PHQ20	% non-admitted RTT <18wks	98.3	95	98.6	Full Year
PHQ21	% incomplete RTT <18wks	92.7	92	91.0	Full Year
PHQ22	% diagnostics waiters >6wks	6.1	1.0	0.2	Full Year
PHQ23	% A&E waits <4h (James Paget University Hospitals)	93.56	95	97.5	Full Year
PHQ24	Cancer 2 weeks stnd	97.0	93	96.0	Full Year
PHQ25	Cancer 2 weeks breast stnd	98.1	93	97.7	Full Year
PHQ26	Mixed sex accommodation (MSA) breaches	3	0	7	Full Year
QUALITY 5. Treating + caring for people in safe environment + protecting from harm					
PHQ27	MRSA	5	3	2	Full Year
PHQ28	Clostridium difficile	92	54	34	Full Year
PUBLIC HEALTH					
PHQ30	Smoking quitters	2,299	2418	2,122	Full Year
PHQ31_02	Health checks received	6,801	8,090	5,458	Full Year

10. Operating and Financial Review

For Great Yarmouth & Waveney PCT Annual Report 2012/13:

This operating and financial review has been prepared by reference to the seven principles set out in the NHS Manual for Accounts for PCTs. Key indicators of our performance against our principle strategic service objectives are shown in the table on page 26.

All PCTs have four statutory financial targets:

- To provide health care for all of its population within a set budget known as its revenue resource limit
- To maintain capital expenditure within a permitted allocation (capital resource limit)
- To break even on the services it provides (provider full cost recovery duty)
- To keep cash spending within a designated cash limit

Great Yarmouth & Waveney PCT has achieved all relevant financial targets in 2012-13.

Revenue Resource Limit

	2012-13 £'000	**2011-12 £'000**
Total Spend	412,896	411,765
Revenue Resource Limit	414,514	412,774
Over (Under) spend	(1,618)	(1,009)

In 2012-13 the PCT has seen cost pressures in acute services and high cost packages of care. Price control and medicines management has led to achievement of the QIPP target and underspends on primary prescribing costs. However the ageing population of Great Yarmouth & Waveney has led to further pressure on the costs of continuing healthcare. Additionally, central government announced a series of deadlines by which any people wishing to claim retrospectively for NHS funding of continuing healthcare, had to register their claim. Known as restitution claims, these have always been a feature of continuing healthcare costs, but the introduction of a specific series of deadlines has increased the incidence of claims markedly in 2012-13. The PCT has made a significant provision for the cost of those claims which is detailed in note 17 of the Annual Accounts.

Following the introduction of the NHS and Social Care Act 2012, 2012-13 has marked the final year of the PCT as an organisation. Future commissioning of general acute and community healthcare for the patients of Great Yarmouth & Waveney will be undertaken by Great Yarmouth & Waveney Clinical Commissioning Group (GYW CCG). Specialist and Primary care will be commissioned by NHS England East Anglia Area Team. Public Health services will be commissioned by Norfolk County Council, Suffolk County Council and Public Health England. This change has taken considerable planning with commissioning powers being formally delegated by the PCT to the CCG from October 2012. The overall cost of change has included contractual staff severance, those costs are detailed in note 7.3 of the Annual Accounts.

Capital Resource Limit

The PCT has invested considerable capital in backlog maintenance and statutory compliance schemes this year in order to improve its capital assets. The PCT has also continued to invest in primary care facilities. Primary care developments in Reydon and South Lowestoft have begun and will ultimately reflect integrated service delivery.

Following the introduction of the NHS and Social Care Act 2012, ownership of the PCT estate will transfer at the end of the year to NHS Property Services Ltd.

	2012-13 £'000	**2011-12 £'000**
Total Spend	10,227	8,139
Capital Resource Limit	10,277	8,150
Over (under) spend	(50)	(11)

In the opinion of the Directors there is no significant difference between the carrying value and the market value of interests in land held by the PCT. This opinion has been informed by the valuation of the PCT estate undertaken as at 31st March 2013. Further details of the valuation are disclosed at note 9.3 of the Annual Accounts.

Provider full cost recovery

In Great Yarmouth & Waveney provider services were separated from the Primary Care Trust from 1 October 2011, so this financial duty no longer applies to this PCT.

Cash Management

PCTs are required by statute to keep their cash spending within a cash limit.

The PCT achieved its cash spending limit and had a minimal bank balance at 31st March 2013.

Other matters

The Better Payment Practice code requires the PCT to aim to pay valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. NHS Great Yarmouth & Waveney has signed up to the prompt payments code. A full disclosure of the PCT payment performance is included at note 8 of the Annual Accounts.

NHS Great Yarmouth & Waveney's auditors for 2012-13 were Ernst & Young. The cost of the statutory audit was £89640.
The Directors of NHS Great Yarmouth & Waveney confirm that, as far as they are aware, there is no relevant audit information of which the organisation's auditors are unaware. They have taken all the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that the auditors of NHS Great Yarmouth & Waveney are aware of that information.

For information on how pension liabilities are treated, please cross reference to the accounting policy 1.17 and note 7.4 in the Annual Accounts. In respect of senior employees in the PCT, pension entitlements are disclosed in the remuneration report which is located in Appendix 1 of this annual report.

The organisation has not made any political or charitable funds contributions in year. Neither have there been any special severance payments. NHS Great Yarmouth & Waveney has incurred £916k in termination benefits costs in 2012-13; this sum being wholly due to staff contractual entitlement under NHS terms of employment.

Public spending and reporting

As a public body, NHS Great Yarmouth & Waveney complies with the Treasury's Guidance on Public Spending and Reporting (Appendix 6.3) with regard to setting charges for information should this be necessary at any time.

However, NHS Great Yarmouth & Waveney makes every effort to ensure that as much information as possible is available free of charge to the public via its website (www.gywpct.nhs.uk). This includes information about our activities and services, consultation papers and all responses to requests received under the Freedom of Information Act 2000.

Off Payroll Engagement Data

For off payroll engagements at a cost of over £58200 per annum that were in place as of 31 January 2013.

Number in place on 31 January 2012	2
Of which:	
Number that have since come onto the Organisation's payroll	0
Of which:	
Number that have since been renegotiated / re-engaged to include contractual clauses allowing the organisation to seek assurance as to their tax obligations.	0
Number that have not been successfully re-negotiated and therefore continue without contractual clauses allowing the organisation to seek assurance as to their tax obligations	0
Number that have come to an end	0
Total	2

Appendix 1

Remuneration Report

This report gives details of the NHS Great Yarmouth and Waveney's Remuneration Committee and the PCT's policies in relation to the remuneration of its senior managers which the Board has defined as Executive and Non-Executive Directors, the Chair and Chief operating Officer of the CCG, the Chief Executive of the CSU and members of the Clinical Executive Committee.

Details of remuneration payable to the senior managers of NHS Great Yarmouth and Waveney in respect of their services during the year ended 31 March 2013 are given in the tables at the end of this report.

Pay Multiples (this section is subject to audit)
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 mid-point of the banded remuneration of the highest paid director in NHS Great Yarmouth and Waveney in the financial year 2012-13 was £69,487 (2011-12, £207,500). This was 2.2 times (2011-12, 5.3 times) the median remuneration of the workforce, which was £31,532 (2011-12, £38,851).

The drop in value of the median was largely as a result of the restructuring occasioned by the Health and Social Care Act which was underway during the year. The highest paid director was the Chief Executive who was also the Chief Executive of the Cluster . Although changes in the structure of the board were reflected in the directors remuneration, the major change was the sharing of costs between parties to the cluster which was the major cause for the drop in director's remuneration apportioned to each PCT.

In 2012-13, 18 of the employees (2011-12, 0 employees) received remuneration in excess of the highest-paid director. Remuneration ranged from £2,750 to £107953.

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

All staff on Agenda for Change Terms and Conditions on more than £21,000 per annum were subject to a pay freeze in 2012-13 except for annual incremental increases.

The Remuneration Committee
The Remuneration Committee is a committee of the Board and holds responsibility, under its Terms of Reference, for determining the salaries of the Chief Executive and Executive Directors on Very Senior Manager Terms and Conditions. Under the terms of the Framework, the Remuneration Committee has responsibility for determining salary, recruitment and retention premier, additional responsibility allowances and any non-consolidated bonus payments for the Chief Executive and the Directors.

During the year the Committee was chaired by Anna Lincoln (Non Executive Director) and its other members were Sheila Childerhouse (Chair of the Board)and Hilary De Lyon (Non Executive Director). Tracey Parkes (Director of HR) was also in attendance.

Executive Directors: remuneration policy
The salaries for the Chief Executive and Directors of the PCT are determined through national terms and conditions, and the NHS "Pay Framework for Very Senior Managers in Strategic Health Authorities, Special Health Authorities, Primary Care Trusts and Ambulance Trusts" updated 2 April 2009.

Performance bonus payments are non-consolidated, non-pensionable, and in addition to the consolidated annual uplift are payable in organisations that have achieved their financial control targets.

No more than 25% of Very Senior Manager's within each PCT Cluster could receive an award based on 2011-12 performance. Further the monetary ceiling for awards was set at 5% of reckonable pay for A and B performers only.

Mirroring the pay freezes in Agenda for Change staff, the Remuneration Committee determined that no non-consolidated bonus payments would be made for the year ended 31 March 2013 to the Chief Executive and Executive Directors.

Direction for determining notice periods for the Chief Executive and the Directors are laid out in the NHS Bodies Employment Contracts (Notice Periods) Directions 2008. The contracted notice period for the termination of the chief executive is six months by either party and for the executive directors is six months notice from the PCT and 3 months notice from the employee. All of the PCT's Directors, except those members of the Local Area team who were appointed on a substantive basis during the transitionary period to the close of the PCT, have been issued with and signed a contract of employment. Following the demise of the PCT all directors contracts are terminated at 31st March 2013.

Executive Directors and members of the Clinical Executive Committee are eligible to participate in the NHS Pension Scheme which provides salary-related pension benefits on a defined benefit basis.

Most executive directors had rolling service contracts; The table below discloses contract start dates for the PCT and the PCT cluster.

Executive Director in post at 31 March 2013	Role	Start date with GY&W PCT	Contract start date as Cluster Executive Director	Contract Termination date for Fixed term Contracts
Sheila Bremner	Cluster Chief Executive	Not Applicable	1st October 2012	31st March 2013
Maureen Carson	Cluster Deputy Chief Executive; Executive Director of Nursing, Quality and Patient Safety	Not Applicable	31st May 2011	31st March 2013
Adrian Marr	Interim Director of Finance	Not Applicable	5th November 2012	31st March 2013
Dr Alastair Lipp	Cluster Medical Director	1st July 2002	1st September 2011	31st March 2013
Sallie Mills-Lewis	Cluster interim Director of Commissioning	Not Applicable	1st November 2012	31st March 2013
Dr John Stammers	Chair of Great Yarmouth and Waveney CCG	1st October 2012	Not applicable	30th November 2013
Andy Evans	Chief Officer of Great Yarmouth and Waveney CCG	1st October 2012	Not applicable	30th November 2013

Non-Executive Directors: Remuneration policy

Non-Executive Directors are appointed by the NHS Appointments Commission for a fixed term. Their remuneration consists of fees determined by the NHS Appointments Commission. No increase in pay was applied in 2012-13. Non-Executive Directors are reimbursed for out-of-pocket expenses incurred on the PCT's business. Non-Executive Directors are not eligible to participate in the NHS Pension Scheme.

The Non Executive appointments became effective on the following dates:

Non-Executive Director in post at 31 March 2013	Role	Great Yarmouth & Waveney PCT	Norfolk PCT
		Contract date	Contract date
Sheila Childerhouse	Chair	4 November 2011	1 October 2010
Louise Jordan-Hall	Vice Chair	1 December 2007	1 December 2011
Dr. Edward Libbey	Non-Executive director	1 December 2011	1 October 2009
Marion Headicar	Non-Executive director	1 December 2011	1 July 2009
Hilary De Lyon	Non-Executive director	1 December 2011	1 February 2011
Jeff Halliwell	Non-Executive director	1 December 2011	1 April 2011
Anna Lincoln	Non-Executive director	11 February 2002	1 December 2011
John Plaskett	Non-Executive director	1 March 2007	1 December 2011

The Health & Social Care Act provides for the dissolution of all PCTs by 2013. As a consequence all directors contracts have been terminated on 31 March 2013.

Board appointments during 2012-13
Where directors have been identified as working across the Cluster their costs have been split on a 50/50 basis between the two organisations from the date of their cluster appointment. Prior to cluster appointment dates, costs relate exclusively to NHS Great Yarmouth and Waveney.

In accordance with the provisions of the Health and Social care Act 2012 which abolishes PCTs from 1st April 2013, all board appointments to the PCT cluster cease on 31st March 2013.

Following a selection process for roles within Local area Teams of the NHS Commissioning Board the following were confirmed in director roles for the PCT cluster.

Name	Position	Appointment date	Salary paid by existing employer (bands of £5000)
Sheila Bremner	Interim Chief Executive	1st October 2012	160-165
Adrian Marr	Interim Director of Finance	5th November 2012	125-130
Sallie Mills-Lewis	Interim Director of Commissioning	1st November 2012	115-120

In accordance with national guidance the salary costs of the Local Area Office staff have continued to be met in full by their employer, rather than be accounted for in part by Great Yarmouth and Waveney PCT and so are not disclosed in Table 1 of this remuneration report.

The following ceased to be directors of the PCT cluster, but as above their costs remained in full with the PCT Cluster, so are disclosed in this report.

- Alison Taylor was seconded to Birmingham, Solihull and the Black Country NHS Commissioning Board Local Area Team on 5th November 2012
- Andrew Morgan was seconded to the SHA on 1 September 2012 and subsequently became interim Chief Executive of the East of England Ambulance Services NHS Trust.

The CCG Chief Officer and Chair were members of the PCT Board in 2012/13. From 1st October 2012, formal delegation of commissioning responsibilities, in line with the scheme of delegation and the signed Memorandum of Understanding, was given to the CCG. The Governing Body was a committee of the PCT Board. Members of the CCG Governing Body made appropriate disclosures in respect of their role.

- Dr John Stammers was appointed as Chair of Great Yarmouth and Waveney CCG on 1st October 2012
- Andy Evans was appointed as Chief Officer Great Yarmouth and Waveney CCG on 1st October 2012

Other changes to the composition of the board in the year were:

- Ian Ayres resigned on 30th September 2012

- Jenny Harries resigned on 31st January 2013.
- Harper Brown resigned on 31st August 2012.
- Maureen Carson was appointed as Deputy Chief Executive on 1st October 2012 and retained her post as Director of Nursing, Quality and Patient Safety.
- Rob Garner was appointed as Interim Managing Director of the Commissioning Support Unit on 1st October 2012

Senior managers' remuneration for the year ended 31 March 2013

Details of remuneration payable to the senior managers of NHS Great Yarmouth and Waveney PCT in respect of their services during the year ended 31 March 2013 are given in table 1 below.

Name and Title	2012-13						2011-12			
	NHS Great Yarmouth and Waveney			Total Paid (full value of cluster shared posts)			NHS Great Yarmouth and Waveney		Total Paid (full value of cluster shared posts)	
	Salary (bands of £5,000)	Compensation for loss of office (bands of £5000)	Benefits in kind (rounded to the nearest £100)	Salary (bands of £5,000)	Compensation for loss of office (bands of £5000)	Benefits in kind (rounded to the nearest £100)	Salary (bands of £5,000)	Benefits in kind (rounded to the nearest £100)	Salary (bands of £5,000)	Benefits in kind (rounded to the nearest £100)
Great Yarmouth and Waveney PCT Board Members										
Sheila Childerhouse (PCT ClusterChair)	15-20	0	0	35-40	0	0	5-10	0	35-40	0
Louise Jordan-Hall (NHS Great Yarmouth and Waveney Non Executive Director and Vice Chair unitl 2 November 2011)		0	0	0	0	0	5-10	0	0	0
Louise Jordan-Hall (PCT Cluster Vice Chair from 4 November 2011)	5-10	0	0	10-15	0	0	0-5	0	10-15	0
Dr Edward Libbey (PCT Cluster NED)	5-10	0	0	10-15	0	0	0-5	0	10-15	0
Dr Jenny Harries (Cluster Director of Public Health to 31 January 2013)	50-55	0	0	100-105	0	0	55-60	0.7	110-115	0.7

Name and Title	2012-13						2011-12			
	NHS Great Yarmouth and Waveney			Total Paid (full value of cluster shared posts)			NHS Great Yarmouth and Waveney		Total Paid (full value of cluster shared posts)	
	Salary (bands of £5,000)	Compensation for loss of office (bands of £5000)	Benefits in kind (rounded to the nearest £100)	Salary (bands of £5,000)	Compensation for loss of office (bands of £5000)	Benefits in kind (rounded to the nearest £100)	Salary (bands of £5,000)	Benefits in kind (rounded to the nearest £100)	Salary (bands of £5,000)	Benefits in kind (rounded to the nearest £100)
Great Yarmouth and Waveney PCT Board Members										
Hilary de Lyon (PCT Cluster NED)	0-5	0	0	5-10	0	0	0-5	0	5-10	0
Jeff Halliwell (PCT Cluster NED)	0-5	0	0	5-10	0	0	0-5	0	5-10	0
Anna Lincoln (Great Yarmouth and Waveney Non-Executive Director to 30 November 2011)	0	0	0	0	0	0	5-10	0	0	0
Anna Lincoln (PCT Cluster NED from 1 December 2011)	0-5	0	0	5-10	0	0	0-5	0	10-15	0

Name and Title	2012-13						2011-12			
	NHS Great Yarmouth and Waveney			Total Paid (full value of cluster shared posts)			NHS Great Yarmouth and Waveney		Total Paid (full value of cluster shared posts)	
	Salary (bands of £5,000)	Compensation for loss of office (bands of £5000)	Benefits in kind (rounded to the nearest £100)	Salary (bands of £5,000)	Compensation for loss of office (bands of £5000)	Benefits in kind (rounded to the nearest £100)	Salary (bands of £5,000)	Benefits in kind (rounded to the nearest £100)	Salary (bands of £5,000)	Benefits in kind (rounded to the nearest £100)
Great Yarmouth and Waveney PCT Board Members										
John Plaskett (Great Yarmouth and Waveney Non Executive Director) until 30 November 2011	0	0	0	0	0	0	5-10	0	0	0
John Plaskett (PCT Cluster NED)	0-5	0	0	5-10	0	0	0-5	0	10-15	0
Maureen Carson Cluster Deputy Chief Executive; Executive Director of Nursing, Quality and Patient Safety	55-60	110-115	0	115-120	225-230	0	40-45	0	100-105	0

Alistair Lipp (Director of Public Health to 31 August 2011)	**0**	**0**	**0**	**0**	**0**	**0**	**50-55**	**0**	**0**	**0**
Alistair Lipp Cluster Medical Director	**60-65**	**0**	**1.7**	**125-130**	**0**	**3.4**	**35-40**	**0**	**125-130**	**0**

Name and Title	**2012-13**						**2011-12**			
	NHS Great Yarmouth and Waveney			**Total Paid (full value of cluster shared posts)**			**NHS Great Yarmouth and Waveney**		**Total Paid (full value of cluster shared posts)**	
	Salary (bands of £5,000)	**Compensation for loss of office (bands of £5000)**	**Benefits in kind (rounded to the nearest £100)**	**Salary (bands of £5,000)**	**Compensation for loss of office (bands of £5000)**	**Benefits in kind (rounded to the nearest £100)**	**Salary (bands of £5,000)**	**Benefits in kind (rounded to the nearest £100)**	**Salary (bands of £5,000)**	**Benefits in kind (rounded to the nearest £100)**
Great Yarmouth and Waveney PCT Board Members										
Alison Taylor (Great Yarmouth and Waveney Director of Finance until 25th May 2011)	**0**	**0**	**0**	**0**	**0**	**0**	**10-15**	**0**	**0**	**0**
Alison Taylor (Cluster Director of Finance until 5th November 2012	**55-60**	**0**	**0**	**110-115**	**0**	**0**	**45-50**	**0**	**110-115**	**0**

Harper Brown (Director of Commissioning and Performance to 2 June 2011)	**0**	**0**	**0**	**0**	**0**	**0**	**15-20**	**0**	**0**	**0**
Harper Brown (Cluster Director of Integrated Care and Delivery until 31st August 2012)	**20-25**	**0**	**0.4**	**40-45**	**0**	**0.7**	**40-45**	**0**	**100-105**	**0**
Marion Headicar (PCT Cluster NED) from 1 December 2011	**0-5**	**0**	**0**	**5-10**	**0**	**0**	**0-5**	**0**	**5-10**	**0**

Name and Title	**2012-13**						**2011-12**			
	NHS Great Yarmouth and Waveney			**Total Paid (full value of cluster shared posts)**			**NHS Great Yarmouth and Waveney**		**Total Paid (full value of cluster shared posts)**	
	Salary (bands of £5,000)	**Compensation for loss of office (bands of £5000)**	**Benefits in kind (rounded to the nearest £100)**	**Salary (bands of £5,000)**	**Compensation for loss of office (bands of £5000)**	**Benefits in kind (rounded to the nearest £100)**	**Salary (bands of £5,000)**	**Benefits in kind (rounded to the nearest £100)**	**Salary (bands of £5,000)**	**Benefits in kind (rounded to the nearest £100)**
Great Yarmouth and Waveney PCT Board Members										

Ian Ayres (Cluster Executive Director Delivery and Commissioning Development until 30th September 2012)	**30-35**	**0**	**0**	**60-65**	**0**	**0**	**55-60**	**0**	**135-140**	**0**
Andrew Morgan (Cluster Chief Executive until 30 September 2012)	**70-75**	**245-250**	**0.7**	**140-145**	**490-495**	**1.3**	**70-75**	**0.7**	**145-150**	**1.4**
Rob Garner (Interim managing Director of the CSU from 1st October 2012)	**40-45**	**0**	**0**	**285-290**	**0**	**0**	**0**	**0**	**0**	**0**

Name and Title	**2012-13**						**2011-12**		
	NHS Great Yarmouth and Waveney			**Total Paid (full value of cluster shared posts)**			**Total Paid**		
	Salary (bands of £5,000)	**Compensation for loss of Office (bands of £5000)**	**Benefits in kind (rounded to the nearest £100)**	**Salary (bands of £5,000)**	**Compensation for loss of Office (bands of £5000)**	**Benefits in kind (rounded to the nearest £100)**	**Salary (bands of £5,000)**	**Compensation for loss of Office (bands of £5000)**	**Benefits in kind (rounded to the nearest £100)**

Michael Cotton (Non Executive Director, Community Services) from 1 March 2011 to 30 September 2011	0	0	0	0	0	0	0-5	0	0
Pamela Fenner (Director of Nursing Services) until 31 May 2011	0	0	0	0	0	0	15-20	0	0
Dr Jamie Wyllie (Medical Director) from 10 May 2010 to 31 July 2011	0	0	0	0	0	0	30-35	0	0
Kate Gill (Director of Corporate Affairs) until 30 November 2011	0	0	0	0	0	0	70-75	0	0
Rebecca Driver (Associate Director of Communication and Engagement) until 30 November 2011	0	0	0	0	0	0	35-40	0	0
Tracy Parkes(Associate Director of Human Resources) until 1 October 2011	0	0	0	0	0	0	40-45	0	0

Name and Title	**2012-13**				**2011-12**
	NHS Great Yarmouth and Waveney			**Total Paid (full value of cluster shared posts)**	**Total Paid**

	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in kind (rounded to the nearest £100)	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in kind (rounded to the nearest £100)	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in kind (rounded to the nearest £100)
David Edwards (NHS Great Yarmouth and Waveney Chair)until 2 November 2011	**0**	**0**	**0**	**0**	**0**	**0**	**20-25**	**0**	**0**
Patricia Brocklebank (Non Executive Director) until 30 November 2011	**0**	**0**	**0**	**0**	**0**	**0**	**5-10**	**0**	**0**
Peter Hawkins Hargrave (Non Executive Director) from 1 April 2010 to 15 June 2011	**0**	**0**	**0**	**0**	**0**	**0**	**0-5**	**0**	**0**
Stephen Millward (Non Executive Director, Community Services) from 21 February 2011 to 30 September 2011	**0**	**0**	**0**	**0**	**0**	**0**	**0-5**	**0**	**0**
Paul Steward (Non Executive Director, Community Services) from 1 March 2011 to 30 September 2011	**0**	**0**	**0**	**0**	**0**	**0**	**0-5**	**0**	**0**

Name and Title	2012-13						2011-12		
	NHS Great Yarmouth and Waveney			Total Paid (full value of cluster shared posts)			Total Paid		
	Salary (bands of £5,000)	Compensation for loss of Office (bands of £5000)	Benefits in kind (rounded to the nearest £100)	Salary (bands of £5,000)	Compensation for loss of Office (bands of £5000)	Benefits in kind (rounded to the nearest £100)	Salary (bands of £5,000)	Compensation for loss of Office (bands of £5000)	Benefits in kind (rounded to the nearest £100)
David Boakes (Associate Director of Information Technology) until 1 April 2011	0	0	0	0	0	0	5-10	0	0
Roger Moyse (Interim Chief Operating Officer – Community Services) from 18 October 2010 to 17 June 2011	0	0	0	0	0	0	45-50	0	0
Tracey Cannell (Interim Joint managing Director of Community Services) from 18 June 2011 to 30 September 2011	0	0	0	0	0	0	55-60	0	0
Chris Banks (Interim Joint Managing Director of Community Services) from 18 June 2011 to 30 September 2011	0	0	0	0	0	0	50-55	0	0

Name and Title	2012-13						2011-12			
	NHS Great Yarmouth and Waveney			Total Paid (full value of cluster shared posts)			NHS Great Yarmouth and Waveney		Total Paid (full value of cluster shared posts)	
	Salary (bands of £5,000)	Other	Benefits in kind (rounded to the nearest £100)	Salary (bands of £5,000)	Other	Benefits in kind (rounded to the nearest £100)	Salary (bands of £5,000)	Benefits in kind (rounded to the nearest £100)	Salary (bands of £5,000)	Benefits in kind (rounded to the nearest £100)
Clinical Cabinet formerly Clinical Executive Committee										
Martin Vallis	10-15			10-15			10-15	0	10-15	0
Andrew McCall	10-15			10-15			15-20	0	15-20	0
Ian Gibson	25-30			25-30			25-30	0	25-30	0

Both John Stammers and Andy Evans were paid by HealthEast Community Interest Company.

NHS Great Yarmouth and Waveney (this section is subject to audit)
Table 1: Salaries and Allowances
The figures noted above relate to payments within the financial year, rather than annual salary costs. Figures for staff leaving or appointed part way through the year are for that part year only. There were no other remuneration or bonus payments made during 2012-13.

Pension benefit
Disclosures about pension benefits only relate to directors that were in post at 31st March in the relevant financial year.

NHS Great Yarmouth and Waveney clustered with NHS Norfolk during 2011-12. Costs for Directors who work across the cluster have been shared on a 50/50 basis and the pension disclosures above reflect NHS Great Yarmouth and Waveney's share of changes in pension benefits in 2012-13 from the date that the director was appointed to the cluster except for CETV values which are shown in full.

The table below shows the full changes to the clustered director's pensions for the year.

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

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

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

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

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

NHS Great Yarmouth and Waveney does not make any contributions to stakeholder pensions.

Details are not required of non executive directors, non pensionable managers and independent GPs who are on the Clinical Executive Committee of PCT since pension disclosures are not required for these groups.

No CETV values are disclosed for staff over the normal NHS retirement age.

Table 2: Pension Benefits 2012/13

Name & Title	**Real increase in pension at age 60 (bands of £2,500)**	**Real increase in pension lump sum at age 60 (bands of £2,500**	**Total accrued pension at age 60 at 31 March 2013 (bands of £5,000)**	**Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000)**	**Cash Equivalent Transfer Value at 31 March 2013**	**Cash Equivalent Transfer Value at 31 March 2012**	**Real increase in Cash Equivalent Transfer Value**
	£000	£000	£000	£000	£000	£000	£000
Great Yarmouth and Waveney PCT Board Members							
Andrew Morgan	(0-2.5)	(0-2.5)	25-30	80-85	982	973	8
Maureen Carson	0 - 2.5	0 - 2.5	20-25	60-65	829	801	28

Alastair Lipp	(0 -2.5)	(0 –2.5)	15-20	55-60	740	721	19
Alison Taylor	0 - 2.5	0 - 2.5	10-15	40-45	479	455	25

Table 3: Cluster Pension Benefits 2012/13

Name & Title	**Real increase in pension at age 60 (bands of £2,500)**	**Real increase in pension lump sum at age 60 (bands of £2,500**	**Total accrued pension at age 60 at 31 March 2013 (bands of £5,000)**	**Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000)**	**Cash Equivalent Transfer Value at 31 March 2013**	**Cash Equivalent Transfer Value at 31 March 2012**	**Real increase in Cash Equivalent Transfer Value**
	£000	£000	£000	£000	£000	£000	£000
Andrew Morgan	(0-2.5)	(2.5-5)	50-55	160-165	982	973	8
Maureen Carson	0 - 2.5	0-2.5	40-45	120 -125	829	801	28
Alastair Lipp	(0–2.5)	(0–2.5)	35-40	115 - 120	740	721	19
Alison Taylor	0 - 2.5	0 - 2.5	25-30	80 - 85	479	455	25

Table 4: Pension Benefits 2011/12

Name and Title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at age 60 (bands of £2,500	Total accrued pension at age 60 at 31 March 2012 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2012 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2012	Cash Equivalent Transfer Value at 31 March 2011	Real increase in Cash Equivalent Transfer Value
	£000	£000	£000	£000	£000	£000	£000
GYW PCT Board Members							
Andrew Morgan	0-2.5	2.5-5	25-30	75-80	925	758	143
Ian Ayres	0-2.5	0-2.5	5-10	25-30	494	423	58
Maureen Carson	0-2.5	0-2.5	15-20	45-50	762	690	50
Harper Brown	(0-2.5)	(0-2.5)	10-15	35-40	498	473	11
Alistair Lipp	0-2.5	0-2.5	25-30	80-85	686	582	86
Alison Taylor	0-2.5	5-7.5	10-15	40-45	432	320	102
Jenny Harries	2.5-5	7.5-10	10-15	35-40	511	352	148

In the budget on 23 March 2011, HM Treasury confirmed its intention to review the basis for the calculation of CETVs payable from public service schemes, including the NHS Pension Scheme. The review was undertaken and revised guidance was issued on 26 October 2011.

For the calculation of CETVs as at 31 March 2012, NHS Pensions have followed the revised guidance and have used the updated Government Actuary Department (GAD) factors in their calculations. The revised GAD factors are different to those used as at 31 March 2011 so direct comparison between financial periods is not possible.

The new factors will have differing impacts of the CETVs of the individuals concerned depending on their age and normal retirement age.

Other Compensation Schemes - Exit Packages

There is a requirement to disclose exit package information which is set out in the table below:-

Exit package cost band (including special payment element)	Number of compulsory redundancies	Total cost to Great Yarmouth and Waveney PCT of exit packages by cost band	Total cost to the PCT cluster of exit packages by cost band
£100,001 - £200,000	1	£114,000	£228,000
£200,001 - £250,000	1	£246,000	£492,000
Total number of exit packages by type (total cost)	2	£360,000	£720,000

There were no payments in respect of other departures in 2012/13.The total number of special payments included in the table is £Nil. The total cost of special payments included in the table is £Nil.

Department of Health

NHS

Great Yarmouth and Waveney Primary Care Trust

2012-13 Accounts

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Great Yarmouth and Waveney Primary Care Trust

2012-13 Accounts

Appendix 2
Full Accounts, including Annual Governance Statement and Independent Auditor's report to the Directors of Norfolk Primary Care Trust

Annual

Accounts

2012/2013

CONTENTS

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

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

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

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

Signed.....Designated Signing Officer

Name: ANDREW REED

Date 7th June 2013

2012-13 Annual Accounts of Great Yarmouth and Waveney Primary Care Trust

STATEMENT OF RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

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

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

- make judgements and estimates which are reasonable and prudent;

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

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

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

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

By order of the Permanent Secretary.

4th Jun 2013 Date ..... Signing Officer

4th June 2013 Date ..... Finance Signing Officer

ANNUAL GOVERNANCE STATEMENT NHS GREAT YARMOUTH & WAVENEY 2012/13

1. Scope of responsibility

1.1. The Accountable Officer of NHS Great Yarmouth & Waveney had overall responsibility for maintaining a sound system of internal control to support the achievement of the organisation's objectives during 2012/13 and responsibility for safeguarding public funds and the organisation's assets, for demonstrating effective propriety and regularity, for prudent, economical administration and achievement of value for money, as set out in the Accountable Officer memorandum. The Audit Committee provided challenge in relation to their responsibilities to inquire into matters of propriety and regularity, supported by the programme of Internal Audit, culminating in the Head of Internal Audit Opinion.

1.2. There have been changes in Accountable Officer during the year, with formal handover processes followed. Andrew Morgan was Accountable Officer until 31st September, Sheila Bremner from 1st October, with Adrian Marr covering her role due to sickness absence from 29th December. I fulfilled the Accountable Officer role from the end of March.

1.3. NHS Great Yarmouth & Waveney Primary Care Trust (PCT) and NHS Norfolk Primary Care Trust joined together to form the Cluster PCT NHS Norfolk & Waveney in 2011 and although operating as a cluster, the two PCTs maintained a separate legal status and prepared separate accounts. This Annual Governance Statement relates to NHS Great Yarmouth & Waveney.

2. Governance Framework

2.1. The Board – Performance and Effectiveness

2.1.1. The NHS Great Yarmouth & Waveney Board was responsible for reviewing the effectiveness of the PCT's system of internal control. The system was designed to manage, rather than eliminate, the risk of failure to achieve business objectives and provided reasonable, not absolute, assurance that:

- the risks to the achievement of the PCT's objectives were identified and prioritised
- the likelihood of those risks being realised was evaluated and the impact, should they be realised, was managed efficiently, effectively and economically.

2.1.2. The Board was composed of the Chair, 7 non-officer members and 7 voting officer members and contained a balance of skills, experience, knowledge, diversity and independence to discharge its duties effectively, particularly during transition to the new architecture in relation to the Health & Social Care Act 2012. Clinical Commissioning Group (CCG) Chief Officers and Chairs were formally appointed as non-voting members as of 1st October 2012.

2.1.3. The Board met every two months in public. Between April and October it held additional private meetings and held Board to Board meetings with our main providers. It reviewed performance against the national priorities set out in the NHS Operating Framework 2012/13, quality and safety of patient care, financial management, the delivery of the Quality Innovation Productivity and Prevention (QIPP) schemes and the discharge of statutory functions. It provided robust challenge where there was underperformance, such as with ambulance turnaround and cost of continuing health care. It received regular reports on progress with transition and the delegation of commissioning to CCGs, ensuring the maintenance of operational and financial grip.

2.1.4. The Board benefited from good attendance, regular exchange between non-executives and the Chair and from development sessions throughout the year. The action plan produced following the formal review of Board effectiveness in March 2012, against the UK Corporate Governance Code, was implemented, resulting in a revised agenda focused on priority risk issues, inclusion of patient stories, greater involvement of CCGs and an improved performance report. Sheila Bremner undertook a review in October 2012 of the effectiveness of the Cluster structures and the Board approved the establishment of a CCG Performance Committee to improve assurance to the Board.

2.1.5. The Scheme of Delegation, Standing Orders and Financial Instructions were reviewed throughout the year and approved by the Board.

2.2. Board Committee - The Audit Committee

2.2.1. The Audit Committee met six times in the year to oversee financial, corporate and clinical governance, the discharge of statutory functions and risk management. In reviewing the adequacy of systems of internal control, the committee

relied on the work of its sub-committees such as the Probity Group, Information Governance Committee, Health & Safety Committee and Business Continuity Group and received reports from the Quality & Patient Safety Committee, Finance Scrutiny Committee, the latter was replaced with the CCG Performance Committee from November 2012, and from Executive Directors, senior managers, the Commissioning Support Unit (CSU) and CCGs on their risk mitigation actions. The Committee reviewed areas of high risk within the PCT's Board Assurance Framework (BAF), Part 2 BAF and supporting risk registers. It authorised and monitored the work of Internal Audit, External Audit and Counter Fraud, ensuring recommendations were actioned by management, and scrutinised the appropriateness of PCT tender waivers. The Committee reviewed the annual accounts and areas of judgement.

2.3. **Board Committee - The Remuneration Committee**

2.3.1. The levels of remuneration, terms of service of the Board and those in Very Senior Managers posts and key severance decisions were scrutinised by the Remuneration Committee and reported to Board and members of the Audit Committee.

2.4. **Board Committee - The Quality & Patient Safety Committee**

2.4.1. The Quality & Patient Safety Committee monitored clinical risks and the quality and safety of provider services, including serious incidents, complaints, safeguarding issues, healthcare acquired infections, Care Quality Commission (CQC) reports and challenged poor performance of independent contractors via the Decision Making Group. Risks and issues were summarised in the confidential Part 2 BAF. Membership of the Committee in 2012/13 included representatives from the CCGs.

2.5. **Board Committee - Clinical Commissioning Committee**

2.5.1. The Clinical Commissioning Committee (CCC) provided clinical leadership and strategic commissioning direction and supported safe transition to CCG-led commissioning. In September, the Board approved that the Great Yarmouth & Waveney CCG Governing Body replaced the CCC as the Board Committee and the CCC continued in its strategic function but was no longer responsible for the execution of delegated functions from the Board.

2.6. **Board Committees - Clinical Commissioning Groups (CCGs)**

2.6.1. The Board of the CCG was constituted as a committee of the PCT Board in 2012/13, to ensure robust governance and support for its authorisation as statutory bodies from 1st April 2013. The Board approved a Memorandum of Understanding with the CCG Board.

2.6.2. Great Yarmouth & Waveney CCG was fully authorised without conditions (in wave 1).

2.7. The Time-Limited CCG Authorisation Committee

2.7.1. This was established in July 2012 in order to approve any CCG Policies and procedures necessary for authorisation and to provide advice and support for CCG governance processes.

2.8. Board Committee - CCG Performance Committee

2.8.1. The Committee was established by the Board in November 2012 to monitor CCGs against their delegated responsibilities and statutory duties, providing the Board with assurance on delivery. It met monthly and was chaired by a Non-Executive Director and included two other Non Executive Directors and members of the Executive.

2.9. Board Committee - Commissioning Support Unit (CSU)

2.9.1. The CSU Board was constituted as a committee of the Board in 2012/13 to ensure robust governance during its development and business assurance review process. The Managing Director attended the Board in a non-voting capacity.

2.10. Board Committee - The Pharmacy & Dispensing Committee

2.10.1. The Committee was responsible for determining applications submitted under the NHS (Pharmaceutical Services) Regulations 2005 and from 1st August 2012, the 2012 regulations.

2.11. Compliance with the Corporate Governance Code

2.11.1. The NHS Great Yarmouth & Waveney Board complied with all aspects of the UK Corporate Governance Code, namely leadership, effectiveness, accountability and remuneration and arrangements for the discharge of statutory functions were legally compliant.

2.12. Handover and Closure

2.12.1. The Transition Leads Group met weekly, led by the Director of Development & Interim Director of Corporate Affairs, reporting to the Executive Team, Board and Audit Committee, via the Transition and Closedown milestone report and working closely with legal advisors. The closedown plan and transfer schemes, supporting the transfer of assets, liabilities, contracts and staff to receiver organisations, were reported regularly to the SHA, the Audit Committee and to the March Board. Transition risks were escalated as appropriate to the Board Assurance Framework (BAF) and transition was a priority area for internal audit.

2.12.2. Following delegation of functions, risks from the BAF were formally transferred to CCGs and the CSU, with the PCT retaining full statutory accountability until the 31st March and with the Board continuing to review all significant risks throughout the year. Outstanding risk issues were included in the General and Quality Handover documents for receiver organisations.

2.12.3. Formal, minuted meetings were held with successor bodies for handing over quality issues in the Quality Handover Document, iterations of which had been submitted to the SHA, regularly reviewed by the Quality & Patient Safety Committee and presented to the March Board.

2.12.4. As key staff moved to new organisations, formal handover meetings were held and appropriately recorded to ensure formal transfer of responsibilities, issues and risks. This included the Accountable Officer.

2.12.5. A governance framework was established to ensure the scrutiny and sign off of PCT 2012/13 accounts in line with the guidance in Gateway ref 18561, statutory financial returns and agreement of closing balances. Two Non-Executive members of the Audit Committee and the PCT Chair were nominated as members of the Audit Sub-Committee of the Department of Health Audit & Risk Committee.

3. Risk Assessment

3.1. There was a robust risk assessment process throughout NHS Great Yarmouth & Waveney in 2012/13, articulated through the Risk Strategy and Risk Management Framework, updated in year to reflect delegation to the CCGs and approved by the Board in September 2012.

3.2. The PCT supported a positive culture of risk management, encouraging staff to identify, report and assess risks to the delivery of corporate objectives, quantifying impact and likelihood. Risks were identified by proactive and reactive risk assessments via incidents, complaints, audits, CQC reports unannounced visits, patient and staff feedback, national inquiries and the Whistleblowing Policy.

3.3. The Executive Team and the Transition Leads Group assessed risks at each meeting reviewing the effectiveness of risk mitigation action and controls and any change in risk rating and recording this in the relevant risk register, escalating where necessary. Clinical risks were assessed by the Quality & Patient Safety Committee and reported to the Board via the confidential part 2 BAF. Residual risk continued to be evaluated. This defined the risk profile for NHS Great Yarmouth & Waveney.

3.4. Newly identified risks this year were:-

- Risks to operational grip with delegation to the CCG was mitigated by appointing the Chief Officer as a member of the Executive Team and Board, reporting on performance and financial management to each Board meeting and with the CCG Performance Committee monitoring performance with delegated responsibilities.
- Risk of failure to implement the recommendations from the Winterbourne View Hospital Report. A local action plan was developed and monitored by the Mental Health Commissioning Board and Quality & Patient Safety Committee.
- Risk of impact of the Mid Staffordshire NHS Foundation Trust Public Inquiry “The Francis Report” was debated at the last PCT Board in March. Actions will be taken forward by successor bodies.
- Risk of excess running costs - an establishment process was introduced and the Executive Team regularly reviewed capacity, recruitment to new structures and redundancies.
- Risk of failure of IT during transition - the Chief Information Officer was a key member of the Transition Leads group, which monitored risks. With the migration of IT services and setting up services in a number of new bodies, no significant incidents occurred.

3.5. On-going risks which remained highly rated this year included:-

- Risk of failure to deliver QIPP initiatives - QIPP was allocated to the CCGs as of October 2012 and monitored closely by the CCG Performance Committee and the Board. At the end of the year, the PCT had achieved QIPP savings of £11.637 against a plan of £11.609m.
- Failure to manage demand at acute hospitals remained an issue in 2012/13 and was mitigated by a number of QIPP schemes managed by the CCGs, monitored by more robust contract management and the work of the Commissioning Boards.
- Risk to financial resilience –at the end of the year, the PCT achieved a surplus of £1.6m exceeding its financial control target £1m surplus, but below the revised target of £3m
- Pressure on costs of continuing healthcare and restitution payments was mitigated by holding back investment reserves. The existing continuing care action plan continued to be implemented, vacancies were recruited to, QIPP plans in regard high cost packages and personal health budgets delivered savings. A turnaround plan was instigated by CCGs in Quarter 4.
- Risk of failure to achieve performance targets, specifically treating patients within 18 weeks from referral, inconsistent A&E performance, ambulance response targets and poor turnaround at acute hospitals. QIPP schemes, contract penalties and recovery action plans were implemented to improve performance; Serious Incidents and patient stories closely monitored A joint review of patient flows, Project Domino, has system-wide stakeholder support, work continues on improving urgent care, new winter funding initiatives, help in A&E from the national Intensive Support Team, an East Anglia Quality Surveillance Group (attendees included commissioners, CQC, Monitor and Healthwatch) and a Regional Summit were held in March to better support East of England Ambulance Services Trust (EEAST) to improve performance and patient safety. The Board reviewed progress at each meeting.
- Risk to viability of CSU, with regard recruitment of permanent Managing Director and leadership team - an appointment process was agreed with the NHS Commissioning Board for interim support, both the Managing Director and Chief Financial Officer are now in post.

3.6. Outstanding risks at the end of year were formally passed on to the relevant successor bodies via the General and Quality Handover Documents.

3.7. Risks to data security were assessed according to Department of Health guidance, monitored by the Information Governance (IG) Committee and the Caldicott Guardian and reported as required to the Information Commissioner. Incident trends were reviewed and lessons learnt widely shared to prevent recurrence. The Senior Information Risk Owner (SIRO) and the Information Asset Owners (IAOs) were responsible for information systems and staff undertook mandatory IG training. NHS Great Yarmouth & Waveney submitted its cluster IG Toolkit assessment, using Internal Audit's feedback on

their review of a sample of PCT's evidence as further guidance. The IG Toolkit met level 2 (equating to Green, Satisfactory) for all requirements for 2012/13. The IG team supported transition, including Transfer Schemes, to ensure the emerging organisations complied with statutory requirements.

3.8. Lapses in data security were assessed according to the Department of Health Gateway 13177 guidance (where level 0 is the lowest level of impact and 5 is the most serious) and fully discussed at the Information Governance Committee. Only 4 incidents were reported in 2012/13 and these were low level (level 1).

3.9. There were no data security lapses that met the criteria for reporting to the Information Commissioner during 2012/13 (levels 3-5).

4. The risk and control framework

4.1. The Risk Framework

4.1.1. The PCT revised its governance structures and reporting processes for the 2012/13 transition year to facilitate the handover of responsibility to receiving organisations in line with the national NHS reforms.

4.1.2. The PCT followed a proactive, systematic process for identifying, evaluating, mitigating and escalating risk as outlined in the Risk Strategy and the Risk Management Framework. Risks were recorded, managed at the appropriate level and escalated as follows:-

4.1.3. The Board Assurance Framework (BAF) contained the PCT's significant risks against its four strategic priorities for 2012/13:

- Maintain and improve quality
- Financial control and operational grip (against national priorities set out in the NHS Operating Framework)
- QIPP
- Transition

4.1.4. The BAF was maintained by the Executive Team who agreed risk tolerance and risk appetite and was reported to each meeting of the public Board. Assurances on controls were provided by: internal audit reviews, performance reports, local counter fraud work, clinical audits, staff surveys, staff appraisals and training, incident and complaint

investigations, IG toolkit evidence, Commissioning for Quality and Innovation (CQuIN) schemes, benchmarking, LINks, external regulators etc. The Audit Committee scrutinised the BAF and underlying risk management processes to provide further assurance to the Board.

4.1.5. The confidential Part 2 BAF contained significant clinical and quality risks of commissioned services, was scrutinised by the Quality & Patient Safety Committee and reported to the private Board meetings and regularly to the Audit Committee.

4.1.6. The Corporate Risk Register (CRR) contained significant operational risks and was managed by the Executive Team. In November, the Audit Committee approved the pragmatic merger of the BAF and Corporate Risk Register to better identify the main risks to the delivery of the PCT's priorities for 2012/13 and as the CCGs had established an assurance framework reviewed at their Governing Bodies, reporting their risks to the PCT Board.

4.1.7. The Audit Committee challenged executives and senior managers on the effectiveness of their mitigation for supporting risk registers, including the CSU and CCG, and examined the development of the risk strategy and assurance framework by the CCG. The CCG Performance Committee provided further scrutiny of CCG risk management.

4.1.8. The CCG/PCT governance leads group provided an informal forum for sharing learning and rationalising resource for managing risk to CCG authorisation.

4.2. Risk Prevention

4.2.1. Learning from adverse events (such as serious incidents and complaints) was shared widely to prevent further occurrence.

4.2.2. There was a robust programme of counter fraud and anti-bribery activity, supported by the Local Counter Fraud Specialist (LCFS), who reported to the Director of Finance and whose annual programme of prevention, deterrence and detection was scrutinised by the Audit Committee.

4.2.3. The Primary Care Services Probity Group ensured payments to primary care contractors complied with regulations and were value for money.

4.2.4. The Scheme of Delegation, Standing Financial Instructions and Standing Orders were reviewed in year, specifically following the delegation of functions and budgets to CCGs.

4.2.5. Risks associated with the provision of services to patients were mitigated through robust contract management of provider services and the work of the Quality & Patient Safety team.

4.2.6. NHS Great Yarmouth & Waveney met all statutory and legal duties with regard to risk management, Health & Safety, IG, Equality & Diversity, Freedom of Information and sustainability during 201/3. As an employer with staff entitled to membership of the NHS Pensions Scheme, control measures were in place throughout 2012/13 to ensure all employer obligations were complied with.

5. Effectiveness of Risk Management and Internal Control

5.1. As Accountable Officer, I am responsible for reviewing the effectiveness of the system of internal control. My review was informed in a number of ways:

- The work of the Board in ensuring sound systems of internal control, the regular update of governance arrangements to manage transition and monitoring of strategic risks via the BAF.
- The Executive Team managed operational risk to the delivery of strategic objectives, capturing of risk discussions via the BAF and the Corporate Risk Register. Membership included the CCG Chief Operating Officers for the whole year.
- The work of the Transition Leads Group, monitoring transition milestone progress, the closure plan, the transfer schemes of assets and liabilities and the development of the General and Quality handover documents.
- The work of Board committees, particularly the Audit Committee and CCG Performance Committee which scrutinised and challenged the executive and CCGs on governance and risk management and sought assurances on the effectiveness of controls.
- The work of the Executive Director of Nursing, Quality & Patient Safety team and CCG Chief Officer and Quality leads in carrying out unannounced visits, inspections, monitoring provider serious incidents and risks, and reviewing governance trend reports.
- Contract meetings with providers holding them to account for the quality of patient services.

- The Health & Safety Committee which reviewed health & safety risks and ensured the health & safety of the workforce and any persons working or visiting the premises.
- The IG Committee, SIRO and Caldicott Guardian who reviewed potential breaches of data security, IT security, the PCT's obligations under the Data Protection Act 1998 and progress with the IG Toolkit action plan.
- The work of regulatory bodies such as Monitor and the CQC whose inspection reports provided assurance to the Board on the quality and governance of our provider services and helped triangulate local information.
- Third party assurance (ISAE 3402) for Serco in relation to finance systems.
- The work of the Local Counter Fraud Specialist.
- Governance and performance reports on specialised commissioning.
- The external auditor's opinion and reports, including his conclusion of the PCT's value for money arrangements.
- The Serious Incident (SI) process for reporting and investigating serious incidents. Action plans were robustly monitored to ensure recommendations were actioned and risk mitigated.
- Regular performance reviews with the Strategic Health Authority. Positive feedback was received on the Annual Accountability Review and on the approach taken to directing the transition to clinical commissioning.
- The work of the Health Overview & Scrutiny Committee provided an independent view.
- Internal Audit, who provided an independent, objective opinion on the degree to which governance and risk management supported the achievement of the organisation's objectives.

5.2. **The work of Internal Audit**

5.2.1. The annual Head of Internal Audit Opinion (HoIA) contributed to the assurance available to the Accountable Officer and the Board and underpinned the Board's own assessment of the effectiveness of the organisation's system of internal control. The HoIA in turn assisted the Board in the completion of its Annual Governance Statement and was one of Significant Assurance for 2012/13. However, some weaknesses in the design and/or inconsistent application of controls put the achievement of particular objectives at risk, as detailed below. The Audit Committee received assurance at each meeting on progress to address these weaknesses. The Opinion was based solely on internal audit's assessment of whether the controls in place supported the achievement of management's objectives as set out in the Annual Internal Audit Risk Assessment and Plan and in individual assignment reports.

5.2.2. The review of the BAF and risk management was carried out as part of Internal Audit's annual plan and adequate assurance was received.

5.2.3. Internal Audit support was useful in assessing the impact on transition. Limited assurance opinion was given for:

- Business Continuity – revision of plans was on going in 2012/13 due to re-structuring and movement of staff, however business continuity underpinned the transition work and was tested throughout e.g. with IT migration. The CSU and CCGs are using the recommendations to develop their own business continuity plans.
- QIPP – the QIPP target for 2012/13 was apportioned between the CCGs which were required to identify new schemes. Since the audit, the CCG Performance Committee was established to provide better scrutiny and challenge. CCGs are introducing standardised QIPP initiation processes.
- Transition Management – Contract Transfer – responsibility for the shift phase of contract transition was assigned to the CSU, capacity was addressed and the project plan finalised with CCG leads in December. Weekly monitoring was undertaken.
- Accounts Payable – issues with the purchase ordering system in respect to Eros, used for low value, non-medical supplies, were mitigated by controls for the approval of expenditure at invoice receipt stage. A new purchasing system was in place from the beginning of the new financial year which included the facility to perform electronic ordering.
- ITIL Service Desk – the PCT commissioned a gap analysis against aspirational standards to aid the introduction of formal service management process. Work is underway to address the gaps by the CSU.

5.3. Significant Issues

5.3.1. My review identified a number of other significant issues during 2012/13, which are summarised below:

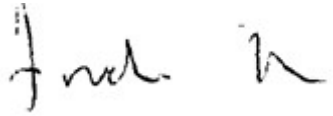
- Failure to meet waiting times, mixed sex breaches, stroke, ambulance and A&E targets. QIPP schemes, robust contract management, Project Domino, and regional summits were used to support the providers to improve performance.
- There were a number of clinical issues such as surgical “Never events “serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented” (NPSA definition) and the high number of pressure ulcers have been closely monitored through reporting, audit, unannounced visits, monitoring of the use of the WHO checklist and robust contract management.
- There are a significant number of outstanding, high-cost continuing health care restitution claims and any accrual or provision entered into the accounts for these claims is expected to be significant and possibly material to the accounts.

6. Conclusion

6.1. With the exception of the internal control issues that I have outlined in the Annual Governance Statement, to which appropriate action has been or is being taken by successor bodies, my review confirms that a sound system of internal control was in place in NHS Great Yarmouth & Waveney for the year ended 31 March 2013 and up to the date of approval of the annual report and accounts. This is supported by the Head of Internal Audit Opinion of Significant Assurance.

Accountable Officer: Andrew Reed

Organisation: NHS Great Yarmouth & Waveney



Signature ……

Date : 7th June 2013……..

INDEPENDENT AUDITORS' REPORT TO THE ACCOUNTABLE OFFICER FOR GREAT YARMOUTH AND WAVENEY PRIMARY CARE TRUST

We have audited the financial statements of Great Yarmouth and Waveney Primary Care Trust for the year ended 31 March 2013 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 33. 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 for Great Yarmouth and Waveney Primary Care Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Accountable Officer, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of the Signing Officer and Finance Signing Officer, and auditors

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

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the Trust; and
- the overall presentation of the financial statements.

In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

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

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

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

Opinion on other matters

In our opinion:

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

Matters on which we report by exception

We report to you if:

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

We have nothing to report in these respects

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

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

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

- our review of the Governance Statement; and

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

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

Certificate

We certify that we have completed the audit of the accounts of Great Yarmouth and Waveney Primary Care Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Neil Harris
for and on behalf of Ernst & Young LLP
400 Capability Green
Luton
Beds
LU1 3LU
7th June 2013

FOREWORD TO THE ACCOUNTS

Great Yarmouth & Waveney Primary Care Trust

These accounts for the year ended 31 March 2013 have been prepared by the Great Yarmouth & Waveney Primary Care Trust under the National Health Service Act 2006 in the form which the Secretary of State has, with the approval of the Treasury, directed.

Statement of Comprehensive Net Expenditure for year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure			
Gross employee benefits	7	**7,974**	18,530
Other costs	5	**419,375**	406,983
Income	4	**(14,453)**	(13,748)
Net operating costs for the financial year		**412,896**	411,765
Of which:			
Administration Costs			
Gross employee benefits		**6,567**	5,444
Other costs		**4,444**	4,630
Income		**(1,539)**	(601)
Net administration costs for the financial year		**9,472**	**9,473**
Programme Expenditure			
Gross employee benefits		**1,407**	13,086
Other costs		**414,931**	402,353
Income		**(12,914)**	(13,147)
Net programme expenditure for the financial year		**403,424**	**402,292**

Other Comprehensive Net Expenditure		2012-13 £000	2011-12 £000
Net (gain) on revaluation of property, plant & equipment	9	**(139)**	(633)
Release of Reserves to Statement of Comprehensive Net Expenditure		**189**	
Total comprehensive net expenditure for the year		**412,946**	**411,132**

Statement of Financial Position at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	9	**36,437**	27,607
Intangible assets	10	**92**	137
Total non-current assets		**36,529**	27,744
Current assets:			
Trade and other receivables	14	**3,317**	3,331
Cash and cash equivalents	15	**32**	0
Total current assets		**3,349**	3,331
Total assets		**39,878**	31,075
Current liabilities			
Trade and other payables	16	**(17,145)**	(13,635)
Provisions	17	**(2,265)**	(465)
Total current liabilities		**(19,410)**	(14,100)
Non-current assets plus/less net current assets/liabilities		**20,468**	16,975
Total Assets Employed:		**20,468**	16,975
Financed by taxpayers' equity:			
General fund		17,885	14,531
Revaluation reserve	9	2,583	2,444
Total taxpayers' equity:		**20,468**	16,975

The notes on pages 79 to117 form part of this account.

The financial statements on pages 75 to 78 were approved by the Audit Sub-Committee of the Department of Health Audit and Risk Committee on 7 June 2013 and signed on its behalf by

Andrew Reed
Designated Accountable Officer
(on behalf of Departmentof Health)

Date: 7th June 2013

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

	General fund	Revaluation reserve	Total reserves
	£000	£000	£000
Balance at 1 April 2012	**14,531**	**2,444**	**16,975**
Changes in taxpayers' equity for 2012-13			
Net operating cost for the year	(412,896)		**(412,896)**
Net gain on revaluation of property, plant, equipment		139	**139**
Release of Reserves to SOCNE	(189)		**(189)**
Total recognised income and expense for 2012-13	**(413,085)**	**139**	**(412,946)**
Net Parliamentary funding	416,439		**416,439**
Balance at 31 March 2013	**17,885**	**2,583**	**20,468**
Balance at 1 April 2011	**11,328**	**1,811**	**13,139**
Changes in taxpayers' equity for 2011-12			
Net operating cost for the year	(411,765)		(411,765)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment		633	633
Total recognised income and expense for 2011-12	(411,765)	633	(411,132)
Net Parliamentary funding	414,968		414,968
Balance at 31 March 2012	**14,531**	**2,444**	**16,975**

In 2011-12 the Provider Arm of the PCT divested and became East Coast Community Healthcare (ECCH). As part of the divestment process the new organisiation purchased the balance of assets and liabilities relating to the Provider Arm activities and paid a consideration of £850k to the PCT. This was treated as a gain in the 2011/12 PCT accounts and the whole amount was taken to the General Reserve as the transaction was outside the SOCNE. Following review of the transactions it was determined that the payment of £850k was incorrect and a refund was paid back to ECCH. To avoid this payment incorrectly impacting on expenditure, a transfer of £189k was made from the General Reserve back to the SOCNE

Statement of cash flows for the year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities			
Net Operating Cost Before Interest		**(412,896)**	(411,765)
Depreciation and Amortisation	9	**1,498**	1,238
Impairments and Reversals	9	**83**	1,174
Release of Reserves to SOCNE		**(189)**	0
(Increase)/Decrease in Inventories		**0**	39
(Increase)/Decrease in Trade and Other Receivables	14	**14**	1,666
Increase/(Decrease) in Trade and Other Payables	16	**2,951**	207
Provisions Utilised	17	**(161)**	(72)
Increase/(Decrease) in Provisions	17	**1,961**	346
Net Cash Inflow/(Outflow) from Operating Activities		**(406,739)**	**(407,167)**
Cash flows from investing activities			
(Payments) for Property, Plant and Equipment		**(9,667)**	(7,667)
(Payments) for Intangible Assets		**(1)**	(137)
Net Cash Inflow/(Outflow) from Investing Activities		**(9,668)**	**(7,804)**
Net cash inflow/(outflow) before financing		**(416,407)**	**(414,971)**
Cash flows from financing activities			
Net Parliamentary Funding		**416,439**	414,968
Net Cash Inflow/(Outflow) from Financing Activities		**416,439**	**414,968**
Net increase/(decrease) in cash and cash equivalents		**32**	**(3)**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**0**	**3**
Cash and Cash Equivalents (and Bank Overdraft) at year end		**32**	**0**

1. Accounting policies

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

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

In accordance with the directed accounting policy from the Secretary of State, the PCT does not consolidate the NHS charitable funds for which it is the corporate trustee.

1.1 Accounting Conventions

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

Acquisitions and Discontinued Operations

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

Critical accounting judgements and key sources of estimation uncertainty

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

Critical judgements in applying accounting policies

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

1) The PCT has used judgment to establish that all current land leases are operating leases and they do not need to be re-classified as finance leases in accordance with IAS 17.

2) The PCT has used judgment to determine that component accounting in relation to property, plant and equipment is not required in accordance with IAS 16.

Key sources of estimation uncertainty

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

1) The PCT includes an estimate of the potential costs and timing of settlement of restitution and redress for continuing healthcare claims. Further details are given in the provisions note 17 to this account.

1. Accounting policies (continued)

2) The PCT uses estimation in formulating its provisions and the likely timing of the expenditure.
3) The PCT estimates the useful life of its assets in order to determine the amount of annual depreciation.

Going concern
As a consequence of the Health and Social Care Act 2012, Great Yarmouth & Waveney PCT will be dissolved on 31 March 2013. Its functions will be transferred to various new or existing public sector entities.

The Secretary of State has directed that , where Parliamentary funding continues to be voted to permit the relevant services to be carried out elsewhere in the public sector, this is normally sufficient evidence of going concern.

As a result the Board of Great Yarmouth & Waveney PCT have prepared these accounts on a going concern basis.

1.2 Revenue and Funding

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

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

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

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

1.3 Pooled budgets

The PCT has entered into a pooled budget with Suffolk County Council. Under the arrangement funds are pooled under s75 of the National Health Service Act 2006 for Mental Health activities.

The pool is hosted by Suffolk County Council. As a commissioner of healthcare services, the PCT makes contributions to the pool, which are then used to purchase healthcare services. The PCT accounts for its share of the assets, liabilities, income and expenditure of the pool as determined by the pooled fund agreement.

1.4 Taxation

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

1.5 Administration and Programme Costs

Treasury has set performance targets in respect of non-frontline expenditure (administration expenditure).From 2011-12, PCTs therefore analyse and report revenue income and expenditure by "admin and programme"
For PCTs, the Department has defined "admin and programme" in terms of running costs.
The broad definition of running costs includes any cost incurred that is not a direct payment for the provision of healthcare or healthcare related services.
Expense incurred under NHS transition redundancy programmes is however classed as "programme" under Treasury budgetary control arrrangements and so is recorded as such in the financial statements.

1. Accounting policies (continued)

1.6 Property, Plant & Equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the PCT;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

Valuation

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

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

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

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

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

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

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

Subsequent expenditure

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

1. Accounting policies (continued)

1.7 Intangible Assets

Recognition

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

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

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement

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

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

1.8 Depreciation, amortisation and impairments

Freehold land, properties under construction and assets held for sale are not depreciated.

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

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

1. Accounting policies (continued)

1.9 Donated assets

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

1.10 Government grants

Following the accounting policy change outlined in the Treasury FREM for 2011-12, a government grant reserve is no longer maintained. The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.11 Non-current assets held for sale

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

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

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.12 Cash and cash equivalents

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

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

1.13 Losses and Special Payments

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

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

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

The NHSLA operates a risk pooling scheme under which the PCT pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure in the year that it is due.

1. Accounting policies (continued)

1.15 Employee benefits

Short-term employee benefits

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

Retirement benefit costs

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

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

1.16 Research and Development

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

1.17 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.

1.18 Grant making

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

1.19 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 are valued at fair value at the end of the reporting period.

1. Accounting policies (continued)

1.20 Contingencies

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

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

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

1.21 Leases

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

The PCT as lessee

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

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

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

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

The PCT as lessor

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

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

1.22 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. Accounting policies (continued)

1.23 Restructuring Provisions

A restructuring provision is recognised when the PCT has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures 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.

1.24 Financial Instruments

Financial assets

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

Financial assets are initially recognised at fair value.

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

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 discounted cash flow valuation techniques.

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

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

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

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

Financial liabilities

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

Financial liabilities are initially recognised at fair value.

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

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. Accounting policies (continued)

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

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

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

Operating Segments

	JPUH		Acute		Mental Health & LD		Prescribing & Pharmacy		Primary Care		Community Health		Community Provider		Other		Total	
	£000 **2012-13**	£000 2011-12	£000 **2012-13**	£000 2011-12	£000 **2012-13**	£000 2011-12	£000 **2012-13**	£000 2011-12	£000 **2012-13**	£000 2011-12	£000 **2012-13**	£000 2011-12	£000 **2012-13**	£000 2011-12	£000 **2012-13**	£000 2011-12	£000 **2012-13**	£000 2011-12
Expenditure	**129,093**	**126,621**	**75,746**	**72,709**	**41,383**	**40,402**	**43,997**	**46,366**	**48,022**	**47,244**	**55,055**	**40,252**	**0**	**16,068**	**19,601**	**22,103**	**412,896**	**411,765**
Surplus/(deficit)	**63**	**(220)**	**(4,321)**	**(4,524)**	**(419)**	**(566)**	**1,754**	**1,661**	**1,128**	**254**	**(3,656)**	**(6,985)**	**0**	**0**	**7,069**	**11,389**	**1,618**	**1,009**
Net Assets:	**1,655**	**(316)**	**(3,185)**	**(2,985)**	**(1,627)**	**241**	**(2,949)**	**(3,283)**	**(1,332)**	**(644)**	**(4,868)**	**527**	**0**	**0**	**32,776**	**23,435**	**20,469**	**16,975**

The only external provider to the PCT accounting for more than 10% of total expenditure is the James Paget University Hospital Foundation Trust.

3. Financial Performance Targets

3.1 Revenue Resource Limit

	2012-13 £000	2011-12 £000
The PCTs' performance for the year ended 2012-13 is as follows:		
Total Net Operating Cost for the Financial Year		411,765
Net operating cost plus (gain)/loss on transfers by absorption	**412,896**	
Revenue Resource Limit	**414,514**	412,774
Under/(Over)spend Against Revenue Resource Limit (RRL)	1,618	1,009

3.2 Capital Resource Limit

	2012-13 £000	2011-12 £000
The PCT is required to keep within its Capital Resource Limit.		
Capital Resource Limit	**10,277**	8,150
Charge to Capital Resource Limit	**10,227**	8,139
(Over)/Underspend Against CRL	**50**	**11**

3.3 Provider full cost recovery duty

	2012-13 £000	2011-12 £000
The PCT is required to recover full costs in relation to its provider functions.		
Provider gross operating costs	**0**	17,861
Provider Operating Revenue	**0**	(1,793)
Net Provider Operating Costs	**0**	16,068
Costs Met Within PCTs Own Allocation	**0**	(16,068)
Under/(Over) Recovery of Costs	**0**	0

The Provider Arm of the PCT divested on 1 October 2011, therefore there are no recovery costs for 2012/13

3.4 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**416,439**	414,968
Cash Limit	**421,439**	414,968
Under/(Over)spend Against Cash Limit	**5,000**	**0**

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

	2012-13 £000
Total cash received from DH (Gross)	364,105
Sub total: net advances	**364,105**
Plus: cost of Dentistry Schemes (central charge to cash limits)	10,802
Plus: drugs reimbursement (central charge to cash limits)	41,532
Parliamentary funding credited to General Fund	**416,439**

4 Miscellaneous Revenue

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Dental Charge income from Contractor-Led GDS & PDS	**4,249**	0	4,249	3,953
Prescription Charge income	**2,035**	0	2,035	2,434
Strategic Health Authorities	**2,045**	95	1,950	2,102
NHS Trusts	**0**	0	0	1
NHS Foundation Trusts	**1,769**	0	1,769	594
Primary Care Trusts - Other	**673**	26	647	1,468
English RAB Special Health Authorities	**25**	25	0	0
Recoveries in respect of employee benefits	**840**	840	0	489
Local Authorities	**163**	28	135	998
Education, Training and Research	**0**	0	0	84
NHS Injury Costs Recovery	**0**	0	0	22
Rental reenue from operating leases	**68**	18	50	115
Other revenue	**2,586**	507	2,079	1,488
Total miscellaneous revenue	**14,453**	**1,539**	**12,914**	**13,748**

5. Operating Costs

5.1 Analysis of operating costs:

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
Goods and Services from Other PCTs				
Healthcare	**29,084**	0	29,084	26,278
Non-Healthcare	**550**	473	77	423
Total	**29,634**	**473**	**29,161**	**26,701**
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	**12,907**	0	12,907	12,759
Goods and services (other, excl Trusts, FT and PCT))	**0**	0	0	23
Total	**12,907**	**0**	**12,907**	**12,782**
Goods and Services from Foundation Trusts	**191,799**	302	191,497	188,894
Purchase of Healthcare from Non-NHS bodies	**62,828**	0	62,828	51,968
Non-GMS Services from GPs	**169**	0	169	204
Contractor Led GDS & PDS (excluding employee benefits)	**16,083**	0	16,083	15,586
Chair, Non-executive Directors & PEC remuneration	**30**	30	0	81
Executive committee members costs	**89**	89	0	68
Consultancy Services	**133**	51	82	430
Prescribing Costs	**35,560**	0	35,560	37,572
G/PMS, APMS and PCTMS (excluding employee benefits)	**32,957**	0	32,957	32,276
Pharmaceutical Services	**1,076**	0	1,076	856
New Pharmacy Contract	**9,306**	0	9,306	9,902
General Ophthalmic Services	**2,525**	0	2,525	2,497
Supplies and Services - Clinical	**14,273**	1	14,272	15,588
Supplies and Services - General	**60**	54	6	162
Establishment	**891**	621	270	1,970
Transport	**25**	25	0	105
Premises	**1,936**	1,562	374	2,371
Impairments & Reversals of Property, plant and equipment	**83**	0	83	1,174
Depreciation	**1,452**	341	1,111	1,238
Amortisation	**46**	0	46	0
Audit Fees	**100**	100	0	201
Other Auditors Remuneration	**86**	86	0	74
Clinical Negligence Costs	**46**	46	0	45
Education and Training	**44**	22	22	223
Grants for capital purposes	**1,444**	0	1,444	0
Other	**3,793**	641	3,152	4,015
Total Operating costs charged to Statement of Comprehensive Net Expenditure	**419,375**	**4,444**	**414,931**	**406,983**

5.1 Analysis of operating costs:(Cont'd)

Employee Benefits (excluding capitalised costs)				
Employee Benefits associated with PCTMS	**0**	0	0	153
PCT Officer Board Members	**509**	509	0	799
Other Employee Benefits	**7,465**	6,058	1,407	17,578
Total Employee Benefits charged to SOCNE	**7,974**	**6,567**	**1,407**	**18,530**
Total Operating Costs	**427,349**	**11,011**	**416,338**	**425,513**

Analysis of grants reported in total operating costs				
For capital purposes				
Grants to fund Capital Projects - GMS	**1,444**	0	1,444	0
Total Capital Grants	**1,444**	**0**	**1,444**	**0**

	Total	**Commissioning Services**	**Public Health**
PCT Running Costs 2012-13			
Running costs (£000s)	**9,472**	8,216	1,256
Weighted population (number in units)*	**245,878**	245,878	245,878
Running costs per head of population (£ per head)	**39**	**33**	**5**
PCT Running Costs 2011-12			
Running costs (£000s)	**9,473**	8,903	570
Weighted population (number in units)	**245,878**	245,878	245,878

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

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

5.2 Analysis of operating expenditure by expenditure classification	2012-13 £000	2011-12 £000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	32,957	32,429
Prescribing costs	35,560	37,572
Contractor led GDS & PDS	15,800	15,586
General Ophthalmic Services	2,525	2,497
Pharmaceutical services	1,076	856
New Pharmacy Contract	9,306	9,902
Non-GMS Services from GPs	169	204
Total Primary Healthcare purchased	**97,393**	99,046
Purchase of Secondary Healthcare		
Learning Difficulties	4,798	4,622
Mental Illness	36,585	36,385
Maternity	8,398	7,587
General and Acute	198,074	195,008
Accident and emergency	7,802	7,365
Community Health Services	55,485	56,320
Total Secondary Healthcare Purchased	**311,142**	307,287
Grant Funding		
Grants for capital purposes	1,444	0
Total Healthcare Purchased by PCT	**409,979**	**406,333**
PCT self-provided secondary healthcare included above	0	16,068
Healthcare from NHS FTs included above	204,519	188,486

6. Operating Leases

The leasing arrangements are for buildings, lease cars and photocopiers. The significant lease arrangement is for the PCT headquarters building and car park.

6.1 PCT as lessee

	Buildings £000	Other £000	2012-13 Total £000	2011-12 £000
Payments recognised as an expense				
Minimum lease payments			**463**	594
Total			**463**	**594**
Payable:				
No later than one year	**448**	**3**	**451**	406
Between one and five years	**1,764**	**1**	**1,765**	1,325
After five years	**3,378**	**0**	**3,378**	2,851
Total	**5,590**	**4**	**5,594**	**4,582**

The PCT leases the Headquarters building at Beccles and sub-lets parts of it to other bodies. The total income received from sub letting in 2012/13 was £50k

GMS Leases:
Great Yarmouth & Waveney PCT has entered into certain financial arrangements involving the use of GP premises.
In considering *IAS 17 Leases, SIC 27 Evaluating the substance of transactions involving the legal form of a lease* and *IFRIC 4 Determining whether an arrangement contains a lease*, the PCT has determined that those operating leases must be recognised. However as there is no defined term in the arrangements entered into, it is not possible to anaylse the arrangements over financial years.

6.2 PCT as lessor

The PCT sub-lets buildings to two General Practice surgeries

	2012-13 £000	2011-12 £000
Recognised as income		
Rental Revenue	**68**	115
Total	**68**	115
Receivable:		
No later than one year	**68**	272
Between one and five years	**272**	808
After five years	**1,360**	1,850
Total	**1,700**	2,930

7. Employee benefits and staff numbers

7.1 Employee benefits

	2012-13								
				Permanently employed			Other		
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Employee Benefits - Gross Expenditure									
Salaries and wages	**6,016**	5,592	424	**5,381**	5,127	254	**635**	465	170
Social security costs	**432**	403	29	**432**	403	29	**0**	0	0
Employer Contributions to NHS BSA - Pensions Division	**610**	572	38	**610**	572	38	**0**	0	0
Termination benefits	**916**	0	916	**916**	0	916	**0**	0	0
Total employee benefits	**7,974**	**6,567**	**1,407**	**7,339**	**6,102**	**1,237**	**635**	**465**	**170**
Less recoveries in respect of employee benefits (table below)	**(840)**	(840)	0	**(840)**	**(840)**	**0**	**0**	**0**	**0**
Total - Net Employee Benefits	**7,134**	**5,727**	**1,407**	**6,499**	**5,262**	**1,237**	**635**	**465**	**170**
Gross Employee Benefits	**7,974**	**6,567**	**1,407**	**7,339**	**6,102**	**1,237**	**635**	**465**	**170**
Recognised as:									
Commissioning employee benefits	**7,974**			**7,339**			**635**		
Gross Employee Benefits excluding capitalised costs	**7,974**			**7,339**			**635**		

There are no capitalised staff costs included in the figures above

	2012-13		Permanently employed	
	Total £000	Admin £000	Total £000	Admin £000
Employee Benefits - Revenue				
Salaries and wages	**675**	675	**675**	675
Social Security costs	**66**	66	**66**	66
Employer Contributions to NHS BSA - Pensions Division	**90**	90	**90**	90
Other Employment Benefits	**9**	9	**9**	9
TOTAL excluding capitalised costs	**840**	**840**	**840**	**840**

7. Employee benefits and staff numbers

7.1 Employee benefits (Continued)

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	**15,513**	14,183	1,330
Social security costs	**1,030**	1,013	17
Employer Contributions to NHS BSA - Pensions Division	**1,839**	1,808	31
Termination benefits	**148**	148	0
Total gross employee benefits	**18,530**	**17,152**	**1,378**
Less recoveries in respect of employee benefits	**(489)**	(489)	0
Total - Net Employee Benefits	**18,041**	**16,663**	**1,378**
Gross Employee Benefits	**18,530**	**17,152**	**1,378**
Recognised as:			
Commissioning employee benefits	**7,226**		
Provider employee benefits	**11,304**		
Gross Employee Benefits	**18,530**		

7.2 Staff Numbers

	2012-13			2011-12		
	Total Number	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number
Average Staff Numbers						
Medical and dental	**4**	4	0	**5**	5	0
Ambulance staff	**0**	0	0	**0**	0	0
Administration and estates	**105**	93	11	**182**	175	6
Healthcare assistants and other support staff	**0**	0	0	**68**	64	4
Nursing, midwifery and health visiting staff	**2**	2	0	**123**	119	4
Scientific, therapeutic and technical staff	**4**	4	0	**68**	67	1
Other	**0**	0	0	**1**	1	0
TOTAL	**115**	**104**	**11**	**447**	**431**	**16**

No staff shown above have been engaged in capital projects

7.3 Exit Packages agreed during 2012-13

	2012-13			2011-12		
Exit package cost band (including any special payment element)	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**	***Number of compulsory redundancies**	**Total number of exit packages by cost band**	
	Number	**Number**	**Number**	**Number**	**Number**	
Less than £10,000	**4**	**0**	**4**	1	**1**	
£10,001-£25,000	**2**	**1**	**3**	1	**1**	
£25,001-£50,000	**3**	**1**	**4**	2	**2**	
£50,001-£100,000	**1**	**1**	**2**	1	**1**	
£100,001 - £150,000	**2**	**0**	**2**	0	**0**	
Total number of exit packages by type (total cost	**12**	**3**	**15**	**5**	**5**	
	£s	**£s**	**£s**	**£s**	**£s**	**£s**
Total resource cost	435,274	144,526	**579,800**	148,000	0	**148,000**

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 Pension Scheme. Where the PCT has agreed early retirements, the additional costs are met by the PCT and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This note includes payments made to three members of staff who left the PCT under the Mutually Agreed Redundancy Scheme (MARS). These costs are not met by the NHS Pension Scheme.

This disclosure reports the number and value of exit packages taken by staff leaving in the year but also includes the provision for one member of staff who has been formally notified of redundancy but who will be leaving in 2013/14.

The disclosure excludes the redundancy costs of two senior staff officers employed by Norfolk PCT but who had a dual responsibility for Great Yarmouth and Waveney PCT under the Cluster arrangements. The disclosure of their costs is reported wholly in the NHS Norfolk accounts

7.4 Pension costs

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

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM 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	**9,812**	**81,011**	12,440	55,463
Total Non-NHS Trade Invoices Paid Within Target	**9,512**	**77,700**	11,536	50,774
Percentage of NHS Trade Invoices Paid Within Target	96.94%	95.91%	92.73%	91.55%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,414**	**244,181**	2,929	249,629
Total NHS Trade Invoices Paid Within Target	**2,287**	**238,409**	2,622	242,919
Percentage of NHS Trade Invoices Paid Within Target	94.74%	97.64%	89.52%	97.31%

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.

9.1 Property, plant and equipment

2012-13	Land	Buildings excluding dwellings	Assets under construction and payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:							
At 1 April 2012	**3,654**	**15,008**	**5,807**	**878**	**5,511**	**1,682**	**32,540**
Additions of Assets Under Construction	0	0	7,017	0	0	0	**7,017**
Additions Purchased	0	2,232		0	878	99	**3,209**
Reclassifications	100	335	(435)	0	0	0	**0**
Upward revaluation/positive indexation	0	139	0	0	0	0	**139**
At 31 March 2013	**3,754**	**17,714**	**12,389**	**878**	**6,389**	**1,781**	**42,905**
Depreciation							
At 1 April 2012	**167**	**0**	**0**	**389**	**3,505**	**872**	**4,933**
Impairments	0	83	0	0	0	0	**83**
Charged During the Year	0	675	0	103	580	94	**1,452**
At 31 March 2013	**167**	**758**	**0**	**492**	**4,085**	**966**	**6,468**
Net Book Value at 31 March 2013	**3,587**	**16,956**	**12,389**	**386**	**2,304**	**815**	**36,437**
Purchased	3,571	16,709	12,389	374	2,304	802	**36,149**
Donated	16	247	0	12	0	13	**288**
Total at 31 March 2013	**3,587**	**16,956**	**12,389**	**386**	**2,304**	**815**	**36,437**
Asset financing:							
Owned	3,587	16,956	12,389	386	2,304	815	**36,437**
Total at 31 March 2013	**3,587**	**16,956**	**12,389**	**386**	**2,304**	**815**	**36,437**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Plant & machinery	Total
	£000's	£000's	£000's	£000's
At 1 April 2012	**853**	**1,585**	**6**	**2,444**
Movements (specify)	0	139	0	**139**
At 31 March 2013	**853**	**1,724**	**6**	**2,583**

Additions to Assets Under Construction in 2012-13

	£000
Buildings excl Dwellings	6,869
Information Technology	85
Plant & Machinery	39
Fixtures & Fittings	24
Balance as at YTD	**7,017**

9.2 Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	Assets under construction and payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	**£000**
Cost or valuation:							
At 1 April 2011	**3,842**	**9,892**	**5,327**	**869**	**4,382**	**1,377**	**25,689**
Additions - purchased	0	106	6,441	27	1,116	312	**8,002**
Reclassifications	(208)	6,169	(5,961)	0	0	0	**0**
Revaluation & indexation gains	0	633	0	0	0	0	**633**
At 31 March 2012	**3,634**	**16,800**	**5,807**	**896**	**5,498**	**1,689**	**34,324**
Depreciation							
At 1 April 2011	**167**	**0**	**0**	**288**	**3,170**	**680**	**4,305**
Impairments	0	1,323	0	0	0	0	**1,323**
Reversal of Impairments	0	(149)	0	0	0	0	**(149)**
Charged During the Year	0	610	0	101	335	192	**1,238**
At 31 March 2012	**167**	**1,784**	**0**	**389**	**3,505**	**872**	**6,717**
Net Book Value at 31 March 2012	**3,467**	**15,016**	**5,807**	**507**	**1,993**	**817**	**27,607**
Purchased	3,451	14,731	5,807	489	1,993	800	**27,271**
Donated	16	285	0	18	0	17	**336**
At 31 March 2012	**3,467**	**15,016**	**5,807**	**507**	**1,993**	**817**	**27,607**
Asset financing:							
Owned	3,467	15,016	5,807	507	1,993	817	**27,607**
At 31 March 2012	**3,467**	**15,016**	**5,807**	**507**	**1,993**	**817**	**27,607**

9.3 Property, plant and equipment

A desktop revaluation of Great Yarmouth and Waveney PCT land and buildings was carried out on 31 March 2013 by the Valuation Office Agency. For specialist properties, the valuation method applied was a standard approach of depreciated replacement cost valuations based on modern equivalent assets. Non specialist operational assets were valued using the Existing Use Value method. This is defined as an estimated amount for which a property should exchange on the date of valuation between a willing buyer and willing seller in an arm's length transaction.

Economic Lives of Non-Current Assets

	Min Life Years	Max Life Years
Property, Plant and Equipment		
Buildings exc Dwellings	11	58
Plant & Machinery	2	15
Information Technology	2	5
Furniture and Fittings	2	15

During 2012/13 the PCT terminated the lease on a building used as a surgery. As part of the lease agreement the PCT has a liability to repair and make good any damage or wear and tear to the building. The costs of repair have been estimated as £20k and have been included as a provision in the accounts

10.1 Intangible non-current assets

2012-13	Software purchased £000	Total £000
At 1 April 2012	175	175
Additions - purchased	1	1
At 31 March 2013	**176**	**176**
Amortisation		
At 1 April 2012	38	38
Charged in year	46	46
At 31 March 2013	**84**	**84**
Net Book Value at 31 March 2013	**92**	**92**
Net Book Value at 31 March 2013 comprises		
Purchased	92	92
Total at 31 March 2013	**92**	**92**

2011-12	Software purchased £000	Total £000
At 1 April 2011	**38**	**38**
Additions - purchased	137	**137**
At 31 March 2012	**175**	**175**
Amortisation		
At 1 April 2011	**38**	**38**
At 31 March 2012	**38**	**38**
Net Book Value at 31 March 2012	**137**	**137**
Net Book Value at 31 March 2012 comprises		
Purchased	137	**137**
Total at 31 March 2012	**137**	**137**

Economic Lives of Non-Current Assets

	Min Life Years	Max Life Years
Intangible Assets		
Software Licences	3	3

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

	2012-13 Total £000	2012-13 Programme £000
Property, Plant and Equipment impairments and reversals taken to SoCNE		
Other	83	83
Total charged to Annually Managed Expenditure	**83**	**83**
Of which:		
Impairment on revaluation to "modern equivalent asset" basis	**2**	2
Impairment due to demolition of asset	**81**	81

12 Commitments

Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2013 £000	31 March 2012 £000
Property, plant and equipment	**8,900**	0
Total	**8,900**	0

13 Intra-Government and other balances

	Current receivables £000s	Current payables £000s
Balances with other Central Government Bodies	560	2,793
Balances with Local Authorities	60	482
Balances with NHS Trusts and Foundation Trusts	1,694	2,389
Balances with bodies external to government	1,003	11,481
At 31 March 2013	**3,317**	**17,145**
prior period:		
Balances with other Central Government Bodies	468	903
Balances with Local Authorities	48	388
Balances with NHS Trusts and Foundation Trusts	280	2,618
Balances with bodies external to government	2,535	9,726
At 31 March 2012	**3,331**	**13,635**

14.1 Trade and other receivables

	Current	
	31 March 2013 £000	31 March 2012 £000
NHS receivables - revenue	**1,850**	518
NHS prepayments and accrued income	**350**	0
Non-NHS receivables - revenue	**476**	575
Non-NHS prepayments and accrued income	**587**	2,008
VAT	**54**	230
Total	**3,317**	3,331
Total current and non current	**3,317**	3,331

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

The credit quality of any other receivables that are neither past due nor impaired is judged to be be good as reflected by the insignificant amount written off in year

14.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	**34**	172
By three to six months	**25**	23
By more than six months	**0**	4
Total	**59**	199

15 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**0**	3
Net change in year	**32**	(3)
Closing balance	**32**	0
Made up of		
Cash with Government Banking Service	**32**	0
Cash and cash equivalents as in statement of financial position	**32**	0
Cash and cash equivalents as in statement of cash flows	**32**	0

16 Trade and other payables

	Current	
	31 March 2013 £000	31 March 2012 £000
NHS payables - revenue	**5,141**	2,533
NHS accruals and deferred income	**0**	972
Family Health Services (FHS) payables	**5,107**	5,250
Non-NHS payables - revenue	**1,171**	1,212
Non-NHS payables - capital	**1,131**	572
Non_NHS accruals and deferred income	**4,535**	3,007
Social security costs	**0**	32
Tax	**41**	0
Other	19	57
Total	**17,145**	13,635

17 Provisions

Comprising:

	Total £000s	Pensions to Former Directors £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Continuing Care £000s	Other £000s	Redundancy £000s
Balance at 1 April 2012	**465**	32	17	25	0	328	63
Arising During the Year	**2,225**	0	0	0	1,881	69	275
Utilised During the Year	**(161)**	(32)	(17)	0	0	(86)	(26)
Reversed Unused	**(264)**	0	0	(20)	0	(242)	(2)
Balance at 31 March 2013	**2,265**	**0**	**0**	**5**	**1,881**	**69**	**310**
Expected Timing of Cash Flows:							
No Later than One Year	**2,265**	**0**	**0**	**5**	**1,881**	**69**	**310**

Legal Claims

The £5k for legal claims relates to a potential payment to the NHSLA for an ongoing staff claim.

Other Provisions

Items included in Other Provisions are as follows:

1) £49k to support a GP's developmental training.

2) £20k relating to the PCT's liability to repair and make good a building following termination of the lease

Redundancy

As a result of the reforms undertaken in accordance with the NHS and Social Care Act 2012, two members of staff employed within the NHS Norfolk and Waveney Cluster have been served a notice of redundancy, however, the timing of their departure was uncertain as at 31 March 2013 and, as such, a provision rather than an accrual for their redundancy costs have been included in the accounts.

Continuing Care

The continuing care provision relates to the potential costs of restitution claims following the Coughlan judgement on responsibility for funding of continuing care.

On 15 March 2012 the Department of Heath announced the introduction of deadlines for individuals to request an assessment of eligibility for NHS Continuing HealthCare. These were based on the period of care:

- For care received between 1 April 2004 and 31 March 2011, the deadline was 30 Sept 2012
- For care received since 1 April 2011, the deadline was 31 March 2013.

All restitution claims received are subject to a clinical assessment and are reviewed by a Continuing Care panel. The panel considers each assessment and decides whether the claimant should have received NHS funded continuing care according to the Coughlan judgement. The panels are chaired by a medical professional and membership includes other clinical staff and a non-executive director. In 2011/12, cases where a panel had decided that the claimant was eligible for continuing care were reflected accordingly as accruals or as provisions, depending on the progress with settlement of the claim.

This approach was changed in 2012/13 where the provision has been based on the population of cases considered to be ready for nurse assessment, which precedes cases being passed to panel for a final decision. This is on the assumption that the population of cases ready for full nurse assessment are more likely than not to result in an outflow of benefits across the population as a whole. At the point of nurse assessment there is sufficient review and evidence to determine the eligibility of the claim and each case can be passed to the review panel with either a recommendation for approval or a recommendation against approval. This revised approach provides an assumed 50% ultimate success rate of the population of cases considered to be ready for nurse assessment ie each case has a 50% chance of being forwarded to the panel with a recommendation for approval. The number of PCT cases ready for full nurse assessment and panel review as at 31 March 2013 total 31

The provision amount has been calculated by applying a number of variables as follows to the cases ready for full nurse assessment and panel review:

1) The average cost of the care home has been calculated as £650 per week based on care homes rates across the Norfolk and Waveney area.

2) The estimated number of years for each claim is 2.5. This is based on historical data relating to the average of previous claims that were judged to be eligible and for which funding is now in place.

3) An assumed interest rate of 8% based upon County Court rates as advised by the Department of Health.

4) 50% of the cases at the full nurse assessment stage will be eligible as described above

Outside of the provision there remains a balance of 242 cases that are not yet ready for assessment but present a potential contingent liability. In prior year accounts the PCT has produced an estimated figure for this liability but owing to the deadlines imposed by the Department of Health, the subsequent receipt of a large number of 'no win no fee' claims from solicitors on behalf of claimants which are judged to be unrealistic and the extremities of the variables impacting on the eligibility of the claims, it has not been possible to determine a figure that would be meaningful and add benefit to the accounts. As such, a contingent liability figure for the continuing care restitution claims has not been shown in note 18 for 2012-13

18 Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities		
Continuing Care	**0**	1,462
NHS LA	**1**	7
Net Value of Contingent Liabilities	**1**	1,469

The NHS LA liability relates to the amount that the PCT may have to pay in respect of the ongoing staff claim disclosed in note 17.

19 Financial Instruments

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

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

Interest rate risk

PCTs are not permitted to borrow and therefore has low exposure to interest-rate fluctuations

Credit Risk
Because the majority of the PCT's income comes from funds voted by Parliament the PCT has low exposure to credit risk.

Liquidity Risk
The PCT is required to operate within limits set by the Secretary of State for the financial year and draws down funds from the Department of Health as the requirement arises. The PCT is not, therefore, exposed to significant liquidity risks.

19.1 Financial Assets	**Loans and receivables £000**	**Total £000**
Receivables - NHS	2,200	**2,200**
Receivables - non-NHS	944	**944**
Cash at bank and in hand	32	**32**
Total at 31 March 2013	**3,176**	**3,176**
Receivables - NHS	696	696
Receivables - non-NHS	355	355
Other financial assets	230	230
Total at 31 March 2012	1,281	1,281

19.2 Financial Liabilities	**Other £000**	**Total £000**
NHS payables	5,141	**5,141**
Non-NHS payables	7,409	**7,409**
Other financial liabilities	4,595	**4,595**
Total at 31 March 2013	**17,145**	**17,145**
NHS payables	3,166	3,166
Non-NHS payables	6,380	6,380
Other financial liabilities	4,101	4,101
Total at 31 March 2012	13,647	13,647

Other is defined as any liabilities that are not held at fair value through profit and loss.

20.1 Related Party Transactions

Great Yarmouth & Waveney PCT is a body corporate established by order of the Secretary of State for Health. In 2011 the PCT clustered with NHS Norfolk and a joint NHS Norfolk and Waveney Cluster Board was established

The Cluster Board Members, and persons related to them, have declared interests with related parties as follows:

1) Sheila Bremner who is CEO of NHS Suffolk, CEO of NHS Cambridgeshire & Peterborough Cluster, East Anglia Local Area Team Director. The PCT had transactions of £16,600 in 2012-13 and £16,930 in 2011-12 with NHS Cambridgeshire and transactions of £203,898 in 2012-13 and £327,363 in 2011-12 with NHS Suffolk

2) Andrew Morgan who is a Non Executive Director of Health Enterprise East Ltd with which the PCT had a transaction of £3,600 in 2012-13 and £3,600 in 2011-12

3) Sheila Childerhouse who is a Trustee of the Keystone Development Trust with which the PCT had NIL transactions

4) Hilary De Lyon who is an Honorary Fellow of the College of General Practitioners, a Fellow of the Royal college of Medicine, an independent Advisor to and Chair of the Nominations Committee of The College of Social Work, Member of the Executive Committee of Labour Women's Network, member of the Labour Party, Ordinand sponsored by Norwich Diocese, studying at St Mellitus College. The PCT had NIL transactions with these organisations

5) Andy Evans who is the Chief Executive of HealthEast CIC with which the PCT had transactions of £373,182 in 2012-13 and £871,494 in 2011-12

6) Jeff Halliwell who is Chair of Cafedirect Plc with which the PCT had NIL transactions

7) Dr Jenny Harries who is a Director of Movente Ltd with which the PCT had NIL transactions

8) Marion Headicar who is Chair of Healthwatch with which the PCT had NIL transactions

9) Louise Jordan-Hall who is a Director of Props East Ltd and a Lead Assessor with the Institue for Education Business Excellence. The PCT had NIL transactions with these organisations

10) Edward Libbey who is the Chair of World Energy Solutions and Audit Chair of NHS Cambridgeshire & Peterborough Cluster. The PCT had transactions of £16,600 in 2012-13 and £16,930 in 2011-12 with NHS Cambridgeshire

11) Dr Alistair Lipp who is an honorary senior lecturer at the University of East Anglia, Head of School of Public Health, Trustee and Board member of the Faculty of Public Health, member of the Public Health Programme Advisory Board at the National Institue of Health Research. The PCT had transactions of £87,530 in 2012-13 and £37,571 in 2011-12 with the University of East Anglia

12) Adrian Marr who is a Governor at Holbrook High School, Director of Finance for the East Anglia Local Area Team, Director of Finance for NHS Cambridgeshire & Peterborough Cluster. The PCT had transactions of £16,600 in 2012-13 and £16,930 in 2011-12 with NHS Cambridgeshire

13) John Plaskett who is the Lay Director with HealthEast CIC and a Director of Norlife Ltd. The PCT had transactions of £373,182 in 2012-13 and £871,494 in 2011-12 with HealthEast CIC

14) Dr John Stammers who is the Chair of HealthEast CIC and a Director of Applicable Ltd. The PCT had transactions of £373,182 in 2012-13 and £871,494 in 2011-12 with HealthEast CIC

15) Patrick Thompson who is Chairman of the National Osteoporosis Society, Board member of HCAI Research, Trustee of TOC-H, Chairman of Health Trainers Great Yarmouth & Waveney, member of the Department of Health Service Users Research Forum and Policy Research Programme Standing Commissioning Panel. Excluding the main funding from the Department of Health, the PCT had NIL transactions with these organisations

20.2 Related Party Transactions

During the year none of the Board Members or members of the key management staff or parties related to them, has undertaken any material transactions with Great Yarmouth and Waveney PCT, except that the General Practitioner members of the Clinical Commissioning Committee and Board have received remuneration under standard GMS/PMS contract arrangements and other payments for additional services provided. Details of these transactions are set out below:

	Payments to Related Party 2012-13	Payments to Related Party 2011-12	Receipts from Related Party 2012-13	Receipts from Related Party 2011-12	Amounts owed to Related Party 2012-13	Amounts owed to Related Party 2011-12	Amounts due from Related Party 2012-13	Amounts due from Related Party 2011-12
Dr Martin Vallis								
Rosedale Practice	1,451,277	1,391,488	0	0	7,415	0	0	0
Dr Andrew Mc Call								
Millwood Surgery	1,265,123	1,228,088	0	(385)	3,850	0	0	0
Dr Myles Duffield								
Park Surgery	1,358,888	1,223,424	0	(135)	19,170	0	0	0
Dr John Stammers								
Southwold	1,052,021	1,039,685	0	0	0	0	0	0
Dr Clive Wiggins								
Beccles Medical Centre	2,833,184	2,506,870	(2,357)	(187)	25,037	13,780	0	0
Dr Jamie Wylie								
Falkland Surgery	749,929	849,064	0	0	0	0	0	0
Dr Ian Gibson								
Coastal Villages Practice	3,036,580	2,870,700	(77,458)	(121,866)	4,200	0	0	0
Dr Mariella Elissen								
Bungay Medical Centre	2,262,738	2,197,909	0	0	0	0	0	0
Dr Maarten Derks								
Rosedale Practice	1,443,237	1,391,488	0	0	5,825	0	0	0

20.3 Related Party Transactions

The Department of Health is regarded as a related party. During the year, Great Yarmouth and Waveney PCT has had a significant number of material transactions with the Department and with other entities for which the Department is regarded as the parent. These entities are:

East of England Ambulance Trust
James Paget University Hospitals NHS Foundation Trust
Norfolk & Norwich University Hospital NHS Foundation Trust
Norfolk and Suffolk NHS Foundation Trust
East of England Strategic Health Authority
NHS Suffolk
Mid Essex PCT
NHS Norfolk
Norfolk Community Health and Care
South East Essex Primary Care Trust
Cambridge and Peterborough NHS Trust
Ipswich Hospital NHS Trust
Cambridge University Hospital NHS Foundation Trust
Papworth Hospital NHS Foundation Trust

In addition, the PCT has had a number of material transactions with other Government departments and other central and local Government bodies. Most of these transactions have been with Suffolk County Council and Norfolk County Council.

21 Losses and special payments

The total number of losses cases in 2012-13 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses - debt write off	3,535	10
Losses - salary overpayment	1,749	1
Special payments - personal injury with advice	65,468	3
Total losses	5,284	11
Total special payments	65,468	3
Total losses and special payments	**70,752**	**14**

The total number of losses cases in 2011-12 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses - PCT management costs	56,250	20
Special payments - PCT management costs	126,013	4
Total losses	56,250	20
Total special payments	126,013	4
Total losses and special payments	**182,263**	**24**

The PCT does not have any exceptional items.

24 Events after the end of the reporting period

Great Yarmouth and Waveney PCT closed as at 31 March 2013. The activities of the PCT have been shared between a range of successor bodies from 1 April 2013, primarily NHS Great Yarmouth and Waveney Clinical Commissioning Group, NHS England - East Anglia area office, Public Health (Norfolk County Council and NHS England) and NHS Property Services Ltd.

NHS Great Yarmouth and Waveney Clinical Commissioning Group is responsible for commissioning the following services (previously commissioned by the PCT):
Secondary and community healthcare from NHS and non NHS providers;
GP prescribing;
Primary care - local enhanced services;
Primary care - out of hours.

NHS England is responsible for commissioning the following services (previously commissioned by the PCT):
Specialised services;
Prison healthcare;
GP services;
General dental services;
General ophthlamic services;
Pharmaceutical services;
Secondary dental care;
Public health (including health visiting and screening services).

Norfolk County Council is responsible for commissioning the following services (previously commissioned by the PCT):
Public health (including sexual health, drug and alcohol misuse and school nursing services).

NHS Property Services Ltd has undertaken the management of the PCT's freehold and leasehold estates.

A number of non-current assets transferred to NHS Property Services Ltd on 1 April 2013. These were considered operational at the year end and so have not been impaired in the PCT accounts. It is for the successor body to consider whether it is necessary to review these for impairment in 2013-14.