Department of Health

NHS

Medway Primary Care Trust

2012-13 Annual Report and Accounts

Published to gov.uk, in PDF format only.

www.gov.uk/dh

Medway Primary Care Trust

2012-13 Annual Report

NHS Medway

Annual Report

2012/13

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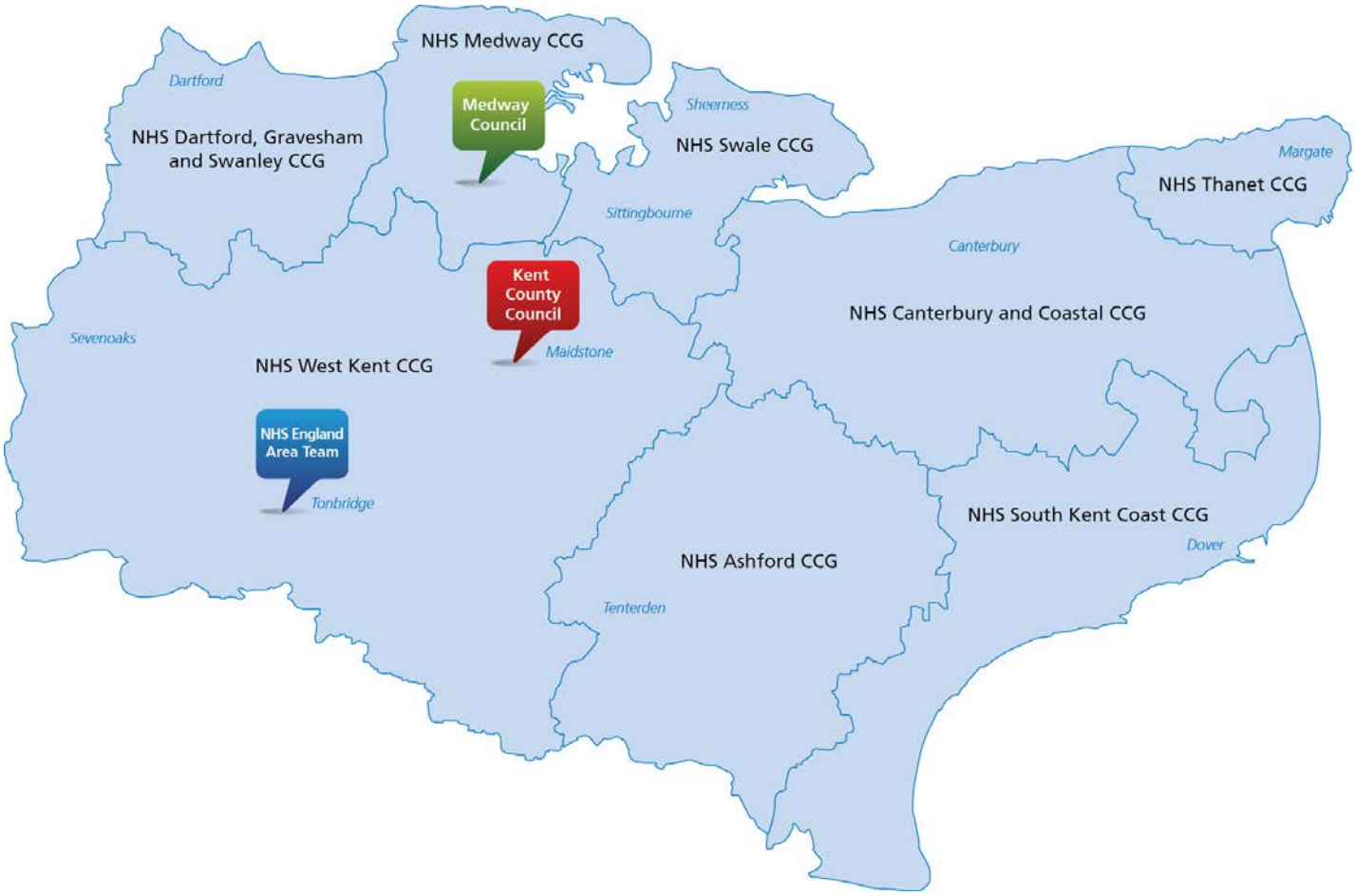


Foreword

This annual report marks the beginning of a new era for healthcare in Kent and Medway. Primary Care Trusts closed on 31 March 2013, and their responsibilities have been taken on by other organisations, including Clinical Commissioning Groups (CCGs), NHS England, and Kent and Medway Councils.

Under the new system, commissioning decisions are mainly made by GPs who are close to their communities, with a deep understanding of their needs. Patients have more opportunities to be closely involved in decision-making – this is one of the principles of the Health and Social Care Act 2012.

In practice, of course, the new system had been running in shadow form for some time. So the 12 months up to 31 March 2013 – the period covered by this report - was a time of transition, and while it has meant huge change for staff, for patients the changes have been seamless. As time goes by we hope people will develop a greater awareness of their local CCG, and some will want to get involved, for example through Patient Participation Groups.

But over the past year our focus, as NHS Kent and Medway, representing the Primary Care Trusts in east Kent, west Kent and Medway, was to ensure that quality and safety of care for patients remained at the top of everyone's agenda. Creating new systems would be meaningless if better care was not our target.

We saw GPs and managers in the emerging CCGs working alongside PCT colleagues to review and improve care pathways where needed, ensuring that the whole population is getting the services it needs to reduce health inequalities, and that providers such as our acute hospitals are performing as we want and expect them to.

It is clear from the Francis report into standards of care in Mid-Staffordshire that all of us who work in the NHS are responsible for the safety of patients and the quality of their care, and this remained a key focus for the PCTs this year, with providers asked to carry out reviews and produce action plans. This provided assurance, but clearly is not a one-off piece of work.

CCGs have now taken on the role of holding providers to account, and the Kent and Medway Area Team of NHS England is setting up Quality Surveillance Groups to have an overview of quality across the local NHS.

The PCTs upheld the principles and values of the NHS Constitution, and this was the legacy we handed over to the new organisations: patients at the heart of everything, quality and safety as the number one priority.

Colin Tomson, Chair, NHS Kent and Medway

Felicity Cox, Chief Executive, NHS Kent and Medway, and Director Kent and Medway, NHS England

Vision and Priorities

Our vision is to offer the best healthcare for our population within the resources available, as well as supporting them to live, work and thrive in the best possible health. We will do this by providing more choice, better information, best practice in care and treatment closer to home.

This was the vision of NHS Kent and Medway that guided our commissioning priorities during 2012/13, consistent with Annual Operating Frameworks published by the Department of Health and by NHS South of England.

At the outset we said we were committed to ensuring the delivery of high quality care in a personalised and proactive manner, eliminating waste and improving both outcomes and experience for patients, and as the CCGs have taken on their responsibilities they have shared these aims, with a desire to shift the emphasis to care in a community setting wherever possible and appropriate.

We continued to see assistive technologies and telehealth improving people's lives, and, importantly, outcomes for patients with long term conditions. With close monitoring using technology, they can receive the advice and reassurance they need, with fewer visits to hospital.

We also saw changes in referral rates, and better use of data leading to improvements in the urgent care system.

During the past year we had an additional priority, to ensure a smooth handover from the PCT to new organisations, supporting them to take on leadership roles, particularly developing clinical leadership which is at the core of the NHS reforms. We saw strong leadership emerge, which gives confidence that there is real potential for transformation in our local NHS.

We also worked with Kent County Council and Medway Council as they prepared to take on public health responsibilities, which is such an important element of tailoring healthcare to the needs of the population. And we supported the setting up of Health and Wellbeing boards by these two local authorities, another key part of the jigsaw.

Our Board

NHS Kent and Medway, the Kent and Medway PCT cluster, represented three Primary Care Trusts – NHS Medway, NHS Eastern and Coastal Kent and NHS West Kent.

Cluster Board Delegation

In May 2011 NHS Medway, NHS Eastern and Coastal Kent and NHS West Kent. Boards agreed the delegation of PCT functions to the NHS Kent and Medway Board, also known as the cluster board. The governance arrangements were supported by an Establishment Agreement between the constituent PCT members of the cluster, revised Standing Orders and Standing Financial Instructions and a Scheme of Delegation being adopted by each PCT to delegate authority to newly formed joint committees.

The PCT cluster was committed to commissioning high quality healthcare services for the people of Kent and Medway. We also supported Clinical Commissioning Groups as they prepared to take on their commissioning responsibilities, as well as maintaining relationships with partner organisations.

The board comprised six part-time Non-Executive Directors as well as a number of full time Executive Directors, and was chaired by a Non-Executive Director appointed by the NHS Independent Appointments Commission.

Transition Governance arrangements

While there was no formal transfer of PCT statutory functions, accountability or budgets before April 2013 for new organisations to become operational, the accountable officer for NHS Kent and Medway (the PCT cluster) from 1 October 2012 was Felicity Cox, Kent and Medway Area Team Director for NHS England.

Under these changes Area Team Directors took on management responsibility for teams, managing both 2012/13 operational delivery and planning for 2013/14; being accountable to their new organisations for future planning and development; and being accountable to their PCTs for delivery and performance in the 2012/13 system.

Until 31 March 2013, the cluster PCTs retained their statutory governance arrangements and the new bodies are accountable for responsibilities consistent with their preparatory powers and planning for 2013/14.

Cluster Board Non Executive Directors

Colin Tomson – Chair
Graham Mayes (resigned 15 June 2012)
David Mayes
Jill Ruddock
Harshad Topiwala
Adrian Hosford
Mike Cosgrove
David Lewis

Executive Directors

Felicity Cox (appointed 1 October 2012)
Ann Sutton – Chief Executive (until 31 August 2012)
Helen Buckingham – Director of Whole Systems Commissioning
Sarah Andrews – Director of Nursing and Quality
Daryl Robertson – Director of Performance and Assurance
Dr Robert Stewart, Dr Peter Green, Dr James Thallon – Medical Directors
Bill Jones – Director of Financial Performance and Contracting
Rod Smith – Director of Financial Strategy and Planning
Jonathan Bates – Director of Financial Stewardship and Governance
Meradin Peachey – Kent Director of Public Health
Dr Alison Barnett – Medway Director of Public Health
Sally Allum – Acting Director of Nursing and Quality (from 20 July 2012)

The Medical Directors together constituted one voting member, the Directors of Finance together constituted one voting member and the Directors of Public Health together constituted one voting member of the cluster board.

Non-voting members of the Cluster Executive Team

Hazel Carpenter – Director of Commissioning Development and Workforce
Jude Mackenzie – Director of Communications and Engagement (until 30 September 2012)
Judy Clabby – Assistant Chief Executive
Lynne Stuart – Company Secretary

Further details on the PCT board and cluster board are given in the Annual Governance Statement later in this report.

Chairman and Non-Executive Directors of the NHS Medway Board

Our Non-Executive Directors offered the board a broad mix of skills and expertise with which to challenge and inform policies on the direction of NHS Medway locally.

Non-Executive Directors of the PCT, not appointed to the cluster board, were required to resign as directors of the PCT. The cluster PCTs retained those affected as Board Advisors to continue to service cluster committees and to ensure that their expertise on quality and safety and services was retained on an ongoing basis, in particular, providing expertise in a number of the transition work streams to the new NHS architecture.

During 2012/13 the following were members of the board:

Colin Tomson – Chair

Graham Mayes

David Mayes

Harshad Topiwala

Jill Ruddock

David Lewis

Mike Cosgrove

Adrian Hosford

Chief Executive and Executive Directors

Felicity Cox (appointed 1 October 2012)
Ann Sutton – Chief Executive (from 1 June 2011 until 31 August 2012)
Helen Buckingham - Deputy Chief Executive
Jonathan Bates – Director of Finance
Sarah Andrews – Director of Nursing and Quality
Dr Peter Green – Medical Director
Dr Alison Barnett – Director of Public Health (Medway)

During 2012/13, the NHS Medway board held two meetings in public and eight cluster board meetings were held in public.

Directors' declarations of Interest

Declarations of relevant and material interests of Board members

Under the NHS Codes of Conduct and Accountability, board members are required to declare any business interests which are relevant and material to the NHS board of which they are a member. Interests which are regarded as relevant and material are:

- Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies);
- Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;
- Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS
- A position of authority in a charity or voluntary organisation in the field of health and social care;
- Any connection with a voluntary or other organisation contracting for NHS services;
- Research funding/grants that may be received by an individual or their department;
- Interests in pooled funds that are under separate management (any relevant company included in this fund that has a potential relationship.

The following board members have declared interests:

Felicity Cox	Lead negotiator for NHS Employers on the Community Pharmacy Contractual Framework
Jonathan Bates	Public Sector Non-Executive Director of Medway Community Estates
Mike Cosgrove	Director, Faversham Consultancy Services Ltd Elected member, Swale Borough Council Chair, Faversham Creek Consortia Trustee Bestel House Charity
Adrian Hosford	Chairman, The Communication Trust Director and Chairman, Moodscope Trustee, "I Can" Charity 16 per cent ownership of Moodscope
David Lewis	Part time Treasurer, Kent Police Authority Vice Chair, Wittersham Parish Council Member of: Weald of Kent Preservation Society, Open Spaces Society and Kent Wildlife Trust

David Mayes	Trustee Director of Credit Suisse (UK) Pension Fund
Ann Sutton	Governor, University of Kent
Hazel Carpenter	Company Secretary, Four Lakes Consulting Ltd
Sarah Andrews	Member and former committee member, Royal College of Nursing Member and former trustee, Action on Elder Abuse Member and former trustee, Marie Curie Cancer Care Member, Clinical Advisory Group, Co-operation and Competition Panel
Dr Robert Stewart	Director of Health and Europe Centre Principal GP with PMS contract, Hawkinge and Alkham Valley Practice
Sally Allum	Member and former committee member, Royal College of Nursing

Clinical decision making

The involvement of clinicians in decision-making for healthcare commissioning further increased during 2012 in preparation for the handover of responsibilities to Clinical Commissioning Groups on 1 April 2013.

Over the 12 months we moved from clinicians sitting on PCT Clinical Executive Teams, to GPs taking over the reins of 70 per cent of commissioning, with all that entails.

For more than a year the PCTs, clustered as NHS Kent and Medway since June 2011, worked with emerging Clinical Commissioning Groups (CCGs) across the county to understand what the reforms will mean for them, and for patients. The original 13 CCGs, each with a leading GP acting as a shadow accountable officer, merged so that there are now eight, seven of which will work together in two federated arrangements, with some sharing management structures and some decision making.

During 2012/13 NHS Medway CCG (along with the other CCGs in Kent) was authorised so that it was ready for its new responsibilities on 1 April 2013. It was unusually challenging work for all concerned, but as a result, we are now led by clinicians as never before, and Kent and Medway stands on the threshold of an exciting future. While getting the structures and governance in place was important, what is equally essential, and potentially more transformational in terms of healthcare, is the principle of getting the decision making closer to patients.

GPs understand what their communities need and this lies at the heart of the NHS reforms. By working with Health and Wellbeing Boards, local authorities, and the Integrated Plan Board they are able to influence policy across the whole health and social care system.

In the lead up to authorisation there was excellent clinical engagement on clinical policy, such as a more joined-up approach to Individual Funding Requests, and GP appraisals aimed at improving the standard of primary care in a consistent way.

The CCGs made significant progress in developing the skills of their leadership teams. Some work has been led internally by the CCGs themselves, and some by NHS Kent and Medway in the form of specific workshops addressing the identified learning needs of the CCGs.

The top priority for clinical leaders over the next year remains improving care for the growing number of people with long term conditions. As has been identified

nationally, this is in the interests of everyone, system leaders, GPs, and, most importantly, patients and their carers.

Over the past year we have made great progress on our priority areas, which we identified as:

- Transform life chances for disadvantaged children
- Tackle the key killers of vascular disease, cancer and respiratory disease
- Promote well being and good mental health
- Revolutionise services for older people
- Break the cycle of inequalities.

Quality, safety, effectiveness and patient experience

Our aim was to continuously improve quality outcomes for the prevention, diagnosis and treatment of illness, by delivering high quality safe care and treatment.

To achieve this aim we applied national, regional and local quality outcome measures to our commissioned services across Kent and Medway. We benchmarked quality and performance to drive out inefficiencies, and deliver a positive experience of safe, effective care.

We listened, heard and acted on the views of patients and our public to improve the safety, effectiveness and experience of services and deliver consistently high quality care.

Our quality, innovation, productivity and prevention (QIPP), Safe Care and Compassion programme, and our Quality in Transition Plan (QiT) supported the achievement of improved patient outcomes.

We worked in partnership with Clinical Commissioning Groups through this transitional year to deliver our Quality in Transition plan through the following quality workstreams:

- HCAI (healthcare acquired infection) Programme
- Safeguarding Programme
- Safe Workforce Programme
- Safe Care and Compassion Programme: inclusive of Experience of Care
- Effectiveness Programme
- Governance of Service Providers Programme: inclusive of CQUINs and Quality Accounts

To support delivery of the QiT plan we:

- Ensured Quality in Transition and associated workstreams were integral to our quality handover to Clinical Commissioning Groups (CCGS)

- Benchmarked nationally, and regionally to drive up quality
- Worked collaboratively with CCG colleagues to deliver the quality agenda across Kent and Medway

During 2012/13 we agreed quality measures with our commissioned providers to improve clinical effectiveness, safety, and patient experience leading to the following:

- Agreeing Commissioning for Quality and Innovation (CQUINs) plans, which drive up quality outcomes across care pathways, and reflect national, regional and local priorities. These included improving thrombosis assessment rate for patients to more than 95 per cent across Kent and Medway
- Improved safeguarding outcomes for vulnerable children and adults as a result of investigating and learning from safeguarding incidents and reviews
- Significantly improved timeliness of health assessment reviews for looked after children
- Reduced the number of healthcare associated infections in hospital, care homes and the community
- Improved privacy and dignity standards by sustaining the elimination of mixed sex accommodation
- Led and delivered the national patient feedback challenge pilot to improve patients' experience of care. This also supports the patients voice being heard, listened to and acted upon by responding to complaints, compliments and patient feedback
- Used the best available evidence and national guidance to ensure the delivery of up to date high quality safe care
- Worked with providers to ensure the delivery of harm free care across care pathways
- Improved patient safety outcomes as a result of investigating and learning from incidents, national inquiries and Ombudsmen reports. In particular, reduced avoidable falls and pressure ulcers
- Increased reporting of medication errors and disseminated the learning across commissioned services

How we engaged with local people

All three Primary Care Trusts within NHS Kent and Medway would like to say a big thank you to everyone who was involved in helping us. We benefitted from your knowledge, experience and enthusiasm, assisting us to plan, design and deliver services with your support. Over the last year we concentrated on supporting our Clinical Commissioning Groups in establishing their own means to listen to their local communities: using their patient and citizen networks, reference groups, websites, and newsletters to reach out to people and build connections.

The PCTs used many ways to listen, record and act upon what local people want in the design, delivery and quality of care they receive. We hope that the transition to clinical commissioning groups has been a smooth one and we would like to thank all those individuals and organisations who contributed their views – we rely on you when organisations and services are changing, to make sure we deliver high quality care and make the most of our services and staff.

Health Networks

All eight Clinical Commissioning Groups across Kent and Medway have set up Health Networks, these are made up of interested individuals and organisations who wish to be kept informed about health services, how they are planned and delivered, and to contribute their views. Largely they will work virtually, providing CCGs with a versatile way to engage with a really broad range of their patients and stakeholders.

Case study: NHS Medway CCG's Health Network

Medway Health Network was launched in 2010 via a set of public roadshows at shopping centres.

- More than 900 people across Medway have now joined this network
- The network has been advertised to all Medway Practice Participation Groups, CCG Patient Council and public meetings.
- It has also been advertised in the local Health Matters and Medway Matters magazines.

Health Network members receive email bulletins informing them of ways they can get involved including events, surveys and focus groups. They have participated in procurement exercises, attended prioritisation events and behaviour change campaigns.

Service redesign

Over the last year, NHS Kent and Medway, in partnership with Kent and Medway NHS and Social Care Partnership Trust, undertook a review and consultation regarding the future of services for people in mental health crisis across Kent and Medway. The review of current services found:

- Reduced use of hospital beds over four years, due to successful alternatives being established in the community,
- An imbalance between capacity and demand, meaning there are too few acute beds in East Kent and too many in West Kent, with people often placed out of the area covered by their community-based Crisis Resolution and Home Treatment (CRHT) team, a situation that prevents seamless care and creates delays
- Long-standing concerns about the quality of the environment in A Block at Medway Maritime Hospital, the inpatient unit for people from Medway and Swale, despite considerable previous effort to identify a local inpatient alternative
- Psychiatric intensive care is supported in west Kent by a very effective acute ward outreach service (PICO), not currently available for east Kent.

Over the last eight years commissioners and the Kent and Medway NHS and Social Care Partnership Trust had looked repeatedly at how they could replace facilities in Medway (A Block) without success. Questions remain about the suitability of the site and capacity of the service to continue to deliver safe high quality care.

Engagement

KMPT and mental health commissioners have well established means of working with service users and carers so that their views influence plans and services. In February, 50 GPs, mental health clinicians, service users, carers and voluntary sector organisations met to debate and appraise potential options for improving consistency of delivery, the quality of care and the resilience of services in the current financial climate. The short listed options were then tested further with Locality Planning and Monitoring Groups (which bring together commissioners and providers with local voluntary organisations, service users and carers to bring a local focus to mental health services), Swale and Medway service user groups, Clinical Commissioning Groups and other stakeholders before formally being consulted upon with the wider public from July to October 2012.

The proposals set out to:

- Strengthen the Crisis Resolution Home Treatment teams
- Develop three hospital *centres of excellence*, each providing a better patient experience, high quality care, and the opportunity to innovate and demonstrate best practice from a firm research evidence base, delivered by a stronger staff team able to offer more therapeutic interventions seven days a

week, in a modern facility with a calm, therapeutic environment and individual en suite bedrooms.
- Consolidate the Psychiatric Intensive Care unit at Dartford's Little Brook hospital, expanding the psychiatric intensive care outreach service to cover the whole of Kent and Medway.

This means KMPT expanding the facilities at St. Martin's in Canterbury, re-opening an additional ward at Little Brook Hospital in Dartford for Medway service users in need of acute inpatient care, and moving out of the two A Block wards on the site of Medway Maritime Hospital.

The two organisations sent more than 4,000 invitations to take part to organisations and individuals, offering to attend local meetings or events where people were interested in the review to provide further information and listen to what people thought of the plans. Eight public consultation meetings were set up at a range of times in accessible and well used venues. 184 people attended these eight meetings with a few carers attending several meetings.

KMPT had a specific page on its website, with information available and suitable links on the three PCT websites, the *live it well* website and from partners in social care. The consultation was also publicised through social media such as Facebook and Twitter, *Medway Matters,* which goes to every household in Medway and its equivalent in Swale; in *Your Health,* the NHS magazine with a circulation in excess of 50,000, local media and in newsletters from the LINk and Kent Community Action Network.

There were public meetings, focus groups and outreach sessions at 15 other events.

All responses were logged and sent to independent researchers from the University of Greenwich who collated and analysed all the information. They found that:
- More than 80 per cent of respondents strongly agreed 'everyone should have the same high quality of care and hospital facilities'.
- 70 per cent strongly agreed that people with mental health problems make a better and faster recovery in a calm environment
- 62 per cent strongly agreed that crisis treatment at home should support carers as well as service users.

Concern over travel and transport was clearly a major issue for many people. Respondents were strongly in favour of the volunteer driver scheme, clear information and better signage.

When asked about their priorities for improving acute mental health services, people cited:
- **Access**
- **Greater resources**
- **The quality of individual care**
- **The quality of service provision**

- **Improved community provision.**

In February the NHS Kent and Medway Board approved in principle option A in the consultation which will provide beds for:

- People from Medway (as well Dartford, Gravesham and Swanley) in Dartford
- People from Sittingbourne and Sheppey (as well as Maidstone, Malling, Sevenoaks, Tonbridge and Tunbridge Wells) in Maidstone
- People from Faversham (as well as Canterbury, Thanet, Dover, Shepway and Ashford) in Canterbury.

This was also agreed in principle by the Clinical Commissioning Groups and the KMPT Board, with additional caveats made by the NHS Kent and Medway Board prior to implementation, which include:

- the strengthening of crisis services in the community
- a fully developed transport plan
- a quality impact assessment
- further analysis of the numbers of inpatient beds required to meet patient need into the future

Procurement

Case study: Patient Transport Service

Contracting services is a long and technical process. This year we have been delighted to have the support of local people in procuring the non-emergency Patient Transport Service across Kent and Medway. The need for changes was highlighted by a report by Kent LINk, which found wide variation in patients' experience of the service. Working with Kent LINk colleagues and following further discussions with service users, nine patient representatives enabled the PCT cluster to tailor the service specification to set out exacting requirements for a high quality service.

These included the consistency of eligibility criteria, booking arrangements and travel for all residents of Kent and Medway who are eligible for patient transport journeys.

Patient and LINk representatives then assisted in the technical scoring of the bids and so influenced the decision on awarding the contract. We would like to commend them for their efforts as they continue to work with the CCGs and provider trusts through the mobilisation and implementation stage of the project. The new service is due to launch on 1 July 2013.

Service Improvement

Cast study: estates and primary care contracting

St Werburgh Medical Practice approached NHS Kent and Medway with plans to close one of its four branch sites on the Isle of Grain. The site was located in a retail unit on a parade of shops and was unlikely to meet Care Quality Commission standards. There were also issues with privacy and dignity, as well as an unsecured dispensary. So the practice felt it could better meet the needs of patients by consolidating services in the other three branch surgeries.

NHS Kent and Medway engaged with patients from May to August 2012, about potential issues arising from closure of the St Werburgh Practice and any improvements that could be made to the remaining surgeries. Patients were invited to three drop in sessions during May, June and July. In addition, the Isle of Grain Carers and Disabled Group ran two events, one for patients to talk to us, and one feedback event for us to provide answers to their queries. These events reached out to more vulnerable patients. More than 50 patients attended the meetings and spoke to NHS Kent and Medway.

Key themes from feedback and responses included:

- **Phlebotomy service**: Patients asked what would happen to the phlebotomy (blood-taking) service at St Werburgh Medical Practice.

NHS Kent and Medway worked with another local practice to successfully relocate the service.

- **Prescription services**: Patients were concerned about prescription collection once the practice closed and wondered whether they could post requests. They asked if there could be a post box facility to drop off prescriptions in Grain.

A box has been installed in Grain for patients to drop off prescriptions, for their convenience.

- **Condition of the Elms/new facility**: Patients asked why a new facility could not be built as the other local practice they could register with is not in good repair.

NHS Kent and Medway looked into options as to how facilities could be improved at the other local practice and met with the parish council several times during the consultation period to discuss this. Via investment from the PCT and parish council, works are currently ongoing to improve the facilities by:

- Providing a disabled access toilet (for surgery use only)
- Providing three dedicated rooms

- Moving the dispensary into the middle room and having two consulting rooms – one either side of the dispensary

- **Appointment availability at other St Werburgh sites**: Patients asked if we could guarantee that patients using the other sites would not be adversely affected.

St Werburgh Medical Practice increased opening times at their other sites to ensure that there is additional capacity to meet the needs of new patients without restricting their existing patients. The number of GPs will not change, the practice has four full time partners and this remains the same.

- **Appointment availability at the other local practice:** What assurances do patients have that appointment availability will improve? The triage system means that you cannot pre-book appointments but you have to call on the day. There are problems with the Elms opening hours and with patients registering there.

The local practice took on two full time doctors, meaning they have six whole time GPs. NHS Kent and Medway has sought assurances from the practice that, as patient registrations increase, it will increase appointment availability, and if necessary employ additional staff to meet the needs of the rising number of patients.

Our staff

The most important asset in NHS Medway was our staff. It was through them that we were able to improve health services for local people.

2012/13 was a year of significant change for all staff employed by the PCTs in Kent and Medway as, having clustered on 1 April 2011, the staff were once again engaged with change as transition plans were developed during 2012. We worked to transfer most staff into the new NHS architecture on 1 April 2013. On 1 April 2012, NHS Kent and Medway (the PCT cluster) employed 1,103 staff within the three PCTs.

During this period of extensive and extended change, the structures of the new receiving organisations were confirmed and staff aligned to new roles in these structures, to enable the formal transfer to the receiving organisations on 1 April 2013 by Transfer Order. The alignment of staff was undertaken in accordance with the nationally prescribed HR framework.

The NHS Kent and Medway Executive Team remained in place until the autumn of 2012, spanning Kent and Medway, to ensure that the cluster delivered its main priorities and focus.

Adherence to the NHS Constitution pledges ensured that staff had:

- Clear roles and responsibilities and rewarding jobs that made a difference to patients, their families and carers and communities.
- Clear work objectives through a cluster appraisal process with job descriptions reviewed to reflect cluster-wide working arrangements.
- Personal development, access to appropriate training for their jobs and line management support to succeed.

Staff were supported in their personal development with a range of programmes from local training through to relevant degree and post graduate studies. The in-house Learning and Development function ensured that training was focused across NHS Kent and Medway to ensure staff had the best possible opportunity of a successful transfer into the new NHS structure.

These development programmes included management and leadership, customer services and personal development. Building resilience and engaging with change were also covered, as well as education and training specific to particular professions. Staff were also offered CV writing and interview skills training to help them move into new roles.

We put in place support and opportunities for staff to maintain their health, wellbeing and safety, through events organised by the health and wellbeing forum. The forum followed best public health practice, basing its activity on a staff needs assessment.

Sickness absence levels remained at around two per cent, despite the organisational changes taking place.

We engaged staff in decisions that affected them, individually, through representative organisations and through local partnership arrangements and the Cluster Joint Consultative Committee, chaired by the Chief Executive, which was the formal forum for consultation during this year of change.

Other staff engagement ranged from live video team briefs led by the Chief Executive to staff briefings in all locations across the cluster.

Equal opportunities

NHS Medway believes that every employee should be treated with equal respect and dignity. We value the rich diversity and creative potential of people with differing backgrounds and abilities and encourage a culture of equal opportunities in which personal success depends on personal merit and performance.

We are fully committed to a programme of action to ensure the promotion of equal opportunity for all and the elimination of discrimination in all aspects of employment. Our policy on equal opportunities and disabled employees is set out in our Single Equality Scheme, which complies with current law and codes of practice.

Complaints

The role of the Customer Services Team

During this period, the three Customer Services teams based across the cluster continued to move together to form one cohesive team. Local processes were harmonised prior to the changes to the NHS in April 2013. The team continued to follow the guidance of the Department of Health best practice guidance, 'Listening, Responding, Improving – a guide to better customer care', published in February 2009.

The Customer Services team dealt with all enquires and complaints received from members of the public and MPs. The Patient Advice and Liaison Service (PALS) provided quick resolution of their problems or concerns, or pointed people in the right direction when they were looking for particular services. If a complaint required investigation and a written response, it was allocated to a Customer Services Case Manager. The Case Manager contacted the complainant or enquirer and agreed with them how to best handle their issues.

If a complaint is solely about the provision of a service, it is often best for the provider of that service to investigate and respond to the issue. In these cases, the Customer Services Team liaised with the provider and asked to see a copy of the provider's response to the complaint. Where appropriate, the response was shared with the relevant commissioner and/or an independent clinical adviser. This, in combination with reports to various committees, ensured a mechanism for the organisation to learn from complaints. If the issue being raised concerned the way in which a service was commissioned, the Customer Services Team requested a response from a senior commissioner. All letters and emails of response were signed by the Chief Executive.

How we monitored and learned from complaints

In order to improve the patient experience, we focused on learning from complaints and taking action when they highlighted an issue with services. We ensured any complainant was informed when changes to a service were made. Complaints to NHS Kent and Medway were monitored through reports to the Quality Committee and also at regular meetings held between the Chief Executive and Kent MPs. Clinical issues were examined by the Independent Contractors Office.

Case study one

An MP enquired on behalf of a parent of a child suffering from Type 1 diabetes, who was concerned there was insufficient awareness of Type 1 diabetes among health professionals, particularly in relation to paediatric care.

The commissioners met with providers from several Kent Trusts to ensure that patients would receive an improved package of care. Patients now have a minimum of four clinic appointments a year with a multi-disciplinary team, an additional eight contacts a year with a paediatric specialist nurse or dietician and a structured education programme tailored to the child or young person as well as their family's needs.

Case study two

A patient complained about their local pharmacy which had changed its opening hours on Saturday without adequate communication, leaving the complainant without their prescription.

The lead pharmacist for the Cluster's Community Pharmacy team contacted the pharmacy chain concerned because all stores in the chain had changed their opening hours in the previous three months. She requested that all the affected pharmacies should display their change of hours prominently in store.

Case study three

A patient with multiple sclerosis contacted us about background music at her GP surgery, which she found extremely distracting and distressful. The response explained that music is played for reasons of patient confidentiality but assured the patient that background music will be kept to acceptable levels.

Case study four

A complaint was received about a data protection breach involving details of another patient being displayed on a public information screen in the waiting area of a GP surgery.

Following investigation, it was found that a recent upgrade to the system had resulted in a technical problem which had caused the board to malfunction. To ensure that this does not happen again and that information governance standards are fully maintained, staff have been instructed that all patient screens must be switched off during upgrades. A member of the PCT's Informatics Team came out to the surgery to restart the server in the basement and reconfigure the agent which runs the software to stop any further incidents. Practice staff will check all message boards following system upgrades.

Case study five

A woman contacted us about lack of care for her late husband by their GP surgery.

The complainant and GP surgery were involved in a mediation process which had positive results for both and the complainant advised that matters were concluded satisfactorily. Improvements to complaints handling and training have been made in

the GP practice and their procedure revisited in terms of the way support is offered to next of kin by GPs.

Case study six

A complaint was received from a relative on behalf of a prisoner with heart failure about healthcare provided by Prison Healthcare Centre and that his oxygen cylinder had been removed from his cell. Reassurance was given to the prisoner and a palliative care nurse was asked to visit and review the care provided.

Case study seven

A patient complained about a GP who had apparently opted out of using Choose and Book system for getting an outpatient appointment with a hospital consultant, allegedly breaching NHS patients' rights. The GP was contacted by the cluster's Contracts Manager to remind them of the need to use the Choose and Book system, and the section of the NHS Constitution where it clearly states the right of patients to exercise choice about their referral.

Complaints and enquiries Medway

Complaints received	44
Number well founded (at the time of reporting three cases are still being investigated)	(0) 7 open
Number of cases referred to the Ombudsman	0
Written comments and enquiries received	56
PALS enquiries	808

Complaints received about NHS providers that were referred to provider for response

Medway NHS Foundation Trust	20
Other local NHS Trusts	11
GPs	96
GP Out of Hours Services (see local NHS Trust – Medway Community Healthcare)	8
Dentists	12

Prison Health Services	1
Other small providers	4
Total complaints and enquiries handled	**1,065**

Subject matter of complaints

The main issues were:

Access to services	17	Most of the complaints received were about access to services where the patient had not met the criteria for NHS funding. In some cases where additional evidence was provided by clinicians the Individual Funding Request panel proceeded to approve the funding.
Medication	6	Most of these complaints relate to the changes in gluten-free prescribing.
Communication	4	One of these relates to the policy on the use of 0844 numbers, the rest to out of date information on the NHS Medway website.
Treatment	3	Two of these related to mental health commissioning decisions and one to the change in the wheelchair contract.
Others	14	The remainder of complaints related to a variety of issues such as the proposed relocation of the Gillingham Walk-in Centre.

Environmental Action

The leaders at NHS Kent and Medway recognised the importance of the health of the environment and the health of the population and used the principles of environmental sustainability to underpin their approach to providing excellent healthcare.

The PCT Cluster was very active in addressing the challenges of climate change, environmental degradation and resource depletion using policies that yielded maximum health co-benefits while reducing risk from pollution and environmental destruction. The Sustainable Development Board ensured a coordinated approach to reducing NHS carbon emissions, procuring sustainable health services and being resilient in the face of climate related emergencies.

This board worked closely with local authorities and the developing health and wellbeing boards to maximise the public health benefits that can result from a more sustainable approach. Examples include tackling fuel poverty and the associated risks from cardiovascular and respiratory disease by providing free insulation for vulnerable people, encouraging active transport to improve wellbeing and reduce obesity and promoting locally sourced fresh fruit and vegetables as part of a healthy diet. We worked in partnership with the local authorities through such groups as the Local Nature Partnership, the Kent Climate Change Network, the Kent Resilience Forum, the Air Quality Network and the new network to implement the Green Deal.

We continued to develop our initiative for GP practices to become more sustainable and aware of their environmental responsibilities. The Sustainable Surgeries Award Scheme was the first of its kind in the country and, following the successful pilot, was rolled out, with 10 further practices enrolled with the scheme. The scheme is designed to engage staff and patients in a wide variety of simple changes that help reduce carbon emissions and improve health. A number of PCT Carbon Champions were trained to deliver the programme. Each practice goes on to train staff and to ensure the culture of the practice inspires patients to consider lifestyle changes that can improve health as well reduce environmental impact.

All three PCTs continued to make significant progress with their carbon reduction targets, making the NHS in Kent and Medway more efficient and lowering its negative impact on the environment. The PCT Cluster saved over 4000 tons of carbon dioxide representing an energy saving of £2.4 million, most of which will be recurring. The percentage of carbon saved on direct emissions is 24 per cent, which is ahead of target. We also made significant progress towards the key goal of our carbon management plans: to make carbon management instinctive for all and embed sustainable principles across the health economy in NHS Kent and Medway.

There was extensive progress in improvements to PCT buildings across Kent and Medway, leading to efficiencies in energy usage and costs. Business travel continued to be reviewed by the local NHS and further improvements are expected

as remote working and improved computer technologies are further utilised. There was also a significant decrease in landfill use across the three PCTs with landfill reserved for occasional ad hoc site clearance. All general waste was processed at an Energy from Waste plant, which not only delivers carbon savings in terms of waste diverted from landfill but also in the energy generated and fed back into the National Grid.

This year also saw the establishment of a strategic Sustainable Travel Group. It aimed to bring together all those across Kent and Medway involved in improving and modernising travel infrastructure to encourage sustainable choices. Examples include electric vehicle charging point infrastructure, information about cycling networks and training support, integration of bus and rail services and affordable low carbon travel options. All staff in NHS Kent and Medway were encouraged to use videoconferencing and teleconferencing as far as possible to avoid needless travel. In addition flexible working wherever possible from home or from the nearest base was encouraged. The savings in terms of time and mileage payments were remarkable and many staff reported improvements in stress levels as an extra benefit.

NHS Kent and Medway exceeded its initial aims with regard to reduction of direct carbon emissions and focused its attention on indirect emissions and a whole NHS approach so that collectively we will be on track to contribute to the national target of 10 per cent reduction in total NHS carbon footprint by 2015. To that end we have incorporated sustainable principles and indicators into all major procurement processes and into all major contracts with providers.

A further new initiative this year was the registration of NHS Kent and Medway as part of the national NHS Forest. We actively involved staff from across the NHS to take part in sponsoring and planting trees that will directly benefit health both now and in the future. An essential mark of the success of the NHS Forest will be its long-term legacy. This project is not just about planting trees in the ground but more about engaging people with their immediate environment by jointly creating space that will be used and continually improved by staff, patients and the local community. A sense of ownership of the NHS Forest by all these groups will help to ensure its survival.

Kent and Medway NHS representatives were active at national, regional and local events to ensure the NHS is developing an integrated approach to healthcare which values social and environmental capital. These included the NHS Sustainable Development Unit Route Map events and the Prince of Wales' Accounting for Sustainability Project where we played an active role in the launch of *Future Proofed Decision Making*. As we moved towards the new NHS structure, the focus was on developing awareness of the benefits to health and wellbeing of maintaining this approach.

Information governance

The Information Governance function across Kent and Medway continued to work effectively in 2012/13, with the team achieving continually high compliance rates. Work undertaken with the emerging Clinical Commissioning Groups also enabled the CCGs to meet the Information Governance requirements in their authorisation process.

Freedom of Information requests (FOI) and Subject Access Requests (SAR) continued to have a very high rate of response compliance, with FOI requests responded to in 20 working days and SARs responded to in 40 calendar days.

The target of 95 per cent of staff in NHS Kent and Medway being compliant with their annual Information Governance training was met. This provided assurance that our staff were handling information in a secure manner and also ensured they were aware of their Information Governance responsibilities. This has provided assurance for the annual Information Governance Toolkit assessment submission which recorded a compliant score for the PCTs and the CCGs.

The Records Management Legacy project successfully ensured that as the PCTs closed down, the records were passed onto the correct receiver organisations, and that effective Records Management processes were in place for the new organisations.

Medway PCT (known as NHS Medway) had seven Information Governance serious incidents in 2012/13.

Public sector organisations are expected to make information available in the public interest either free or at low cost. NHS Medway provided details of its services and how to access healthcare through the internet and a newsletter delivered to all households, partly subsidised by sponsorship. For these services, there was no charge.

The PCT did not supply information to other parties, for example, for research or publication by third parties. It therefore complied with the Treasury's guidance on setting charges for information.

Emergency preparedness and response

Introduction

The maintenance of appropriate emergency and business continuity plans is a high priority in the NHS. This section summarises the work undertaken in the last year to ensure the resilience of NHS Kent and Medway. It describes how NHS Kent and Medway met its statutory responsibilities to plan for and respond to emergencies, contributed to multi-agency planning and response, and coordinated provider service organisations ensuring that all NHS funded organisations were fully prepared to delivery an integrated response to any emergencies that may impact on the county.

It also summarises the new Emergency Preparedness Response and Resilience Guidance, indicates the measures that have been taken to ensure the current arrangements meet these and highlights the decisions that will need to be taken to ensure that the current high levels of resilience are maintained during the current reconfiguration of services.

Statutory Responsibilities

NHS Kent and Medway was required by the Department of Health to have plans that complied with the NHS Emergency Planning Guidance 2005 and underpinning materials, and was required to produce and maintain a business continuity plan that was compliant with the British Standard BS NHS 25999-1. NHS Kent and Medway was identified as a Category One responder under the Civil Contingencies Act (2004) requiring it to:

- Assess the risk of emergencies occurring and use this to inform contingency planning
- Put in place emergency plans
- Put in place Business Continuity Management arrangements
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- Share information with other local responders to enhance co-ordination
- Co-operate with other local responders to enhance co-ordination and efficiency.

In addition, NHS Kent and Medway had statutory duties to plan for and exercise the response to emergencies at the Channel Tunnel and Dungeness Power Station.

Key achievements for 2012/13

Internal arrangements

The three PCTs' Emergency Planning and Business Continuity Teams were successfully clustered into a single, streamlined NHS Kent and Medway Resilience Team.

The best practice from each of the three PCTs' Emergency Plans and Business Continuity Plans were used to put in place a single, county-wide response to emergencies.

NHS Kent and Medway had a single, board-approved, Strategic Major Incident Plan, which was tested by exercise.

NHS Kent and Medway had a board-approved Business Continuity Policy and Plan aligned with British Standard BS NHS 25999-1, which were tested by exercise.

We replaced the expired supplies of potassium iodate tablets surrounding Dungeness Power station.

The Executive Director on call rota and Emergency Response Management Team who supported them were security cleared to allow them to respond effectively to deliberate incidents.

The Emergency Response Management Team responded to a wide range of alerts and incidents including chemical spills, transport accidents and an evacuation of a train at the Channel Tunnel.

Coordination of NHS funded organisations

NHS Kent and Medway ensured the sharing of good practice and integration of Provider Service Organisations' Emergency Planning and Response capabilities through its coordination and chairing of Local Health Emergency Planning Group.

NHS Kent and Medway ensured that the Kent Resilience Forum had health service input into all of its working groups. By coordinating the work of all NHS Trusts it was possible to ensure that each NHS Trust met its obligations without needing to attend every meeting.

The Resilience Team reviewed all Provider Services Organisations' Emergency Planning and Business Continuity capabilities through Emergency Planning Surgeries and presented the results to the Strategic Health Authority.

Emergency Response Exercises

NHS Kent and Medway led planning for and participation in a wide range of multi-agency emergency planning exercises on behalf of the NHS, including:

- Bi-National (Channel Tunnel) exercises 22 and 22b (additional Olympic exercise)
- Dungeness Power Station, exercise Windrush
- Eurostar evacuation live exercise Sabre
- Exercise Vandella, Regional Exercise to test Olympic command and control arrangements.

2012 Olympics

NHS Kent and Medway led the NHS participation in multi-agency preparations for the 2012 Olympics and provided assurance that provider service organisations were prepared for the Olympics. This work included:

- Communications and procurement workshops for all NHS funded organisations

- Development of Kent Resilience Forum Olympics Response plans and completion of national assurance templates for the Department of Health and Cabinet Office.

- Participation in three Olympics Command Post Exercises including, Exercise Black Chariot, Exercise Golden Chariot and Exercise Green Altius

- Preparation for the Olympic Torch relay and associated events by representing the NHS at 14 Safety Advisory Groups.

Preparation for the Future

On 3 May 2012 the Department of Health published the Arrangements for Health Emergency Preparedness, Resilience and Response from April 2013.

This document describes the principles that underpin Emergency Preparedness Response and Resilience from April 2013, and sets out the roles and functions of the Secretary of State for Health, the Department of Health, NHS England (formerly known as the NHS Commissioning Board), Public Health England, and Directors of Public Health working in local authorities.

It describes how health service planning for emergencies will be conducted through Local Health Resilience Partnerships (LHRPs). The LHRP will be aligned with Local Resilience Forum boundaries (the county of Kent) and be co-chaired by the lead Director for the Kent and Medway Area Team of NHS England and the lead Director of Public Health. They will bring together all health sector organisations involved in

emergency preparedness and response and will be responsible for ensuring effective planning, testing and response to emergencies.

The responsibility for coordinating the NHS response to emergencies has been clearly placed with NHS England as a Category One Responder under the Civil Contingencies Act.

Clinical Commissioning Groups have been identified as Category Two responders with a duty to share information and cooperate with other organisations as well as meeting the NHS Emergency Planning Guidance and being compliant with British Standard BS NHS 25999-1.

The existing arrangements in Kent were designed in anticipation of this guidance. A partnership group is in place, jointly chaired by the Kent Director of Public Health and the emergency preparedness and response lead for the Kent and Medway Area Team of NHS England, who also represents the NHS at the Kent Resilience Forum.

The role of the emergency preparedness and response lead is to lead NHS emergency preparedness and response at the local resilience forum level, and provide necessary support to enable planning and response to emergencies that require NHS resources.

Operating and Financial Review

All PCTs have to meet the same statutory and financial duties

Revenue Resource Limit

Contain expenditure within the revenue resource limit set by the Department of Health.

Capital Resource Limit

Contain expenditure within the capital resource limit set by the Department of Health.

Cash Limit

A statutory duty not to spend more than the cash allocated to them. PCTs have a combined cash limit for both revenue and capital.

Capital Charges

A requirement to pay capital charges on their assets. These include a depreciation charge to reflect the use of fixed assets (other than land) and a 3.5 per cent cost of capital charge on net relevant assets.

Medway PCT met its financial duties for 2012/13 and in line with annual plans, achieved target savings of £4.6million.

This surplus will be carried forward to successor bodies and included as a non-recurrent resource in 2013/14. It will be available for the CCG and other successor bodies to invest in patient services during 2013/14.

The following tables set out the Summary Financial Statements. These financial statements might not contain sufficient information for a full understanding of the PCT's financial position and performance. The full Annual Accounts are available on request from the Finance Department, Kent and Medway Area Team, Wharf House, Medway Wharf Road, Tonbridge, Kent TN9 1RE.

External Audit

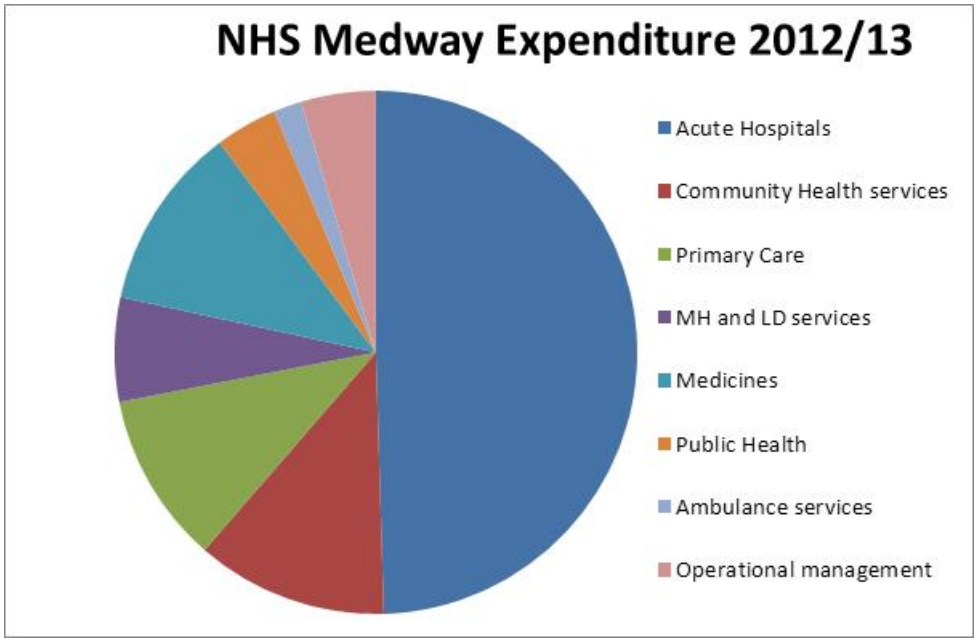
External Auditors, appointed by the Audit Commission, provide assurance to the Trust Board and external stakeholders on internal control mechanisms and overall probity. The Annual Accounts are also subject to scrutiny by the External Auditors.

For Medway PCT, the External Auditors are BDO LLP. The cost of audit services in the year is set out below regardless of the method of payment.

Accounts and Governance	£90,990
Use of Resources (including risk based work)	£0
Review of redundancy cases (required by DH)	£0
Total	£90,990

Your money

We had £467.8 million to spend on healthcare between 1 April 2012 and 31 March 2013: this means that for each man, woman and child in Medway, we spent £1,703.



The chart above illustrates how, of every £100:

- £50 was spent on acute hospitals (of which £28 went on services provided by Medway NHS Foundation Trust)
- £12 was spent on community health services (mostly on services provided by Medway Community Healthcare)
- £10 was spent on primary care (GPs, pharmacies, dentistry, optometry)

- £6 was spent on mental health and learning disability services (of which £4 went on services provided by Kent and Medway NHS and Social Care Partnership Trust)
- £11 was spent on medicines
- £4 was spent on our public health team and healthy living services
- £2 was spent on ambulance services
- £5 was spent on operational and management costs.

The main differences between what we expected to spend and what we actually spent were the result of:

- more patients than expected being treated in acute hospitals such as Medway Maritime Hospital, and some of these treatments are becoming more complex and expensive
- rising costs of the continuing care of patients in the community
- rising prescribing costs
- savings arising from the reduction in running the organisation, which allowed additional investment in frontline services.

In total, we spent £462.9 million of our revenue budget, giving a surplus of £4.6 million.

We also spent £2.4million on capital costs, including:

£1.2 million on maintenance of capital stock, and

£0.4 million on grants to GP and dental practices.

Summary Financial Statements

The summary financial statements and remuneration report are appended to this report.

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

The banded remuneration of the highest paid director in Medway PCT in the financial year 2012/13 was £135,000 – £140,000 (2011/12, £135,000 - £140,000). This was 5.47 times (2011/12, 6.06 times) the median remuneration of the workforce, which was £23,589 (2011/12, £22,676).

In 2012/13, zero (2011/12, zero) employees received remuneration in excess of the highest-paid director. Remuneration ranged from salary bands of £10,000 – £15,000 to

£135,000 - £140,000 (2011/12 salary bands ranged from £10,000 – £15,000 to £135,000 - £140,000).

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

The relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce (the "pay multiplier") shows a reduction between 2011/12 and 2012/13. This reflects additional entitlements earned by the highest paid director.

The number of days lost through staff sickness reduced between 2011/12 and 2012/13. As the table below illustrates:

	2012-13 Number	2011-12 Number
Total Days Lost	2,551	11,080
Total Staff Years	425	1,280
Average working Days Lost	6.00	8.66

No members of staff retired early on ill health grounds in 2012/13.

Medway PCT (known as NHS Medway) became part of the Kent and Medway Cluster in 2011/12. This allowed some posts to be shared across PCTs to provide greater efficiency. A number of Director and Non Executive Director posts were shared, and these were recharged based on the relative weighted populations. The Remuneration Report details these posts: the cost of the posts falling to Medway PCT is shown in Section A of the report, and Section B shows the gross costs of these posts where posts are shared.

Valuation of Assets

Property assets were revalued as at 31 March 2013 by the District Valuer. LIFT assets were revalued at fair value; all other assets were revalued on the Modern Equivalent Asset basis. Consequently, there was no difference between the carrying amount and market value of interests in land.

Pension Scheme

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.

Better Payment Practice Code

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. The performance of the PCT is set out in the table below:

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**12,729**	**112,047**	13,811	111,889
Total Non-NHS Trade Invoices Paid Within Target	**12,107**	**108,444**	12,788	108,146
Percentage of NHS Trade Invoices Paid Within Target	95.11%	96.78%	92.59%	96.65%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**4,395**	**298,770**	4,700	288,095
Total NHS Trade Invoices Paid Within Target	**4,122**	**292,356**	3,901	283,804
Percentage of NHS Trade Invoices Paid Within Target	93.79%	97.85%	83.00%	98.51%

The PCT is not a signatory to the Prompt Payments Code, but its performance for non-NHS bodies exceeds the 95 per cent compliance target for both the number of invoices paid and their value.

Forward look

Looking forward, the PCT has worked closely with the emerging Clinical Commissioning Groups (CCGs) to agree how future funding should be used most effectively.

Top slice

During 2012/13 NHS Medway received non-recurrent funding allocations from the Department of Health relating to deployment of top slice funding within the health economy. Top slice funding was non-recurrent funding held by the Department of Health which equated to 2 per cent of total PCT funding allocations. Use of funding was controlled by the Strategic Health Authority and the Department of Health.

Principal risks and uncertainties

We have assessed the principal risks and uncertainties that may affect the PCT's successor bodies over the next few years as we hand over our functions to our successor organisations as being:

- financial risks: NHS budgets will not be reduced but with demand for NHS services increasing annually, along with the range of services the NHS can

offer (such as new drugs and technologies), we have to be very careful about getting value for money

- health of our population: growing need for services, falling capacity within the NHS, or an increased focus on Kent-wide services, could result in inability to meet the specific health needs of our local population
- transition risks: at this time of organisational change, there is a risk of key people leaving, resulting in over-stretched systems failing to deliver the local NHS vision
- whole system risks: different parts of the NHS and social care, in eastern and coastal Kent, Medway, west Kent and beyond, could fail to co-ordinate in every aspect needed to deliver necessary improvements to quality, innovation, productivity and prevention
- enabling risks: in an era of transformational change, our staff need far greater capacity and flexibility from estates and information technology to support skills which enable that transformation.

The plans the successor bodies have put in place for 2013/14 and future years are designed to address these risks and to ensure that the health service in Medway continues to respond to the needs of our population and to deliver value for money to taxpayers.

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: Felicity Cox

So far as each director is aware, there is no relevant audit information of which the PCT"s auditors are unaware. Each director has taken all the steps which he/she ought to have taken as a director to order to make him/herself aware of any relevant audit information and to establish that the PCT's auditors are aware of that information.

Governance Statement

1. Scope of responsibility

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

In particular the Accountable Officer Memorandum also assigns the Accountable Officer responsibility for:

- The propriety and regularity of NHS finances;
- The keeping of proper accounting books and records;
- Prudent, efficient and effective administration;
- The avoidance of waste and extravagance;
- The efficient and effective use of all resources within the charge of the Accountable Officer;
- Ensuring managers at all levels have a clear view of their objectives, the means to assess achievement against those objectives, and the information and training to exercise their responsibilities effectively.

I have ensured that a robust integrated governance framework is embedded within the PCT which is aligned with Department of Health guidance and established best practice.

The Memorandum also places responsibility on the Accountable Officer for developing and maintaining key relationships, which include:

- Local communities through public meetings and the publishing of annual reports and accounts;
- Patients through the PCT's Local Involvement Networks (LINks) and the Customer Services Team;
- The South of England Strategic Health Authority through regular meetings and forums;
- Partners through the Integrated Plan Board and through a range of service and care specific committees and working groups;
- Local authorities through developing Health and Well Being Boards and the appointment of co-opted members from the Local Authority to the Cluster Board;
- Other PCT Clusters through joint commissioning arrangements.

The context in which risk within the organisation is managed takes into consideration the stakeholders listed above.

The Accountable Officer is able to monitor and fulfil the commitments placed on the role by:

- Regular reporting to the Board by both clinical and operational management teams;
- The Joint Audit Committee;
- The Finance and Performance Committee;
- The implementation of a Risk Management Policy/Strategy agreed by the Board which clearly defines roles and responsibilities in relation to Risk Management at all levels from the Chief Executive to front line staff and addresses both clinical and non-clinical risk;
- The Health and Safety Committee;
- The Quality Committee which incorporates Clinical Governance;
- Regular briefings to the South of England Strategic Health Authority;
- The process of Internal and External Audit;
- The use of the Assurance Framework to manage principal risks associated with key objectives together with a dashboard displaying corporate objective performance.

Internal audit annually produce an overall Opinion on the effectiveness of the systems of internal control. In addition there have been a number of audits carried out on the key functions and systems that directly contribute to their maintenance of the Accountable Officer responsibilities. These audits include:

- The Board Assurance Framework
- Risk and Control Framework (including the Risk Management Strategy)
- Information Governance
- Core Financial Systems
- Payroll systems, maintenance and application
- Landlord Compliance Checks
- Provider Care Quality Commission registration and management
- GP Quality Development Framework

An audit recommendation action list to ensure the learning from these reviews is embedded into any system changes or redesigns is held and reviewed by the Kent and Medway Joint Audit Committee. The Joint Audit Committee is chaired by two alternating Non Executive Directors.

2. The governance framework of the organisation

The Cluster Board

Membership of the cluster board comprised the cluster Chair and a further six cluster Non-Executive Directors and six voting cluster Executive Directors, as follows:-

- Cluster Chair;
- Six other cluster Non-Executive Directors drawn (two each) from each of the PCT's Chairs or Non-Executive Directors
- The cluster Chief Executive
- The cluster Directors of Finance (together having one vote)
- The Medical Director of each of the PCTs (together having one vote)
- The cluster Director of Nursing and Quality
- The cluster Director of Whole Systems Commissioning
- The cluster Director of Performance and Assurance
- The cluster Directors of Public Health (together having one vote)

Additionally the following members of the cluster Executive Team were designated as non-voting members of the cluster board:

- The cluster Director of Commissioning Development and Workforce
- The cluster Director of Communications and Citizen Engagement

The Assistant Chief Executive and Company Secretary were also members of the cluster Executive Team and attended board meetings.

The cluster board met in public at least bi-monthly.

The cluster board focused on strategic issues while assuring itself of the performance of the whole cluster. It achieved a balance by:

- Long range board agenda planning – coordinated by the Company Secretary with input from the cluster Executive Team and Chairman;
- Regular board development sessions to cover key strategic and development issues;
- Monthly Non-Executive Director meetings to discuss key topical and strategic issues chaired by the Chairman with the Chief Executive and Company Secretary in attendance.

Board Committees

To support the cluster board in carrying out its duties effectively, sub-committees reporting to the cluster board were formally established. Each sub-committee received a set of regular reports, as outlined within their terms of reference and provided summary reports to the cluster board after each meeting.

The main committees of the cluster board were:-

- Joint Audit Committee
- Joint Remuneration and Terms of Service Committee
- Joint Quality Committee
- Commissioning Committee
- Finance and Performance Committee
- Commissioning Development and Transition Committee

Joint Audit Committee

The committee was established as a joint sub-committee of the cluster board. The committee met at least three times a year and otherwise as required.

The Audit Committee's primary role was to oversee the adequacy and effective operation of the overall internal control system supporting each PCT in the cluster. The Audit Committee independently monitored, reviewed and reported to the cluster board on the process of governance and, where appropriate, facilitated and supported, through its independence, the attainment of effective processes.

The Audit Committee was charged with monitoring the effectiveness of internal control systems on behalf of the board and did so as part of its annual work programme and through reporting to the cluster board after each of its meetings. Additionally the committee was required to provide assurance that robust risk management arrangements were in place throughout the PCT cluster and that they were working effectively.

The membership of the Audit Committee comprised two Chairs (until 15 June 2012 when one of the Chairs resigned) and one member from each of West Kent PCT, Eastern and Coastal Kent PCT and Medway PCT. The cluster Chief Executive was invited to attend the Audit Committee, at least annually, to discuss the process for assurance that supported the Annual Governance Statement.

The Director of Finance Stewardship and Governance was normally present at each meeting of the Audit Committee, together with representatives from Internal and External Audit and Counter Fraud Services.

Joint Remuneration and Terms of Service Committee

In line with the requirements of the NHS Codes of Conduct and Accountability, the PCT was required to constitute a Remuneration Committee. The committee was

established as a joint Non-Executive sub-committee of the cluster board. The committee met at least twice a year.

The committee's purpose was to determine the remuneration and conditions of service of the cluster Chief Executive, cluster executives and other cluster directors with board responsibility who reported directly to the Chief Executive, ensuring that these properly supported the objectives of the cluster and/or relevant PCT, represented value for money and complied with statutory requirements.

The Remuneration and Terms of Service Committee followed an annual work programme and reported annually to the cluster board.

Quality Committee

The purpose of the Quality Committee was to ensure that the cluster board delivered its statutory responsibilities for care quality through transition, including the domains of safety, effectiveness and patient experience.

The Quality Committee was delegated by the cluster board to undertake specific duties and provide assurance to the cluster board that:

- A Quality In Transition Plan was developed and delivered in line with the *Shared Cluster Operating Model for PCT Clusters* (published August 2011);
- The services commissioned on behalf of the local community were safe, of a consistently high standard and responsive to patient needs and experiences;
- The commissioned services met the necessary standards of quality specified in Care Quality Commission (CQC) registration requirements, standard contracts, professional guidance, the NHS Operating Framework and other relevant sources;
- The commissioned services, including rebalanced commissioned services, maintained quality standards and drove improvements in health outcomes within available resources;
- There were robust contract monitoring arrangements for all providers in place, using hard and soft intelligence so that any serious failures were prevented or identified at an early stage and resolved;
- The CQC, the SHA Cluster and providers themselves were immediately notified where performance monitoring identified signs of non–compliance with registration requirements;
- Any unresolved provider performance concerns were comprehensively documented in legacy documents for successor organisations;
- That providers had good clinical governance (effectiveness) processes, patient safety frameworks and methods to capture and act upon patient experience and feedback;
- That providers were reporting incidents appropriately and implementing the learning from analysis of incident data;
- That there was a culture of open and honest cooperation so that staff, patients and the public were pro-actively listened to in order to understand their concerns and experiences;

- That there were safe arrangements in place for the provision of a safe and effective system wide workforce;
- That any concerns with the conduct and professional performance of independent contractors registered on the cluster PCTs' Medical, Dental and Optical Performers Lists were identified and managed.

Commissioning Committee

The purpose of this committee was to ensure that the PCT was able to deliver its strategic commissioning objectives by specifically ensuring that:

- The goals and initiatives outlined in the PCT's Strategic Commissioning Plan were developed and delivered in accordance with the Operating Framework and the four key strategic drivers outlined in the White Paper: Equity and Excellence: Liberating the NHS namely:

1. Putting patients and public first
2. Improving healthcare outcomes
3. Autonomy, accountability and democratic legitimacy
4. Cutting bureaucracy and improving efficiency

The committee worked with other committees of the cluster board to achieve high quality, financially viable services meeting all quality, innovation, productivity and prevention challenges (QIPP). In undertaking this work the committee ensured that it had oversight of risks to delivery of the Operational Plan, the Strategic Commissioning Plan and the cluster's strategic objectives. This committee reported specific assurances determined in the Assurance Framework. The committee was responsible for the governance and clinical leadership through transition to Clinical Commissioning Groups including organisational development, role design and staffing to ensure delivery of the Operational Plan during and after transition including strategic development within the financial resources available.

Finance and Performance Committee

The Finance and Performance Committee provided the cluster board with assurance that all financial and performance issues were being identified, progressed regularly and that appropriate actions were in place to deliver the standards required. Specifically, the committee monitored delivery of Clinical Commissioning Group work stream plans and progress against the integrated plan for the PCT including the QIPP programme.

Commissioning Development and Transition Committee

The purpose of the Commissioning Development and Transition Committee was to ensure that the cluster delivered its Commissioning Development Plan (CDP) across the cluster and to provide assurance to the cluster board in this respect. The committee had responsibility for:

- Coordinating and facilitating the links between the Commissioning Development work streams, the Strategic Health Authority cluster, local authorities and other stakeholders and ensuring alignment and convergence of local, regional and national work streams;
- Coordinating and facilitating the links between commissioning delivery and developmental new commissioning architecture to enable safe transition to Clinical Commissioning Groups by March 2013;
- Reviewing monthly updates and guidance from the SHA Regional Commissioning Development Board and Local Government Association ensuring that the controls and mitigations to managing transition risks were in place and adequate;
- Reviewing monthly delivery and performance from each work programme through reporting from the Programme Management Office (who had responsibility for tracking delivery of the CDP).

Clinical Commissioning Groups (CCGs)

On 25 January 2012 the cluster PCT Boards approved the establishment of emerging Clinical Commissioning Groups as committees of the relevant PCT Board for the following areas:

- Ashford
- Canterbury and Coastal (Canterbury, Herne Bay, Whitstable, Faversham, Sandwich and Ash)
- Dartford, Gravesham and Swanley
- Medway
- South Kent Coast (Deal, Dover and Shepway)
- West Kent (Maidstone, Tunbridge Wells, Tonbridge and Malling and most of Sevenoaks district)
- Thanet
- Swale

Terms of Reference for each CCG, a Memorandum of Understanding and a detailed Scheme of Delegation were also approved by the PCT Boards thereby creating the

governance required for full delegation of commissioning budgets, required nationally in April 2012, to allow a full year of shadow operation for emerging CCGs.

Attendance at the Cluster Board and Committee meetings

Committee	Average attendance of members
Cluster Board	79%
Joint Audit Committee	53%
Joint Remuneration Committee	67%
Joint Quality Committee	53%
Commissioning Committee	67%
Finance and Performance Committee	72%
Commissioning Development and Transition Committee	66%

Corporate Governance

The UK Corporate Governance Code is a guide to a number of key components of effective board practice. It is based on the underlying principles of all good governance: accountability, transparency, probity and focus on the sustainable success of an entity over the longer term. The PCT and PCT cluster adhered to the principles set out in the UK Corporate Governance Code in the following ways.

Leadership

The PCT and PCT cluster were headed by an effective board which was collectively responsible for the long-term success of the PCT and cluster. There was a clear division of responsibilities between the running of the board and the executive responsibility for the running of the cluster's and PCT's business. No one individual had unfettered powers of decision and decision making powers were clearly governed by the PCT's Standing Orders and Standing Financial Instructions, Terms of Reference of individual committees and schemes of delegation.

The Chairman was independently appointed by the Appointments Commission and was responsible for leadership of the board and ensuring its effectiveness in all aspects of its role. As part of their role as members of a unitary board, Non-

Executive Directors constructively challenged and helped develop proposals on strategy.

Effectiveness

The board and its committees had the appropriate balance of skills, experience, independence and knowledge to enable them to discharge their respective duties and responsibilities effectively.

There was a formal, rigorous and transparent procedure for the appointment of new directors to the board which was managed independently for Non-Executive Directors by the Appointments Commission.

Non-Executive Directors' and Board Advisors' portfolios of committee memberships were carefully managed by the Chairman to reflect their areas of special interest and expertise and to ensure that they were able to allocate sufficient time to discharge their responsibilities effectively. All directors received a programme of induction on joining the board and regularly updated and refreshed their skills and knowledge through a formal process of appraisal and identification of training and personal development needs. Board papers were supplied in a timely manner, with minimum timescales for receipt of papers set out in the PCT's Standing Orders. Board papers were prepared with information in a form and of a quality appropriate to enable the board to discharge its duties.

All Directors were subject to annual performance review.

Non-Executive Directors were subject to re-appointment processes every three years subject to continued satisfactory performance.

Accountability

The board considered that it presented a balanced and understandable assessment of the PCT's position and prospects. The board was responsible for determining the nature and extent of the significant risks it was willing to take in achieving its strategic objectives. The board maintained sound risk management and internal control systems. The board established formal and transparent arrangements for considering how it should apply risk management and internal control principles and for maintaining an appropriate relationship with the PCT's auditor.

Remuneration

Remuneration for all Directors was set by reference to national pay rates. No Director was involved in deciding his or her remuneration.

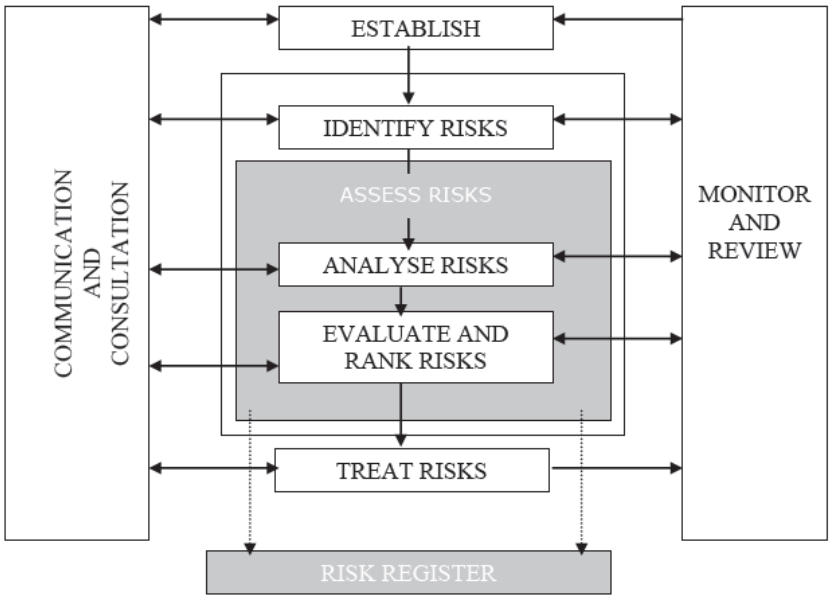
3. Risk assessment

The organisation implemented an integrated Risk Management Strategy to ensure there was a systematic and consistent approach to risk management throughout the organisation. It is important to ensure that risks are identified, assessed, controlled and dealt with at the appropriate management level.

The organisation recognised that risk management has to function in an environment in which the risk appetite and type are defined and this shaped the development of the risk management model.

Following risk identification and assessment, risks were categorised by their type of risk or the key business driver that may affect the delivery of an objective(s). An individual risk appetite existed for each category and these, along with the risk profile for the organisation, were set following consultation with the Executive Team and the Non-Executive Directors.

Risk management model



The organisation expected to see risk management in all parts of the organisation's operation and the absence of risk was not considered to be positive.

Medway PCT (known as NHS Medway) had seven Information Governance serious incidents in 2012/13.

4. The risk and control framework

The risk management process was designed to identify the principal risks to the achievement of the organisation's objectives; to evaluate the nature and extent of those risks and determine the organisation's appetite for those risks; and to manage

them efficiently, effectively and economically. The PCT's risk management system covered six types of risks and controls:

i. Patient Safety/Quality/Prevention risks – covered by the Quality Committee report to the board and recorded in the Quality risk register. Executive accountability for clinical risk management resided with the Director of Nursing and Quality.

ii. Compliance and Legislation risks – covered by the annual report on risk management and recorded in the Assurance Framework, and Corporate Objectives report. Executive accountability for organisational risks rested ultimately with the Chief Executive.

iii. Financial risks - covered by the annual report on risk management and recorded in the Assurance Framework and Corporate Objectives report. Financial Risks are also reported in Finance Reports to the Board, the Finance and Performance Committee and the Joint Audit Committee. Executive accountability for financial risk management rested with the Director of Finance Stewardship and Governance.

iv. Risks to the delivery of the operating plan- (risks which would impact on the achievement of corporate objectives) – covered by the annual report on risk management and the Annual Governance Statements. These risks were also recorded in the Assurance Framework. Risk assessment formed part of all strategic policy decisions.

v. Transition/cluster risks – (risks which would impact on the achievement of the national transition programme). These risks were recorded in the Corporate Risk Register and form part of the organisational development and transfer role of the Cluster.

vi. Performance risks – Covered by the annual report on risk management and monthly performance reports to both the Board and the Joint Audit Committee. These risks were recorded in the corporate risk register and formed part of the strategic planning and commissioning decisions.

Risks in all these areas were recorded in directorate risk registers and fed into the corporate risk register.

Using the reports detailed above, and regular performance update reports, these risk areas were monitored regularly by:

- The board
- The Joint Audit Committee
- The Finance and Performance Committee
- The Quality Committee

- The Executive Team
- The Commissioning Development and Transition Committee
- The Commissioning Committee

Risk management awareness and the purpose of assessment and monitoring of risk and the organisation's appetite for the risk categories were embedded in the activity of the organisation at all levels through:

- Including risk and residual risk rating in business cases, board reports/papers relating to all development proposals and all performance reports, corporate and team objectives;
- The development of directorate risk registers in all services and sites informed by risk assessments carried out by staff trained and competent to assess both physical and geographical risks posed by location and client group;
- The development of action plans to address risks identified and monitoring mechanisms to ensure key controls are effective.

Risk themes for 2012/13

Organisational risks identified can be summarised by the following themes:

- The ability of the organisation to maintain staff resources especially in key positions due to instability within the NHS;
- The effect of the transition agenda on achieving PCT and integrated commissioning forecast savings;
- The achievement of financial balance at year end;
- The protection of key assets including information assets during the transition phase;
- Breaching nationally issued targets on healthcare acquired infections;
- The development of the Commissioning Support Service and its leadership;
- The ability to develop and support emerging CCGs while delivering PCT objectives;
- Loss of key skills as Public Health and CCGs evolved through transition.

These risks were continually monitored to ensure they were mitigated as far as possible. Additionally, the board, Joint Audit Committee and the Executive Team reviewed the risks to ensure the internal controls are robust.

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

A review of effectiveness is informed in a number of ways. The Company Secretary and the Director of Finance Stewardship and Governance had responsibility for the overall arrangements for gaining assurance through the Assurance Framework and on controls reviewed as part of the internal audit work. Executive Directors within the

organisation also shared the responsibility for the development and maintenance of the system of internal control.

South Coast Audit were appointed as the internal auditor for the clustered PCTs and were asked to provide an Opinion on the effectiveness of the system for internal control, including the Board Assurance Framework and underpinning risk management processes for the 2012/13 period.

The approach taken by the auditors was to complete a high level assessment of the controls and processes that inform the Assurance Framework and Risk Management processes and confirm that these processes were effective from an operational perspective. The auditors also assessed if the board was fulfilling its responsibility to ensure there is an effective system of internal control in place.

Following the audit, South Coast Audit were able to provide significant assurance that there were effective systems of internal control, including the Board Assurance Framework and underpinning risk management processes in place.

The audit did not identify any significant issues and gave assurance on risk management processes and internal control.

Other reviews included our information governance toolkit assessment verified by internal audit, clinical audits and “deep dives” carried out by the Director of Nursing and Quality.

Reliance was placed upon these indicators during the reporting period.

6. Significant Issues

There are no significant issues to disclose.

My review confirms that the PCT has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

Felicity Cox

Chief Executive NHS Kent and Medway, and Director Kent and Medway, NHS England

Auditor's Report

INDEPENDENT AUDITOR'S REPORT TO THE DEPARTMENT OF HEALTH'S FINANCE SIGNING OFFICER IN RESPECT OF MEDWAY PCT

We have examined the summary financial statement for the year ended 31 March 2013 which comprises the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes on staff sickness and compliance with the Better Payment Practice Code.

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

Respective responsibilities of finance signing officer and auditor

The finance signing officer is responsible for preparing the Annual Report.

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

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

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

Opinion

In our opinion the summary financial statement is consistent with the statutory financial statements of Medway PCT for the year ended 31 March 2013.

Robert Grant (senior statutory auditor
for and on behalf of BDO LLP, statutory auditor
London, UK Date

Remuneration Report

Salaries and Allowances
A. Net Cost to Medway PCT
(Where posts are shared with other PCTs, only the share relevant to Medway PCT is shown below)

Name and title		Contract of service dated	Date of Leaving	2012-13 Salary (bands of £5,000) £000	2012-13 Other remuneration (bands of £5,000) £000	2012-13 Bonus Payments (bands of £5,000) £000	2012-13 Benefits in kind (rounded to the nearest £100) £00	2011-12 Salary (bands of £5,000) £000	2011-12 Other remuneration (bands of £5,000) £000	2011-12 Bonus Payments (bands of £5,000) £000	2011-12 Benefits in kind (rounded to the nearest £100) £00
Colin Tomson	Cluster Chairman	01.06.11		5 - 10			1	5 - 10			1
Graham Mayes	Non Executive Director	01.04.10	30.07.12	0 - 5				0 - 5			
David Mayes	Non Executive Director	01.03.10		0 - 5				0 - 5			1
Adrian Hosford	Non Executive Director	11.01.12		0 - 5				0 - 5			
Mike Cosgrove	Non Executive Director	11.01.12		0 - 5				0 - 5			
Dr Harshad Topiwala	Non Executive Director	11.01.12		0 - 5			1	0 - 5			1
Jill Ruddock	Non Executive Director	11.01.12		0 - 5			1	0 - 5			1
David Lewis	Non Executive Director	11.01.12		0 - 5			1	0 - 5			
Trevor Cooper	Board Adviser	17.02.03		5 - 10				5 - 10			
Gillian Wells	Board Adviser	01.04.10		5 - 10				5 - 10			
Ann Sutton ↕	Chief Executive	01.04.11	30.9.12	20 - 25				20 - 25			1
Felicity Cox ⚔	Chief Executive	01.10.12									
Helen Buckingham	Deputy Chief Executive and Director of Whole Systems Commissioning	01.03.09		15 - 20				15 - 20			
Dr Alison Barnett	Director of Public Health	03.03.08		135 - 140			4	135 - 140			4
Dr Peter Green	Medical Director (Quality Assurance, Information Intelligence and Technology) and Medway CCG Accountable Officer	13.10.03		15 - 20				10 - 15	0 - 5		1
Dr Robert Stewart	Medical Director and Director of Clinical Commissioning	01.06.11		20 - 25				20 - 25	0 - 5		
Dr James Thallon	Medical Director (Primary care)	01.06.11		15 - 20			2	15 - 20			2
Jonathan Bates	Director of Financial Stewardship and Governance	13.11.06		15 - 20				15 - 20			1
Bill Jones	Director of Financial Performance and Contracting	19.09.11		15 - 20	0 - 5		6	15 - 20	0 - 5		
Rod Smith	Director of Financial Strategy and Planning	19.09.11		15 - 20				15 - 20			-
Daryl Robertson	Director of Performance and Assurance	01.06.11		20 - 25			4	15 - 20			
Hazel Carpenter	Director of Commissioning Development and Workforce and Thanet and South Kent Coast CCGs' Accountable Officer	01.04.11		15 - 20			5	15 - 20			
Sarah Andrews	Director of Nursing and Quality	01.04.11		15 - 20	0 - 5			15 - 20	0 - 5		
Sally Allum	Interim Director of Nursing and Quality			5 - 10	0 - 5						
Jude Mackenzie	Director of Citizen Engagement and Communications	05.10.11		5 - 10				5 - 10			

↕ Seconded to the National Commissioning Board with effect from October 2012
⚔ On secondment from NHS Bedfordshire and Luton

	2012-13	2011-12
Band of Highest Paid Director's Total Remuneration (£'000)	135 - 140	135 - 140
Median Total	£ 25,528	£ 22,676
Remuneration Ratio	5.47	6.06

Benefits in kind relate to the amount paid by the PCT in respect of expenses claims, which is in excess of the amount nationally agreed by the Inland Revenue

Remuneration waived by directors and allowances paid in lieu
£0 (2011-12, £5 - £10,000) remuneration was waived by 0 (2011-12, 1) director.
£0 (2011-12, £0) of allowances were paid in lieu to 0 (2011-12, 0) directors.

Salaries and Allowances
B. Gross Cost of posts
(Where posts are shared with other PCTs, the full cost of the post is shown below. Posts are shared Eastern & Coastal Kent PCT 46.24%, Medway PCT 15.86% and West Kent PCT 37.90%)

Name and title		Contract of service dated	Date of Leaving	2012-13 Salary (bands of £5,000)	2012-13 Other remuneration (bands of £5,000)	2012-13 Bonus Payments (bands of £5,000)	2012-13 Benefits in kind (rounded to the nearest £100)	2011-12 Salary (bands of £5,000)	2011-12 Other remuneration (bands of £5,000)	2011-12 Bonus Payments (bands of £5,000)	2011-12 Benefits in kind (rounded to the nearest £100)
				£000	£000	£000	£00	£000	£000	£000	£00
Colin Tomson	Chairman	01.06.11		40 - 45			4	40 - 45			5
Graham Mayes	Non Executive Director	01.04.10	31.07.12	0 - 5			1	10 - 15			1
David Mayes	Non Executive Director	01.03.10		5 - 10			1	5 - 10			3
Adrian Hosford	Non Executive Director	11.01.12		5 - 10				5 - 10			1
Mike Cosgrove	Non Executive Director	11.01.12		5 - 10			2	5 - 10			0
Dr Harshad Topiwala	Non Executive Director	11.01.12		5 - 10			6	10 - 15			6
Jill Ruddock	Non Executive Director	11.01.12		5 - 10			9	5 - 10			4
David Lewis	Non Executive Director	11.01.12		10 - 15			3	10 - 15			1
Ann Sutton ↕	Chief Executive	01.04.11	30.09.12	145 - 150				145 - 150			5
Felicity Cox ⚔	Chief Executive	01.10.12									
Helen Buckingham	Deputy Chief Executive and Director of Whole Systems Commissioning	01.03.09		105 - 110				100 - 105			2
Dr Peter Green	Medical Director (Quality Assurance, Information Inteligence and Technology) and Medway CCG Accountable Officer	13.10.03		110 - 115			3	90 - 95	10 - 15		5
Dr Robert Stewart	Medical Director and Director of Clinical Commissioning	01.06.11		130 - 135				130 - 135	10 - 15		
Dr James Thallon	Medical Director (Primary care)	01.06.11		105 - 110			14	105 - 110			14
Jonathan Bates	Director of Financial Stewardship and Governance	13.11.06		100 - 105				95 - 100			4
Bill Jones	Director of Financial Performance and Contracting	19.09.11		95 - 100	5 - 10		41	95 - 100	5 - 10		
Rod Smith	Director of Financial Strategy and Planning	19.09.11		110 - 115				110 - 115			0
Daryl Robertson	Director of Performance and Assurance	01.06.11		125 - 130			25	110 - 115			12
Hazel Carpenter	Director of Commissioning Development and Workforce and Thanet and South Kent Coast CCGs' Accountable Officer	01.04.11		95 - 100			32	95 - 100			
Sarah Andrews	Director of Nursing and Quality	01.04.11		95 - 100	0 - 5		3	95 - 100	0 - 5		1
Sally Allum	Interim Director of Nursing and Quality			60 - 65	0 - 5						
Jude Mackenzie	Director of Citizen Engagement and Communications	05.10.11		55 - 60				60 - 65			

↕ Seconded to the National Commissioning Board with effect from October 2012
⚔ On secondment from NHS Bedfordshire and Luton

C. 2012/13 Pension Benefits

Name and title		Real increase in pension at age 60 (bands of £2,500)	Real increase in lump Sum at aged 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	Employer's contribution to stakeholder pension (rounded to nearest £00)
		£000	£000	£000	£000	£000	£000	£000	£
Ann Sutton	Chief Executive	(0 - 2.5)	(2.5 - 5)	60 - 65	185 - 190	1,278	1,203	13	
Felicity Cox ⋇	Chief Executive								
Helen Buckingham	Deputy Chief Executive and Director of Whole Systems Commissioning	0-2.5	0-2.5	25 - 30	75 - 80	381	352	11	-
Dr Alison Barnett	Director of Public Health	2.5 - 5.0	7.5 - 10.0	40 - 45	120 - 125	765	662	65	-
Jonathan Bates	Director of Financial Stewardship and Governance	0-2.5	0-2.5	20 - 25	60 - 65	417	383	14	-
Bill Jones	Director of Financial Performance and Contracting	0 - 2.5	2.5 - 5	20 - 25	70 - 75	539	464	51	-
Rod Smith	Director of Financial Strategy and Planning	(0 - 2.5)	(0 - 2.5)	35 - 40	110 - 115	700	655	10	-
Daryl Robertson	Director of Performance and Assurance	5 - 7.5	20 - 22.5	45 - 50	135 - 140	955	773	142	
Hazel Carpenter	Director of Commissioning Development and Workforce and Thanet and South Kent Coast CCGs' Accountable Officer	(0 - 2.5)	(0 - 2.5)	25 - 30	80 - 85	406	377	6	-
Sarah Andrews	Director of Nursing and Quality	(0 - 2.5)	(0 - 2.5)	30 - 35	90 - 95	n/a	n/a	n/a	-
Jude Mackenzie *	Director of Citizen Engagement and Communications	-	-	-	-	-	-	-	-
Sally Allum	Interim Director of Nursing and Quality	0 - 2.5	2.5 - 5	25 - 30	80 - 85	442	385	25	-

* Jude Mackenzie is not members of the NHS Pension Scheme

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

Cash Equivalent Transfer Values

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

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

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

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation and contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement). The CETV at 31 March 2013 has been calculated using the most recent (November 2012) actuarial factors produced by the Government Actuary's Department. This is a departure from the NHS Manual for Accounts, which requires common market valuation factors to be used for the start and end of the period.

Policy on the Remuneration of Senior Managers

The VSM Pay Framework introduces new arrangements that were implemented in 06/07.
The total reward package for very senior managers includes:
- Basic Pay: A spot rate for the post
- Additional payments where appropriate
- An Annual performance bonus scheme

No performanace bonuses were given to Exceutive Directors in the last financial year.
All Senior Managers are on permanent contracts and the notice periods do not exceed 6 months

D. Reporting of other compensation schemes - exit packages

2012/13

Exit package cost band (including any special payment element)	*Number of compulsory redundancies Number	*Cost of compulsory redundancies £000s	Number of other departures agreed Number	Cost of other departures agreed £000s	Total number of exit packages Number	Total cost of exit packages £000s	Number of departures where special payments have been made Number	Cost of special payment element included in exit packages £000s
Less than £10,000	9	46	0	0	9	0	0	0
£10,001 - £25,000	9	160	0	0	9	0	0	0
£25,001 - £50,000	3	122	0	0	3	0	0	0
£50,001 - £100,000	3	228	0	0	3	0	0	0
£100,001 - £150,000	3	342	0	0	3	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	**27.00**	**898**	**0.00**	**0**	**27.00**	**0**	**0.00**	**0**

2011/12

Exit package cost band (including any special payment element)	*Number of compulsory redundancies Number	*Cost of compulsory redundancies £000s	Number of other departures agreed Number	Cost of other departures agreed £000s	Total number of exit packages Number	Total cost of exit packages £000s	Number of departures where special payments have been made Number	Cost of special payment element included in exit packages £000s
Less than £10,000	0	0	0	0	0.00	0	0	0
£10,001 - £25,000	0	0	0	0	0.00	0	0	0
£25,001 - £50,000	0	0	0	0	0.00	0	0	0
£50,001 - £100,000	0	0	0	0	0.00	0	0	0
£100,001 - £150,000	0	0	0	0	0.00	0	0	0
£150,001 - £200,000	0	0	0	0	0.00	0	0	0
>£200,000	0	0	0	0	0.00	0	0	0
Total	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**

* This note provides an analysis of Exit Packages agreed during the year

Statement of Comprehensive Net Expenditure for year ended 31 March 2013

	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure		
Gross employee benefits	13,245	11,686
Other costs	473,664	466,868
Income	(25,627)	(34,324)
Net operating costs before interest	461,282	444,230
Investment income	(162)	(82)
Other (Gains)/Losses	(13)	16
Finance costs	1,845	1,741
Net operating costs for the financial year	462,952	445,905
Transfers by absorption -(gains)	0	0
Transfers by absorption - losses	0	0
Net (gain)/loss on transfers by absorption	0	0
Net Operating Costs for the Financial Year including absorption transfers	462,952	445,905
Of which:		
Administration Costs		
Gross employee benefits	5,413	4,933
Other costs	4,983	6,061
Income	(127)	(260)
Net administration costs before interest	10,269	10,734
Investment income	0	0
Other (Gains)/Losses	0	0
Finance costs	0	0
Net administration costs for the financial year	10,269	10,734
Programme Expenditure		
Gross employee benefits	7,832	6,753
Other costs	468,681	460,807
Income	(25,500)	(34,064)
Net programme expenditure before interest	451,013	433,496
Investment income	(162)	(82)
Other (Gains)/Losses	(13)	16
Finance costs	1,845	1,741
Net programme expenditure for the financial year	452,683	435,171

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	878	247
Net (gain) on revaluation of property, plant & equipment	(1,176)	(1,636)
Net (gain) on revaluation of intangibles	0	0
Net (gain) on revaluation of financial assets	0	0
Net (gain)/loss on other reserves	0	0
Net (gain)/loss on available for sale financial assets	0	0
Net (gain) /loss on Assets Held for Sale	0	0
Release of Reserves to Statement of Comprehensive Net Expenditure	0	0
Net actuarial (gain)/loss on pension schemes	0	0
Reclassification Adjustments		
Reclassification adjustment on disposal of available for sale financial assets	0	0
Total comprehensive net expenditure for the year*	462,654	444,516

Statement of Financial Position at 31 March 2013

	31 March 2013	31 March 2012
	£000	£000
Non-current assets:		
Property, plant and equipment	**43,835**	45,536
Intangible assets	**224**	185
investment property	**0**	0
Other financial assets	**625**	628
Trade and other receivables	**0**	1,142
Total non-current assets	**44,684**	47,491
Current assets:		
Inventories	**0**	0
Trade and other receivables	**4,458**	5,641
Other financial assets	**0**	0
Other current assets	**0**	0
Cash and cash equivalents	**785**	81
Total current assets	**5,243**	5,722
Non-current assets held for sale	**350**	680
Total current assets	**5,593**	6,402
Total assets	**50,277**	53,893
Current liabilities		
Trade and other payables	**(24,329)**	(30,568)
Other liabilities	**0**	0
Provisions	**(3,134)**	(514)
Borrowings	**(566)**	(629)
Other financial liabilities	**0**	0
Total current liabilities	**(28,029)**	(31,711)
Non-current assets plus/less net current assets/liabilities	**22,248**	22,182
Non-current liabilities		
Trade and other payables	0	(1,142)
Other Liabilities	0	0
Provisions	(1,502)	(1,615)
Borrowings	(18,712)	(19,278)
Other financial liabilities	0	0
Total non-current liabilities	**(20,214)**	(22,035)
Total Assets Employed:	**2,034**	147
Financed by taxpayers' equity:		
General fund	(7,541)	(9,758)
Revaluation reserve	9,575	9,905
Other reserves	0	0
Total taxpayers' equity:	**2,034**	147

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

	General fund	Revaluation reserve	Other reserves	Total reserves
	£000	£000	£000	£000
Balance at 1 April 2012	**(9,758)**	**9,905**	**0**	**147**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(462,952)	0	0	**(462,952)**
Net gain on revaluation of property, plant, equipment	0	1,176	0	**1,176**
Net gain on revaluation of intangible assets	0	0	0	**0**
Net gain on revaluation of financial assets	0	0	0	**0**
Net gain on revaluation of assets held for sale	0	0	0	**0**
Impairments and reversals	0	(878)	0	**(878)**
Movements in other reserves	0	0	0	**0**
Transfers between reserves	628	(628)	0	**0**
Release of Reserves to SOCNE	0	0	0	**0**
Reclassification Adjustments				
Transfers between Revaluation Reserve & General Fund in respect of assets transferred under absorption	0	0	0	**0**
Net actuarial gain/(loss) on pensions	0	0	0	**0**
Total recognised income and expense for 2012-13	**(462,324)**	**(330)**	**0**	**(462,654)**
Net Parliamentary funding	464,541	0	0	**464,541**
Balance at 31 March 2013	**(7,541)**	**9,575**	**0**	**2,034**

Balance at 1 April 2011	**-3,141**	**8,932**	**0**	**5,791**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(445,905)	0	0	(445,905)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment	0	1,636	0	1,636
Net Gain / (loss) on Revaluation of Intangible Assets	0	0	0	0
Net Gain / (loss) on Revaluation of Financial Assets	0	0	0	0
Net Gain / (loss) on Assets Held for Sale	0	0	0	0
Impairments and Reversals	0	(247)	0	(247)
Movements in other reserves	0	0	0	0
Transfers between reserves	416	(416)	0	0
Release of Reserves to Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification Adjustments				
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0	0
On disposal of available for sale financial assets	0	0	0	0
Net actuarial gain/(loss) on pensions	0	0	0	0
Total recognised income and expense for 2011-12	(445,489)	973	0	(444,516)
Net Parliamentary funding	438,872	0	0	438,872
Balance at 31 March 2012	**(9,758)**	**9,905**	**0**	**147**

Statement of cash flows for the year ended 31 March 2013

	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities		
Net Operating Cost Before Interest	**(461,282)**	(444,230)
Depreciation and Amortisation	**3,357**	3,324
Impairments and Reversals	**359**	869
Other Gains / (Losses) on foreign exchange	**0**	0
Donated Assets received credited to revenue but non-cash	**0**	0
Government Granted Assets received credited to revenue but non-cash	**0**	0
Interest Paid	**(1,697)**	(1,650)
Release of PFI/deferred credit	**0**	0
(Increase)/Decrease in Inventories	**0**	0
(Increase)/Decrease in Trade and Other Receivables	**2,325**	4,608
(Increase)/Decrease in Other Current Assets	**0**	0
Increase/(Decrease) in Trade and Other Payables	**(7,640)**	43
(Increase)/Decrease in Other Current Liabilities	**0**	0
Provisions Utilised	**(360)**	(341)
Increase/(Decrease) in Provisions	**2,688**	1
Net Cash Inflow/(Outflow) from Operating Activities	**(462,250)**	**(437,376)**
Cash flows from investing activities		
Interest Received	**162**	82
(Payments) for Property, Plant and Equipment	**(1,692)**	(1,484)
(Payments) for Intangible Assets	**(35)**	(8)
(Payments) for Other Financial Assets	**0**	0
(Payments) for Financial Assets (LIFT)	**0**	0
Proceeds of disposal of assets held for sale (PPE)	**603**	509
Proceeds of disposal of assets held for sale (Intangible)	**0**	0
Proceeds from Disposal of Other Financial Assets	**0**	0
Proceeds from the disposal of Financial Assets (LIFT)	**3**	2
Loans Made in Respect of LIFT	**0**	0
Loans Repaid in Respect of LIFT	**0**	0
Rental Revenue	**0**	0
Net Cash Inflow/(Outflow) from Investing Activities	**(959)**	**(899)**
Net cash inflow/(outflow) before financing	**(463,209)**	**(438,275)**
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**(628)**	(574)
Net Parliamentary Funding	**464,541**	438,872
Capital Receipts Surrendered	**0**	0
Capital grants and other capital receipts	**0**	0
Cash Transferred (to)/from Other NHS Bodies (free text note required)	**0**	0
Net Cash Inflow/(Outflow) from Financing Activities	**463,913**	**438,298**
Net increase/(decrease) in cash and cash equivalents	**704**	**23**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**81**	**58**
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies	**0**	0
Cash and Cash Equivalents (and Bank Overdraft) at year end	**785**	**81**

Department of Health

NHS

Medway Primary Care Trust

2012-13 Accounts

Published to gov.uk, in PDF format only.

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Medway Primary Care Trust

2012-13 Accounts

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: Felicity Cox

Date 4 June 2013

2012-13 Annual Accounts of Medway 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.

4 June 2013 Date.....Signing Officer

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

GOVERNANCE STATEMENT

Medway Primary Care Trust

1. Scope of responsibility

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

In particular the Accountable Officer Memorandum also assigns the Accountable Officer responsibility for:

- The propriety and regularity of NHS finances;
- The keeping of proper accounting books and records;
- Prudent, efficient and effective administration;
- The avoidance of waste and extravagance;
- The efficient and effective use of all resources within the charge of the Accountable Officer;
- Ensuring managers at all levels have a clear view of their objectives, the means to assess achievement against those objectives, and the information and training to exercise their responsibilities effectively.

I have ensured that a robust integrated governance framework is embedded within the PCT which is aligned with Department of Health guidance and established best practice.

The Memorandum also places responsibility on the Accountable Officer for developing and maintaining key relationships, which include:

- Local communities through public meetings and the publishing of annual reports and accounts;
- Patients through the PCT's Local Involvement Networks (LINks) and the Customer Services Team;
- The South of England Strategic Health Authority through regular meetings and forums;
- Partners through the Integrated Plan Board and through a range of service and care specific committees and working groups;
- Local authorities through developing Health and Well Being Boards and the appointment of co-opted members from the Local Authority to the Cluster Board;
- Other PCT Clusters through joint commissioning arrangements.

The context in which risk within the organisation is managed takes into consideration the stakeholders listed above.

The Accountable Officer is able to monitor and fulfil the commitments placed on the role by:

- Regular reporting to the Board by both clinical and operational management teams;
- The Joint Audit Committee;
- The Finance and Performance Committee;
- The implementation of a Risk Management Policy/Strategy agreed by the Board which clearly defines roles and responsibilities in relation to Risk Management at all levels from the Chief Executive to front line staff and addresses both clinical and non-clinical risk;
- The Health and Safety Committee;
- The Quality Committee which incorporates Clinical Governance;
- Regular briefings to the South of England Strategic Health Authority;
- The process of Internal and External Audit;
- The use of the Assurance Framework to manage principal risks associated with key objectives together with a dashboard displaying corporate objective performance.

Internal audit annually produce an overall Opinion on the effectiveness of the systems of internal control. In addition there have been a number of audits carried out on the key functions and systems that directly contribute to their maintenance of the Accountable Officer responsibilities. These audits include:

- Board Assurance Framework and underpinning risk management arrangements – for the Kent and Medway cluster
- Core Financial Systems at the PCT
- Payroll analysis – for the Kent and Medway cluster
- Payroll systems – non routine payments – for the Kent and Medway cluster
- Serious Incident Reporting – for the Kent and Medway cluster
- Human Resources systems – business cases (for redundancy) – for the Kent and Medway cluster
- Dental contracts – for the Kent and Medway cluster
- Prescribing budgets – for the Kent and Medway cluster
- Information Governance Toolkit – for the Kent and Medway cluster
- Transfer of information to successor bodies – for the Kent and Medway cluster
- Disposal of IT/information assets – for the Kent and Medway cluster

An audit recommendation action list to ensure the learning from these reviews is embedded into any system changes or redesigns is held and reviewed by the Kent and Medway Joint Audit Committee. The Joint Audit Committee was chaired by a Non-Executive Director.

2. The governance framework of the organisation

The Cluster Board

Membership of the Cluster Board comprised the Cluster Chair and a further six Cluster Non-Executive Directors and six voting Cluster Executive Directors, as follows:-

- Cluster Chair;
- Six other Cluster Non-Executive Directors drawn (two each) from each of the PCT's Chairs or Non-Executive Directors
- The Cluster Chief Executive

- The Cluster Directors of Finance (together having one vote)
- The Medical Director of each of the PCTs (together having one vote)
- The Cluster Director of Nursing and Quality
- The Cluster Director of Whole Systems Commissioning
- The Cluster Director of Performance and Assurance
- The Cluster Directors of Public Health (together having one vote)

Additionally the following members of the Cluster Executive Team were designated as non voting members of the Cluster Board:

- The Cluster Director of Commissioning Development and Workforce
- The Cluster Director of Communications and Citizen Engagement

The Assistant Chief Executive and Company Secretary were also members of the Cluster Executive Team and attended Board meetings.

The Cluster Board met in public at least bi-monthly.

The Cluster Board focused on strategic issues whilst assuring itself of the performance of the whole Cluster. It achieved a balance by:

- Long range Board agenda planning – coordinated by the Company Secretary with input from the Cluster Executive Team and Chairman;
- Regular Board Development sessions to cover key strategic and development issues;
- Monthly Non-Executive Director meetings to discuss key topical and strategic issues chaired by the Chairman with the Chief Executive and Company Secretary in attendance.

Board Committees

To support the Cluster Board in carrying out its duties effectively, sub-committees reporting to the Cluster Board were formally established. Each sub-committee received a set of regular reports, as outlined within their terms of reference and provided summary reports to the Cluster Board after each meeting.

The main committees of the Cluster Board were:-

- Joint Audit Committee
- Joint Remuneration and Terms of Service Committee
- Joint Quality Committee
- Commissioning Committee
- Finance and Performance Committee
- Commissioning Development and Transition Committee

Joint Audit Committee

The Committee was established as a joint sub-committee of the Cluster Board. The Committee met at least three times a year and otherwise as required.

The Audit Committee's primary role was to oversee the adequacy and effective operation of the overall internal control system supporting each PCT in the Cluster. The Audit Committee independently monitored, reviewed and reported to the Cluster Board on the process of governance and, where appropriate, facilitated and

supported, through its independence, the attainment of effective processes. The Audit Committee was charged with monitoring the effectiveness of internal control systems on behalf of the Board and did so as part of its annual work programme and through reporting to the Cluster Board after each of its meetings. Additionally the Committee was required to provide assurance that robust Risk Management arrangements were in place throughout the Trust and that they were working effectively.

The membership of the Audit Committee comprised two Chairs (until 15 June 2012 when one of the Chairs resigned) and one member from each of West Kent PCT, Eastern and Coastal Kent PCT and Medway PCT. The Cluster Chief Executive was invited to attend the Audit Committee, at least annually, to discuss the process for assurance that supports the Annual Governance Statement.

The Director of Finance Stewardship and Governance was normally present at each meeting of the Audit Committee, together with representatives from Internal and External Audit and Counter Fraud Services.

Joint Remuneration and Terms of Service Committee

In line with the requirements of the NHS Codes of Conduct and Accountability, the PCT was required to constitute a Remuneration Committee. The Committee as established as a joint Non Executive sub-committee of the Cluster Board. The Committee met at least twice a year.

The Committee's purpose was to determine the remuneration and conditions of service of the Cluster Chief Executive, Cluster Executives and other Cluster Directors with Board responsibility who reported directly to the Chief Executive ensuring that these properly support the objectives of the Cluster and/or relevant PCT, represented value for money and complied with statutory requirements.

The Remuneration and Terms of Service Committee followed an annual work programme and reported annually to the Cluster Board.

Quality Committee

The purpose of the Quality Committee was to ensure that the Cluster Board delivered its statutory responsibilities for care quality through transition, including the domains of safety, effectiveness and patient experience.

The Quality Committee was delegated by the Cluster Board to undertake specific duties and provide assurance to the Cluster Board that:

- A Quality In Transition Plan is developed and delivered in line with the *Shared Cluster Operating Model for PCT Clusters* (published August 2011);
- The services commissioned on behalf of the local community are safe, are of a consistently high standard and responsive to patient needs and experiences;
- The commissioned services meet the necessary standards of quality specified in Care Quality Commission (CQC) registration requirements, standard contracts, professional guidance, the NHS Operating Framework and other relevant sources;

- The commissioned services, including rebalanced commissioned services maintain quality standards and drive improvements in health outcomes within available resources;
- There are robust contract monitoring arrangements for all providers in place, using hard and soft intelligence so that any serious failures are prevented or identified at an early stage and resolved;
- The CQC, the SHA Cluster and providers themselves are immediately notified where performance monitoring identifies signs of non–compliance with registration requirements;
- Any unresolved provider performance concerns are comprehensively documented in legacy documents for successor organisations;
- That providers have good clinical governance (effectiveness) processes, patient safety frameworks and methods to capture and act upon patient experience and feedback;
- That providers are reporting incidents appropriately and implementing the learning from analysis of incident data;
- That there is a culture of open and honest cooperation so that staff, patients and the public are pro-actively listened to in order to understand their concerns and the experiences;
- That there are safe arrangements in place for the provision of a safe and effective system wide workforce;
- That any concerns with the conduct and professional performance of independent contractors registered on the Cluster PCTs' Medical, Dental and Optical Performers Lists are identified and managed.

Commissioning Committee

The purpose of this Committee was to ensure that the PCT was able to deliver its strategic commissioning objectives by specifically ensuring that:

- The goals and initiatives outlined in the PCT's Strategic Commissioning Plan are developed and delivered in accordance with the Operating Framework and the four key strategic drivers outlined in the White Paper: Equity and Excellence: Liberating the NHS namely:

1. Putting patients and public first
2. Improving healthcare outcomes
3. Autonomy, accountability and democratic legitimacy
4. Cutting bureaucracy and improving efficiency

The Committee worked with other committees of the Cluster Board to achieve high quality, financially viable services meeting all quality, innovation, productivity and prevention challenges (QIPP). In undertaking this work the Committee ensured that it had oversight of risks to delivery of the Operational Plan, the Strategic Commissioning Plan and the Cluster's strategic objectives. This Committee reported specific assurances determined in the Assurance Framework. The Committee was responsible for the governance and clinical leadership through transition to Clinical Commissioning Groups including organisational development, role design and staffing to ensure delivery of the Operational Plan during and after transition including strategic development within the financial resources available.

Finance and Performance Committee

The Finance and Performance Committee provided the Cluster Board with assurance that all financial and performance issues were being identified, progressed regularly and that appropriate actions were in place to deliver the standards required. Specifically, the Committee monitored delivery of Clinical Commissioning Group work stream plans and progress against the integrated plan for the PCT including the QIPP programme.

Commissioning Development and Transition Committee

The purpose of the Commissioning Development and Transition Committee was to ensure that the Cluster delivered its Commissioning Development Plan (CDP) across the Cluster and to provide assurance to the Cluster Board in this respect. The Committee had responsibility for:

- Coordinating and facilitating the links between the Commissioning Development work streams, the Strategic Health Authority Cluster, Local Authorities and other stakeholders and ensure alignment and convergence of local, regional and national work streams;
- Coordinating and facilitating the links between commissioning delivery and developmental new commissioning architecture to enable safe transition to Clinical Commissioning Groups by March 2013;
- Reviewing monthly updates and guidance from the SHA Regional Commissioning Development Board and Local Government Association ensuring that the controls and mitigations to managing transition risks are in place and adequate;
- Reviewing monthly delivery and performance from each work programme through reporting from the Programme Management Office (who have responsibility for tracking delivery of the CDP).

Clinical Commissioning Groups (CCGs)

On 25 January 2012 the Cluster PCT Boards approved the establishment of emerging Clinical Commissioning Groups as committees of the relevant PCT Board for the following areas-

- Ashford
- Canterbury and Coastal (C4G)
- Dartford, Gravesham and Swanley
- Medway
- South Kent Coast (Deal, Dover and Shepway)
- West Kent (Maidstone and Malling and West Kent)
- Thanet
- Swale

Terms of Reference for each CCG, a Memorandum of Understanding and a detailed Scheme of Delegation were also approved by the PCT Boards thereby creating the governance required for full delegation of commissioning budgets, required nationally in April 2012, to allow a full year of shadow operation for emerging CCGs.

Attendance at the Cluster Board and Committee meetings

Committee	Average attendance of members
Cluster Board	79%
Joint Audit Committee	53%
Joint Remuneration Committee	67%
Joint Quality Committee	53%
Commissioning Committee	67%
Finance and Performance Committee	85%
Commissioning Development and Transition Committee	66%

Corporate Governance

The UK Corporate Governance Code is a guide to a number of key components of effective Board practice. It is based on the underlying principles of all good governance: accountability, transparency, probity and focus on the sustainable success of an entity over the longer term. The PCT and Cluster adhere to the principles set out in the UK Corporate Governance Code in the following ways.

Leadership

The PCT and Cluster is headed by an effective Board which is collectively responsible for the long-term success of the PCT and Cluster. There is a clear division of responsibilities between the running of the Board and the executive responsibility for the running of the Cluster's and PCT's business. No one individual has unfettered powers of decision and decision making powers are clearly governed by the PCT's Standing Orders and Standing Financial Instructions, Terms of Reference of individual committees and schemes of delegation.

The Chairman is independently appointed by the Appointments Commission and is responsible for leadership of the Board and ensuring its effectiveness on all aspects of its role. As part of their role as members of a unitary board, Non-Executive Directors constructively challenge and help develop proposals on strategy.

Effectiveness

The Board and its committees have the appropriate balance of skills, experience, independence and knowledge to enable them to discharge their respective duties and responsibilities effectively.

There is a formal, rigorous and transparent procedure for the appointment of new directors to the Board which is managed independently for Non-Executive Directors by the Appointments Commission.

Non-Executive Directors' and Board Advisors' portfolios of committee memberships are carefully managed by the Chairman to reflect their areas of special interest and expertise and to ensure that they are able to allocate sufficient time to discharge their responsibilities effectively. All directors receive a programme of induction on joining the Board and regularly update and refresh their skills and knowledge through a formal process of appraisal and identification of training and personal development needs. Board papers are supplied in a timely manner, with minimum timescales for receipt of papers set out in the PCT's Standing Orders. Board papers are prepared with information in a form and of a quality appropriate to enable the Board to discharge its duties.

All Directors are subject to annual performance review.

Non-Executive Directors are subject to re-appointment processes every three years subject to continued satisfactory performance.

Accountability
The Board considers that it presents a balanced and understandable assessment of the PCT's position and prospects. The Board is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives. The Board maintains sound risk management and internal control systems. The Board has established formal and transparent arrangements for considering how they should apply risk management and internal control principles and for maintaining an appropriate relationship with the PCT's auditor.

Remuneration
Remuneration for all Directors is set by reference to national pay rates. No Director is involved in deciding his or her remuneration.

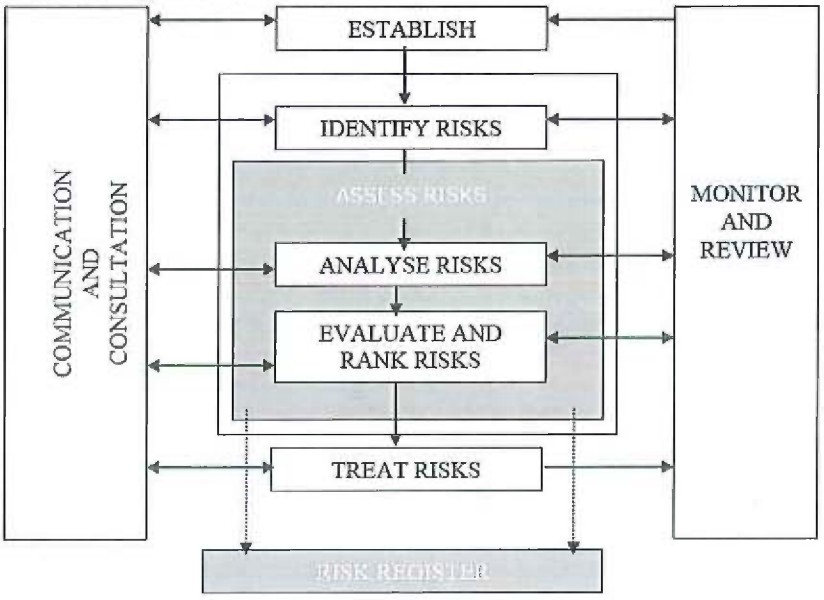
3. Risk assessment

The organisation has implemented an integrated Risk Management Strategy to ensure there is a systematic and consistent approach to risk management throughout the organisation. It is important to ensure that risks are identified, assessed, controlled and dealt with at the appropriate management level.

The organisation recognises that risk management has to function in an environment in which the risk appetite and type are defined and this has shaped the development of the risk management model.

Following risk identification and assessment, risks are then categorised by their type of risk or the key business driver that may affect the delivery of an objective(s). An individual risk appetite exists for each category and these along with the risk profile for the organisation were set following consultation with the Executive Team and the Non-Executive Directors.

Risk management model



The organisation expects to see risk management in all parts of the organisation's operation and the absence of risk is not considered to be positive.

4. The risk and control framework

The risk management process is designed to identify the principal risks to the achievement of the organisation's objectives; to evaluate the nature and extent of those risks and determine the organisation's appetite for those risks; and to manage them efficiently, effectively and economically. The PCT's risk management system covers six types of risks and controls:

i. Patient Safety/Quality/Prevention risks – Covered by the Quality Committee report to the Board and recorded in the Quality risk register. Executive accountability for clinical risk management resides with the Director of Nursing and Quality.

ii. Compliance and Legislation risks – Covered by the annual report on risk management and recorded in the Assurance Framework, and Corporate Objectives report. Executive accountability for organisational risks rests ultimately with the Chief Executive.

iii. Financial risks - Covered by the annual report on risk management and recorded in the Assurance Framework and Corporate Objectives report. Financial Risks are also reported in Finance Reports to the Board, the Finance and Performance Committee and the Joint Audit Committee. Executive accountability for financial risk management rests with the Director of Finance Stewardship and Governance.

iv. Risks to the delivery of the operating plan- (risks which will impact on the achievement of corporate objectives) – Covered by the annual report on risk management and the Annual Governance Statements. These risks are also recorded in the Assurance Framework. Risk assessment forms part of all strategic policy decisions.

v. Transition/Cluster risks – (risks which will impact on the achievement of the national transition programme). These risks are recorded in the Corporate Risk Register and form part of the organisational development and transfer role of the Cluster.

vi. Performance risks – Covered by the annual report on risk management and monthly performance reports to both the Board and the Joint Audit Committee. These risks are recorded in the Corporate Risk Register and form part of the strategic planning and commissioning decisions.

Risks in all these areas are recorded in directorate risk registers and feed into the corporate risk register.

Using the reports detailed above, and regular performance update reports, these risk areas are monitored regularly by:

- The Board
- The Joint Audit Committee
- The Finance and Performance Committee

- The Quality Committee
- The Executive Team
- The Commissioning Development and Transition Committee
- The Commissioning Committee

Risk management awareness and the purpose of assessment and monitoring of risk and the organisation's appetite for the risk categories are embedded in the activity of the organisation at all levels through:

- Including risk and residual risk rating in business cases, Board reports/papers relating to all development proposals and all performance reports, corporate and team objectives;
- The development of directorate risk registers in all services and sites informed by risk assessments carried out by staff trained and competent to assess both physical and geographical risks posed by location and client group;
- The development of action plans to address risks identified and monitoring mechanisms to ensure key controls are effective.

Risk themes for 2012/13

Organisational risks identified can be summarised by the following themes:

- The ability of the organisation to maintain staff resources especially in key positions due to instability within the NHS;
- The effect of the transition agenda on achieving PCT and integrated commissioning forecast savings;
- The achievement of financial balance at year end;
- The protection of key assets including information assets during the transition phase;
- Breaching nationally issued targets on Healthcare Acquired infections;
- The development of the Commissioning Support Unit and its leadership;
- The ability to develop and support emerging CCGs whilst delivering PCT objectives;
- Loss of key skills as Public Health and CCGs evolve through transition.

These risks were continually monitored to ensure they were mitigated as far as possible. Additionally, the Board, Joint Audit Committee and the Executive Team reviewed the risks to ensure the internal controls are robust.

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

A review of effectiveness is informed in a number of ways. The Company Secretary and the Director of Finance Stewardship and Governance had responsibility for the overall arrangements for gaining assurance through the Assurance Framework and on controls reviewed as part of the internal audit work. Executive Directors within the organisation also shared the responsibility for the development and maintenance of the system of internal control.

South Coast Audit were appointed as the internal auditor for the clustered PCTs and were asked to provide an Opinion on the effectiveness of the system for internal control, including the Board Assurance Framework and underpinning risk management processes for the 2012/13 period.

The approach taken by the auditors was to complete a high level assessment of the controls and processes that inform the Assurance Framework and Risk Management

processes and confirm that these processes were effective from an operational perspective. The auditors also assessed if the Board was fulfilling its responsibility to ensure there is an effective system of internal control in place.

Following the audit South Coast Audit were able to provide significant assurance that there are effective systems of internal control, including the Board Assurance Framework and underpinning risk management processes in place.

The audit did not identify any significant issues and made only minor recommendations relating to the reporting of the progress made against action plans.

Other reviews include our information governance toolkit assessment verified by internal audit, clinical audits and "deep dives" carried out by the Director of Nursing and Quality.

Reliance upon these indicators has been placed during the reporting period.

6. Significant Issues

There are no significant issues to disclose.

My review confirms that the PCT has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

Felicity Cox
Signing Officer

Independent auditor's report to the Accountable Officer for Medway Primary Care Trust

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

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

- the table of salaries and allowances of senior managers (pages 56 and 57)
- the table of pension benefits of senior managers (page 56)
- the table of pay multiples (page 58)

This report is made solely to the Accountable Officer for Medway 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.

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 Medway 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 Primary Care Trust'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;
- the work of other relevant regulatory bodies or inspectorates, to the extent that the results of this work impact on our responsibilities at the Trust; and
- our locally determined risk-based work.

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 Medway 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.

Robert Grant (senior statutory auditor)
for and on behalf of BDO LLP, statutory auditor
London, UK

6 June 2013

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Statement of Comprehensive Net Expenditure for year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure			
Gross employee benefits	7.1	**13,245**	11,686
Other costs	5.1	**473,664**	466,868
Income	4	**(25,627)**	(34,324)
Net operating costs before interest		**461,282**	444,230
Investment income	9	**(162)**	(82)
Other (Gains)/Losses	10	**(13)**	16
Finance costs	11	**1,845**	1,741
Net operating costs for the financial year		**462,952**	445,905
Transfers by absorption -(gains)		**0**	0
Transfers by absorption - losses		**0**	0
Net (gain)/loss on transfers by absorption		**0**	0
Net Operating Costs for the Financial Year including absorption transfers		**462,952**	**445,905**
Of which:			
Administration Costs			
Gross employee benefits	7.1	**5,413**	4,933
Other costs	5.1	**4,983**	6,061
Income	4	**(127)**	(260)
Net administration costs before interest		**10,269**	**10,734**
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**0**	0
Net administration costs for the financial year		**10,269**	**10,734**
Programme Expenditure			
Gross employee benefits	7.1	**7,832**	6,753
Other costs	5.1	**468,681**	460,807
Income	4	**(25,500)**	(34,064)
Net programme expenditure before interest		**451,013**	**433,496**
Investment income	9	**(162)**	(82)
Other (Gains)/Losses	10	**(13)**	16
Finance costs	11	**1,845**	1,741
Net programme expenditure for the financial year		**452,683**	**435,171**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**878**	247
Net (gain) on revaluation of property, plant & equipment	**(1,176)**	(1,636)
Net (gain) on revaluation of intangibles	**0**	0
Net (gain) on revaluation of financial assets	**0**	0
Net (gain)/loss on other reserves	**0**	0
Net (gain)/loss on available for sale financial assets	**0**	0
Net (gain) /loss on Assets Held for Sale	**0**	0
Release of Reserves to Statement of Comprehensive Net Expenditure	**0**	0
Net actuarial (gain)/loss on pension schemes	**0**	0
Reclassification Adjustments		
Reclassification adjustment on disposal of available for sale financial assets	**0**	0
Total comprehensive net expenditure for the year*	**462,654**	**444,516**

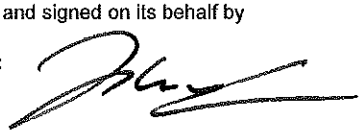
*This is the sum of the rows above plus net operating costs for the financial year after absorption accounting adjustments.
The notes on pages 5 to 47 form part of this account.

Statement of Financial Position at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	12	**43,835**	45,536
Intangible assets	13	**224**	185
investment property	15	**0**	0
Other financial assets	21	**625**	628
Trade and other receivables	19	**0**	1,142
Total non-current assets		**44,684**	47,491
Current assets:			
Inventories	18	**0**	0
Trade and other receivables	19	**4,458**	5,641
Other financial assets	21	**0**	0
Other current assets	22	**0**	0
Cash and cash equivalents	23	**785**	81
Total current assets		**5,243**	5,722
Non-current assets held for sale	24	**350**	680
Total current assets		**5,593**	6,402
Total assets		**50,277**	53,893
Current liabilities			
Trade and other payables	25	**(24,329)**	(30,568)
Other liabilities	26,28	**0**	0
Provisions	30	**(3,134)**	(514)
Borrowings	27	**(566)**	(629)
Other financial liabilities	28	**0**	0
Total current liabilities		**(28,029)**	(31,711)
Non-current assets plus/less net current assets/liabilities		**22,248**	22,182
Non-current liabilities			
Trade and other payables	25	0	(1,142)
Other Liabilities	28	0	0
Provisions	30	(1,502)	(1,615)
Borrowings	27	(18,712)	(19,278)
Other financial liabilities	28	0	0
Total non-current liabilities		**(20,214)**	(22,035)
Total Assets Employed:		**2,034**	147
Financed by taxpayers' equity:			
General fund		(7,541)	(9,758)
Revaluation reserve		9,575	9,905
Other reserves		0	0
Total taxpayers' equity:		**2,034**	147

The notes on pages 5 to 47 form part of this account.

The financial statements on pages 1 to 4 were approved by the Department of Health Sub Committee for Kent & Medway on 4 June 2013 and signed on its behalf by

Signing Officer:  Date: 4.6.2013

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

	General fund	Revaluation reserve	Other reserves	Total reserves
	£000	£000	£000	£000
Balance at 1 April 2012	**(9,758)**	**9,905**	**0**	**147**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(462,952)	0	0	**(462,952)**
Net gain on revaluation of property, plant, equipment	0	1,176	0	**1,176**
Net gain on revaluation of intangible assets	0	0	0	**0**
Net gain on revaluation of financial assets	0	0	0	**0**
Net gain on revaluation of assets held for sale	0	0	0	**0**
Impairments and reversals	0	(878)	0	**(878)**
Movements in other reserves	0	0	0	**0**
Transfers between reserves	628	(628)	0	**0**
Release of Reserves to SOCNE	0	0	0	**0**
Reclassification Adjustments				
Transfers between Revaluation Reserve & General Fund in respect of assets transferred under absorption	0	0	0	**0**
Net actuarial gain/(loss) on pensions	0	0	0	**0**
Total recognised income and expense for 2012-13	**(462,324)**	**(330)**	**0**	**(462,654)**
Net Parliamentary funding	464,541	0	0	**464,541**
Balance at 31 March 2013	**(7,541)**	**9,575**	**0**	**2,034**
Balance at 1 April 2011	**-3,141**	**8,932**	**0**	**5,791**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(445,905)	0	0	(445,905)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment	0	1,636	0	1,636
Net Gain / (loss) on Revaluation of Intangible Assets	0	0	0	0
Net Gain / (loss) on Revaluation of Financial Assets	0	0	0	0
Net Gain / (loss) on Assets Held for Sale	0	0	0	0
Impairments and Reversals	0	(247)	0	(247)
Movements in other reserves	0	0	0	0
Transfers between reserves	416	(416)	0	0
Release of Reserves to Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification Adjustments				
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0	0
On disposal of available for sale financial assets	0	0	0	0
Net actuarial gain/(loss) on pensions	0	0	0	0
Total recognised income and expense for 2011-12	(445,489)	973	0	(444,516)
Net Parliamentary funding	438,872	0	0	438,872
Balance at 31 March 2012	**(9,758)**	**9,905**	**0**	**147**

Statement of cash flows for the year ended 31 March 2013

	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities		
Net Operating Cost Before Interest	**(461,282)**	(444,230)
Depreciation and Amortisation	**3,357**	3,324
Impairments and Reversals	**359**	869
Other Gains / (Losses) on foreign exchange	**0**	0
Donated Assets received credited to revenue but non-cash	**0**	0
Government Granted Assets received credited to revenue but non-cash	**0**	0
Interest Paid	**(1,697)**	(1,650)
Release of PFI/deferred credit	**0**	0
(Increase)/Decrease in Inventories	**0**	0
(Increase)/Decrease in Trade and Other Receivables	**2,325**	4,608
(Increase)/Decrease in Other Current Assets	**0**	0
Increase/(Decrease) in Trade and Other Payables	**(7,640)**	43
(Increase)/Decrease in Other Current Liabilities	**0**	0
Provisions Utilised	**(360)**	(341)
Increase/(Decrease) in Provisions	**2,688**	1
Net Cash Inflow/(Outflow) from Operating Activities	**(462,250)**	**(437,376)**
Cash flows from investing activities		
Interest Received	**162**	82
(Payments) for Property, Plant and Equipment	**(1,692)**	(1,484)
(Payments) for Intangible Assets	**(35)**	(8)
(Payments) for Other Financial Assets	**0**	0
(Payments) for Financial Assets (LIFT)	**0**	0
Proceeds of disposal of assets held for sale (PPE)	**603**	509
Proceeds of disposal of assets held for sale (Intangible)	**0**	0
Proceeds from Disposal of Other Financial Assets	**0**	0
Proceeds from the disposal of Financial Assets (LIFT)	**3**	2
Loans Made in Respect of LIFT	**0**	0
Loans Repaid in Respect of LIFT	**0**	0
Rental Revenue	**0**	0
Net Cash Inflow/(Outflow) from Investing Activities	**(959)**	**(899)**
Net cash inflow/(outflow) before financing	**(463,209)**	**(438,275)**
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**(628)**	(574)
Net Parliamentary Funding	**464,541**	438,872
Capital Receipts Surrendered	**0**	0
Capital grants and other capital receipts	**0**	0
Cash Transferred (to)/from Other NHS Bodies	**0**	0
Net Cash Inflow/(Outflow) from Financing Activities	**463,913**	**438,298**
Net increase/(decrease) in cash and cash equivalents	**704**	**23**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**81**	**58**
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies	**0**	0
Cash and Cash Equivalents (and Bank Overdraft) at year end	**785**	**81**

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.

Under the provisions of *The Health and Social Care Act 2012 (Commencement No.4. Transitional, Savings and Transitory Provisions) Order 2013,* Medway PCT was dissolved on 1st April 2013. The PCT's functions, assets and liabilities transferred to other public sector entities as outlined in Note 41 *Events after the Reporting Period*. Where reconfigurations of this nature take place within the public sector, Government accounting requires that the activities concerned are to be considered as continuing operations, and so the closing entity prepares accounts on a "going concern" basis.

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

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.

The PCT has considered how to account for operating leases and LIFT schemes. Operating leases were considered individually using the criteria set out in IAS17 to determine whether they should be accounted for as Operating Leases or Finance Leases.

LIFT schemes were assessed for accounting treatment under IFRIC 12 and it was concluded from that assessment that that the four schemes should be treated as assets of the Trust.

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

Details of the calculation of asset values are set out in Notes 1.7 to 1.10. Details of asset lives and the indexation methodology employed are set out and further information is included in Note 12. The fixed assets were revalued by the District Valuer as at 31 March 2013, and the resulting change in valuation was posted to the Revaluation Reserve, where adequate reserve existed, or to revenue where it did not.

The PCT has also assessed the value of provisions relating to matters where there has been an Obligating Event, but where the value is uncertain. The total value of provisions held is £4.6m, of which the majority relates to pension provisions and provisions for retrospective claims for Continuing Health Care. These provisions are disbursed through payments over a number of years, and are not expected to have any significant impact on any future year.

A provision for retrospective claims for continuing Health Care was established following a national campaign to raise awareness of arrangements for patients to reclaim a proportion of these costs. A Cluster-wide process (covering Eastern & Coastal Kent PCT, Medway PCT and West Kent PCT) was led by an appropriately qualified senior officer to assess the claims and calculate the required provision. Although there are inherent uncertainties in assessing final outcomes, all claims have been considered for provision based on information provided by claimants and the judgement of trained continuing care professionals experienced in assessing claims. Estimate calculations for individual claims have taken into account the value of the claim and the probability of the claim being successful. Where necessary, further supporting information has been requested from claimants, and in some cases this information has not yet been received. No claim is unassessed and no contingent liabilities have been identified

1. Accounting policies (continued)

1.2 Revenue and Funding

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

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

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

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

1.3 Care Trust Designation

Medway PCT is not designated a Care Trust.

1.4 Pooled budgets

The PCT no longer has any pooled budgets. The last pooled budget finished on 31 March 2011.

1.5 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.

1.6 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 classified to "programme" under Treasury budgetary control arrangements and so is recorded as such in the financial statements

1. Accounting policies (continued)

1.7 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)

1.8 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.

1.9 Depreciation, amortisation and impairments

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

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

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

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

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

1. Accounting policies (continued)

1.10 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.

1.11 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.

1.12 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.

1.13 Cash and cash equivalents

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

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

1.14 Losses and Special Payments

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

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

1.15 Clinical Negligence Costs

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

The NHSLA operates a risk pooling scheme under which the PCT pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure in the year that it is due. The total value of clinical negligence provisions carried by the NHSLA on behalf of the PCT is disclosed at Note 32.

1. Accounting policies (continued)

1.17 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: although staff were not allowed to carry leave forward to successor bodies, an exception was made for staff on maternity leave or long term sickness absence.

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.

1.18 Other expenses

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

1.19 Grant making

Under section 256 of the National Health Service Act 2006, the 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. Accounting policies (continued)

1.22 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.

1.23 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. No finance leases have been identified by the PCT.

The PCT as lessee

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

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.

1.24 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.

1.25 Provisions

Provisions are recognised when the PCT has a present legal or constructive obligation as a result of a past event, it is probable that the PCT will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.2% (2.8% in respect of early staff departures) in real terms.

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

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

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

1. Accounting policies (continued)

1.26 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.

Financial assets at fair value through profit and loss

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

Held to maturity investments

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

Available for sale financial assets

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

Loans and receivables

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

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

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

At the Statement of Financial Position date, the 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.

1. Accounting policies (continued)

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.

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

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.

1.27 Private Finance Initiative (PFI) and NHS LIFT transactions

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

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:
a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

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

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

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

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

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

1. Accounting policies (continued)

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

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

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

c) Lifecycle replacement
Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the PCT's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

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

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

1. Accounting policies (continued)

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

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

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

2 Operating segments

The PCT has two main functions, to commission primary care services from GP practices, dental surgeries, pharmacies and opticians, and secondly, to commission secondary and tertiary health services from NHS bodies and others.

These form two distinct segments which are regularly reported to the Board or its sub committee.

The Provider segment reported on in previous years is now included under the secondary and tertiary health segment subsequent to the transfer of Provider Services to Medway Community Healthcare CIC from April 2011.

The most significant external providers, each amounting to more than approximately 10% of total expenditure, are Medway NHS Foundation Trust, where, during 2012/13, services costing £146m, were commissioned, and Medway Community Healthcare CIC, where services costing £41m were commissioned.

	Primary Care		Commissioning		Total	
	2012-13	2011-12	**2012-13**	2011-12	**2012-13**	2011-12
	£000	£000	**£000**	£000	**£000**	£000
Income						
Income	**0**	0	**367,038**	351,434	**367,038**	351,434
Revenue from other segments	**100,538**	98,967	**0**	0	**100,538**	98,967
Miscellaneous income	**3,196**	3,065	**22,431**	31,259	**25,627**	34,324
	103,734	102,032	**389,469**	382,693	**493,203**	484,725
Surplus/(Deficit)						
Segment surplus/(deficit)	**0**	0	**0**	0	**0**	0
Common costs	**(101,827)**	(101,061)	**(385,082)**	(377,493)	**(486,909)**	(478,554)
Surplus/(deficit) before interest	**1,907**	**971**	**4,387**	5,200	**6,294**	6,171
Net Assets:						
Segment net assets	**(8,128)**	(6,017)	**30,376**	6,164	**22,248**	147

3. Financial Performance Targets

3.1 Revenue Resource Limit

	2012-13 £000	2011-12 £000
The PCTs' performance for the year ended 31 March 2013 is as follows:		
Total Net Operating Cost for the Financial Year	**462,952**	445,905
Net operating cost plus (gain)/loss on transfers by absorption	**462,952**	445,905
Adjusted for prior period adjustments in respect of errors	**0**	0
Revenue Resource Limit	**467,576**	450,401
Under/(Over)spend Against Revenue Resource Limit (RRL)	4,624	4,496

2011-12 performance data has not been adjusted in respect of restated items and remains as shown in the 2011-12 published accounts.
This reflects the way in which PCT performance is recorded by the Department.

3.2 Capital Resource Limit

	2012-13 £000	2011-12 £000
The PCT is required to keep within its Capital Resource Limit.		
Capital Resource Limit	**1,578**	2,291
Charge to Capital Resource Limit	**1,426**	957
(Over)/Underspend Against CRL	**152**	**1,334**

3.3 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**464,541**	438,872
Cash Limit	**466,841**	443,922
Under/(Over)spend Against Cash Limit	**2,300**	**5,050**

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

	2012-13 £000
Total cash received from DH (Gross)	402,514
Less: Trade Income from DH	0
Less/(Plus): movement in DH working balances	0
Sub total: net advances	**402,514**
(Less)/plus: transfers (to)/from other resource account bodies (free text note required)	0
Plus: cost of Dentistry Schemes (central charge to cash limits)	13,787
Plus: drugs reimbursement (central charge to cash limits)	48,240
Parliamentary funding credited to General Fund	**464,541**

4 Miscellaneous Revenue

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Fees and Charges	**0**	0	0	0
Dental Charge income from Contractor-Led GDS & PDS	**3,196**	0	3,196	3,065
Dental Charge income from Trust-Led GDS & PDS	**0**	0	0	4
Prescription Charge income	**2,144**	0	2,144	2,539
Strategic Health Authorities	**624**	31	593	200
NHS Trusts	**1,014**	59	955	807
NHS Foundation Trusts	**0**	0	0	79
Primary Care Trusts Contributions to DATs	**0**	0	0	0
Primary Care Trusts - Other	**3,572**	19	3,553	2,077
Primary Care Trusts - Lead Commissioning	**9,194**	0	9,194	20,988
English RAB Special Health Authorities	**0**	0	0	0
NDPBs and Others (CGA)	**0**	0	0	0
Department of Health - SMPTB	**0**	0	0	0
Department of Health - Other	**678**	0	678	678
Recoveries in respect of employee benefits	**0**	0	0	0
Local Authorities	**353**	0	353	53
Patient Transport Services	**0**	0	0	0
Education, Training and Research	**17**	17	0	37
Non-NHS: Private Patients	**0**	0	0	0
Non-NHS: Overseas Patients (Non-Reciprocal)	**0**	0	0	0
NHS Injury Costs Recovery	**0**	0	0	0
Other Non-NHS Patient Care Services	**0**	0	0	0
Charitable and Other Contributions to Expenditure	**0**	0	0	99
Receipt of donated assets	**0**	0	0	0
Receipt of Government granted assets	**0**	0	0	0
Rental revenue from finance leases	**0**	0	0	0
Rental revenue from operating leases	**2,842**	0	2,842	2,930
Other revenue	**1,993**	1	1,992	768
Total miscellaneous revenue	**25,627**	**127**	**25,500**	**34,324**

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	**22,607**	0	22,607	17,472
Non-Healthcare	**1,250**	1,065	185	1,103
Total	**23,857**	**1,065**	**22,792**	**18,575**
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	**51,711**	562	51,149	51,065
Goods and services (other, excl Trusts, FT and PCT))	**378**	125	253	384
Total	**52,089**	**687**	**51,402**	**51,449**
Goods and Services from Foundation Trusts	**181,260**	225	181,035	173,400
Purchase of Healthcare from Non-NHS bodies	**73,597**	0	73,597	88,122
Social Care from Independent Providers	**0**	0	0	0
Expenditure on Drugs Action Teams	**2,385**	0	2,385	2,388
Non-GMS Services from GPs	**0**	0	0	0
Contractor Led GDS & PDS (excluding employee benefits)	**17,307**	0	17,307	15,795
Salaried Trust-Led PDS & PCT DS (excluding employee benefits)	**0**	0	0	0
Chair, Non-executive Directors & PEC remuneration	**494**	494	0	456
Executive committee members costs	**0**	0	0	0
Consultancy Services	**506**	300	206	511
Prescribing Costs	**42,610**	0	42,610	42,521
G/PMS, APMS and PCTMS (excluding employee benefits)	**34,485**	0	34,485	33,275
Pharmaceutical Services	**523**	0	523	423
Local Pharmaceutical Services Pilots	**0**	0	0	0
New Pharmacy Contract	**10,743**	0	10,743	10,812
General Ophthalmic Services	**2,178**	0	2,178	2,261
Supplies and Services - Clinical	**10,576**	11	10,565	9,978
Supplies and Services - General	**388**	3	385	185
Establishment	**1,694**	539	1,155	933
Transport	**57**	29	28	87
Premises	**6,205**	1,878	4,327	4,939
Impairments & Reversals of Property, plant and equipment	**259**	0	259	869
Impairments and Reversals of non-current assets held for sale	**100**	0	100	0
Depreciation	**3,214**	113	3,101	3,229
Amortisation	**143**	0	143	95
Impairment & Reversals Intangible non-current assets	**0**	0	0	0
Impairment and Reversals of Financial Assets	**0**	0	0	0
Impairment of Receivables	**(666)**	(666)	0	(193)
Inventory write offs	**0**	0	0	0
Research and Development Expenditure	**0**	0	0	0
Audit Fees	**109**	109	0	191
Other Auditors Remuneration	**22**	22	0	30
Clinical Negligence Costs	**72**	0	72	188
Education and Training	**250**	116	134	170
Grants for capital purposes	**396**	0	396	438
Grants for revenue purposes	**0**	0	0	0
Impairments and reversals for investment properties	**0**	0	0	0
Goods and services from Local Authorities	**5,700**	0	5,700	5,161
Provisions	**2,499**	0	2,499	10
Other	**612**	58	554	570
Total Operating costs charged to Statement of Comprehensive Net Expenditure	**473,664**	**4,983**	**468,681**	**466,868**
Employee Benefits (excluding capitalised costs)				
Employee Benefits associated with PCTMS	**0**	0	0	0
Trust led PDS and PCT DS	**0**	0	0	0
PCT Officer Board Members	**716**	544	172	740
Other Employee Benefits	**12,529**	4,869	7,660	10,946
Total Employee Benefits charged to SOCNE	**13,245**	**5,413**	**7,832**	**11,686**
Total Operating Costs	**486,909**	**10,396**	**476,513**	**478,554**
Analysis of grants reported in total operating costs				
For capital purposes				
Grants to fund Capital Projects - GMS	**396**	0	396	228
Grants to Local Authorities to Fund Capital Projects	**0**	0	0	0
Grants to Private Sector to Fund Capital Projects	**0**	0	0	0
Grants to Fund Capital Projects - Dental	**0**	0	0	210
Grants to Fund Capital Projects - Other	**0**	0	0	0
Total Capital Grants	**396**	**0**	**396**	**438**
Grants to fund revenue expenditure				
To Local Authorities	**0**	0	0	0
To Private Sector	**0**	0	0	0
To Other	**0**	0	0	0
Total Revenue Grants	**0**	**0**	**0**	**0**
Total Grants	**396**	**0**	**396**	**438**

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**10,269**	10,073	196
Weighted population (number in units)*	**259,900**	259,900	259,900
Running costs per head of population (£ per head)	**39.51**	**38.76**	**0.75**
PCT Running Costs 2011-12			
Running costs (£000s)	**10,734**	10,534	200
Weighted population (number in units)	**259,900**	259,900	259,900
Running costs per head of population (£ per head)	**41.30**	**40.53**	**0.77**

5.2 Analysis of operating expenditure by expenditure classification	2012-13 £000	2011-12 £000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	34,485	33,275
Prescribing costs	40,466	39,982
Contractor led GDS & PDS	17,307	15,795
Trust led GDS & PDS	0	0
General Ophthalmic Services	2,178	2,248
Department of Health Initiative Funding	0	0
Pharmaceutical services	523	423
Local Pharmaceutical Services Pilots	0	0
New Pharmacy Contract	10,743	10,812
Non-GMS Services from GPs	0	0
Other	0	0
Total Primary Healthcare purchased	**105,702**	102,535
Purchase of Secondary Healthcare		
Learning Difficulties	2,871	2,946
Mental Illness	32,392	33,630
Maternity	12,058	11,985
General and Acute	207,783	197,048
Accident and emergency	17,661	17,297
Community Health Services	48,591	47,230
Other Contractual	708	911
Total Secondary Healthcare Purchased	**322,064**	311,047
Grant Funding		
Grants for capital purposes	396	438
Grants for revenue purposes	0	0
Total Healthcare Purchased by PCT	**428,162**	**414,020**
Healthcare from NHS FTs included above	181,184	173,249

6. Operating Leases

The PCT leases office accommodation and equipment at market rents.

6.1 PCT as lessee

	Land £000	Buildings £000	Other £000	2012-13 Total £000	2011-12 £000
Payments recognised as an expense					
Minimum lease payments				**733**	1,037
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**733**	**1,037**
Payable:					
No later than one year	**1**	**440**	**9**	**450**	482
Between one and five years	**0**	**1,896**	**0**	**1,896**	1,773
After five years	**0**	**589**	**0**	**589**	1,093
Total	**1**	**2,925**	**9**	**2,935**	**3,348**
Total future sublease payments expected to be received				0	0

6.2 PCT as lessor

The PCT owns property, the majority of which is leased to local health care providers.

	2012-13 £000	2011-12 £000
Recognised as income		
Rental Revenue	**2,842**	2,930
Contingent rents	**0**	0
Total	**2842**	2,930
Receivable:		
No later than one year	**2,097**	1,941
Between one and five years	**3,576**	633
After five years	**264**	0
Total	**5,937**	2,574

7. Employee benefits and staff numbers

7.1 Employee benefits

2012-13								
				Permanently employed			Other	
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Employee Benefits - Gross Expenditure								
Salaries and wages	**10,406**	4,573	5,833	**9,449**	4,090	5,359	**957**	483	474
Social security costs	**773**	334	439	**773**	334	439	**0**	0	0
Employer Contributions to NHS BSA - Pensions Division	**1,169**	506	663	**1,169**	506	663	**0**	0	0
Other pension costs	**0**	0	0	**0**	0	0	**0**	0	0
Other post-employment benefits	**0**	0	0	**0**	0	0	**0**	0	0
Other employment benefits	**0**	0	0	**0**	0	0	**0**	0	0
Termination benefits	**897**	0	897	**897**	0	897	**0**	0	0
Total employee benefits	**13,245**	**5,413**	**7,832**	**12,288**	**4,930**	**7,358**	**957**	**483**	**474**
Less recoveries in respect of employee benefits (table below)	**0**	0	0	**0**	**0**	**0**	**0**	**0**	**0**
Total - Net Employee Benefits including capitalised costs	**13,245**	**5,413**	**7,832**	**12,288**	**4,930**	**7,358**	**957**	**483**	**474**
Employee costs capitalised	**0**	0	0	**0**	0	0	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**13,245**	**5,413**	**7,832**	**12,288**	**4,930**	**7,358**	**957**	**483**	**474**
Recognised as:									
Commissioning employee benefits	**13,245**			**12,288**			**957**		
Provider employee benefits	**0**			**0**			**0**		
Gross Employee Benefits excluding capitalised costs	**13,245**			**12,288**			**957**		

** There was no revenue in 2012/13 associated with employee benefits*

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	**9,804**	9,076	728
Social security costs	**734**	734	0
Employer Contributions to NHS BSA - Pensions Division	**1,148**	1,148	0
Other pension costs	**0**	0	0
Other post-employment benefits	**0**	0	0
Other employment benefits	**0**	0	0
Termination benefits	**0**	0	0
Total gross employee benefits	**11,686**	**10,958**	**728**
Less recoveries in respect of employee benefits	**0**	0	0
Total - Net Employee Benefits including capitalised costs	**11,686**	**10,958**	**728**
Employee costs capitalised	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**11,686**	**10,958**	**728**
Recognised as:			
Commissioning employee benefits	**11,686**		
Provider employee benefits	**0**		
Gross Employee Benefits excluding capitalised costs	**11,686**		

7.2 Staff Numbers

	2012-13			2011-12		
	Total Number	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number
Average Staff Numbers						
Medical and dental	**5**	5	0	**6**	6	0
Ambulance staff	**0**	0	0	**0**	0	0
Administration and estates	**174**	152	22	**174**	159	15
Healthcare assistants and other support staff	**3**	3	0	**11**	3	8
Nursing, midwifery and health visiting staff	**7**	7	0	**9**	9	0
Nursing, midwifery and health visiting learners	**0**	0	0	**0**	0	0
Scientific, therapeutic and technical staff	**10**	10	0	**7**	7	0
Social Care Staff	**0**	0	0	**0**	0	0
Other	**90**	88	2	**86**	86	0
TOTAL	**288**	**265**	**24**	**294**	**270**	**23**
Of the above - staff engaged on capital projects	**0**	0	0	**0**	0	0

Staff numbers for "other" staff have been calculated as at year-end and not on an average basis.

7.3 Staff Sickness absence and ill health retirements

	2012-13 Number	2011-12 Number
Total Days Lost	**2,551**	**11,080**
Total Staff Years	**425**	**1,280**
Average working Days Lost	6.00	8.66

7.4 Exit Packages agreed during 2012-13

	2012-13			2011-12		
Exit package cost band (including any special payment element)	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**
	Number	**Number**	**Number**	**Number**	**Number**	**Number**
Lees than £10,000	**9**	**0**	**9**	0	0	**0**
£10,001-£25,000	**9**	**0**	**9**	0	0	**0**
£25,001-£50,000	**3**	**0**	**3**	0	0	**0**
£50,001-£100,000	**3**	**0**	**3**	0	0	**0**
£100,001 - £150,000	**3**	**0**	**3**	0	0	**0**
>£150,001	**0**	**0**	**0**	0	0	**0**
Total number of exit packages by type (total cost	**27**	**0**	**27**	**0**	**0**	**0**
	£s	**£s**	**£s**	**£s**	**£s**	**£s**
Total resource cost	897,766	0	**897,766**	0	0	**0**

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

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

7.5 Pension costs

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

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) 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 to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2011, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data.

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) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

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.

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 statement of comprehensive income at the time the PCT commits itself to the retirement, regardless of the method of payment.

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

8. Better Payment Practice Code

8.1 Measure of compliance

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**12,729**	**112,047**	13,811	111,889
Total Non-NHS Trade Invoices Paid Within Target	**12,107**	**108,444**	12,788	108,146
Percentage of Non-NHS Trade Invoices Paid Within Target	95.11%	96.78%	92.59%	96.65%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**4,395**	**298,770**	4,700	288,095
Total NHS Trade Invoices Paid Within Target	**4,122**	**292,356**	3,901	283,804
Percentage of NHS Trade Invoices Paid Within Target	93.79%	97.85%	83.00%	98.51%

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

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

There were no claims made or costs incurred under this legislation in 2012/13 or 2011/12

9. Investment Income

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Rental Income				
PFI finance lease revenue (planned)	**0**	**0**	**0**	0
PFI finance lease revenue (contingent)	**0**	**0**	**0**	0
Other finance lease revenue	**0**	**0**	**0**	0
Subtotal	**0**	**0**	**0**	0
Interest Income				
LIFT: equity dividends receivable	**80**	**0**	**80**	0
LIFT: loan interest receivable	**82**	**0**	**82**	82
Bank interest	**0**	**0**	**0**	0
Other loans and receivables	**0**	**0**	**0**	0
Impaired financial assets	**0**	**0**	**0**	0
Other financial assets	**0**	**0**	**0**	0
Subtotal	**162**	**0**	**162**	82
Total investment income	**162**	**0**	**162**	82

10. Other Gains and Losses

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Gain/(Loss) on disposal of assets other than by sale (PPE)	**0**	**0**	**0**	(16)
Gain/(Loss) on disposal of assets other than by sale (intangibles)	**0**	**0**	**0**	0
Gain/(Loss) on disposal of Financial Assets - other than held for sale	**0**	**0**	**0**	0
Gain (Loss) on disposal of assets held for sale	**13**	**0**	**13**	0
Gain/(loss) on foreign exchange	**0**	**0**	**0**	0
Change in fair value of financial assets carried at fair value through the SoCNE	**0**	**0**	**0**	0
Change in fair value of financial liabilities carried at fair value through the SoCNE	**0**	**0**	**0**	0
Change in fair value of investment property	**0**	**0**	**0**	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	**0**	**0**	**0**	0
Total	**13**	**0**	**13**	(16)

11. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest				
Interest on obligations under finance leases	**0**	**0**	**0**	0
Interest on obligations under PFI contracts:				
- main finance cost	**0**	**0**	**0**	0
- contingent finance cost	**0**	**0**	**0**	0
Interest on obligations under LIFT contracts:				
- main finance cost	**1,297**	**0**	**1,297**	1,336
- contingent finance cost	**401**	**0**	**401**	314
Interest on late payment of commercial debt	**0**	**0**	**0**	0
Other interest expense	**0**	**0**	**0**	**0**
Total interest expense	**1,698**	**0**	**1,698**	**1,650**
Other finance costs	**0**	**0**	**0**	0
Provisions - unwinding of discount	**147**		**147**	91
Total	**1,845**	**0**	**1,845**	**1,741**

12.1 Property, plant and equipment

2012-13	Land	Buildings excluding dwellings	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000
Cost or valuation:						
At 1 April 2012	**6,925**	**36,373**	**1,191**	**5,481**	**827**	**50,797**
Additions of Assets Under Construction	0	0	0	0	0	**0**
Additions Purchased	0	1,294	0	540	0	**1,834**
Additions Donated	0	0	0	0	0	**0**
Additions Government Granted	0	0	0	0	0	**0**
Additions Leased	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	**0**
Reclassifications as Held for Sale	(106)	(254)	0	0	0	**(360)**
Disposals other than for sale	(46)	(2,378)	(1,139)	(3,089)	(146)	**(6,798)**
Upward revaluation/positive indexation	36	1,140	0	0	0	**1,176**
Impairments/negative indexation	(94)	(784)	0	0	0	**(878)**
Reversal of Impairments	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	**0**
At 31 March 2013	**6,715**	**35,391**	**52**	**2,932**	**681**	**45,771**
Depreciation						
At 1 April 2012	**0**	**0**	**967**	**3,810**	**484**	**5,261**
Reclassifications	0	0	0	0	0	**0**
Reclassifications as Held for Sale	0	0	0	0	0	**0**
Disposals other than for sale	(46)	(2,378)	(1,139)	(3,089)	(146)	**(6,798)**
Upward revaluation/positive indexation	0	0	0	0	0	**0**
Impairments	46	213	0	0	0	**259**
Reversal of Impairments	0	0	0	0	0	**0**
Charged During the Year	0	2,165	197	772	80	**3,214**
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	**0**
At 31 March 2013	**0**	**0**	**25**	**1,493**	**418**	**1,936**
Net Book Value at 31 March 2013	**6,715**	**35,391**	**27**	**1,439**	**263**	**43,835**
Purchased	6,315	34,661	27	1,439	263	**42,705**
Donated	400	730	0	0	0	**1,130**
Government Granted	0	0	0	0	0	**0**
Total at 31 March 2013	**6,715**	**35,391**	**27**	**1,439**	**263**	**43,835**
Asset financing:						
Owned	6,715	14,790	27	1,439	263	**23,234**
Held on finance lease	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	20,601	0	0	0	**20,601**
PFI residual: interests	0	0	0	0	0	**0**
Total at 31 March 2013	**6,715**	**35,391**	**27**	**1,439**	**263**	**43,835**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Plant & machinery	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	**1,639**	**8,069**	**29**	**3**	**32**	**9,772**
Movements	(88)	(86)	(29)	(3)	(7)	**(213)**
At 31 March 2013	**1,551**	**7,983**	**0**	**0**	**25**	**9,559**

12.2 Property, plant and equipment

	Land	Buildings excluding dwellings	Plant & machinery	Information technology	Furniture & fittings	Total
2011-12						
	£000	£000	£000	£000	£000	**£000**
Cost or valuation:						
At 1 April 2011	**7,350**	**37,868**	**1,191**	**4,979**	**827**	**52,215**
Additions - purchased	0	963	0	502	0	**1,465**
Additions - donated	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale	(437)	(960)	0	0	0	**(1,397)**
Disposals other than by sale	0	(742)	0	0	0	**(742)**
Revaluation & indexation gains	12	1,624	0	0	0	**1,636**
Impairments	0	(247)	0	0	0	**(247)**
Reversals of impairments	0	0	0	0	0	**0**
In-year transfers to/from NHS bodies	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluatio	0	(2,133)	0	0	0	**(2,133)**
At 31 March 2012	**6,925**	**36,373**	**1,191**	**5,481**	**827**	**50,797**
Depreciation						
At 1 April 2011	**0**	**0**	**824**	**3,021**	**385**	**4,230**
Reclassifications	0	0	0	0	0	**0**
Reclassifications as Held for Sale	(53)	(139)	0	0	0	**(192)**
Disposals other than for sale	0	(742)	0	0	0	**(742)**
Upward revaluation/positive indexation	0	0	0	0	0	**0**
Impairments	53	816	0	0	0	**869**
Reversal of Impairments	0	0	0	0	0	**0**
Charged During the Year	0	2,198	143	789	99	**3,229**
In-year transfers to/from NHS bodies	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluatio	0	(2,133)	0	0	0	**(2,133)**
At 31 March 2012	**0**	**0**	**967**	**3,810**	**484**	**5,261**
Net Book Value at 31 March 2012	**6,925**	**36,373**	**224**	**1,671**	**343**	**45,536**
Purchased	6,525	35,592	224	1,671	343	**44,355**
Donated	400	781	0	0	0	**1,181**
Government Granted	0	0	0	0	0	**0**
At 31 March 2012	**6,925**	**36,373**	**224**	**1,671**	**343**	**45,536**
Asset financing:						
Owned	6,925	15,476	224	1,671	343	**24,639**
Held on finance lease	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	20,897	0	0	0	**20,897**
PFI residual: interests	0	0	0	0	0	**0**
At 31 March 2012	**6,925**	**36,373**	**224**	**1,671**	**343**	**45,536**

12.3 Property, plant and equipment

Property assets were revalued as at 31 March 2013 by the District Valuer. LIFT assets were revalued at fair value; all other assets were revalued on the Modern Equivalent Asset basis.

The economic lives of the assets are set out below:

	Min life Years	Max life Years
Property, Plant and Equipment		
Buildings exc Dwellings	5	60
Plant & Machinery	5	15
Transport Equipment	7	7
Information Technology	3	15
Furniture and Fittings	10	10

13.1 Intangible non-current assets

2012-13	Software internally generated £000	Software purchased £000	Development expenditure £000	Total £000
At 1 April 2012	**0**	**910**	**0**	**910**
Additions - purchased	0	182	0	**182**
Additions - internally generated	0	0	0	**0**
Additions - donated	0	0	0	**0**
Additions - government granted	0	0	0	**0**
Additions Leased	0	0	0	**0**
Reclassifications	0	0	0	**0**
Reclassified as held for sale	0	0	0	**0**
Disposals other than by sale	0	(722)	0	**(722)**
Revaluation & indexation gains	0	0	0	**0**
Impairments	0	0	0	**0**
Reversal of impairments	0	0	0	**0**
In-year transfers to/from NHS bodies	0	0	0	**0**
At 31 March 2013	**0**	**370**	**0**	**370**
Amortisation				
At 1 April 2012	**0**	**725**	**0**	**725**
Reclassifications	0	0	0	**0**
Reclassified as held for sale	0	0	0	**0**
Disposals other than by sale	0	(722)	0	**(722)**
Revaluation or indexation gains	0	0	0	**0**
Impairments charged to operating expenses	0	0	0	**0**
Reversal of impairments charged to operating expenses	0	0	0	**0**
Charged during the year	0	143	0	**143**
In-year transfers to NHS bodies	0	0	0	**0**
At 31 March 2013	**0**	**146**	**0**	**146**
Net Book Value at 31 March 2013	**0**	**224**	**0**	**224**
Net Book Value at 31 March 2013 comprises				
Purchased	0	224	0	**224**
Donated	0	0	0	**0**
Government Granted	0	0	0	**0**
Total at 31 March 2013	**0**	**224**	**0**	**224**

Revaluation reserve balance for intangible non-current assets

	Software internally generated £000's	Software purchased £000's	Development expenditure £000's	Total £000's
At 1 April 2012	**0**	**0**	**0**	**0**
Movements (specify)	0	0	0	**0**
At 31 March 2013	**0**	**0**	**0**	**0**

13.2 Intangible non-current assets

2011-12	Software internally generated	Software purchased	Development expenditure	Total
	£000	£000	£000	£000
At 1 April 2011	**0**	**891**	**0**	**891**
Additions - purchased	0	19	0	**19**
Additions - internally generated	0	0	0	**0**
Additions - donated	0	0	0	**0**
Additions - government granted	0	0	0	**0**
Reclassifications	0	0	0	**0**
Reclassified as held for sale	0	0	0	**0**
Disposals other than by sale	0	0	0	**0**
Revaluation & indexation gains	0	0	0	**0**
Impairments	0	0	0	**0**
Reversal of impairments	0	0	0	**0**
In-year transfers to/from NHS bodies	0	0	0	**0**
Cumulative dep netted off cost following revaluation	0	0	0	**0**
At 31 March 2012	**0**	**910**	**0**	**910**
Amortisation				
At 1 April 2011	**0**	**630**	**0**	**630**
Reclassifications	0	0	0	**0**
Reclassified as held for sale	0	0	0	**0**
Disposals other than by sale	0	0	0	**0**
Revaluation or indexation gains	0	0	0	**0**
Impairments charged to operating expenses	0	0	0	**0**
Reversal of impairments charged to operating expenses	0	0	0	**0**
Charged during the year	0	95	0	**95**
In-year transfers to NHS bodies	0	0	0	**0**
Less cumulative dep written down on revaluation	0	0	0	**0**
At 31 March 2012	**0**	**725**	**0**	**725**
Net Book Value at 31 March 2012	**0**	**185**	**0**	**185**
Net Book Value at 31 March 2012 comprises				
Purchased	0	185	0	**185**
Donated	0	0	0	**0**
Government Granted	0	0	0	**0**
Total at 31 March 2012	**0**	**185**	**0**	**185**

13.3 Intangible non-current assets

Intangible non-current assets relate to purchased software. This is held at amortised purchase cost.

Economic Lives of Intangible Non-Current Assets

	Min Life Years	Max Life Years
Intangible Assets		
Software Licences	3	5
Development Expenditure	0	0

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

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000
Property, Plant and Equipment impairments and reversals taken to SoCNE			
Loss or damage resulting from normal operations	0	0	0
Over-specification of assets	0	0	0
Abandonment of assets in the course of construction	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen obsolescence	0	0	0
Loss as a result of catastrophe	0	0	0
Other	0	0	0
Changes in market price	259	0	259
Total charged to Annually Managed Expenditure	**259**	**0**	**259**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Loss or damage resulting from normal operations	0	0	0
Over Specification of Assets	0	0	0
Abandonment of assets in the course of construction	0	0	0
Unforeseen obsolescence	0	0	0
Loss as a result of catastrophe	0	0	0
Other	0	0	0
Changes in market price	878	0	878
Total impairments for PPE charged to reserves	**878**	**0**	**878**
Total Impairments of Property, Plant and Equipment	**1,137**	**0**	**1,137**
Intangible assets impairments and reversals charged to SoCNE			
Loss or damage resulting from normal operations	0	0	0
Over-specification of assets	0	0	0
Abandonment of assets in the course of construction	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen obsolescence	0	0	0
Loss as a result of catastrophe	0	0	0
Other	0	0	0
Changes in market price	0	0	0
Total charged to Annually Managed Expenditure	**0**	**0**	**0**
Intangible Assets impairments and reversals charged to the Revaluation Reserve			
Loss or damage resulting from normal operations	0	0	0
Over-specification of assets	0	0	0
Abandonment of assets in the course of construction	0	0	0
Unforeseen obsolescence	0	0	0
Loss as a result of catastrophe	0	0	0
Other	0	0	0
Changes in market price	0	0	0
Total impairments for Intangible Assets charged to Reserves	**0**	**0**	**0**
Total Impairments of Intangibles	**0**	**0**	**0**

14. Analysis of impairments and reversals recognised in 2012-13 (contd)	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000
Financial Assets charged to SoCNE			
Loss or damage resulting from normal operations	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Loss as a result of catastrophe	0	0	0
Other	0	0	0
Total charged to Annually Managed Expenditure	**0**	**0**	**0**
Financial Assets impairments and reversals charged to the Revaluation Reserve			
Loss or damage resulting from normal operations	0	0	0
Loss as a result of catastrophe	0	0	0
Other	0	0	0
TOTAL impairments for Financial Assets charged to reserves	**0**	**0**	**0**
Total Impairments of Financial Assets	**0**	**0**	**0**
Non-current assets held for sale - impairments and reversals charged to SoCNE.			
Loss or damage resulting from normal operations	0	0	0
Abandonment of assets in the course of construction	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen obsolescence	0	0	0
Loss as a result of catastrophe	0	0	0
Other	0	0	0
Changes in market price	100	0	100
Total charged to Annually Managed Expenditure	**100**	**0**	**100**
Total impairments of non-current assets held for sale	**100**	**0**	**100**
Inventories - impairments and reversals charged to SoCNE			
Loss or Damage Resulting from Normal Operations	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen Obsolescence	0	0	0
Loss as a Result of a Catastrophe	0	0	0
Other (Free text note required)*	0	0	0
Changes in Market Price	0	0	0
Total charged to Annually Managed Expenditure	**0**	**0**	**0**
Total impairments of Inventories	**0**	**0**	**0**
Investment Property impairments charged to SoCNE			
Loss or Damage Resulting from Normal Operations	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen Obsolescence	0	0	0
Loss as a Result of a Catastrophe	0	0	0
Other (Free text note required)*	0	0	0
Changes in Market Price	0	0	0
Total charged to Annually Managed Expenditure	**0**	**0**	**0**
Total Investment Property impairments charged to SoCNE	**0**	**0**	**0**
Investment Property impairments and reversals charged to the Revaluation Reserve			
Loss or Damage Resulting from Normal Operations	0	0	0
Over Specification of Assets	0	0	0
Abandonment of Assets in the Course of Construction	0	0	0
Unforeseen Obsolescence	0	0	0
Loss as a Result of a Catastrophe	0	0	0
Other (Free text note required)*	0	0	0
Changes in Market Price	0	0	0
TOTAL impairments for Investment Property charged to Reserves	**0**	0	0
Total Investment Property Impairments	**0**	**0**	**0**
Total Impairments charged to Revaluation Reserve	878	0	0
Total Impairments charged to SoCNE - DEL	0	0	0
Total Impairments charged to SoCNE - AME	359	0	359
Overall Total Impairments	**1,237**	**0**	**359**
Of which:			
Impairment on revaluation to "modern equivalent asset" basis	**0**	0	0
Donated and Gov Granted Assets, included above -			
PPE - Donated and Government Granted Asset Impairments: amount charged to SoCNE -DEL*	0	0	0
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SoCNE - AME*	0	0	0

15 Investment Property

The PCT does hold any property for investment purposes

16 Commitments

The PCT has not entered into any non-cancellable contracts or capital commitments that extend beyond 2012/13.

17 Intra-Government and other balances

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with other Central Government Bodies	1,028	0	1,176	0
Balances with Local Authorities	0	0	601	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	1,934	0	6,626	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	1,496	0	15,926	0
At 31 March 2013	**4,458**	**0**	**24,329**	**0**
prior period:				
Balances with other Central Government Bodies	2,395	1,142	1,219	0
Balances with Local Authorities	44	0	3,641	0
Balances with NHS Trusts and Foundation Trusts	960	0	5,826	1,142
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	2,242	0	19,882	0
At 31 March 2012	**5,641**	**1,142**	**30,568**	**1,142**

18 Inventories

The PCT no longer holds inventories of any category

19.1 Trade and other receivables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
NHS receivables - revenue	**2,622**	1,871	**0**	1,142
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**282**	1,484	**0**	0
Non-NHS receivables - revenue	**1,151**	2,717	**0**	0
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**64**	136	**0**	0
Provision for the impairment of receivables	**(107)**	(871)	**0**	0
VAT	**58**	18	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	**388**	286	**0**	0
Interest receivables	**0**	0	**0**	0
Finance lease receivables	**0**	0	**0**	0
Operating lease receivables	**0**	0	**0**	0
Other receivables	**0**	0	**0**	0
Total	**4,458**	5,641	**0**	1,142
Total current and non current	**4,458**	6,783		
Included above:				
Prepaid pensions contributions	**0**	0		

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.

19.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	**2,380**	1,725
By three to six months	**1**	63
By more than six months	**7**	713
Total	**2,388**	2,501

19.3 Provision for impairment of receivables

	2012-13 £000	**2011-12 £000**
Balance at 1 April 2012	**(871)**	(1,064)
Amount written off during the year	**98**	0
Amount recovered during the year	**772**	0
(Increase)/decrease in receivables impaired	**(106)**	193
Balance at 31 March 2013	**(107)**	(871)

20 NHS LIFT investments

	Loan £000	Share capital £000	Total £000
Balance at 1 April 2012	**628**	**0**	**628**
Additions	**0**	**0**	**0**
Disposals	**0**	**0**	**0**
Loan repayments	**(3)**	**0**	**(3)**
Revaluations	**0**	**0**	**0**
Loans repayable within 12 months	**0**	**0**	**0**
Balance at 31 March 2013	**625**	**0**	**625**
Balance at 1 April 2011	630	0	630
Additions	0	0	0
Disposals	0	0	0
Loan repayments	(2)	0	(2)
Revaluations	0	0	0
Loans repayable within 12 months	0	0	0
Balance at 31 March 2012	**628**	**0**	**628**

21.1 Other financial assets - Current

	31 March 2013 £000	31 March 2012 £000
Opening balance 1 April	0	0
Transfers (to)/from Other Public Sector Bodies in year	0	0
Other Movements	0	0
Closing balance 31 March	**0**	0

21.2 Other Financial Assets - Non Current

	31 March 2013 £000	31 March 2012 £000
Opening balance 1 April	**628**	630
Additions	0	0
Revaluation	0	0
Impairments	0	0
Impairment Reversals	0	0
Transferred to current financial assets	0	0
Disposals	(3)	(2)
Transfers (to)/from Other Public Sector Bodies in year	0	0
Total Other Financial Assets - Non Current	**625**	628

21.3 Other Financial Assets - Capital Analysis

	31 March 2013 £000	31 March 2012 £000
Capital Expenditure	**0**	0
Capital Income	**(3)**	0

22 Other current assets

	31 March 2013 £000	31 March 2012 £000
EU Emissions Trading Scheme Allowance	**0**	0
Other Assets	**0**	0
Total	**0**	0

23 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**81**	58
Net change in year	**704**	23
Closing balance	**785**	81
Made up of		
Cash with Government Banking Service	**785**	81
Commercial banks	**0**	0
Cash in hand	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**785**	81
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**785**	81
Patients' money held by the PCT, not included above	**0**	0

24 Non-current assets held for sale

	Land	Buildings, excl. dwellings	Plant and Machinery	Information Technology	Furniture and Fittings	Intangible Assets	Total
	£000	£000	£000	£000	£000	£000	£000
Balance at 1 April 2012	259	421	0	0	0	0	**680**
Plus assets classified as held for sale in the year	106	254	0	0	0	0	**360**
Less assets sold in the year	(200)	(390)	0	0	0	0	**(590)**
Less impairment of assets held for sale	(37)	(63)	0	0	0	0	**(100)**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	**0**
Transfers (to)/from other public sector bodies	0	0	0	0	0	0	**0**
Revaluation	0	0	0	0	0	0	**0**
Balance at 31 March 2013	**128**	**222**	**0**	**0**	**0**	**0**	**350**
Liabilities associated with assets held for sale at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**
							0
Balance at 1 April 2011	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	384	821	0	0	0	0	**1,205**
Less assets sold in the year	(125)	(400)	0	0	0	0	**(525)**
Less impairment of assets held for sale	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	**0**
Balance at 31 March 2012	**259**	**421**	**0**	**0**	**0**	**0**	**680**
Liabilities associated with assets held for sale at 31 March 2012	0	0	0	0	0	0	**0**

Revaluation reserve balances in respect of non-current assets held for sale were:

At 31 March 2012	133
At 31 March 2013	16

Two new properties, namely 10 Leyton Avenue, Gillingham and 68 Gayhurst Drive, Sittingbourne have been classified as non-current assets held for sale during the year. These properties are residential type premises, adapted for use within the NHS.

These two properties were disposed of in year, in addition to properties at 12 Balmoral Road, Gillingham and Kings Road Clinic.

The remaining property is Elm House Clinic, which has a revised open market valuation of £350k. This property has not sold during the year and remains a difficult property to sell. However, the property is still being actively marketed and has attracted a number of interested parties. The PCT is confident of a sale within the next six months.

25 Trade and other payables

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Interest payable	**0**	0	**0**	0
NHS payables - revenue	**1,411**	3,325	**0**	1,142
NHS payables - capital	**123**	0	**0**	0
NHS accruals and deferred income	**6,129**	3,720	**0**	0
Family Health Services (FHS) payables*	**8,742**	6,853	**0**	0
Non-NHS payables - revenue	**1,275**	3,942	**0**	0
Non-NHS payables - capital	**326**	190	**0**	0
Non-NHS accruals and deferred income	**5,631**	12,401	**0**	0
Social security costs	**3**	0	**0**	0
VAT	**0**	0	**0**	0
Tax	**134**	0	**0**	0
Payments received on account	**0**	0	**0**	0
Other	**555**	137	0	0
Total	**24,329**	30,568	**0**	1,142
Total payables (current and non-current)	**24,329**	**31,710**		

Other payables relates to an additional payroll on the 5th April mainly in relation to redundancy payments
* In 2011/12 Non NHS Accruals included prescribing accruals, in 2012/13 these are included in Family Health Services payables

26 Other liabilities

The PCT has no other current or non current liabilities

27 Borrowings

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Bank overdraft - Government Banking Service	**0**	0	**0**	0
Bank overdraft - commercial banks	**0**	0	**0**	0
PFI liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
LIFT liabilities:				
Main liability	**566**	629	**18,712**	19,278
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**0**	0	**0**	0
Other (describe)	**0**	0	**0**	0
Total	**566**	**629**	**18,712**	**19,278**
Total other liabilities (current and non-current)	**19,278**	**19,907**		

28 Other financial liabilities

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Embedded Derivatives at Fair Value through SoCNE	**0**	0	**0**	0
Financial liabilities carried at fair value through SoCNE	**0**	0	**0**	0
Amortised Cost	**0**	0	**0**	0
Total	**0**	0	**0**	0
Total other liabilities (current and non-current)	**0**	**0**		

29 Deferred income

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Opening balance at1 April 2012	**50**	58	**0**	0
Deferred income addition	**0**	0	**0**	0
Transfer of deferred income	**(50)**	(8)	**0**	0
Current deferred Income at 31 March 2013	**0**	50	**0**	0
Total other liabilities (current and non-current)	**0**	**50**		

30 Provisions

Comprising:

	Total £000s	Pensions to Former Directors £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Restructuring £000s	Continuing Care £000s	Equal Pay £000s	Agenda for Change £000s	Other £000s	Redundancy £000s
Balance at 1 April 2012	**2,129**	0	1,632	145	0	318	0	0	34	0
Arising During the Year	**3,028**	0	0	59	0	1,901	0	0	870	198
Utilised During the Year	**(360)**	0	(158)	(185)	0	(17)	0	0	0	0
Reversed Unused	**(340)**	0	0	(6)	0	(300)	0	0	(34)	0
Unwinding of Discount	**147**	0	141	6	0	0	0	0	0	0
Change in Discount Rate	**32**	0	27	5	0	0	0	0	0	0
Transferred (to)/from otherPublic Sector bodies	**0**	0	0	0	0	0	0	0	0	0
Balance at 31 March 2013	**4,636**	**0**	**1,642**	**24**	**0**	**1,902**	**0**	**0**	**870**	**198**
Expected Timing of Cash Flows:										
No Later than One Year	**3,134**	**0**	**159**	**5**	**0**	**1,902**	**0**	**0**	**870**	**198**
Later than One Year and not later than Five Years	**801**	**0**	**797**	**4**	**0**	**0**	**0**	**0**	**0**	**0**
Later than Five Years	**701**	**0**	**686**	**15**	**0**	**0**	**0**	**0**	**0**	**0**

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at 31 March 2013	2
As at 31 March 2012	0

Pension Provisions - £605k relates to a pension provision for Dentists. £1037k relates to Pre 1995 Pensions which were inherited by the PCT from the former West Kent Health Authority. Payments are made quarterly to each former employee until they reach State Retirement Age.

Other Legal Provisions - £22k falls under "Back to Back" arrangements with NHS Trusts. £2k relates to PCT liability notified by the NHS Litigation Authority (NHSLA).

Other Provisions - £1902k relates to Continuing Care Provisions, following the Coughlan Report, £870k relates to an outstanding HMRC taxation issue over payments made to General Practitioners

Redundancy Provisions - Relates to restructuring following Health and Social Care Act 2012

31 Contingencies

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

32. LIFT - additional information

32.1 NHS LIFT schemes on-Statement of Financial Position

Medway PCT reached financial close on three LIFT schemes in May 2005. Following financial close, construction of the new buildings was started and this work was completed and handed over to the PCT in August 2006 for Lordswood and Rainham Healthy Living Centres and in October 2006 for Rochester Healthy Living Centre

A fourth LIFT scheme, Balmoral Gardens, reached financial close in 2009, and was completed and handed over to the PCT in July 2010.

The terms of the contract signed by the PCT mean that the Operator (Medway FundCo Ltd) is required to make the project assets available to the PCT for use as community health centre accommodation. The PCT pays FundCo monthly amounts (lease plus payments) in return for which Medway FundCo operates and maintains the assets to agreed standards.

The annual lease plus payments due vary from a base amount determined in the Lease Plus Agreement according to changes in the Retail Prices Index (All Items). Medway FundCo is required to make the assets available until 31 March 2031 for Lordswood and Rainham, 30 September 2031 for Rochester, and July 2034 for Balmoral.

There is an option to purchase the project assets on expiry of the Term, and at an amount based on the assets' open market value (OMV) as at expiry of the contract. The assets' open market value is adjusted by an amount depending on the difference between OMV and the estimated value of OMV held within the Model.

The schemes were assessed for accounting treatment under IFRIC 12 and it was concluded from that assessment that that the four schemes should be treated as assets of the Trust. The substance of the transaction is that the PCT has a finance lease and payments comprise two elements - finance lease charges and service charges

33 LIFT - additional information

33.1 Charges to operating expenditure and future commitments in respect of on and off SOFP LIFT	**31 March 2013**	31 March 2012
	£000	£000
Total Charge to Operating Expenses in year - OFF SOFP LIFT	**0**	0
Service element of on SOFP LIFT charged to operating expenses in year	**782**	754
Total	**782**	754

	31 March 2013	31 March 2012
	£000	£000
Payments committed to in respect of off SOFP LIFT and the service element of on SOFP LIFT.		
LIFT Scheme Expiry Date:		
No Later than One Year	**647**	620
Later than One Year, No Later than Five Years	**2,805**	2,672
Later than Five Years	**14,345**	14,916
Total	**17,797**	18,208

The estimated annual payments in future years are expected to be materially different from those which the NHS Trust is committed to make during the next year. The likely financial effect of this is:

	31 March 2013	31 March 2012
	£000	£000
Estimated capital value of project - off SOFP LIFT	0	0
Value of Deferred Assets - off SOFP LIFT	0	0
Value of Residual Interest - off SOFP LIFT	0	0

Imputed "finance lease" obligations for on SOFP LIFT Contracts due	**31 March 2013**	31 March 2012
	£000	£000
No Later than One Year	**1,824**	1,926
Later than One Year, No Later than Five Years	**7,503**	7,412
Later than Five Years	**24,169**	26,084
Subtotal	**33,496**	35,422
Less: Interest Element	**(14,218)**	(15,515)
Total	**19,278**	19,907

34 Impact of IFRS treatment - 2012-13

	Total	Admin	Programme
	£000	£000	£000
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g LIFT/PFI)			
Depreciation charges	**1,039**	0	1,039
Interest Expense	**1,698**	0	1,698
Impairment charge - AME	**0**		0
Impairment charge - DEL	**0**	0	0
Other Expenditure	**782**	0	782
Revenue Receivable from subleasing	**(2,213)**	0	(2,213)
Total IFRS Expenditure (IFRIC12)	**1,306**	**0**	**1,306**
Revenue consequences of LIFT/PFI schemes under UK GAAP / ESA95 (net of any sublease income)	**(1,026)**	0	(1,026)
Net IFRS change (IFRIC12)	**280**	**0**	**280**

Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12	
Capital expenditure 2012-13	29
UK GAAP capital expenditure 2012-13 (Reversionary Interest)	0

35 Financial Instruments

Financial risk management

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

Currency risk

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

Interest rate risk

PCTs are not permitted to borrow. The PCT therefore has low exposure to interest-rate fluctuations

Credit Risk

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

Liquidity Risk

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

35.1 Financial Assets	**At 'fair value through profit and loss' £000**	**Loans and receivables £000**	**Available for sale £000**	**Total £000**
Embedded derivatives	0	0	0	**0**
Receivables - NHS	0	2,622	0	**2,622**
Receivables - non-NHS	0	1,151	0	**1,151**
Cash at bank and in hand	0	785	0	**785**
Other financial assets	0	625	0	**625**
Total at 31 March 2013	**0**	**5,183**	**0**	**5,183**
Embedded derivatives	0	0	0	0
Receivables - NHS	0	3,013	0	3,013
Receivables - non-NHS	0	2,717	0	2,717
Cash at bank and in hand	0	81	0	81
Other financial assets	0	628	0	628
Total at 31 March 2012	0	6,439	0	6,439

35.2 Financial Liabilities	**At 'fair value through profit and loss' £000**	**Other £000**	**Total £000**
Embedded derivatives	0	0	**0**
NHS payables	0	1,411	**1,411**
Non-NHS payables	0	10,709	**10,709**
Other borrowings	0	0	**0**
PFI & finance lease obligations	0	19,278	**19,278**
Other financial liabilities	0	0	**0**
Total at 31 March 2013	**0**	**31,398**	**31,398**
Embedded derivatives	0	0	0
NHS payables	0	4,467	4,467
Non-NHS payables	0	11,122	11,122
Other borrowings	0	0	0
PFI & finance lease obligations	0	19,907	19,907
Other financial liabilities	0	34	34
Total at 31 March 2012	**0**	35,530	35,530

36 Related party transactions

During the year none of the Department of Health Ministers, trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Medway Primary Care Trust

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

	Balances with related Parties 2012/13			
	Payables £000s	**Receivables £000s**	**Revenue £000s**	**Expenditure £000s**
South East Coast Strategic Health Authority	0	0	635	134
Eastern and Coastal Kent PCT	136	7	2,923	209
West Kent PCT	1,826	963	9,844	23,880
Dartford and Gravesham NHS Trust	19	0	0	3,741
Kent Community NHS Trust	108	0	58	2,583
East Kent Hospitals University Foundation Trust	43	370	0	6,486
Guys and St Thomas' Foundation Trust	594	0	0	12,961
Kent and Medway NHS and Social Care Partnership Trust	210	0	(8)	25,500
Kings Healthcare Foundation Trust	119	0	0	7,407
Maidstone and Tunbridge Wells NHS Trust	677	0	62	16,500
Medway NHS Foundation Trust	3,747	1,500	(139)	145,988
Oxleas NHS Foundation Trust	5	0	0	1,943
Queen Victoria Foundation Trust	11	0	0	4,413
South London and Maudsley Foundation Trust	163	0	0	1,797
University College London Foundation Trust	195	0	0	1,823
Medway Council	193	0	353	9,615

In addition, the PCT has had a number of material transactions with other government departments and other central and local government bodies. Most of the transactions have been with the Pensions Agency, HM Revenue and Customs, and the NHS Business Services Authority (Prescription Pricing Authority).

37 Losses and special payments

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

	Total Value of Cases £s	**Total Number of Cases**
Losses - PCT management costs	109,739	117
Special payments - PCT management costs	11,000	1
Losses in respect of the provision of family practitioner services	0	0
Special payments in respect of he provision of family practitioner services	0	0
Total losses	109,739	117
Total special payments	11,000	1
Total losses and special payments	120,739	118

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	0	0
Special payments - PCT management costs	0	0
Losses in respect of the provision of family practitioner services	0	0
Special payments in respect of he provision of family practitioner services	2550	1
Total losses	0	0
Total special payments	2,550	1
Total losses and special payments	2,550	1

38 Third party assets

The PCT held no cash and cash equivalents at 31 March 2013 on behalf of patients (£0 at 31 March 2012).

39 Cashflows relating to exceptional items

There were no cashflows relating to exceptional items.

40 Events after the end of the reporting period

Under the provisions of *The Health and Social Care Act 2012 (Commencement No.4. Transitional, Savings and Transitory Provisions) Order 2013,* Medway PCT was dissolved on 1st April 2013. The PCT's functions, assets and liabilities transferred to other public sector entities .

The main functions carried out by Medway PCT in 2012-13 are to be carried out in 2013-14 by the following public sector bodies:

Successor Body	Main Function	Initial Budget
- Medway CCG	Commissioning non - specialised services	£ 328,418,000
- Kent & Medway Area Team, part of the NCB	Primary care, Offender Health, Secondary Dental Services and Public Health	£ 99,757,000
- Surrey & Sussex Area Team, part of the NCB	Commissioning specialised services	£ 34,749,000
- Medway Council	Public Health services	£ 10,872,000
- Property Services & Community Health Partnerships	Estates management	£ 2,665,000

Certain assets have transferred to NHS Property Services *o* n 1st April 2013. These were considered operational at the year end, and so have not been impaired in the PCT books. It is for the successor body to consider whether, in 2013-14, it is necessary to review these for impairment.