Department of Health

NHS

NHS Sussex Cluster Primary Care Trusts

2012-13 Annual Report and Accounts

Brighton and Hove City Teaching Primary Care Trust

East Sussex Downs and Weald Primary Care Trust

Hastings and Rother Primary Care Trust

West Sussex Primary Care Trust

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

© Crown copyright

Published to gov.uk, in PDF format only.

www.gov.uk/dh

NHS Sussex Primary Care Trusts

2012-13 Annual Report

Brighton and Hove City Teaching Primary Care Trust

East Sussex Downs and Weald Primary Care Trust

Hastings and Rother Primary Care Trust

West Sussex Primary Care Trust

Annual Report and Accounts, 2012/13

NHS Sussex

Incorporating:
NHS Brighton and Hove
NHS East Sussex Downs and Weald
NHS Hastings and Rother
NHS West Sussex

NHS Sussex Annual report and accounts 2012/13

NHS Sussex Annual report and accounts 2012/13 1
Section 1: Directors' report 4
About us 4
Our organisation 4
Our aims and priorities 4
Our Board 4
About our Board 4
The role of non-executive directors 5
The role of executive directors 5
Board committees 5
Declarations of interests 5
Directors' statement 5
Taking forward the NHS reforms 5
Development of clinical commissioning groups 6
Sussex Together 6
Progress against public health priorities 6
Joint Commissioning 7
Health and Wellbeing Boards 7
NHS England 8
Specialised commissioning 8
Commissioning support services 8
Section 2 - Operating and financial review 9
Our performance 9
The Francis Report 9
Performance targets and outcomes 9
QIPP (quality, innovation, productivity and prevention) 10
Quality, safety and infection control 11
Quality reviews 11
Integrated governance reviews 11
Mixed sex accommodation 11
Healthcare associated infections 11
Patient safety 11
Never Events 12
Serious incidents 12
CQUIN 12
Quality accounts 12
Financial review 12
Our financial performance – NHS Brighton and Hove 12
Our financial performance – NHS East Sussex Downs and Weald 14
The past year 14
Better payment practice code 14
IFRS Reporting 15
Our financial performance – NHS Hastings and Rother 15
The past year 15
Better payment practice code 16
IFRS Reporting 17
Audit 17
Our financial performance – NHS West Sussex 17

Sussex-wide financial challenges ahead 18
Section 3 – Other information about our organisation 19
Social and community issues 19
Local checks on our activities 19
NHS Sussex Sustainability Report 19
Emergency preparedness 19
Off-payroll engagements 20
Our staff 20
Employee profile 20
Equality, diversity and human rights 20
Staff involvement and consultation 21
Knowledge and skills framework (KSF) 21
GP appraisal 21
Training and development 21
Staff sickness absence 21
Information governance 22
Serious untoward incidents - personal data 22
Other incidents – personal data 22
Access to Information 22
Learning from patients 22
Remuneration report: NHS Brighton and Hove 24
Remuneration report: NHS East Sussex Downs and Weald 27
Remuneration report: NHS Hastings and Rother 30
Remuneration report: NHS West Sussex 33
Information governance incidents 50
Summary of Serious Untoward Incidents 50
Control and risk related to performance indicators 51
Information governance incidents 60
Summary of Serious Untoward Incidents 60
Control and risk related to performance indicators 60
Information governance incidents 70
Summary of Serious Untoward Incidents 70
Control and risk related to performance indicators 70
Information governance incidents 80
Control and risk related to performance indicators 80

Section 4. Statements and accounts

(four sets by PCT, N.B. page numbers restart)

Within each set are contained:

- Chief executive's statement
- Directors' statement
- Annual Governance Statement
- Auditor's report
- Accounts

This document is the formal 2012/13 Annual Report and Accounts for:

- **NHS Brighton and Hove**
- **NHS East Sussex Downs and Weald**
- **NHS Hastings and Rother**
- **NHS West Sussex**

These four primary care trusts (PCTs) together comprise NHS Sussex PCT cluster.

Most of the document reflects a cluster-wide perspective but information relating to the individual PCTs is included where it is required.

Section 1: Directors' report

About us

Our organisation

NHS Sussex was created in June 2011 to oversee the commissioning (buying) and performance of health services across the county, and prepare for the move to GP-led commissioning from 1 April 2013.

Commissioning and performance management for Sussex had previously been carried out by four primary care trusts (PCTs):

- NHS Brighton and Hove
- NHS East Sussex Downs and Weald
- NHS Hastings and Rother
- NHS West Sussex

Each PCT had delegated most functions and responsibilities to NHS Sussex but they remained as statutory organisations until they closed on 31 March 2013 as part of national NHS reforms.

Some non-executive directors from each PCT became members of the NHS Sussex Board from June 2011. The remainder stayed as non-executive directors of their local PCT Board until their roles ceased in January 2012. A single Board was responsible for NHS Sussex and all four statutory PCTs throughout 2012/13.

Details of Board membership in 2012/13 are shown in Appendix 1.

Our aims and priorities

We aimed to improve the health and well-being of people in Sussex, and give them easy access to the health services they needed. Particular emphasis was given to the health of children and younger people, people with poor mental health, older people, and those people most likely to need hospital treatment.

We also wanted to ensure that the NHS in Sussex delivered the Government's NHS reforms.

Our priorities were to:

- deliver the plans agreed by primary care trusts and clinical commissioning groups (CCGs);
- make the NHS in Sussex financially stable and sustainable;
- help clinical commissioning groups develop successfully and offer them support in future;
- transfer staff and services to clinical commissioning groups, local councils and other new organisations; and
- assist local NHS Trusts to become NHS Foundation Trusts by 2014.

Our Board

About our Board

Our Board had a non-executive chairman, six non-executive directors and six voting executive directors. Other executive directors also attended board meetings regularly. The Board set strategic direction and ensured that the organisation met its financial, statutory and legal responsibilities.

A member from the county's Local Involvement Networks (LINks), which represented the interests of patients and the public in health and social care, attended Board meetings and could address the Board.

There were 8 public board meetings and an annual general meeting in 2012/13.

The Board's role ceased on 31 March 2013.

The role of non-executive directors

Our non-executive directors brought a wide range of skills and experience from a variety of backgrounds. They provided independent, constructive challenge to the executive team and ensured that the interests of patients and local communities were taken fully into account. They were appointed by the Appointments Commission.

The role of executive directors

The chief executive oversaw the management and operation of the organisation as a whole. Other executive directors were each responsible for a particular area of work (e.g. finance, planning and governance, quality) and managing the staff who delivered it. Executive directors were appointed through a formal selection process.

Board committees

Non-executive directors played a vital role on Board committees, particularly the statutorily-required audit and remuneration committees.

The audit committee independently reviewed the controls over:

- financial systems;
- corporate governance;
- healthcare quality standards;
- codes of conduct and best practice guidance;
- information systems; and
- statutory practices.

The remuneration committee ensured that employment costs for senior staff were managed effectively. Salaries for senior staff were agreed according to national criteria and guidance, and benchmarked against similar roles elsewhere in the NHS.

Declarations of interests

NHS Sussex was committed to open, transparent decision-making.

We maintained a register in which Board members declared any relevant interests (e.g. business interests, positions of authority in a health or social care charity or voluntary body, or any connection with an organisation that held or made bids for NHS contracts). The register of interests was presented annually to the Board and submitted to our auditors in support of the annual audit process.

Board members declared any conflict of interests which could have influenced, or been perceived to influence, their judgement when conducting NHS business. Declaration of interests were requested at the start of Board and committee meetings and formally recorded in the minutes. Interests of NHS Sussex Board members are shown in Appendix 1.

Directors' statement

For 2012/13 each director confirmed that as far as she/he was aware there was no relevant audit information of which the organisation's auditors were unaware and she/he took all the steps that she/he ought to have taken as a director in order to make herself/himself aware of any relevant audit information and establish that the organisation's auditors were aware of that information.

Taking forward the NHS reforms

NHS Sussex worked successfully with partner organisations to prepare for the NHS reforms that came into effect on 1 April 2013. This section provides a brief overview of progress during 2012/13.

Development of clinical commissioning groups

All seven clinical commissioning groups in Sussex had been authorised by the end of March 2013, although all of the authorisations included conditions and some included directions. These conditions and directions are being addressed.

Sussex Together

Sussex Together brought the NHS and partner organisations together to make best use of the county's health budget, and support CCGs and providers in developing and implementing sustainable models of care which address local needs. The programme concentrated in 2012 on establishing a delivery-focused governance structure across organisations in Sussex, and continuing to develop Sussex Clinical Senate to ensure meaningful clinical leadership.

Progress against public health priorities

During 2012/13 the three NHS public health teams transferred their role and responsibilities to East Sussex County Council, West Sussex County Council, and Brighton and Hove City Council respectively.

These local authorities will now provide population health advice, information and expertise to CCGs to support them in commissioning health services that improve health and reduce inequalities.

Local authorities will also ensure plans are in place to protect the health of their population, support infectious disease surveillance and control, and support emergency preparedness and response.

The three public health teams continued their work on health improvements during 2012/13. The following paragraphs outline some of their achievements during the year.

Public Health in West Sussex

- Integrated Sexual Health services commissioned successfully.
- Sustained improvement in childhood immunisation rates.
- HPV vaccination programme delivered successfully in local schools by school nurses.
- Health & Wellbeing services embedded and strengthened.
- Social support services commissioned successfully to tackle social isolation and provide practical assistance in the home.
- Continued growth in schools programmes around alcohol prevention, emotional resilience, peer mentoring and smoke free schools.
- West Sussex HealthWatch service commissioned successfully.
- Led work on the new public health plan *'Healthy & Well in West Sussex 2012-2017'.*
- Completed health needs assessments relating to military veterans (in collaboration with East Sussex and Brighton and Hove), people detained in immigration removal centres, and families and children of Thorney Island Military Base.
- Intervention training on healthy weight in children and alcohol in adults commissioned successfully.
- 26% more health checks offered and 46% more health checks delivered than in 2011/12 with an increase in the number of primary care and community providers.
- Successful commissioning of a non-NHS provider to deliver over 2,500 health checks in the community and workplace, and an NHS provider to deliver NHS workplace checks.

Public Health in East Sussex

- Public Health scorecards and commentaries refreshed and published on the Joint Strategic Needs Assessment (JSNA) website.
- Continued improvement in the percentage of children who have had their primary immunisations by their first birthday.
- Publication of the 2012/13 public health report 'Reducing health inequalities among children and young people in East Sussex'.
- Tobacco control partnership established; a tobacco plan is in development.
- Agreed the public health 'offer' to Clinical Commissioning Groups.

Public Health in Brighton and Hove

- Supported primary care development through briefings and strategy workshops which fed through to CCG priorities and investment decisions.
- Secured support for an audit to inform future action to reduce mortality in people aged under 75.
- Re-launched the Joint Strategic Needs Assessment; the document has informed the priorities of the new Health and Wellbeing Board and its draft strategy.
- Worked with the Older People's Council to improve age-friendly features in Brighton & Hove (now a member of the WHO Global Network of Age-Friendly Cities and Communities).
- Supported 25 businesses working towards the Workplace Wellbeing Charter
- Contributed to the development of a Sussex-wide HIV network which was established in 2012/13.
- Reduced the number of dependent drinkers presenting frequently to A&E, with consequent reductions in anti-social behaviour and evictions from hostels.
- Increased the proportion of opiate users who successfully completed their treatment.
- Provided targeted support to improve breastfeeding rates in areas where they is low (the overall city rate for breastfeeding at 6-8 weeks remains significantly above the national average).
- Achieved more than 90% uptake of the primary baby immunisations at one year and MMR at 2 years.
- On track to meet the annual target of 2000 smokers having successfully quit at 4 weeks.
- Signed up 98% of GP surgeries signed up to deliver NHS Health Checks. The outreach Workplace NHS Health Checks achieved their target.

Joint Commissioning

NHS Sussex jointly commissioned many services with local authorities. Brief details are shown below.

Joint commissioning with East Sussex County Council
We worked with the County Council to create a Joint Commissioning Board. It provided strategic oversight and direction of adult services including intermediate care, mental health and continuing healthcare assessment.

Joint commissioning with West Sussex County Council
A Joint Commissioning Unit of NHS and local authority staff continued to deal with adult and children's services. Day-to-day management of the unit was undertaken by West Sussex County Council.

Joint commissioning with Brighton and Hove City Council
Joint commissioning in the city continued through formal section 75 arrangements for adult services and children's services. We continued to collaboratively commission a number of other areas (e.g. carers' services and residential care) which were not subject to formal section 75 arrangements.

CCGs and local authorities will continue to use established partnership arrangements until further decisions are made about joint/collaborative commissioning.

Health and Wellbeing Boards

Local authorities are now expected to:

- lead on the development of joint strategic needs assessments and Health and Wellbeing strategies;
- appoint Directors of Public Health; and
- commission or provide health improvement services including sexual health services, NHS Health Checks, and the National Child Measurement Programme.

This work is being managed through Health and Wellbeing Boards which bring together councillors, service commissioners (including clinical commissioning groups, Directors of Public Health, children's services and adult social care departments) and a representative of the local Healthwatch (the successor organisations to Local Involvement Networks).

NHS England

NHS England (formerly known as the NHS Commissioning Board) is responsible for ensuring that the NHS delivers better outcomes for patients. It provides leadership to the service as a whole as well as supporting clinical commissioning groups and holding them to account.

The Board directly commissions services best managed at a national or regional level (e.g. major trauma services, specialist burns care), and local primary care services that it would be inappropriate for CCGs to commission from their own member practices.

Specialised commissioning

Specialised commissioning is now managed through a national team to enable standardisation and consistency in the quality and effectiveness of specialised services, and more consistent patient outcomes.

Commissioning support services

The Sussex Commissioning Support Unit (CSU) provided a range of services and support to NHS Sussex and its emerging clinical commissioning groups in 2012/13 including contract support, market management and procurement, business intelligence, and primary care contracting and commissioning.

Sussex CSU worked closely with clients to ensure that contracts reflected commissioning intentions, providers were held to account for delivery, and performance management measures were applied consistently across Sussex.

The CSU developed its relationships with CCGs through a range of initiatives. These included placing customer account managers within CCG teams, running surveys, and arranging events such as ‘lunch and learn’ sessions where GPs could explore the technical side of contracting and procurement or challenge the way the services are delivered.

While the business plan for a combined Surrey and Sussex Commissioning Support Service was supported by NHS England in 2012/13, further work to ensure support services are sustainable in the longer term may result in a different operational model being introduced.

Section 2 - Operating and financial review

Our performance

The Francis Report

The Francis Reports into Mid Staffordshire NHS Foundation Trust have provided many salutary lessons for the NHS.

Its main recommendations included more personal liability if a patient is harmed by non-compliance; openness, transparency and candour throughout the system; no-one delivering hands-on care of a patient without being properly trained and registered; a new registered status for those working with older patients; easy access to accurate, useful and relevant information; and NHS leaders being held to account.

NHS Sussex has maintained its focus on safe and effective care at all times. Our Board kept a close check on performance (including value for money) through integrated performance reports presented to each Board meeting.

An innovative local process known as “sit and see” provided invaluable opportunities to reflect on local care systems and suggest improvements to provider organisations. The Quality Handover Document given to CCGs highlighted a number of areas where progress is being made by local providers.

Performance targets and outcomes

National NHS targets continued to focus heavily on the issues which matter most to patients, the public and staff, i.e. waiting times, healthcare- acquired infections, and financial stability.

We also agreed targets for the NHS and partner organisations for public health issues such as alcohol misuse, childhood obesity, smoking, breastfeeding, and teenage pregnancy.

Performance by each PCT against three major indicators (admitted patients treated within 18 weeks; number of patients waiting longer than 6 weeks for diagnostic tests; and 4 hour wait time in accident and emergency) is shown below.

A summary of wider performance against 2012/13 targets by each PCT is provided in Appendix 2.

<u>Admitted patients treated within 18 weeks</u>

Brighton and Hove PCT - target met
Target: 90% Actual performance: 91.42%

East Sussex Downs and Weald PCT – target met
Target: 90% Actual performance: 91.09%

Hastings and Rother PCT – target not met
Target: 90% Actual performance 2012/13: 89.90%

West Sussex PCT – target met
Target: 90% Actual performance 2012/13: 91.94%

<u>Number of patients waiting longer than 6 weeks for diagnostic tests</u>

Brighton and Hove PCT - target met
Target: 1% Actual performance 2012/13: 0.53%

East Sussex Downs and Weald PCT – target not met
Target: 1% Actual performance 2012/13: 1.07%

Hastings and Rother PCT – target met
Target: 1% Actual performance 2012/13: 0.81

West Sussex PCT – target met
Target: 1% Actual performance 2012/13: 0.39%

Providers made significant improvements in relation to this target. In April 2012 1125 people had waited more than six weeks for tests; the equivalent number in March 2013 was 126.

4 hour wait time in accident and emergency

Brighton and Hove PCT - target not met
Target: 95% Actual performance 2012/13: 93.36%

East Sussex Downs and Weald PCT – target not met
Target: 95% Actual performance 2012/13: 94.97%

East Sussex Healthcare NHS Trust failed marginally to meet the target across the year. Some additional resources were offered to it after a local action plan had been agreed with the CCG.

Hastings and Rother PCT – target met
Target: 95% Actual performance 2012/13: 95.73%

West Sussex PCT – target met
Target: 95% Actual performance 2012/13: 95.92%

Although NHS Sussex delivered the A&E 4 hour waiting access target in aggregate across the year, performance at Brighton and Sussex University Hospitals NHS Trust was below expectation from September 2012. NHS Sussex and the emerging CCGs worked with the Trust to resolve this issues which affected Brighton and Hove and East Sussex Downs and Weald PCT performance figures.

QIPP (quality, innovation, productivity and prevention)

The NHS as a whole must reduce its current costs by £20 billion to help offset the effects of population growth, new technologies, inflation and other pressures. This is being achieved through a national QIPP (quality, innovation, productivity, prevention) programme with multiple workstreams covering key clinical and operational functions.

NHS Sussex had a 2012/13 QIPP target of £104.2m. A central Programme Management Office oversaw and supported a number of projects aimed at reducing demand for services, changing care settings and realising prescribing efficiencies. The table below provides a summary of the QIPP target by PCT and the actual savings achieved

	Target	Achieved (2)	Percentage
NHS Brighton and Hove	£12.3m	£11.4m	93%
NHS East Sussex (1)	£42.1m	£37.7m	90%
NHS West Sussex	£49.8m	£46.9m	94%
Total	£104.2m	£101.1m	97%

(1) Combined figure for East Sussex Downs and Weald PCT and Hastings and Rother PCT.
(2) This includes the financial benefit derived from capped contracts negotiated with the main NHS providers in Sussex for 2012/13.

Quality, safety and infection control

The drive for high quality – which encompasses patient safety, patient experience and clinical effectiveness- continued to underpin our commissioning in 2012/13.

We set quality expectations in contracts, monitored them regularly, and held providers to account for their performance. When errors occurred, our quality team ensured that reasons were identified and lessons learned to reduce the risk of any recurrence. These performance monitoring and management tasks were increasingly undertaken by CCGs in the final quarter of the year.

Quality reviews

Each provider trust had a monthly review by the NHS Sussex quality team which focused on clinical quality and reviewed progress on any ongoing issues.

Outcomes from these reviews were shared with the appropriate managers and CCGs. Any particularly significant issues, and any ongoing issues that were not improving as expected, were discussed with a director of the provider in question so that they could be resolved swiftly. South East Coast Audit examined our quality assurance processes and judged them to provide ‘significant assurance’.

Integrated governance reviews

NHS Sussex introduced integrated governance reviews which drew together hard data and ‘soft’ intelligence covering finance, contract performance, workforce, communication and quality issues for each provider.

Mixed sex accommodation

Our leadership helped providers make good progress towards eliminating mixed sex accommodation. The number of breaches by Sussex providers fell from 79 in April 2012 to 0 in February 2013, and there were only 6 reported breaches after 1 October 2012.

Healthcare associated infections

NHS Sussex continued to work with providers to reduce healthcare associated infections, particularly MRSA and *Clostridium Difficile,* but the stretching targets were not met during 2012/13.

There were 30 MRSA blood stream infections and 497 cases of Clostridium Difficile during the year – 5 cases and 13 cases above the respective Department of Health target maximums.

Our Infection Control Team identified that for the first time there were more community acquired *Clostridium Difficile* cases than hospital acquired cases. We secured additional support and expertise from the Strategic Health Authority to raise awareness and focus on community acquired *Clostridium Difficile*, including a project to reduce recurrence and inappropriate antibiotic use.

Patient safety

Sussex Safe Care Collaborative brought together providers to focus on key areas of patient safety such as catheter-associated urinary tract infections, pressure ulcers, blood clots and falls.

All providers submitted data to the National Patient Safety Thermometer, enabling us to see how well our acute hospitals performed in relation to these specific 4 harms

All Sussex acute and integrated providers provided harm-free care at or better than the national mean (Q1-Q3); all Sussex acute trusts had new pressure ulcer rates at least 50% lower than the national mean; and East Sussex Integrated Trust had a new pressure ulcer rate 20% lower than the national mean (Q1-Q3).

Never Events

Never Events are serious patient safety incidents that should not occur if known best practice guidance is followed.

NHS Sussex providers reported 10 Never Events in 2012/13 (2 classed as wrong site surgery, 6 as surgical error, and 2 as other error). Although this was disappointing, benchmarking by the Strategic Health Authority confirmed that it was not out of line with providers elsewhere.

We reviewed all Never Events, themes and trends; scrutinised progress against each provider's action plans; and undertook a series of additional reviews using the WHO surgical checklist. Lessons learnt from each Never Event were shared with providers across Sussex.

Serious incidents

We performance managed 476 serious incidents relating to NHS and independent providers with which we had a contract in 2012/13. All incidents were managed in line with National Patient Safety Agency and NHS South of England guidelines. South East Coast Audit audited our patient safety systems and processes, and judged them to provide 'significant assurance'.

CQUIN

CQUIN (Commissioning for Quality and Innovation) enables commissioners to drive and reward quality improvements and uptake of innovation by NHS service providers. Performance related CQUIN payments and penalties were not applied in 2012/13 under the capped contracts in force.

Quality accounts

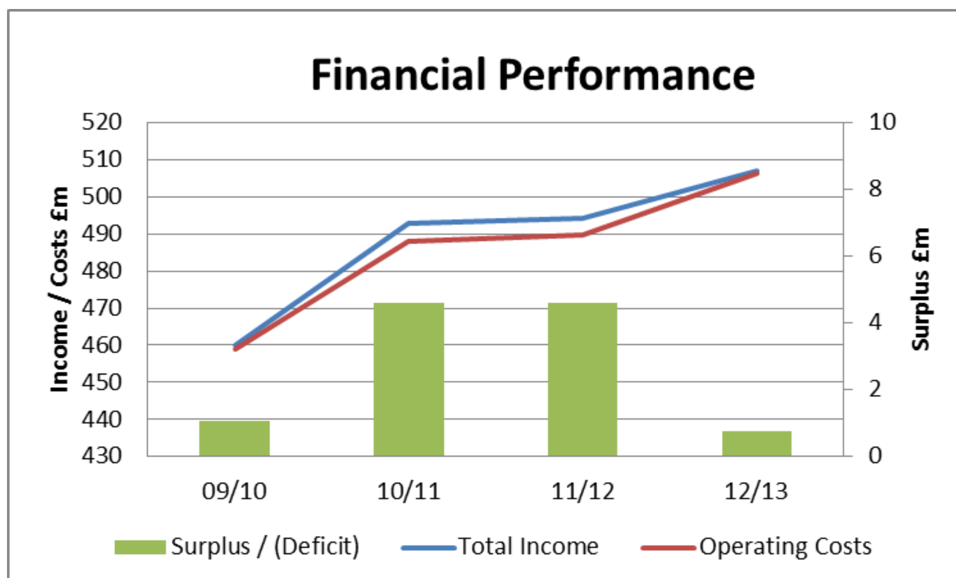
The final quality accounts were due to be published in June 2013 in line with national requirements.

Financial review

Our financial performance – NHS Brighton and Hove

The past year

In 2012/13 we received an annual revenue budget from the Department of Health of £507 million (up from £494 million in 2011/12) which included additional growth of 2.6%. Net operating expenditure increased to £506 million from £489 million in 2011/12. The PCT met its statutory financial duty to break even, ending the year with a £753,000 surplus which was in line with the control total set by the Strategic Health Authority.



We also received a capital budget of £391,000 for building improvements and replacing/upgrading equipment, and spent £270,000 of this.

We remained within the annual cash limit set by the Department of Health, and managed our cash position during the year to ensure that we always had sufficient cash to meet our needs. The cash flow statement in the Annual Accounts provides detailed analyses of net cash movements.

The PCT delegated responsibility for financial performance in 2011/12 and 2012/13 to NHS Sussex. The Board of NHS Sussex monitored key financial indicators which included a risk assessment of achieving statutory duties and other management objectives.

Better payment practice code
All NHS bodies are expected to pay 95 per cent of bills within contract terms (or 30 days where no terms have been agreed). The PCT had signed up to the Prompt Payments Code. Full details of compliance with the code are given in the table below.

Better Payment Practice Code	2012/13	2012/13	2011/12	2011/12
	Number	£000	Number	£000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	13,144	78,287	11,316	95,261
Total Non-NHS Trade Invoices Paid Within Target	12,116	68,222	10,652	86,798
per cent of Non-NHS Trade Invoices Paid Within Target	92.18	87.14	94.1	91.1
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,256	360,567	2,634	310,014
Total NHS Trade Invoices Paid Within Target	2,799	352,882	2,004	300,906
per cent of NHS Trade Invoices Paid Within Target	85.96	97.87	76.1	97.1

Pension liabilities
Employees of the PCT were covered by the provisions of the NHS Pensions Scheme. Note 7 to the Annual Accounts provides full disclosure of the treatment of pension liabilities.

Severance payments
The PCT followed the national guidance on severance payments (i.e. payments that are not made under either legal or contractual obligation) and any payments made followed relevant governance procedures.

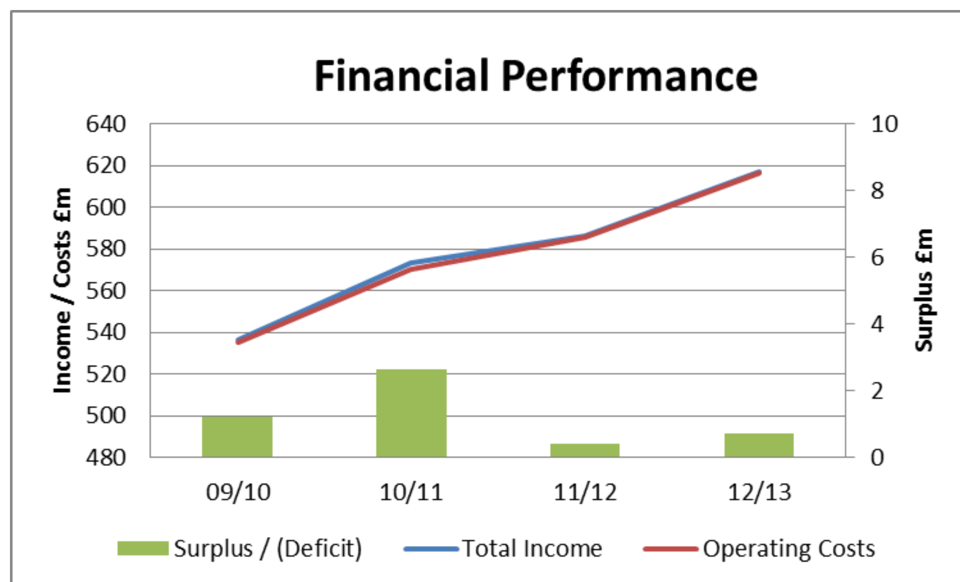
IFRS Reporting
The PCT prepared Annual Accounts under International Finance Reporting Standards as they apply to the NHS. A full set of accounts can be obtained free of charge by request to the Director of Finance, Lanchester House, Trafalgar Place, Brighton, BN1 4FU, tel. 01273 574742.

Audit
Our external auditor was Ernst and Young LLP. We paid audit fees of £120,336 in the year and other audit remuneration of £25,020 for Payment by Results Assurance Framework Review work. Any non-statutory audit work was considered by the Audit Committee before being commissioned.

Our financial performance – NHS East Sussex Downs and Weald

The past year
In 2012/13 we received an annual revenue budget from the Department of Health of £617 million (up from £586 million in 2011/12) which represented an increase of 5.3%.

Net operating expenditure increased to £616 million from £586 million in 2011/12. The PCT met its statutory financial duty to break even, ending the year with a £732,000 surplus which was in line with the control total set by the Strategic Health Authority.



We also received a capital allocation of £4.7 million for building improvements and replacing/upgrading equipment, and used it all. £4.4m was spent on estates and £0.2 million was spent on Information Technology and medical equipment.

We remained within the annual cash limit set by the Department of Health, and managed our cash position during the year to ensure that we always had sufficient cash to meet our needs. The cash flow statement in the Annual Accounts provides detailed analyses of net cash movements.

The PCT delegated responsibility for financial performance in 2011/12 and 2012/13 to NHS Sussex. The Board of NHS Sussex monitored key financial indicators which included a risk assessment of achieving statutory duties and other management objectives.

Better payment practice code
All NHS bodies are expected to pay 95 per cent of bills within contract terms (or 30 days where no terms have been agreed). The PCT had signed up to the Prompt Payments Code. Full details of compliance with the code are given in the table below.

Better Payment Practice Code	2012/13	2012/13	2011/12	2011/12
	Number	£000	Number	£000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	16,627	74,582	19,006	75,003
Total Non-NHS Trade Invoices Paid Within Target	14,884	56,092	17,182	68,102
per cent of Non-NHS Trade Invoices Paid Within Target	89.52%	75.21%	90.40%	90.80%

NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,508	428,760	2,925	405,946
Total NHS Trade Invoices Paid Within Target	2,854	406,698	2,408	392,160
per cent of NHS Trade Invoices Paid Within Target	81.36	94.92	82.32%	96.60%

Pension liabilities
Employees of the PCT were covered by the provisions of the NHS Pensions Scheme. Note 7 to the Annual Accounts provides full disclosure of the treatment of pension liabilities.

Severance payments
The PCT followed the national guidance on severance payments (i.e. payments that are not made under either legal or contractual obligation) and any payments made followed relevant governance procedures.

IFRS Reporting
The PCT prepares Annual Accounts under International Finance Reporting Standards as they apply to the NHS. A full set of accounts can be obtained free of charge by request to the Director of Finance, Lanchester House, Trafalgar Place, Brighton, BN1 4FU, tel. 01273 574742.

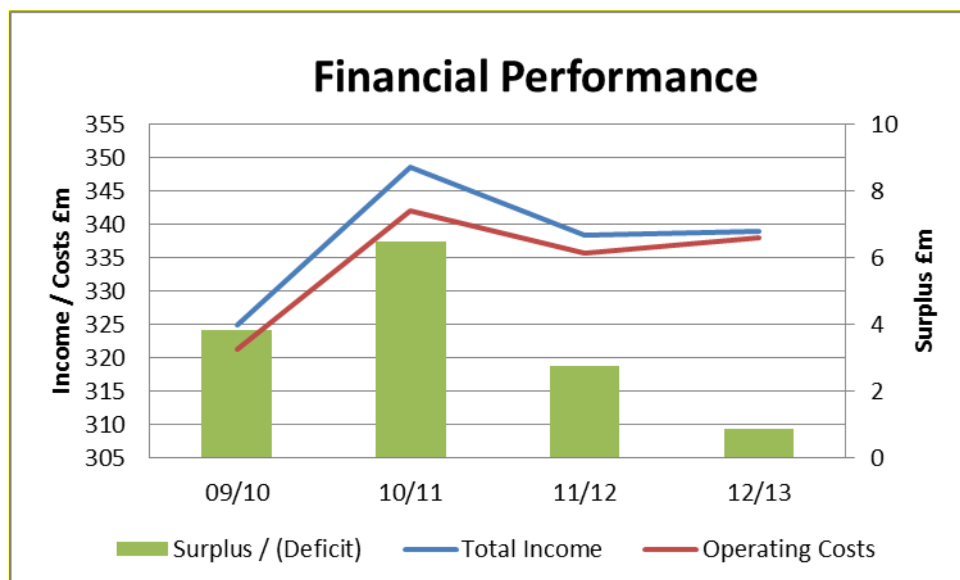
Audit
On 28 March 2013 the Appointed Auditor to the PCT, PKF (UK) LLP, merged its business with BDO LLP. The Audit Commission's Board has novated the contract for the supply of audit services to BDO LLP. Consequently, the audit report for 2012/13 is signed in the name of BDO LLP.

We paid audit fees of £122,242 to BDO LLP in the year for statutory audit work and other auditor's remuneration of £35,741 for audit of contractor payments at Primary Care Support Services. A further £10,130 has been agreed by the PCT for the statutory audit.

We also paid £25,200 to the Audit Commission for Payment By Results Assurance Framework Review. Any non-statutory audit work was considered by the Audit Committee before being commissioned.

Our financial performance – NHS Hastings and Rother

The past year
In 2012/13 we received an annual revenue budget from the Department of Health of £339 million (up from £338 million in 2011/12) which represented an increase of 0.3%. Net operating expenditure increased to £338 million from £336 million in 2011/12. The PCT met its statutory financial duty to break even, ending the year with a £878,000 surplus which was in line with the control total set by the Strategic Health Authority.



We also received a capital allocation of £2.6 million for building improvements and replacing/upgrading equipment. We underspent this allocation by £485,000 (19%).

We remained within the annual cash limit set by the Department of Health, and managed our cash position during the year to ensure that we always had sufficient cash to meet our needs. The cash flow statement in the Annual Accounts provides detailed analyses of net cash movements.

The PCT delegated responsibility for financial performance in 2011/12 and 2012/13 to NHS Sussex. The Board of NHS Sussex monitored key financial indicators which included a risk assessment of achieving statutory duties and other management objectives.

Better payment practice code
All NHS bodies are expected to pay 95 per cent of bills within contract terms (or 30 days where no terms have been agreed). The PCT had signed up to the Prompt Payments Code. Full details of compliance with the code are given in the table below.

Better Payment Practice Code	2012/13	2012/13	2011/12	2011/12
	Number	£000	Number	£000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	3,699	27,696	4,071	25,289
Total Non-NHS Trade Invoices Paid Within Target	3,423	22,268	3,623	22,016
per cent of Non-NHS Trade Invoices Paid Within Target	92.54	80.40%	89.00%	87.06%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,144	242,118	2,108	242,183
Total NHS Trade Invoices Paid Within Target	1,784	237,199	1,846	232,699
per cent of NHS Trade Invoices Paid Within Target	83.21%	97.97%	87.57%	96.08%

Pension liabilities
Employees of the PCT were covered by the provisions of the NHS Pensions Scheme. Note 7 to the Annual Accounts provides full disclosure of the treatment of pension liabilities.

Severance payments
The PCT followed the national guidance on severance payments (i.e. payments that are not made under either legal or contractual obligation) and any payments made followed relevant governance procedures.

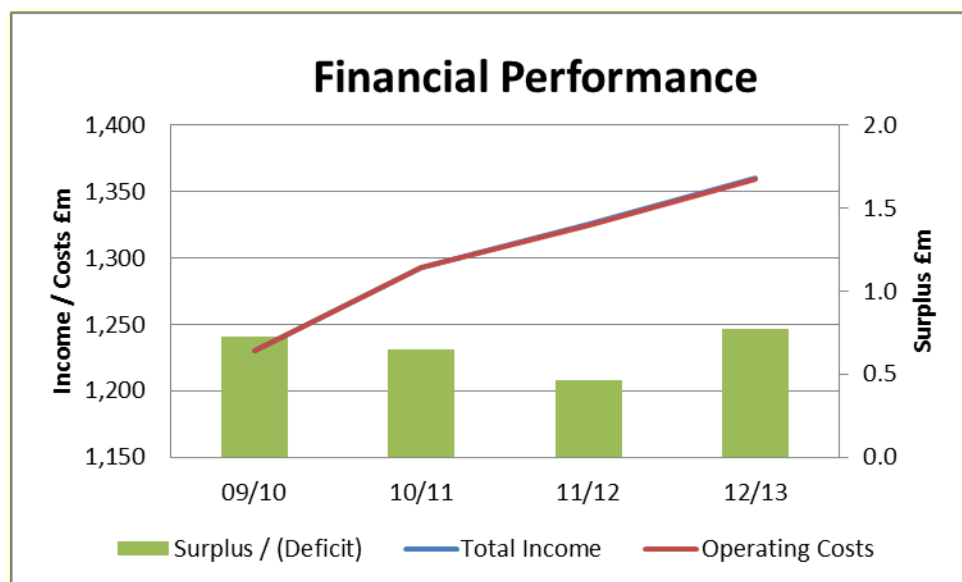
IFRS Reporting
The PCT prepares Annual Accounts under International Finance Reporting Standards as they apply to the NHS. A full set of accounts can be obtained free of charge by request to the Director of Finance, Lanchester House, Trafalgar Place, Brighton, BN1 4FU, tel. 01273 574742.

Audit
On 28 March 2013 the Appointed Auditor to the PCT, PKF (UK) LLP, merged its business with BDO LLP. The Audit Commission's Board has novated the contract for the supply of audit services to BDO LLP. Consequently, the audit report for 2012/13 is signed in the name of BDO LLP.

We paid audit fees of £98,261 to BDO LLP in the year for statutory audit work and a further £10,130 has been agreed by the PCT. We also paid £25,200 to the Audit Commission for Payment By Results Assurance Framework Review work. Any non-statutory audit work was considered by the Audit Committee before being commissioned.

Our financial performance – NHS West Sussex

The past year
In 2012/13 we received an annual revenue budget from the Department of Health of £1,360 million (up from £1,325 million in 2011/12) which represented an increase of 2.6%. Net operating expenditure increased to £1,359 million from £1,325 million in 2011/12. The PCT met its statutory financial duty to break even, ending the year with a modest £777,000 surplus which was in line with the control total set by the Strategic Health Authority.



We also received a capital budget of £13.8 million for building improvements and replacing/upgrading equipment, and spent £12.6 million of this allocation.

We remained within the annual cash limit set by the Department of Health, and managed our cash position during the year to ensure that we always had sufficient cash to meet our needs. The cash flow statement in the Annual Accounts provides detailed analyses of net cash movements.

The PCT delegated responsibility for financial performance in 2011/12 and 2012/13 to NHS Sussex. The Board of NHS Sussex monitored key financial indicators which included a risk assessment of achieving statutory duties and other management objectives.

Better payment practice code
All NHS bodies are expected to pay 95 per cent of bills within contract terms (or 30 days where no terms have been agreed). The PCT had signed up to the Prompt Payments Code. Full details of compliance with the code are given in the table below.

Better Payment Practice Code	2012/13	2012/13	2011/12	2011/12
	Number	£000	Number	£000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	36,260	187,951	39,348	183,988
Total Non-NHS Trade Invoices Paid Within Target	34,741	178,974	37,042	160,450
per cent of Non-NHS Trade Invoices Paid Within Target	96%	95%	94%	87%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	6,257	2,497,073	6,646	2,228,401
Total NHS Trade Invoices Paid Within Target	5,642	2,475,079	5,425	2,152,767
per cent of NHS Trade Invoices Paid Within Target	90%	99%	82%	97%

Pension liabilities
Employees of the PCT were covered by the provisions of the NHS Pensions Scheme. Note 7 to the Annual Accounts provides full disclosure of the treatment of pension liabilities.

Severance payments
The PCT followed the national guidance on severance payments (i.e. payments that are not made under either legal or contractual obligation) and any payments made followed relevant governance procedures. We did not make any such payments in 2012/13.

IFRS Reporting
The PCT prepares Annual Accounts under International Finance Reporting Standards as they apply to the NHS. A full set of accounts can be obtained free of charge by request to the Director of Finance, Lanchester House, Trafalgar Place, Brighton, BN1 4FU, tel. 01273 574742.

Audit
Our external auditor is Ernst and Young LLP. We paid audit fees of £157,657 in the year and other audit remuneration of £25,200 for Payment by Results Assurance Framework Review work. Any non-statutory audit work was considered by the Audit Committee before being commissioned.

Sussex-wide financial challenges ahead

2013/14 will see wide scale organisational change at a time of increasing financial pressures and increasing demand for NHS services.

Maintaining financial grip will be a priority for CCGs in their first year, whilst their longer-term success will depend on their ability to maintain recurrent financial balance and mitigate against in-year financial risk.

Commissioners are required to plan for a 2% recurrent surplus by the end of 2013/14 and hold a further 0.5% contingency against risk. Generating this degree of financial flexibility will require a focused approach to the successful delivery of QIPP.

Section 3 – Other information about our organisation

Social and community issues

Local checks on our activities

Local authority overview and scrutiny committees reviewed our performance and the plans we made for health services. These committees were made up of county councillors, district and borough councillors, and representatives from voluntary organisations and Local Involvement Networks (see below).

Oversight and scrutiny committees can carry out an independent check on any local health services provided and commissioned through the NHS as well as those provided by local authorities. Information about local overview and scrutiny committees can be found at www.eastsussexhealth.org, www.westsussex.gov.uk and www.brighton-hove.gov.uk.

- *Local Involvement Networks (LINks) were independent networks of local people and groups which helped our organisations understand and respond to the needs, experiences and wishes of patients and the public. Their work will now be incorporated into the Health and Wellbeing Board for each county. Legacy information about local LINks can be found at www.bhlink.org (Brighton and Hove), www.thecountylink.net (East Sussex) and www.makesachange.org.uk (West Sussex).*

NHS Sussex Sustainability Report

The NHS Carbon Reduction Strategy, published in 2009, set a target of a 10% reduction in the overall NHS carbon footprint between 2009 and 2015.

Reducing energy use lowers the carbon footprint, minimises the environmental impact of health care provision, and saves money which can be invested in front line services. Other areas such as waste recovery and recycling, reducing greenhouse gas emissions, reducing water consumption and travel are also important factors in improving the sustainability of NHS organisations.

Those properties owned or leased by PCTs in Sussex transferred to NHS Property Services Limited on 1 April 2013. This organisation's roles will include maximising the efficient use of resources, minimising waste, protecting green space and biodiversity, and supporting local communities and economies wherever possible.

CCGs will also have a major influence on sustainability as they design and implement new models of healthcare, and ensure that procurement decisions include an assessment of their impact on sustainability.

Consultation and engagement about a new Sustainable Development Strategy for the health, public health and social care system is currently under way. It will define where organisations need to be by 2020, and set measures and targets against which progress will be measured.

Emergency preparedness

Emergency planning and business continuity staff worked as a single team providing advice, guidance and support to NHS Sussex, its constituent primary care trusts, Directors of Public Health, clinical commissioning groups and other emerging bodies, and the Sussex Resilience Forum.

The team maintained and updated emergency response and resilience plans, liaised with other organisations that responded to emergencies, took part in emergency planning liaison groups, and maintained emergency control centres.

NHS Sussex also had an emergency management response team for any major incident or event that affected, or was likely to affect, the NHS in Sussex. An NHS Sussex Resilience Group was established and reported to the NHS Sussex Board via the Quality and Delivery Assurance Board.

Off-payroll engagements

PCTs were required to disclose information in relation to the number of off-payroll engagements in place on 31 January 2012 whose annual cost exceeded £52,800 per annum.

Number in Place on 31st January 2012	12
Number that have since come onto a PCT Payroll	0
Number that have come to an end	12

PCTs were also required to disclose information about new off-payroll engagements between 23 August 2012 and 31 March 2013 which were for more than £220 per day and lasted more than 6 months.

Number of new engagements	5
Number of new engagements which included contractual clauses giving the DH the right to request assurance in relation to income tax and National Insurance obligations	0
Number for whom assurance was accepted and received	0
Number for who assurance was accepted and not received	5
Number that have been terminated as a result of assurance not been received	0
Total	5

Our staff

Employee profile

NHS Sussex primary care trusts employed 1082 staff in March 2013, as shown below:

East Sussex Downs & Weald PCT	183 *
Hastings and Rother PCT	208
Brighton and Hove PCT	192
West Sussex PCT	499 †

* including Primary Care Support Services Staff
† including Sussex Health Informatics Service Staff

The information above analyses staffing numbers by employing authority. PCT clustering means that many staff work across organisations; the effect of this is incorporated into each PCT's annual accounts.

We published an annual monitoring report that gave a breakdown of the PCT cluster workforce and whether its composition reflected the population served. This enabled us to identify and respond to any inequalities in our role as an employer. The report for 2012 is available on the NHS Sussex website.

Each PCT in the cluster remained committed to being an employer of choice.

Equality, diversity and human rights

We aimed to have a workforce that represented the diversity of the population we serve. Every member of staff could expect to be treated with dignity and respect, and have equal freedom to flourish and develop.

To that end each PCT had an equal opportunities policy which aimed to ensure that the organisation promoted equality and did not discriminate on the grounds of gender; race (including ethnic origin, colour, nationality and national origin); disability; sexual orientation; religion or beliefs; age; gender reassignment; marriage and civil partnership status; pregnancy and maternity.

More information about our equality and diversity achievements is available in our 2012 equality and diversity annual report, available on the NHS Sussex website.

Staff involvement and consultation

We involved and consulted our staff in a variety of ways.

Our Joint Consultative and Negotiating Committee was the main forum for negotiations between managers and staff representatives on issues relating to pay, terms and conditions, and organisational or service change. Its members included executive directors, senior managers, and representatives of recognised trades unions.

Other involvement and consultation included trades union representation on other committees (e.g. Health and Safety Committee); direct consultation with staff on key issues; and regular staff briefings where staff could question the chief executive.

We participated in the annual NHS staff survey, analysed the local results and key findings, and developed action plans in response to these.

Knowledge and skills framework (KSF)

Knowledge and skills development reviews took place annually. Managers and staff set objectives, and identified personal and professional development needs for the coming year. The results of this review were linked to pay progression through Agenda for Change, the NHS pay system.

GP appraisal

Appraisal is an integral part of working life for GPs, who remain keen to develop the skills and knowledge required to provide high quality care.

A high quality, robust appraisal system ensured that each GP is up to date and fit to practise, and that every Sussex GP was appraised annually in line with Department of Health guidelines.

A Sussex-wide GP Appraisal Steering Group made sure that the appraisal system was fit for purpose, operated with integrity, and ensured regular review and improvement.

Training and development

The NHS Sussex PCT cluster did not have a centralised training and development function but directors, managers and the Joint Consultative and Negotiating Committee reviewed organisation-wide needs and considered how these could best be addressed.

Mandatory training was provided via e-learning modules. This allowed us to collate compliance data across NHS Sussex.

Staff sickness absence

Average sickness absence across NHS Sussex in 2012 was 2.71%. This was lower than the overall NHS rate (4.4%) and the national PCT rate (3.12%). Staff sickness absence information for each PCT for the period January to December 2012 is presented below:

Brighton and Hove PCT	
Total days lost	1032
Total Staff Years	176
Average working days lost	5.85

East Sussex Downs and Weald PCT *	
Total days lost	2028
Total Staff Years	166
Average working days lost	12.25

Hastings and Rother PCT

Total days lost	1374
Total Staff Years	180
Average working days lost	7.65

West Sussex PCT**

Total days lost	6155
Total Staff Years	532
Average working days lost	11.56

* this information relates to employees of Primary Care Support Services, a function hosted by this PCT.
** this information includes employees of the Health Informatics Service, a function hosted by this PCT.

Information governance

We ensured that information could be used in the right way, by the right people, for the benefit of individual patients and the public good. At the same time we ensured that records remained confidential and secure, and managed personal information in line with the Data Protection Act 1988.

Members of staff were required to report any incidents where personal information about patients or staff was lost or their confidentiality breached. Mistakes were investigated thoroughly and any necessary changes made as soon as possible to prevent the same thing happening again.

Serious untoward incidents - personal data

Incidents are reported in the attached PCT's Annual Governance Statement(s) for 2012/13.

Other incidents – personal data

Incidents of lesser significance relating to information governance are reported in the attached PCT's Annual Governance Statement(s) for 2012/13.

Access to Information

We gave people access to their medical records in line with Department of Health guidance.

We made other information available through the NHS Sussex website and in response to Freedom of Information requests. Most Freedom of Information requests were answered free of charge; any charges that applied were shown on our website.

Learning from patients

We were always keen to hear peoples' experiences of local health care services. Listening to people helped us resolve mistakes faster, learn how and what to improve, prevent problems from recurring, and give people the best possible service from the NHS.

Our complaints team and Patient Advice and Liaison Service (PALS) offered support and advice about the services we provided and commissioned, and received feedback, complaints and compliments.

Sharing anonymised information with members of our staff helped identify areas where services needed to improve.

Remedies for complainants have included apologies, explanations of why actions were taken, re-assessments of need, and providing the service required.

Sussex PCTs received 795 complaints in 2012/13. Of these, 149 complaints had been copied to the PCT for information only; 508 were investigated by the relevant PCT; and 139 were referred to other organisations for investigation and response.

PCT	Total no. of Complaints received	Complaints investigated by PCT	Complaints referred to other organisations for investigation	Complaints copied to the PCT for information
ESDW	169	105	10	54
H&R	99	74	6	19
WS	339	199	97	43
B&H	188	130	26	33
Total	**795**	**508**	**139**	**149**

Actions and learning arising from complaints

NHS West Sussex

- Explanations provided about the process for considering funding of low priority treatment.
- Patient Transport Bureau and Ambulance Service IT systems improved and more staff employed to reduce call time for patients booking transport.
- Worked with a dental practitioner to ensure periodontal treatment was made available.
- Full apologies offered and explanations given regarding delays in processing retrospective claims for continuing healthcare.
- Worked with a GP practice to improve its registration process.

NHS East Sussex Downs and Weald and NHS Hastings & Rother

- Full apologies offered and explanations given regarding delays in processing retrospective claims for continuing healthcare.
- Confirmed that GP practices could access interpreting services for patients; hospital patients could access interpreting services via the Patient Advice and Liaison Service at the hospital.
- Stickers applied to a glass door at a health centre to improve safety.
- Patient Transport Bureau and Ambulance Service IT systems improved and more staff employed to reduce call time for patients booking transport.

NHS Brighton and Hove

- A number of GP and dental practices engaged with the Professional Performance and Support Group as a result of complaints; all completed the process satisfactorily.
- A GP practice implemented a new procedure to fax urgent prescriptions to the pharmacy to prevent delays.
- Problems identified in the referral processes of two separate organisations. New process in place and both organisations working together to ensure the same errors do not happen again.

Remuneration report: NHS Brighton and Hove

Cluster Arrangements

NHS Sussex is accountable for delivering the statutory functions of NHS Brighton and Hove, NHS West Sussex, NHS Hastings and Rother and NHS East Sussex Downs and Weald. Its executive management team and non-executive directors work across all four PCTs; each PCT is allocated a share of the cost of the cluster's executive and non-executive directors based on weighted population. NHS Brighton & Hove's share is 18%.

Table 1: Total salaries of executive director management team and share attributable to NHS Brighton and Hove

Name	Title	NHS Sussex 2012-13 Salary (bands of £5,000)	Other 2012-13 Remuneration (bands of £5000) (1)	Total 2012-13 Remuneration (bands of £5000)	NHS B&H 2012-13 Salary (bands of £5,000)	NHS B&H 2011-12 Salary (bands of £5,000)
Amanda Fadero	Chief Executive	145 - 150	-	145 – 150	25 – 30	25 – 30
Andrew Foulkes	Medical Director	70 – 75	-	70 – 75	10 -15	10 – 15
Michael Schofield	Director of Finance	110 - 115	-	110 – 115	20- 25	15 – 20
Sue Braysher	Director of Commissioning Development	95 - 100	-	95 – 100	15 - 20	15 – 20
Sarah Creamer	Director of Performance	95 - 100	-	95 – 100	15 - 20	0 – 5
Julia Dutchman-Bailey	Director of Quality and Chief Nurse	95 - 100	-	95 – 100	15 - 20	15 – 20
Amanda Philpott	Director of Strategy and Provider Development secondment from 10th October 2011	105 -110	-	105 – 110	15 - 20	5 – 10
Claire Quigley	Director of Transition and Governance	85 – 90	160 – 165	245 – 250	40 – 45	10 – 15
Frank Sims	Director of the Sussex Commissioning Support Unit	95 – 100	-	95 – 100	15 – 20	15 – 20

- Other remuneration relates to redundancy payments made in 2012/13.
- No executive directors received benefits in kind, or waived remuneration in the financial year.

Table 2: Pensions benefits of the executive management team

Name and Title	Real increase in pension at age 60 (bands of £2,500) (4)	Real increase in pension 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
	£000	£000	£000	£000	£000	£000	£000
Amanda Fadero, Chief Executive	0	0	60 - 65	180 - 185	1156	1089	10
Andrew Foulkes, Medical Director (1)	-	-	-	-	-	-	-
Michael Schofield, Director of Finance (2)	0 – 2.5	0 – 2.5	40 - 45	120 - 125	0	0	0
Sue Braysher, Director of Commissioning Development	0	0	30 - 35	100 - 105	594	556	10
Sarah Creamer, Director of Performance	0	0	25 - 30	75 – 80	381	353	10
Julia Dutchman-Bailey, Director of Quality and Chief Nurse	0	0	25 - 30	80 - 85	539	502	11
Amanda Philpott, Director of Strategy and Provider Development	0	0	25 - 30	80 - 85	440	430	0
Claire Quigley, Director of Transition and Governance	0	0	25 - 30	75 - 80	432	402	9
Frank Sims, Director of Commissioning Support Unit	0	0	25 - 30	85 - 90	545	509	10

1. Not a member of the NHS Superannuation scheme.
2. Reached 60 years of age prior to 31st March 2012. The option to transfer benefits out of the NHS Superannuation scheme for members of the 1995 section of the scheme ceases on reaching 60 years of age and as such there is nil CETV at 31st March 2012 and 31st March 2013.
3. There were no employer contributions to stakeholder pensions.
4. An inflation factor of 5.2% has been used to calculate the real movement in pensions and pension lump sums as advised by NHS Pensions. Where this results in a real decrease, 0 has been entered in the above table.

Pension Benefits – Understanding the Figures
A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

Rewarding directors and senior managers
NHS Sussex set reward packages for directors and senior managers based on national guidance, and taking into account local market circumstances as appropriate. It recognised the need to ensure value for money and had clear performance management processes led by the Chair and the Chief Executive. One executive director received a redundancy payment in 2012/13. The payment was in line with HM Treasury guidance.

Executive Director salaries and benefits
Salaries and terms and conditions for executive directors were determined by the Remuneration Committee which comprised the following non-executive directors as voting members:
- David Clayton-Smith (Chair)
- Charles Everett (Vice Chair)
- Jeremy Alford
- Peter Douglas
- Rita Lewis
- George Mack
- Denise Stokoe

The Department of Health has in place a pay framework for very senior managers in the NHS. We complied with the guidance in this framework and our remuneration for executive directors followed the pattern of national NHS pay awards.

No bonus payments were made to executive directors in 2012/13. Details of salaries and pension increases for each of the serving Executive directors are set out in the previous table. Executive directors are appointed on permanent contracts with a six month notice period and termination payments clauses following national guidance.

Salary and benefits – non-executive directors
NHS Sussex had non-executive directors to provide scrutiny and advice to the NHS Sussex Board in accordance with the principles of corporate governance. They were appointed by the Appointments Commission on nationally defined fixed term contracts.

Each constituent PCT of NHS Sussex is allocated a share of the cost of non-executive directors based on weighted population.

Table 3: Salary of non-executive directors

	NHS Sussex 2012-13 Salary (bands of £5,000)	NHS B&H 2012-13 Salary (bands of £5,000	NHS B&H 2011-12 Salary (bands of £5,000)
David Clayton Smith	40 – 45	5 - 10	-
Charles Everett	5 – 10	0 – 5	0 – 5
Jeremy Alford	5 – 10	0 – 5	0 – 5
Peter Douglas	10 - 15	0 – 5	0 – 5
Rita Lewis	5 – 10	0 – 5	0 – 5
George Mack	10 - 15	0 – 5	0 – 5
Denise Stokoe	5 – 10	0 – 5	0 – 5

- David Clayton-Smith was appointed Chair of NHS Sussex from 1 April 2012 until 31 March 2013. He continued to serve as Chair of NHS Surrey during this time.
- Non-executive directors do not receive pensionable remuneration so there are no entries in respect of pensions.

Pay Multiples

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

The proportion of the highest-paid director's remuneration attributable to NHS Brighton and Hove is taken as the midpoint of the £25-30,000 band rather than their total remuneration across all four PCTs in the NHS Sussex cluster (i.e. £145,000 – £150,000).

The banded remuneration of the highest paid director in NHS Brighton and Hove in 2012-13 was therefore 0.8 times the median remuneration (£34,189) of the NHS Brighton and Hove workforce. This was the same multiple as in 2011/12.

In 2012-13, 131 NHS Brighton and Hove employees were paid more than the highest paid director's NHS Brighton and Hove remuneration. Pay rates within the organisation ranged from £10,899 to £165,000 per annum.

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.

External Audit review

Only the information included in Table 1: Total salaries of the executive director management team and share attributable to NHS Brighton and Hove, Table 2: Pensions benefits of the executive management team, and Table 3: Salary of non-executive directors has been subject to external audit.

Signed: Date:

Amanda Fadero, Director, Surrey and Sussex Area Team
NHS England

Remuneration report: NHS East Sussex Downs and Weald

Cluster Arrangements
NHS Sussex is accountable for delivering the statutory functions of NHS Brighton and Hove, NHS West Sussex, NHS Hastings and Rother and NHS East Sussex Downs and Weald. Its executive management team and non-executive directors work across all four PCTs; each PCT is allocated a share of the cost of the cluster's executive and non-executive directors based on weighted population. NHS East Sussex Downs and Weald's share is 21.2%.

Table 1: Total salaries of executive director management team and share attributable to NHS East Sussex Downs and Weald

Name	Title	NHS Sussex 2012-13 Salary (bands of £5,000)	Other 2012-13 Remuneration (bands of £5000) (1)	Total 2012-13 Remuneration (bands of £5000)	NHS ESDW 2012-13 Salary (bands of £5,000)	NHS ESDW 2011-12 Salary (bands of £5,000)
Amanda Fadero	Chief Executive	145 - 150	-	145 – 150	30 -35	30 -35
Andrew Foulkes	Medical Director	70 – 75	-	70 – 75	15 – 20	15 – 20
Michael Schofield	Director of Finance	110 - 115	-	110 – 115	20 – 25	20 – 25
Sue Braysher	Director of Commissioning Development	95 - 100	-	95 – 100	20 – 25	20 – 25
Sarah Creamer	Director of Performance	95 - 100	-	95 – 100	20 -25	5 - 10
Julia Dutchman-Bailey	Director of Quality and Chief Nurse	95 - 100	-	95 – 100	20 -25	20 -25
Amanda Philpott	Director of Strategy and Provider Development secondment from 10th October 2011	105 -110	-	105 – 110	20 – 25	10 – 15
Claire Quigley	Director of Transition and Governance	85 – 90	160 – 165	245 – 250	50 – 55	15 – 20
Frank Sims	Director of the Sussex Commissioning Support Unit	95 – 100	-	95 – 100	20 – 25	20 – 25

- Other remuneration relates to redundancy payments made in 2012/13.
- No executive directors received benefits in kind or waived remuneration in the financial year.

Table 2: Pensions benefits of the executive management team

Name and Title	Real increase in pension at age 60 (bands of £2,500)(4)	Real increase in pension 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
	£000	£000	£000	£000	£000	£000	£000
Amanda Fadero, Chief Executive	0	0	60 - 65	180 - 185	1156	1089	10
Andrew Foulkes, Medical Director (1)	-	-	-	-	-	-	-
Michael Schofield, Director of Finance (2)	0 – 2.5	0 – 2.5	40 - 45	120 - 125	0	0	0
Sue Braysher, Director of Commissioning Development	0	0	30 - 35	100 - 105	594	556	10
Sarah Creamer, Director of Performance	0	0	25 - 30	75 – 80	381	353	10
Julia Dutchman-Bailey, Director of Quality and Chief Nurse	0	0	25 - 30	80 - 85	539	502	11
Amanda Philpott, Director of Strategy and Provider Development	0	0	25 - 30	80 - 85	440	430	0
Claire Quigley, Director of Transition and Governance	0	0	25 – 30	75 - 80	432	402	9
Frank Sims Director of Commissioning Support Unit	0	0	25 – 30	85 - 90	545	509	10

1. Not a member of the NHS Superannuation scheme.
2. Reached 60 years of age prior to 31st March 2012. The option to transfer benefits out of the NHS Superannuation scheme for members of the 1995 section of the scheme ceases on reaching 60 years of age and as such there is nil CETV at 31st March 2012 and 31st March 2013.
3. There were no employer contributions to stakeholder pensions.
4. An inflation factor of 5.2% has been used to calculate the real movement in pensions and pension lump sums as advised by NHS Pensions. Where this results in a real decrease, 0 has been entered in the above table.

Pension Benefits – Understanding the Figures

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

Rewarding directors and senior managers
NHS Sussex set reward packages for directors and senior managers based on national guidance, and taking into account local market circumstances as appropriate. It recognised the need to ensure value for money and had clear performance management processes led by the Chair and the Chief Executive. One executive director received a redundancy payment in 2012/13. The payment was in line with HM Treasury guidance.

Executive director salaries and benefits
Salaries and terms and conditions for executive directors were determined by the Remuneration Committee which comprised the following non-executive directors as voting members:

- David Clayton-Smith (Chair)
- Charles Everett (Vice Chair)
- Jeremy Alford
- Peter Douglas
- Rita Lewis
- George Mack
- Denise Stokoe

The Department of Health has in place a pay framework for very senior managers in the NHS. We complied with the guidance in this framework and our remuneration for executive directors followed the pattern of national NHS pay awards.

No bonus payments were made to executive directors in 2012/13. Details of salaries and pension increases for each of the serving executive directors are set out in the previous table. Executive directors are appointed on permanent contracts with a six month notice period and termination payments clauses following national guidance.

Salary and benefits – non-executive directors
NHS Sussex had non-executive directors to provide scrutiny and advice to the NHS Sussex Board in accordance with the principles of corporate governance. They were appointed by the Appointments Commission on nationally defined fixed term contracts.

Each constituent PCT of NHS Sussex is allocated a share of the cost of non-executive directors based on weighted population.

Table 3: Salary of non-executive directors

	NHS Sussex 2012-13 Salary (bands of £5,000)	NHS ESDW 2012-13 Salary (bands of £5,000	NHS ESDW 2011-12 Salary (bands of £5,000)
David Clayton Smith	40 - 45	5 – 10	-
Charles Everett	5 – 10	0 – 5	0 – 5
Jeremy Alford	5 – 10	0 – 5	0 – 5
Peter Douglas	10 - 15	0 – 5	0 – 5
Rita Lewis	5 – 10	0 – 5	0 – 5
George Mack	10 - 15	0 – 5	0 – 5
Denise Stokoe	5 – 10	0 – 5	0 – 5

- David Clayton-Smith was appointed Chair of NHS Sussex from 1 April 2012 until 31 March 2013. He continued to serve as Chair of NHS Surrey during this time.
- Non-executive directors do not receive pensionable remuneration so there are no entries in respect of pensions.

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

The proportion of the highest-paid director's remuneration attributable to NHS East Sussex Downs and Weald Hove is taken as the midpoint of the £30-35,000 band rather than their total remuneration across all four PCTs in the NHS Sussex cluster (i.e. £145,000 – £150,000).

The banded remuneration of the highest paid director in NHS Sussex Downs and Weald in 2012-13 was therefore 1.46 times the median remuneration (£21,711) of the NHS Sussex Downs and Weald workforce. This was the down from a multiple of 1.76 in 2011/12.

In 2012-13, 67 NHS Sussex Downs and Weald employees were paid more than the highest paid director's NHS Sussex Downs and Weald remuneration. Pay rates within the organisation ranged from £6,713 to £101,629 per annum.

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.

External Audit review
Only the information included in Table 1: Total salaries of the executive director management team and share attributable to NHS East Sussex Downs and Weald, Table 2: Pensions benefits of the executive management team, and Table 3: Salary of non-executive directors has been subject to external audit.

Signed: Date:

Amanda Fadero, Director, Surrey and Sussex Area Team
NHS England

Remuneration report: NHS Hastings and Rother

Cluster Arrangements

NHS Sussex is accountable for delivering the statutory functions of NHS Brighton and Hove, NHS West Sussex, NHS Hastings and Rother and NHS East Sussex Downs and Weald. Its executive management team and non-executive directors work across all four PCTs; each PCT is allocated a share of the cost of the cluster's executive and non-executive directors based on weighted population. NHS Hastings and Rother's share is 12.5%.

Table 1: Total salaries of executive director management team and share attributable to NHS Hastings and Rother

Name	Title	NHS Sussex 2012-13 Salary (bands of £5,000)	Other 2012-13 Remuneration (bands of £5000) (1)	Total 2012-13 Remuneration (bands of £5000)	NHS H&R 2012-13 Salary (bands of £5,000)	NHS H&R 2011-12 Salary (bands of £5,000)
Amanda Fadero	Chief Executive	145 - 150	-	145 – 150	15 – 20	15 – 20
Andrew Foulkes	Medical Director	70 – 75	-	70 – 75	5 - 10	5 - 10
Michael Schofield	Director of Finance	110 - 115	-	110 – 115	10 - 15	10 - 15
Sue Braysher	Director of Commissioning Development	95 - 100	-	95 – 100	10 - 15	10 - 15
Sarah Creamer	Director of Performance	95 - 100	-	95 – 100	10 - 15	0 - 5
Julia Dutchman-Bailey	Director of Quality and Chief Nurse	95 - 100	-	95 – 100	10 - 15	10 - 15
Amanda Philpott	Director of Strategy and Provider Development secondment from 10th October 2011	105 - 110	-	105 – 110	10 - 15	5 - 10
Claire Quigley	Director of Transition and Governance	85 – 90	160 – 165	245 – 250	30 - 35	10 - 15
Frank Sims	Director of the Sussex Commissioning Support Unit	95 – 100	-	95 – 100	10 - 15	10 - 15

- Other remuneration relates to redundancy payments made in 2012/13.
- No executive directors received benefits in kind or waived remuneration in the financial year.

Table 2: Pensions benefits of the executive management team

Name and Title	Real increase in pension at age 60 (bands of £2,500)(4)	Real increase in pension 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
	£000	£000	£000	£000	£000	£000	£000
Amanda Fadero, Chief Executive	0	0	60 - 65	180 - 185	1156	1089	10
Andrew Foulkes, Medical Director (1)	-	-	-	-	-	-	-
Michael Schofield, Director of Finance (2)	0 – 2.5	0 – 2.5	40 - 45	120 - 125	0	0	0
Sue Braysher, Director of Commissioning Development	0	0	30 - 35	100 - 105	594	556	10
Sarah Creamer, Director of Performance	0	0	25 - 30	75 – 80	381	353	10
Julia Dutchman-Bailey, Director of Quality and Chief Nurse	0	0	25 - 30	80 - 85	539	502	11
Amanda Philpott, Director of Strategy and Provider Development	0	0	25 - 30	80 - 85	440	430	0
Claire Quigley, Director of Transition and Governance	0	0	25 – 30	75 - 80	432	402	9
Frank Sims Director of Commissioning Support Unit	0	0	25 – 30	85 - 90	545	509	10

1. Not a member of the NHS Superannuation scheme.

2. Reached 60 years of age prior to 31st March 2012. The option to transfer benefits out of the NHS Superannuation scheme for members of the 1995 section of the scheme ceases on reaching 60 years of age and as such there is nil CETV at 31st March 2012 and 31st March 2013.
3. There were no employer contributions to stakeholder pensions.
4. An inflation factor of 5.2% has been used to calculate the real movement in pensions and pension lump sums as advised by NHS Pensions. Where this results in a real decrease, 0 has been entered in the above table.

Pension Benefits – Understanding the Figures

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

Rewarding directors and senior managers

NHS Sussex set reward packages for directors and senior managers based on national guidance, and taking into account local market circumstances as appropriate. It recognised the need to ensure value for money and had clear performance management processes led by the Chair and the Chief Executive. One executive director received a redundancy payment in 2012/13. The payment was in line with HM Treasury guidance.

Executive director salaries and benefits

Salaries and terms and conditions for executive directors were determined by the Remuneration Committee which comprised the following non-executive directors as voting members:

- David Clayton-Smith (Chair)
- Charles Everett (Vice Chair)
- Jeremy Alford
- Peter Douglas
- Rita Lewis
- George Mack
- Denise Stokoe

The Department of Health has in place a pay framework for very senior managers in the NHS. We complied with the guidance in this framework and our remuneration for executive directors followed the pattern of national NHS pay awards.

No bonus payments were made to executive directors in 2012/13. Details of salaries and pension increases for each of the serving executive directors are set out in the previous table. Executive directors are appointed on permanent contracts with a six month notice period and termination payments clauses following national guidance.

Salary and Benefits – non-executive directors

NHS Sussex had non-executive directors to provide scrutiny and advice to the NHS Sussex Board in accordance with the principles of corporate governance. They were appointed by the Appointments Commission on nationally defined fixed term contracts.

Each constituent PCT of NHS Sussex is allocated a share of the cost of non-executive directors based on weighted population.

Table 3: Salary of non-executive directors

	NHS Sussex 2012-13 Salary (bands of £5,000)	NHS H&R 2012-13 Salary (bands of £5,000	NHS H&R 2011-12 Salary (bands of £5,000)
David Clayton Smith	40 - 45	5 - 10	-
Charles Everett	5 – 10	0 – 5	0 – 5
Jeremy Alford	5 – 10	0 – 5	0 – 5
Peter Douglas	10 - 15	0 – 5	0 – 5
Rita Lewis	5 – 10	0 – 5	0 – 5
George Mack	10 - 15	0 – 5	0 – 5
Denise Stokoe	5 – 10	0 – 5	0 – 5

- David Clayton-Smith was appointed Chair of NHS Sussex from 1 April 2012 until 31 March 2013. He continued to serve as Chair of NHS Surrey during this time.
- Non-executive directors do not receive pensionable remuneration so there are no entries in respect of pensions.

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

The proportion of the highest-paid director's remuneration attributable to NHS Hastings and Rother is taken as the midpoint of the £15-20,000 band rather than their total remuneration across all four PCTs in the NHS Sussex cluster (i.e. £145,000 – £150,000).

The banded remuneration of the highest paid director in NHS Hastings and Rother in 2012-13 was therefore 1.35 times the median remuneration (£12,923) of the NHS Hastings and Rother workforce, down from a multiple of 1.7 in 2011/12.

In 2012-13, 41 NHS Hastings and Rother employees were paid more than the highest paid director's NHS Hastings and Rother and Hove remuneration. Pay rates within the organisation ranged from £3,960 to £59,944 per annum.

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.

External Audit review
Only the information included in Table 1: Total salaries of the executive director management team and share attributable to NHS Hastings and Rother, Table 2: Pensions benefits of the executive management team, and Table 3: Salary of non-executive directors has been subject to external audit.

Signed: Date:

Amanda Fadero, Director, Surrey and Sussex Area Team
NHS England

Remuneration report: NHS West Sussex

Cluster Arrangements

NHS Sussex is accountable for delivering the statutory functions of NHS Brighton and Hove, NHS West Sussex, NHS Hastings and Rother and NHS East Sussex Downs and Weald. Its executive management team and non-executive directors work across all four PCTs; each PCT is allocated a share of the cost of the cluster's executive and non-executive directors based on weighted population. NHS West Sussex's share is 48.4%.

Table 1: Total salaries of executive director management team and share attributable to NHS West Sussex

Name	Title	NHS Sussex 2012-13 Salary (bands of £5,000)	Other 2012-13 Remuneration (bands of £5000) (1)	Total 2012-13 Remuneration (bands of £5000)	NHS West Sussex 2012-13 Salary (bands of £5,000)	NHS West Sussex 2011-12 Salary (bands of £5,000)
Amanda Fadero	Chief Executive	145 - 150	-	145 – 150	70 – 75	70 – 75
Andrew Foulkes	Medical Director	70 – 75	-	70 – 75	30 – 35	30 – 35
Michael Schofield	Director of Finance	110 - 115	-	110 – 115	50 – 55	70 – 75
Sue Braysher	Director of Commissioning Development	95 - 100	-	95 – 100	45 – 50	45 – 50
Sarah Creamer	Director of Performance	95 - 100	-	95 – 100	45 – 50	10 - 15
Julia Dutchman-Bailey	Director of Quality and Chief Nurse	95 - 100	-	95 – 100	45 – 50	45 - 50
Amanda Philpott	Director of Strategy and Provider Development secondment from 10th October 2011	105 -110	-	105 – 110	50 - 55	20 – 25
Claire Quigley	Director of Transition and Governance	85 - 90	160 – 165	245 – 250	120 – 125	40 - 45
Frank Sims	Director of the Sussex Commissioning Support Unit	95 - 100	-	95 – 100	45 – 50	45 - 50

- Other remuneration relates to redundancy payments made in 2012/13.
- No executive directors received benefits in kind or waived remuneration in the financial year.

Table 2: Pensions benefits of the executive management team

Name and Title	Real increase in pension at age 60 (bands of £2,500)(4)	Real increase in pension 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
	£000	£000	£000	£000	£000	£000	£000
Amanda Fadero, Chief Executive	0	0	60 – 65	180 - 185	1156	1089	10
Andrew Foulkes, Medical Director (1)	-	-	-	-	-	-	-
Michael Schofield, Director of Finance (2)	0 – 2.5	0 – 2.5	40 – 45	120 - 125	0	0	0
Sue Braysher, Director of Commissioning Development	0	0	30 – 35	100 - 105	594	556	10
Sarah Creamer, Director of Performance	0	0	25 - 30	75 – 80	381	353	10
Julia Dutchman-Bailey, Director of Quality and Chief Nurse	0	0	25 - 30	80 - 85	539	502	11
Amanda Philpott, Director of Strategy and Provider Development	0	0	25 - 30	80 - 85	440	430	0
Claire Quigley, Director of Transition and Governance	0	0	25 – 30	75 - 80	432	402	9
Frank Sims, Director of Commissioning Support Unit	0	0	25 – 30	85 - 90	545	509	10

1. Not a member of the NHS Superannuation scheme.
2. Reached 60 years of age prior to 31st March 2012. The option to transfer benefits out of the NHS Superannuation scheme for members of the 1995 section of the scheme ceases on reaching 60 years of age and as such there is nil CETV at 31st March 2012 and 31st March 2013.
3. There were no employer contributions to stakeholder pensions.
4. An inflation factor of 5.2% has been used to calculate the real movement in pensions and pension lump sums as advised by NHS Pensions. Where this results in a real decrease, 0 has been entered in the above table.

Pension Benefits – Understanding the Figures

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

Rewarding directors and senior managers
NHS Sussex set reward packages for directors and senior managers based on national guidance, and taking into account local market circumstances as appropriate. It recognised the need to ensure value for money and had clear performance management processes led by the Chair and the Chief Executive. One executive director received a redundancy payment in 2012/13. The payment was in line with HM Treasury guidance.

Executive director salaries and benefits
Salaries and terms and conditions for executive directors were determined by the Remuneration Committee which comprised the following non-executive directors as voting members:

- David Clayton-Smith (Chair)
- Charles Everett (Vice Chair)
- Jeremy Alford
- Peter Douglas
- Rita Lewis
- George Mack
- Denise Stokoe

The Department of Health has in place a pay framework for very senior managers in the NHS. We complied with the guidance in this framework and our remuneration for executive directors followed the pattern of national NHS pay awards.

No bonus payments were made to executive directors in 2012/13. Details of salaries and pension increases for each of the serving executive directors are set out in the previous table. Executive directors are appointed on permanent contracts with a six month notice period and termination payments clauses following national guidance.

Salary and benefits – non-executive directors
NHS Sussex had non-executive directors to provide scrutiny and advice to the NHS Sussex Board in accordance with the principles of corporate governance. They were appointed by the Appointments Commission on nationally defined fixed term contracts.

Each constituent PCT of NHS Sussex is allocated a share of the cost of non-executive directors based on weighted population.

Table 3: Salary of non-executive directors

	NHS Sussex 2012-13 Salary (bands of £5,000)	NHS West Sussex 2012-13 Salary (bands of £5,000	NHS West Sussex 2011-12 Salary (bands of £5,000)
David Clayton Smith	40 - 45	20 - 25	-
Charles Everett	5 – 10	0 – 5	5 – 10
Jeremy Alford	5 – 10	0 – 5	0 – 5
Peter Douglas	10 - 15	5 – 10	5 – 10
Rita Lewis	5 – 10	0 – 5	0 – 5
George Mack	10 - 15	5 – 10	5 – 10
Denise Stokoe	5 – 10	0 – 5	5 – 10

- David Clayton-Smith was appointed Chair of NHS Sussex from 1 April 2012 until 31 March 2013. He continued to serve as Chair of NHS Surrey during this time.
- Non-executive directors do not receive pensionable remuneration so there are no entries in respect of pensions.

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

The proportion of the highest-paid director's remuneration attributable to NHS West Sussex is taken as the midpoint of the £70-75,000 band rather than their total remuneration across all four PCTs in the NHS Sussex cluster (i.e. £145,000 – £150,000).

The banded remuneration of the highest paid director in NHS West Sussex in 2012-13 was therefore 2.2 times the median remuneration (£33,570) of the NHS West Sussex workforce. This was the same multiple as in 2011/12.

In 2012-13, 11 NHS West Sussex employees were paid more than the highest paid director's NHS West Sussex remuneration. Pay rates within the organisation ranged from £13,995 to £149,065 per annum.

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.

External Audit review
Only the information included in Table 1: Total salaries of the executive director management team and share attributable to NHS West Sussex, Table 2: Pensions benefits of the executive management team, and Table 3: Salary of non-executive directors has been subject to external audit.

Signed: Date:

Amanda Fadero, Director, Surrey and Sussex Area Team
NHS England

Annual report signature

The above combined annual report for the Sussex PCTs, together with the remuneration reports which are an integral part of the annual report, are signed and dated below.

DATE **Amanda Fadero** **Accountable officer**

Appendix 1: Board membership 2012/13

Chair
David Clayton-Smith.
Interests – Chair of Surrey Primary Care Trust

Non-executive directors
Charles Everett (Vice Chair)
Interests – Trustee of St Michaels Hospice; Non Executive Board Member of Surrey and Sussex Probation Trust, a ministerial appointment

Jeremy Alford
Interests – Director of Sunderland Marine Mutual Insurance Company Limited

Peter Douglas (Audit Committee Chair, ESDW, H&R)
Interests – Council Member of the General Optical Council; Member of the Appeals Committee of the General Pharmaceutical Company

Rita Lewis
Interests – Chair of the British Acupuncture Accreditation Board; Deputy Chair of the Optical Consumer Complaints Service; Chair and Trustee of Action versus Medical Accidents

George Mack (Audit Committee Chair, B&H, WSx)
Interests - no declared interests

Denise Stokoe
Interests - no declared interests

Executive directors
Amanda Fadero – Chief Executive
Interests – no declared interests

Andrew Foulkes – Medical Director
Interests – partner in Avisford Medical Group

Michael Schofield – Director of Finance
Interests – no declared interests

Julia Dutchman Bailey – Director of Quality and Chief Nurse
Interests – no declared interests

Sue Braysher – Director of Commissioning Development
Interests – no declared interests

Sarah Creamer – Director of Performance
Interests – no declared interests

Amanda Philpott – Director of Strategy and Provider Development
Interests – Company Secretary Cormack Consulting Limited

Claire Quigley – Director of Transition and Governance
Interests – Trustee of The Circus Project; Governor of Sussex Partnership Foundation Trust; Local Authority Education Governor at St John the Baptist School, Brighton

Frank Sims – Director of Commissioning Support Unit
Interests – no declared interests

Appendix 2: Performance indicators

Targets for 2012/13 and actual performance against them are set out below for each PCT in Sussex. The tables are based on available data at March 2013 unless otherwise stated. The colour key is:

- Red performance more than 5% below target
- Amber performance within 5% of target
- Green performance better than target

Indicator	PCT Performance							
	West Sussex		Brighton & Hove		Hasting & Rother		East Sussex Downs and Weald	
	Plan YTD	Actual YTD	Plan YTD	Actual YTD	Plan YTD	Actual YTD	Plan YTD	Actual YTD
MRSA Infections	14	**17**	3	**8**	4	**4**	4	**1**
Clostridium Difficile	252	**285**	89	**66**	49	**46**	94	**100**
RTT - admitted - 95th percentile	23	**22.6**	23	**22.4**	23	**24.4**	23	**22.8**
RTT - non-admitted - 95th percentile	18	**17.1**	18	**16.3**	18	**17.7**	18	**16.8**
RTT - incomplete - 95th percentile	28	**20.9**	28	**19.9**	28	**17.7**	28	**18.5**
the median time waited for admitted patients whose clocks stopped during the period on an adjusted basis	11	**7.8**	11	**10.8**	11	**10.7**	11	**10.0**
the median time waited for non-admitted patients whose clocks stopped during the period	7	**4.6**	7	**2.9**	7	**5.2**	7	**5.7**
the median time waited for patients on incomplete pathways at the end of the period	7	**6.5**	7	**6.1**	7	**5.6**	7	**5.8**
Numbers waiting on an incomplete Referral to Treatment pathway	42,529	**47,912**	13,952	**12,518**	11,058	**10,087**	17,889	**20,118**
18 Weeks Referral To Treatment - Admitted patients treated within 18 weeks	90.0%	**91.94%**	90.0%	**91.42%**	90.0%	**89.90%**	90.0%	**91.09%**

18 Weeks Referral To Treatment - Non Admitted patients treated within 18 weeks		95.0%	**96.33%**	95.0%	**97.48%**	95.0%	**95.44%**	95.0%	**96.64%**
Percentage of patients waiting >= 6weeks for diagnostic tests		1%	**0.39%**	1%	**0.53%**	1%	**0.81%**	1%	**1.07%**
Ambulance Response times to Cat A - % within 8 minutes (Cluster)		75.0%	**75.50%**	75.0%	**85.90%**	75.0%	**81.60%**	75.0%	**73.60%**
Ambulance Response times to Cat A - % within 19 minutes (Cluster)		95.0%	**96.87%**	95.0%	**99.26%**	95.0%	**97.41%**	95.0%	**96.18%**
Ambulance Response times to Cat A - % within 8 minutes (SECAmb)		Not applicable							
Ambulance Response times to Cat A - % within 19 minutes (SECAmb)		Not applicable							
4 hour wait time in A&E		95.0%	**95.92%**	95.0%	**93.36%**	95.0%	**95.73%**	95.0%	**94.97%**
Emergency Readmissions		8.38%	**7.68%**	9.01%	**8.25%**	7.30%	**6.57%**	7.29%	**6.60%**
A&E to Emergency Admissions Ratio		0.28	**0.28**	0.24	**0.23**	0.21	**0.17**	0.26	**0.25**
Two-week maximum wait from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals		93.0%	**95.55%**	93.0%	**95.85%**	93.0%	**94.20%**	93.0%	**94.13%**
Two-week maximum wait from referral to first outpatient appointment for symptomatic breast patients		93.0%	**94.62%**	93.0%	**97.79%**	93.0%	**92.33%**	93.0%	**95.48%**
Proportion of patients with suspected cancer, referred through GP who wait less than 62 days from referral to treatment		85.0%	**85.48%**	85.0%	**87.69%**	85.0%	**84.67%**	85.0%	**83.64%**
Proportion of patients with suspected cancer, detected through national screening		90.0%	**90.88%**	90.0%	**95.89%**	90.0%	**93.75%**	90.0%	**90.27%**

programmes or by hospital specialists who wait less than 62 days from referral to treatment									
Cancer 62 - Maximum waiting time of two months from Consultant Upgrade to treatment		85.0%	**91.67%**	85.0%	**97.37%**	85.0%	**92.50%**	85.0%	**86.62%**
Cancer 31 - Maximum waiting time of one month from diagnosis to treatment for all cancers		96.0%	**97.89%**	96.0%	**97.99%**	96.0%	**97.75%**	96.0%	**96.86%**
Proportion of patients waiting no more than 31 days for subsequent cancer treatment (surgery)		94.0%	**97.54%**	94.0%	**97.94%**	94.0%	**98.64%**	94.0%	**97.49%**
Proportion of patients waiting no more than 31 days for subsequent cancer treatment (Drug)		98.0%	**99.36%**	98.0%	**99.40%**	98.0%	**100.00%**	98.0%	**100.00%**
Proportion of patients waiting no more than 31 days for subsequent cancer treatment (Radiotherapy)		94.0%	**93.72%**	94.0%	**87.64%**	94.0%	**98.69%**	94.0%	**90.41%**
Proportion of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit		80.0%	**82.19%**	80.0%	**89.38%**	80.0%	**77.22%**	80.0%	**81.28%**
Proportion of people at high risk of Stroke who experience a TIA are assessed and treated within 24 hours		60.0%	**73.12%**	60.0%	**76.03%**	60.0%	**72.13%**	60.0%	**70.83%**
Delayed Transfers of Care per 100,000 population		15	**10.67**	15	**8.25**	15	**10.93**	15	**10.93**
Referral rates per 100,000 population for 1st OP attendances by referral source		437	**417.70**	436	**467.21**	369	**342.30**	389	**375.38**
Low Priority Procedures		Data captured at Provider level so performance against total Trust level							
C section rates as percentage of all		Data captured at Provider level so performance against total Trust level							

births									
Fractured Neck of Femur 48 Hours - Reported Cumulatively		85.0%	**87.12%**	85.0%	**92.32%**	85.0%	**92.22%**	85.0%	**96.79%**
Never events		Data captured at Provider level so performance against total Trust level							
Number of patients receiving NHS primary dental services located within the PCT area within a 24 month period		456,893	**433,972**	159,903	**148,116**	120,518	**110,028**	202,389	**184,782**
Patient reported measure of GP Access		83.3%	**91.09%**	83.3%	**89.49%**	83.3%	**91.81%**	83.3%	**92.46%**
QOF domain scores and exception reporting rate (PERFORMANCE COMPARED AGAINST NATIONAL AVERAGE)		94.7%	**95.25%**	94.7%	**90.46%**	94.7%	**92.37%**	94.7%	**94.25%**
The number of new cases of psychosis served by early intervention teams year to date		92	**92**	44	**54**	20	**25**	36	**31**
The number of Home Treatment episodes carried out by Crisis Resolution/Home Treatment teams - Reported Cumulatively		1228	**1,095**	600	**671**	852	**1,154**	See Hasting & Rother, for East Sussex Total performance	
The proportion of those patients on Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days		95.0%	**97.66%**	95.0%	**97.56%**	95.0%	**98.66%**	95.0%	**97.33%**
% of all people with depression / anxiety disorders who receive psychological therapies		3.6%	**14.8%**	2.8%	**9.7%**	5.5%		See Hasting & Rother, for East Sussex Total performance	
The proportion of people who complete treatment who are moving to recovery		51.0%	**51.1%**	38.0%	**41.8%**	35.0%		See Hasting & Rother, for East Sussex Total performance	
All Women to receive results of cervical screening tests within		98.0%	**95.10%**	98.0%	**93.62%**	98.0%	**98.86%**	98.0%	**97.31%**

2 weeks									
Diabetic Retinopathy Screening Offered		95.0%	**102.20%**	95.0%	**99.10%**	95.0%	**108.76%**	95.0%	**106.99%**
SQU27: Coverage of NHS Health Checks - Offered - Reported Cumulatively		18.2%	**10.9%**	18.3%	**13.9%**	18.1%	**9.4%**	19.4%	**8.7%**
SQU27: Coverage of NHS Health Checks - screened - reported Cumulatively		8.0%	**5.5%**	7.6%	**6.2%**	7.2%	**4.5%**	7.8%	**5.4%**
Maternity 12 weeks		90.0%	**94.46%**	90.0%	**94.41%**	90.0%	**91.04%**	90.0%	**96.56%**
Coverage of breast feeding		95.0%	**90.21%**	95.0%	**94.37%**	95.0%	**95.79%**	95.0%	**94.26%**
Prevalence of breastfeeding at 6-8 wks after birth		48.0%	**49.7%**	69.3%	**68.9%**	45.3%	**43.4%**	48.0%	**50.5%**
Offered access to genito-urinary medicine clinic < 2 days - commissioner		98.0%	**99.93%**	98.0%	**99.85%**	98.0%	**99.91%**	98.0%	**99.54%**
Under 18 conception rate per 1,000 female aged 15 to 17		23	**29.1**	31	**36.5**	31	**35.3**	See Hasting & Rother, for East Sussex Total performance	
Immunisation - Aged 1 immunized for DTaP/IPV/Hib (Sussex Cluster performance is average of the PCTs, actual cluster performance will be available in Q1 11/12)		95.0%	**95.99%**	92.0%	**93.67%**	95.0%	**93.78%**	95.0%	**94.72%**
Immunisation - Aged 2 immunised for PCV (Sussex Cluster actual and plan is the average of the PCTs, actual cluster performance will be available in Q1 11/12)		95.0%	**92.39%**	87.0%	**90.38%**	95.0%	**91.82%**	95.0%	**93.13%**
Immunisation - Aged 2 immunised for Hib/MenC (Sussex Cluster actual and plan is the average of the PCTs, actual cluster performance		96.0%	**94.12%**	89.0%	**90.85%**	95.0%	**92.67%**	95.0%	**93.06%**

will be available in Q1 11/12)									
Immunisation - Aged 2 immunised for MMR (Sussex Cluster actual and plan is the average of the PCTs, actual cluster performance will be available in Q1 11/12)		95.0%	**94.11%**	87.0%	**91.74%**	95.0%	**92.37%**	95.0%	**93.53%**
Immunisation - Aged 5 immunised for DTaP/IPV(Sussex Cluster actual and plan is the average of the PCTs)		96.2%	**90.09%**	80.0%	**89.37%**	95.0%	**89.44%**	95.0%	**87.95%**
Immunisation - Aged 5 immunised for MMR (Sussex Cluster actual and plan is the average of the PCTs)		95.0%	**87.53%**	76.0%	**85.82%**	95.0%	**87.22%**	95.0%	**86.49%**
Immunisation - females aged 12-13 for HPV			86.8%		84.9%		90.4%		83.9%
Number of 4-week smoking quitters that have attended NHS Stop Smoking Services		2,664	**2,356**	1,800	**1,755**	957	**815**	1,219	**1,015**
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period		92.0%	**93.0%**	92.0%	**93.6%**	92.0%	**95.2%**	92.0%	**94.6%**

Annual Governance Statement for West Sussex PCT

1. Scope of responsibility

The Board was accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I had responsibility for maintaining a sound system of internal control that supported the achievement of the organisation's policies, aims and objectives until 31 March 2013. I also had responsibility for safeguarding the public funds and the organisation's assets for which I was personally responsible as set out in the Accountable Officer Memorandum.

West Sussex Primary Care Trust (PCT) achieved its statutory financial duties to remain within its revenue, cash and capital resource limits in the financial year 2012/13. It reported a £777,000 surplus compared to the control total target surplus of £750,000. Capital expenditure in the year was £13.3m with capital receipts of £0.7m resulting in net capital expenditure of £12.6m which was within the Capital Resource Limit of £13.8m. Cash spending was within the cash limit of £1,369m.

2. The governance framework of the organisation

Good corporate governance and the management of risk is a corporate responsibility and, accordingly, the Board took a leading role in ensuring that management strategies and supporting processes were in place. The Board did this through its own annual review of the risk management strategy, by regular review of its assurance framework and through the governance, internal control, risk and assurance work of its committees. The Board was committed to ensuring that good corporate governance and risk management were integral to the organisation's philosophy, practice and planning rather than being viewed or practiced as separate programmes, and to ensuring that responsibility for implementation was accepted at all levels of the organisation. A record of Board members' attendance at Board meetings is presented below.

NHS Sussex Board Meeting Attendance Log

Name	Role	22/05 2012	07/06 2012	24/7 2012	25/09 2012	25/09 2012 AGM	09/11 2012	23/11 2012	22/01 2013	26/03 2013
David Clayton-Smith	Chairman	✓	✓	✓	✓	✓	✓	✓	✓	✓
Amanda Fadero	Chief Executive	✓	✓	✓	✓	✓	✓	✓	✓	✓
Andrew Foulkes	Medical Director	✓	✓	✓	✓	✓	✓	✓	x	✓
Sue Braysher	Director of Commissioning Development	✓	x	x	✓	✓	✓	✓	✓	✓
Sarah Creamer	Director of Performance	✓	✓	✓	✓	✓	✓	✓	x	✓
Julia Dutchman-Bailey	Director of Quality and Chief Nurse	✓	✓	✓	✓	✓	x	✓	✓	✓
Amanda Philpott	Director of Strategy and Provider Development	✓	✓	✓	✓	✓	✓	✓	✓	✓
Claire Quigley	Director of Transition and Governance	✓	x	✓	✓	✓	✓	✓	x	✓
Michael Schofield	Director of Finance	✓	✓	✓	✓	✓	✓	✓	✓	✓
Frank Sims	Director of Commissioning Support Unit	✓	✓	✓	X	x	✓	X	x	✓
Jeremy Alford	Non Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	x

Peter Douglas	Non Executive Director	✓	x	✓	✓	✓	✓	✓	✓	✓
Charles Everett	Non Executive Director (Vice Chair)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rita Lewis	Non Executive Director	✓	✓	✓	✓	✓	✓	✓	x	✓
George Mack	Non Executive Director	✓	✓	x	✓	✓	✓	✓	✓	✓
Denise Stokoe	Non Executive Director	✓	✓	✓	✓	✓	✓	✓	x	✓

✓ = present, x = absent.

I was appointed as Chief Executive of NHS Sussex and each of the four statutory PCTs in Sussex. I led a single executive team across NHS Sussex. I had overall responsibility until 31 March 2013 for ensuring that effective governance and risk management systems were in place, meeting all statutory and legal requirements, and adhering to guidance issued by the Department of Health in respect of governance. My Director of Governance and Transition was accountable to me for the strategic development and implementation of organisational risk management and governance controls. All my executive directors were accountable to me for risk management and governance across the breadth of their functions.

In line with the recommendations of the Integrated Governance Handbook, NHS Sussex established committees responsible for reviewing the management of all types of risk, both clinical and non-clinical.

The Quality and Delivery Assurance Board, supported by the establishment of Clinical Commissioning Groups (CCGs) as committees of the Board with their own assurance processes, and developing through the CCG authorisation process, managed this agenda in 2012/13 in preparation for statutory establishment of CCGs from 1 April 2013.

A Transition Assurance Board (TAB) was established during 2012/13 to oversee the operational handover of current PCT functions to appropriate receiving organisations and provide supporting closure (legacy) documentation. The Director of Transition and Governance, an NHS Sussex board member, was the executive lead member of TAB. Specialist transition groups covering closedown, human resources and finance were also established to support the work of TAB. A transition and closedown report confirming that all PCT-critical closure activities had been covered was received at the final NHS Sussex board meeting.

The governance and risk systems ensured that the PCT discharged its statutory functions during 2012/13 and that these were legally compliant. The TAB had specific responsibility for ensuring the legal closure of the PCT on 31st March 2013 and completion of the necessary Transfer Schemes.

The Audit Committees of the four Sussex PCTs met jointly as NHS Sussex Audit Committee to enable a single senior overview of audit and internal control matters. The Audit Committees reported to the Board and reviewed the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) that supported the achievement of the organisation's objectives.

The Audit Committees ensured that there was an effective internal audit function that met mandatory NHS Internal Audit Standards and provided appropriate independent assurance to the Audit Committees, Chief Executive and Board. The Committees reviewed the work and findings of the external auditors, and considered the implications and managerial response to the auditors' work. The Committees satisfied themselves that the organisation had adequate arrangements in place for countering fraud and reviewed the outcomes of counter fraud work. Directly in relation to financial reporting, the Committees monitored the integrity of the financial statements of the PCTs and ensured that the systems for reporting to the Board, including those of budgetary control, were subject to review as to completeness and accuracy of the information provided to the Board until 31 March 2013. The

Committees reviewed the draft annual report and early working papers for the financial statements of the PCTs, including this Annual Governance Statement. Completion of the 2012/13 accounts and approval for these and the related statements took place after the closure of the PCTs via governance arrangements under the accountability of the NHS Business Services Authority.

In preparing this statement compliance with the five sections of the UK Corporate Governance Code was reviewed as follows:

Leadership
A.1 The Role of the Board. Every company should be headed by an effective board which is collectively responsible for the long-term success of the company. *Compliant. The types of decisions taken by the board or delegated to management were detailed in the published scheme of delegation.*
A.2 Division of Responsibilities. There should be a clear division of responsibilities at the head of the company between the running of the board and the executive responsibility for the running of the company's business. No one individual should have unfettered powers of decision. *Compliant. The roles of Chairman and Chief Executive were separate.*
A.3 The Chairman. The chairman is responsible for leadership of the board and ensuring its effectiveness on all aspects of its role. *Compliant.*
A.4 Non-executive directors. As part of their role as members of a unitary board, non-executive directors should constructively challenge and help develop proposals on strategy. *Compliant. A Senior Independent Director was formally designated.*

Effectiveness
B.1 The Composition of the Board. The board and its committees should have the appropriate balance of skills, experience, independence and knowledge of the company to enable them to discharge their respective duties and responsibilities effectively. *Compliant. Regulations were changed in 2010 enabling non-executive directors to be members of multiple PCTs. NHS Sussex directors held multiple membership of the four PCTs in Sussex. Non-executive directors were appointed independently by the Appointments Commission.*
B.2 Appointments to the Board. There should be a formal, rigorous and transparent procedure for the appointment of new directors to the board. *Compliant. Nominations were put to the Remuneration Committee as a result of transparent appointment processes.*
B.3 Commitment. All directors should be able to allocate sufficient time to the company to discharge their responsibilities effectively. *Compliant. Executive directors allocated time as per contract; non-executive directors complied with and were reviewed against applicable Appointments Commission guidance.*
B.4 Development. All directors should receive induction on joining the board and should regularly update and refresh their skills and knowledge. *Compliant. Mandatory training provided; in 2012/13 non-essential training was limited due to closure of the PCTs but development programmes for CCG senior staff were in place.*
B.5 Information and Support. The board should be supplied in a timely manner with information in a form and of a quality appropriate to enable it to discharge its duties. *Compliant.Adequate resources were available under the guidance of the Chief Executive and executive directors.*
B.6 Evaluation. The board should undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors. *Compliant. Individual performance reviews took place for executive and non-executive directors; the operation of the Board itself was reviewed in April 2012 with particular emphasis on how it would work in the final year of the existence of PCTs. Review and performance management by NHS South of England in place.*
B.7 Re-election. *Not applicable, the composition of PCT Boards was based on statute and followed NHS guidance.*

Accountability
C.1 Financial and Business Reporting. The board should present a balanced and understandable assessment of the company's position and prospects. *Compliant. Provided in annual report.*
C.2 Risk Management and Internal Control. 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 should maintain sound risk management and internal control systems. *Compliant. In 2012/13 there were*

significant changes to NHS commissioning organisations in preparation for new structures in 2013/14; such large scale change inherently carried risks which the Board mitigated as described and published in its board assurance framework.

C.3 Audit Committee and Auditors. The board should establish formal and transparent arrangements for considering how it should apply the corporate reporting and risk management and internal control principles and for maintaining an appropriate relationship with the company's auditor. *Compliant. Contained within the terms of reference of the Audit Committees and described in this Annual Governance Statement.*

Code schedule B. Disclosure on corporate governance arrangements. *Compliant. Described in this Annual Governance Statement.*

Remuneration

D.1 The Level and Components of Remuneration. The levels of remuneration should be sufficient to attract, retain and motivate directors of the quality required to run the company successfully, but a company should avoid paying more than is necessary for this purpose. A significant proportion of executive director's remuneration should be structured so as to link rewards to corporate and individual performance. *Compliant. Remuneration was paid in line with agreed NHS reward schemes.*

D.2 Remuneration Procedure. There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding his or her own remuneration. *Compliant. Remuneration for executives was set by the remuneration committee, not by individual directors.*

Code schedule A. *The design of performance-related remuneration for executive directors was not applicable under NHS schemes.*

Relations with Shareholders

E.1 Dialogue with Shareholders. There should be a dialogue with shareholders based on the mutual understanding of objectives. The board as a whole has responsibility for ensuring that a satisfactory dialogue with shareholders takes place. *Compliant. There were no shareholders but the organisation was accountable to the public for its activities and engaged patients, stakeholder organisations and the public in planning its objectives; particularly when considering larger scale service changes where it had a duty to consult.*

E.2 Constructive use of the AGM. The board should use the AGM to communicate with investors and encourage their participation. *Compliant. There were no investors but patients, stakeholder organisations and the public were encouraged to participate.*

3. The risk and control framework

The system of internal control was designed to manage risk to a reasonable level rather than eliminate all risk of failure to achieve policies, aims and objectives; it could therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control was in place in West Sussex PCT throughout the year ended 31 March 2013.

The NHS Sussex Board operated harmonised risk management across its constituent PCTs. The risk management strategy was approved and reported to the Board. Mandatory risk management training, with a mandatory update every two years, was made available to all staff. A full range of health and safety and other mandatory training packages were made available to relevant staff. Records of attendances were kept and collated for reporting purposes

In line with the Risk Management Strategy the risk and control framework was designed to focus management attention on risks at the appropriate level in the organisation. In particular it was designed to set the most significant risks before the Board and its committees in order that resources could be applied to adjust controls that prevented or mitigated the risks, and gain assurances that those controls were effective. The key components of the risk management system - including the method of risk assessment, directorate risk registers, corporate risk register and the assurance framework - were described clearly in the PCT's Risk Management Strategy. Risk assessment enabled effective mitigating actions to be devised and encouraged the proactive identification and prevention of manifest risks and potential risks. Risk deterrents were also in place, for example through counter fraud work.

The Board assurance framework required high level risks with a score of 15 or above to be presented to the Board. This assurance framework was populated and reviewed at a lower level by the executive team and by CCG committees with responsibility for governance. The assurance framework was developed to provide assurance to the Board that the systems, policies and people it had put in place were operating in a way that supported the delivery of objectives by focusing on preventing and minimising risk. It ensured that the Board was informed of the principal risks which faced the organisation together with action plans to address them. It was a regularly updated or 'live' document linked to the more detailed corporate and departmental risk registers and to key business planning documents for the PCT. The assurance framework identified for each strategic objective of the Board:-

- Principal risks, being the highest risks in the corporate risk register.
- Key controls to assist in managing risks to secure the achievement of the objective.
- The sources of evidence on which reliance of the effectiveness of the systems was placed.
- The detailed assurances obtained showing the evidence presented to the Board including internal assurances on the effectiveness of systems from Board committees, staff, Internal Audit and external bodies (the Audit Commission, NHS Litigation Authority, Care Quality Commission etc).
- Any gaps in control i.e. systems not in place
- Any gaps in assurance i.e. systems in place but evidence not available.
- The detail of actions put in place to mitigate the risk including relevant milestones and target dates for removal.
- Progress on the actions
- Most recent review date
- Target removal date
- Executive ownership

4. Risk assessment

The PCT recognised that it is not possible to eliminate all risks and that systems of control should not be so rigid that they stifle imaginative use of limited resources in order to provide an effective service. In order to establish a consistent framework for assessing and managing risk, the organisation adapted a standard risk assessment tool from the National Patient Safety Agency and determined the levels of authority at which risks should be addressed. This provided a consistent approach across all of the different types of assessment that were undertaken. All identified risks were brought to the attention of Line Managers who had responsibility for making an initial assessment of the risk.

The organisation determined that risks identified as having a total score of 11 (moderate) or below would be managed at team/department level by Line Managers. These risks were considered small enough to have an immaterial effect on the organisation's objectives, or could be controlled effectively in order to minimise adverse consequences.

Those risks identified as scoring 12+ (high) or above, or where a manager could not immediately introduce control measures to reduce the level of risk to an acceptable level, were notified to an appropriate Director who determined how the risk would be addressed. Moderated risks with a score of 12+ formed part of the corporate risk register.

Risks determined with a score of 15+ as moderated by appropriate Directors were escalated to the assurance framework for attention of the Board.

The organisational risk profile was made clear through assurance framework reports presented at each ordinary Board meeting. The reports highlighted risks against principal objectives and included the level of risk, the balance of risks and the trend in risks.

During 2012/13 the emerging CCGs remained under the NHS Sussex risk system. Since 1 April 2013 CCGs run their own risk systems with their own risk management strategies, policies and procedures. A proposal was approved by the NHS Sussex Audit Committee regarding the closedown process for NHS Sussex risks and the transfer of risks to receiving organisations by 31 March 2013. The following table

highlights the key newly identified significant risks in terms of impact and likelihood reported in the final NHS Sussex Board Assurance Framework and the receiving body for these risks.

Key risks included in the Final Assurance Framework, March 2013

Risk No.	Risk description	Risk score	Actions taken
119	There is risk that current breast screening equipment in Worthing will be obsolete before the new West Sussex breast unit is complete.	20	*This risk was subsequently transferred to and accepted by the Surrey and Sussex Area Team, NHS England.*
217	There is a risk of a new strain of influenza pandemic virus developing, and we cannot predict with certainty when it will happen, the epidemiology of an emergent influenza pandemic virus or its clinical behaviour.	20	*This risk was subsequently transferred to and accepted by the Surrey and Sussex Area Team, NHS England, and some of the Sussex CCGs.*
312	There is a risk that there will be insufficient management capacity within the Clinical Commissioning Groups to achieve the scale and scope of change required and this may impact on the delivery of the QIPP plans across Sussex	20	*This risk was subsequently transferred to and accepted by some of the Sussex CCGs.*
314	There is a risk that the centralisation of arterial vascular surgery with 24/7services at BSUH will not be achieved by March 2013	20	*This risk was subsequently transferred to and accepted by the Surrey and Sussex Area Team, NHS England.*
571	DH Guidance relating to the timescales for making retrospective Continuing Healthcare claims has resulted in a significant rise in claims received by PCTs requiring assessment with consequent risk of service disruption.	20	*This risk was subsequently transferred to and accepted by Coastal West Sussex CCG as hosts of the future service.*
140	There is a risk that there is insufficient capacity to deliver core operational processes and there is a delay to operationalisation of the Surrey and Sussex Commissioning Support Unit	16	*This risk was subsequently transferred to and accepted by Surrey and Sussex Commissioning Support Unit*

The Board agreed its principal objectives in May 2012 and monitored them at each standard board meeting during the remainder of 2012/13. These objectives are set out in the table below as Strategic Goals (SG).

Strategic Goal 1. Quality, Delivery and Performance SG1.1 - Deliver the quality and safeguarding responsibilities including the quality standards outlined in the Sussex Plan SG1.2 - Deliver the performance improvements outlined in the Sussex Plan SG1.3 - Deliver the financial plans for 12/13 outlined in the 2 year Sussex plan
Strategic Goal 2. Transition SG2.1 - Supporting our staff through the transition and maximising their talents and capabilities SG2.2 - NHS Sussex responsibilities are transferred to successor organisations by end March 2013 SG2.3 - Establish effective Clinical Commissioning Groups and an effective Commissioning Support Service for the future
Strategic Goal 3. Strategy SG3.1 - Deliver the agreed outcomes from Sussex Together SG3.2 - Foster pan-Sussex working arrangements to improve services for patients SG3.3 - Strengthening our strategic partnerships to improve the health and wellbeing of our population
Strategic Goal 4. Health Outcomes SG4.1 - Reduce Health Inequalities within our population SG4.2 - Improve the health and wellbeing of our population

Information governance incidents

There were no Information Governance Serious Untoward Incidents (IG SUIs) this year (i.e. scored at level 5, the most serious level, on the IG SUI grading matrix.

There was one category 4 Serious Incident this year which related to confidential information being sent to the wrong recipient by email. The data did not leave the boundaries of the NHS and all data was retrieved.

Summary of Serious Untoward Incidents

Category	**Nature of incident**	**West Sussex PCT**
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	0
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	0
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	1
V	Other	0
	Totals for the year	**1**

Information governance incidents of a less significant nature are listed by category in the table below:

Summary of other personal data related incidents

Category	Nature of incident	West Sussex PCT
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	0
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	0
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	5
V	Other	0
	Totals for the year	**5**

Subject Access Requests were dealt with effectively, within the time constraints set out by the Department of Health. A Subject Access Request and Caldicott Log were maintained and updated by the Information Governance Team to keep track of requests from members of the public and any queries raised by staff about the management of personal information.

Control and risk related to performance indicators

More than sixty key performance indicators were regularly monitored by the Board and past performance reports were available to the public on the NHS Sussex website. These reports included nationally agreed operating targets together with supporting measures and wider targets agreed locally. Performance outcomes for 2012/13 are disclosed in the annual report.

For the purpose of this statement the following table identifies those nationally recognised indicators (headline measures and supporting measures) that did not reach target for the full year 2012/13.

Key performance indicator (KPI) grouping	Indicator	West Sussex	
		Full Year Plan	**Full Year Actual**
HCAIs	MRSA Infections	14	**17**
HCAIs	Clostridium Difficile	252	**285**
18 weeks	Numbers waiting on an incomplete Referral to Treatment pathway	42,529	**47,912**
Primary Care	Number of patients receiving NHS primary dental services located within the PCT area within a 24 month period	456,893	**433,972**
Mental Health	The number of Home Treatment episodes carried out by Crisis Resolution/Home Treatment teams - Reported Cumulatively	1228	**1,095**
Screening	All Women to receive results of cervical screening tests within 2 weeks	98.0%	**95.10%**
Screening	SQU27: Coverage of NHS Health Checks - Offered - Reported Cumulatively	18.2%	**10.9%**
Screening	SQU27: Coverage of NHS Health Checks - screened - reported Cumulatively	8.0%	**5.5%**
Maternity	Coverage of breast feeding	95.0%	**90.21%**
Health Improvement	Under 18 conception rate per 1,000 female aged 15 to 17	23	**29.1**
Health Improvement	Immunisation - Aged 2 immunised for PCV (Sussex Cluster actual and plan is the average of the PCTs, actual cluster performance will be available in Q1 11/12)	95.0%	**92.39%**
Health Improvement	Immunisation - Aged 2 immunised for Hib/MenC (Sussex Cluster actual and plan is the average of the PCTs, actual cluster performance will be available in Q1 11/12)	96.0%	**94.12%**

Health Improvement	Immunisation - Aged 5 immunised for DTaP/IPV(Sussex Cluster actual and plan is the average of the PCTs)		96.2%	**90.09%**
Health Improvement	Immunisation - Aged 5 immunised for MMR (Sussex Cluster actual and plan is the average of the PCTs)		95.0%	**87.53%**
Health Improvement	Number of 4-week smoking quitters that have attended NHS Stop Smoking Services		2,664	**2,356**

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

As Accountable Officer, I had responsibility for reviewing the effectiveness of the system of internal control for the financial year ending 31 March 2013. My review was informed in a number of ways. The head of internal audit provided me with an opinion on the overall arrangements for gaining assurance through assessment of the assurance framework and on the controls reviewed as part of the internal auditor's work. Executive managers within the organisation with responsibility for the development and maintenance of the system of internal control provided me with assurance. The assurance framework itself provided me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives were reviewed.

My review was also informed by the work of our external auditors, Ernst and Young LLP (particularly in relation to audit of the financial statements 2012/13 and value for money conclusion 2012/13) and by the work of our internal auditors, South Coast Audit (particularly in relation to audit of risk and assurance processes 2012/13 and audits supporting the financial statements).

The Head of Internal Audit opinion states: "**Significant assurance** can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk."

Internal audit work covered a range of risk-based audit assignments throughout the year. Of the 28 audits and reviews reported against, one 'limited assurance' opinion was given, two 'split assurance' opinions were given, and fifteen 'significant assurance' opinions were given. A further ten consultancy and development reviews were undertaken where no assurance opinion was given. The Head of Internal Audit, in reaching an overall assessment for 2012/13 of 'significant assurance' took into account:

- the relative importance of the areas audited and the positive results from the core annual audit work on key financial systems;
- the number of risk based reviews where 'significant' assurance was provided; and
- the 'significant' assurance provided by the development, design and operation of the Board Assurance Framework and associated risk management processes.

Limited assurance was received regarding Commissioning Support Unit service requirements as no agreed indicators or targets were agreed with service users to assess performance and delivery.

Recommendations and action plans for these areas were managed through the NHS Sussex system of follow-up, and the implementation of audit recommendations was monitored by the Audit Committees. This system gave me assurance that control issues were dealt with effectively by executive directors.

I was advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board and the Audit Committee. A plan to address weaknesses and ensure continuous improvement of the system remained in place until the close of the PCT.

6. Significant Issues

Two areas were identified as significant issues:

- The non-delivery of national priority headline and supporting measures as set out in section 4. Performance Management processes were in place during 2012/13 to mitigate performance risks and the PCT has worked with emerging Clinical Commissioning Groups and other receiving organisations to develop future performance management regimes.

- The PCT will receive a qualified value for money conclusion from its external auditors. The year end financial position has been reached only by the use of non-recurrent measures and the PCT was not able to demonstrate the required reduction of acute demand and costs planned by the Sussex Together programme. During 2012/13 the PCT worked with emerging Clinical Commissioning Groups in West Sussex to develop appropriate QIPP savings initiatives for 2013/14 and beyond to address the underlying issues.

Accountable Officer: Amanda Fadero

Organisation: West Sussex PCT

7th June 2013

Amanda Fadero, Director, Surrey and Sussex Area Team, NHS England

Annual Governance Statement for Hastings and Rother PCT

1. Scope of responsibility

The Board was accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I had responsibility for maintaining a sound system of internal control that supported the achievement of the organisation's policies, aims and objectives until 31 March 2013. I also had responsibility for safeguarding the public funds and the organisation's assets for which I was personally responsible as set out in the Accountable Officer Memorandum.

Hastings and Rother Primary Care Trust (PCT) achieved its statutory financial duties to remain within its revenue, cash and capital resource limits in the financial year 2012/13. It reported a £878,000 surplus compared to the control total target surplus of £750,000. Capital expenditure in the year at £2.1 million was within the Capital Resource Limit of £2.6m and cash spending was within the cash limit of £345m.

2. The governance framework of the organisation

Good corporate governance and the management of risk is a corporate responsibility and, accordingly, the Board took a leading role in ensuring that management strategies and supporting processes were in place. The Board did this through its own annual review of the risk management strategy, by regular review of its assurance framework and through the governance, internal control, risk and assurance work of its committees. The Board was committed to ensuring that good corporate governance and risk management were integral to the organisation's philosophy, practice and planning rather than being viewed or practiced as separate programmes, and to ensuring that responsibility for implementation was accepted at all levels of the organisation. A record of Board members' attendance at Board meetings is presented below.

NHS Sussex Board Meeting Attendance Log

Name	Role	22/05 2012	07/06 2012	24/7 2012	25/09 2012	25/09 2012 AGM	09/11 2012	23/11 2012	22/01 2013	26/03 2013
David Clayton-Smith	Chairman	✓	✓	✓	✓	✓	✓	✓	✓	✓
Amanda Fadero	Chief Executive	✓	✓	✓	✓	✓	✓	✓	✓	✓
Andrew Foulkes	Medical Director	✓	✓	✓	✓	✓	✓	✓	x	✓
Sue Braysher	Director of Commissioning Development	✓	x	x	✓	✓	✓	✓	✓	✓
Sarah Creamer	Director of Performance	✓	✓	✓	✓	✓	✓	✓	x	✓
Julia Dutchman-Bailey	Director of Quality and Chief Nurse	✓	✓	✓	✓	✓	x	✓	✓	✓
Amanda Philpott	Director of Strategy and Provider Development	✓	✓	✓	✓	✓	✓	✓	✓	✓
Claire Quigley	Director of Transition and Governance	✓	x	✓	✓	✓	✓	✓	x	✓
Michael Schofield	Director of Finance	✓	✓	✓	✓	✓	✓	✓	✓	✓
Frank Sims	Director of Commissioning Support Unit	✓	✓	✓	X	x	✓	X	x	✓
Jeremy Alford	Non Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	x
Peter Douglas	Non Executive Director	✓	x	✓	✓	✓	✓	✓	✓	✓
Charles	Non Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓

Everett	(Vice Chair)									
Rita Lewis	Non Executive Director	✓	✓	✓	✓	✓	✓	✓	x	✓
George Mack	Non Executive Director	✓	✓	x	✓	✓	✓	✓	✓	✓
Denise Stokoe	Non Executive Director	✓	✓	✓	✓	✓	✓	✓	x	✓

✓ = present, x = absent.

I was appointed as Chief Executive of NHS Sussex and each of the four statutory PCTs in Sussex. I led a single executive team across NHS Sussex. I had overall responsibility until 31 March 2013 for ensuring that effective governance and risk management systems were in place, meeting all statutory and legal requirements, and adhering to guidance issued by the Department of Health in respect of governance. My Director of Governance and Transition was accountable to me for the strategic development and implementation of organisational risk management and governance controls. All my executive directors were accountable to me for risk management and governance across the breadth of their functions.

In line with the recommendations of the Integrated Governance Handbook, NHS Sussex established committees responsible for reviewing the management of all types of risk, both clinical and non-clinical.

The Quality and Delivery Assurance Board, supported by the establishment of Clinical Commissioning Groups (CCGs) as committees of the Board with their own assurance processes, and developing through the CCG authorisation process, managed this agenda in 2012/13 in preparation for statutory establishment of CCGs from 1 April 2013.

A Transition Assurance Board (TAB) was established during 2012/13 to oversee the operational handover of current PCT functions to appropriate receiving organisations and provide supporting closure (legacy) documentation. The Director of Transition and Governance, an NHS Sussex board member, was the executive lead member of TAB. Specialist transition groups covering closedown, human resources and finance were also established to support the work of TAB. A transition and closedown report confirming that all PCT-critical closure activities had been covered was received at the final NHS Sussex board meeting.

The governance and risk systems ensured that the PCT discharged its statutory functions during 2012/13 and that these were legally compliant. The TAB had specific responsibility for ensuring the legal closure of the PCT on 31st March 2013 and completion of the necessary Transfer Schemes.

The Audit Committees of the four Sussex PCTs met jointly as NHS Sussex Audit Committee to enable a single senior overview of audit and internal control matters. The Audit Committees reported to the Board and reviewed the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) that supported the achievement of the organisation's objectives.

The Audit Committees ensured that there was an effective internal audit function that met mandatory NHS Internal Audit Standards and provided appropriate independent assurance to the Audit Committees, Chief Executive and Board. The Committees reviewed the work and findings of the external auditors, and considered the implications and managerial response to the auditors' work. The Committees satisfied themselves that the organisation had adequate arrangements in place for countering fraud and reviewed the outcomes of counter fraud work. Directly in relation to financial reporting, the Committees monitored the integrity of the financial statements of the PCTs and ensured that the systems for reporting to the Board, including those of budgetary control, were subject to review as to completeness and accuracy of the information provided to the Board until 31 March 2013. The Committees reviewed the draft annual report and early working papers for the financial statements of the PCTs, including this Annual Governance Statement. Completion of the 2012/13 accounts and approval

for these and the related statements took place after the closure of the PCTs via governance arrangements under the accountability of the NHS Business Services Authority.

In preparing this statement compliance with the five sections of the UK Corporate Governance Code was reviewed as follows:

Leadership
A.1 The Role of the Board. Every company should be headed by an effective board which is collectively responsible for the long-term success of the company. *Compliant. The types of decisions taken by the board or delegated to management were detailed in the published scheme of delegation.*
A.2 Division of Responsibilities. There should be a clear division of responsibilities at the head of the company between the running of the board and the executive responsibility for the running of the company's business. No one individual should have unfettered powers of decision. *Compliant. The roles of Chairman and Chief Executive were separate.*
A.3 The Chairman. The chairman is responsible for leadership of the board and ensuring its effectiveness on all aspects of its role. *Compliant.*
A.4 Non-executive directors. As part of their role as members of a unitary board, non-executive directors should constructively challenge and help develop proposals on strategy. *Compliant. A Senior Independent Director was formally designated.*

Effectiveness
B.1 The Composition of the Board. The board and its committees should have the appropriate balance of skills, experience, independence and knowledge of the company to enable them to discharge their respective duties and responsibilities effectively. *Compliant. Regulations were changed in 2010 enabling non-executive directors to be members of multiple PCTs. NHS Sussex directors held multiple membership of the four PCTs in Sussex. Non-executive directors were appointed independently by the Appointments Commission.*
B.2 Appointments to the Board. There should be a formal, rigorous and transparent procedure for the appointment of new directors to the board. *Compliant. Nominations were put to the Remuneration Committee as a result of transparent appointment processes.*
B.3 Commitment. All directors should be able to allocate sufficient time to the company to discharge their responsibilities effectively. *Compliant. Executive directors allocated time as per contract; non-executive directors complied with and were reviewed against applicable Appointments Commission guidance.*
B.4 Development. All directors should receive induction on joining the board and should regularly update and refresh their skills and knowledge. *Compliant. Mandatory training provided; in 2012/13 non-essential training was limited due to closure of the PCTs but development programmes for CCG senior staff were in place.*
B.5 Information and Support. The board should be supplied in a timely manner with information in a form and of a quality appropriate to enable it to discharge its duties. *Compliant.Adequate resources were available under the guidance of the Chief Executive and executive directors.*
B.6 Evaluation. The board should undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors. *Compliant. Individual performance reviews took place for executive and non-executive directors; the operation of the Board itself was reviewed in April 2012 with particular emphasis on how it would work in the final year of the existence of PCTs. Review and performance management by NHS South of England in place.*
B.7 Re-election. *Not applicable, the composition of PCT Boards was based on statute and followed NHS guidance.*

Accountability
C.1 Financial and Business Reporting. The board should present a balanced and understandable assessment of the company's position and prospects. *Compliant. Provided in annual report.*
C.2 Risk Management and Internal Control. 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 should maintain sound risk management and internal control systems. *Compliant. In 2012/13 there were significant changes to NHS commissioning organisations in preparation for new structures in 2013/14;*

such large scale change inherently carried risks which the Board mitigated as described and published in its board assurance framework.
C.3 Audit Committee and Auditors. The board should establish formal and transparent arrangements for considering how it should apply the corporate reporting and risk management and internal control principles and for maintaining an appropriate relationship with the company's auditor. *Compliant. Contained within the terms of reference of the Audit Committees and described in this Annual Governance Statement.*
Code schedule B. Disclosure on corporate governance arrangements. *Compliant. Described in this Annual Governance Statement.*

Remuneration
D.1 The Level and Components of Remuneration. The levels of remuneration should be sufficient to attract, retain and motivate directors of the quality required to run the company successfully, but a company should avoid paying more than is necessary for this purpose. A significant proportion of executive director's remuneration should be structured so as to link rewards to corporate and individual performance. *Compliant. Remuneration was paid in line with agreed NHS reward schemes.*
D.2 Remuneration Procedure. There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding his or her own remuneration. *Compliant. Remuneration for executives was set by the remuneration committee, not by individual directors.*
Code schedule A. *The design of performance-related remuneration for executive directors was not applicable under NHS schemes.*

Relations with Shareholders
E.1 Dialogue with Shareholders. There should be a dialogue with shareholders based on the mutual understanding of objectives. The board as a whole has responsibility for ensuring that a satisfactory dialogue with shareholders takes place. *Compliant. There were no shareholders but the organisation was accountable to the public for its activities and engaged patients, stakeholder organisations and the public in planning its objectives; particularly when considering larger scale service changes where it had a duty to consult.*
E.2 Constructive use of the AGM. The board should use the AGM to communicate with investors and encourage their participation. *Compliant. There were no investors but patients, stakeholder organisations and the public were encouraged to participate.*

3. The risk and control framework

The system of internal control was designed to manage risk to a reasonable level rather than eliminate all risk of failure to achieve policies, aims and objectives; it could therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control was in place in Hastings and Rother PCT throughout the year ended 31 March 2013.

The NHS Sussex Board operated harmonised risk management across its constituent PCTs. The risk management strategy was approved and reported to the Board. Mandatory risk management training, with a mandatory update every two years, was made available to all staff. A full range of health and safety and other mandatory training packages were made available to relevant staff. Records of attendances were kept and collated for reporting purposes

In line with the Risk Management Strategy the risk and control framework was designed to focus management attention on risks at the appropriate level in the organisation. In particular it was designed to set the most significant risks before the Board and its committees in order that resources could be applied to adjust controls that prevented or mitigated the risks, and gain assurances that those controls were effective. The key components of the risk management system - including the method of risk assessment, directorate risk registers, corporate risk register and the assurance framework - were described clearly in the PCT's Risk Management Strategy. Risk assessment enabled effective mitigating actions to be devised and encouraged the proactive identification and prevention of manifest risks and potential risks. Risk deterrents were also in place, for example through counter fraud work.

The Board assurance framework required high level risks with a score of 15 or above to be presented to the Board. This assurance framework was populated and reviewed at a lower level by the executive team and by CCG committees with responsibility for governance. The assurance framework was developed to provide assurance to the Board that the systems, policies and people it had put in place were operating in a way that supported the delivery of objectives by focusing on preventing and minimising risk. It ensured that the Board was informed of the principal risks which faced the organisation together with action plans to address them. It was a regularly updated or 'live' document linked to the more detailed corporate and departmental risk registers and to key business planning documents for the PCT. The assurance framework identified for each strategic objective of the Board:-

- Principal risks, being the highest risks in the corporate risk register.
- Key controls to assist in managing risks to secure the achievement of the objective.
- The sources of evidence on which reliance of the effectiveness of the systems was placed.
- The detailed assurances obtained showing the evidence presented to the Board including internal assurances on the effectiveness of systems from Board committees, staff, Internal Audit and external bodies (the Audit Commission, NHS Litigation Authority, Care Quality Commission etc).
- Any gaps in control i.e. systems not in place
- Any gaps in assurance i.e. systems in place but evidence not available.
- The detail of actions put in place to mitigate the risk including relevant milestones and target dates for removal.
- Progress on the actions
- Most recent review date
- Target removal date
- Executive ownership

4. Risk assessment

The PCT recognised that it is not possible to eliminate all risks and that systems of control should not be so rigid that they stifle imaginative use of limited resources in order to provide an effective service. In order to establish a consistent framework for assessing and managing risk, the organisation adapted a standard risk assessment tool from the National Patient Safety Agency and determined the levels of authority at which risks should be addressed. This provided a consistent approach across all of the different types of assessment that were undertaken. All identified risks were brought to the attention of Line Managers who had responsibility for making an initial assessment of the risk.

The organisation determined that risks identified as having a total score of 11 (moderate) or below would be managed at team/department level by Line Managers. These risks were considered small enough to have an immaterial effect on the organisation's objectives, or could be controlled effectively in order to minimise adverse consequences.

Those risks identified as scoring 12+ (high) or above, or where a manager could not immediately introduce control measures to reduce the level of risk to an acceptable level, were notified to an appropriate Director who determined how the risk would be addressed. Moderated risks with a score of 12+ formed part of the corporate risk register.

Risks determined with a score of 15+ as moderated by appropriate Directors were escalated to the assurance framework for attention of the Board.

The organisational risk profile was made clear through assurance framework reports presented at each ordinary Board meeting. The reports highlighted risks against principal objectives and included the level of risk, the balance of risks and the trend in risks.

During 2012/13 the emerging CCGs remained under the NHS Sussex risk system. Since 1 April 2013 CCGs run their own risk systems with their own risk management strategies, policies and procedures. A proposal was approved by the NHS Sussex Audit Committee regarding the closedown process for NHS Sussex risks and the transfer of risks to receiving organisations by 31 March 2013. The following table

highlights the key newly identified significant risks in terms of impact and likelihood reported in the final NHS Sussex Board Assurance Framework and the receiving body for these risks.

Key risks included in the Final Assurance Framework, March 2013

Risk No.	Risk description	Risk score	Actions taken
119	There is risk that current breast screening equipment in Worthing will be obsolete before the new West Sussex breast unit is complete.	20	*This risk was subsequently transferred to and accepted by the Surrey and Sussex Area Team, NHS England.*
217	There is a risk of a new strain of influenza pandemic virus developing, and we cannot predict with certainty when it will happen, the epidemiology of an emergent influenza pandemic virus or its clinical behaviour.	20	*This risk was subsequently transferred to and accepted by the Surrey and Sussex Area Team, NHS England, and some of the Sussex CCGs.*
312	There is a risk that there will be insufficient management capacity within the Clinical Commissioning Groups to achieve the scale and scope of change required and this may impact on the delivery of the QIPP plans across Sussex	20	*This risk was subsequently transferred to and accepted by some of the Sussex CCGs.*
314	There is a risk that the centralisation of arterial vascular surgery with 24/7services at BSUH will not be achieved by March 2013	20	*This risk was subsequently transferred to and accepted by the Surrey and Sussex Area Team, NHS England.*
571	DH Guidance relating to the timescales for making retrospective Continuing Healthcare claims has resulted in a significant rise in claims received by PCTs requiring assessment with consequent risk of service disruption.	20	*This risk was subsequently transferred to and accepted by Coastal West Sussex CCG as hosts of the future service.*
140	There is a risk that there is insufficient capacity to deliver core operational processes and there is a delay to operationalisation of the Surrey and Sussex Commissioning Support Unit	16	*This risk was subsequently transferred to and accepted by Surrey and Sussex Commissioning Support Unit*

The Board agreed its principal objectives in May 2012 and monitored them at each standard board meeting during the remainder of 2012/13. These objectives are set out in the table below as Strategic Goals (SG).

Strategic Goal 1. Quality, Delivery and Performance SG1.1 - Deliver the quality and safeguarding responsibilities including the quality standards outlined in the Sussex Plan SG1.2 - Deliver the performance improvements outlined in the Sussex Plan SG1.3 - Deliver the financial plans for 12/13 outlined in the 2 year Sussex plan
Strategic Goal 2. Transition SG2.1 - Supporting our staff through the transition and maximising their talents and capabilities SG2.2 - NHS Sussex responsibilities are transferred to successor organisations by end March 2013 SG2.3 - Establish effective Clinical Commissioning Groups and an effective Commissioning Support Service for the future
Strategic Goal 3. Strategy SG3.1 - Deliver the agreed outcomes from Sussex Together SG3.2 - Foster pan-Sussex working arrangements to improve services for patients SG3.3 - Strengthening our strategic partnerships to improve the health and wellbeing of our population
Strategic Goal 4. Health Outcomes SG4.1 - Reduce Health Inequalities within our population SG4.2 - Improve the health and wellbeing of our population

Information governance incidents

There were no Information Governance Serious Untoward Incidents (IG SUIs) this year (i.e. scored at level 5, the most serious level, on the IG SUI grading matrix.

The category 4 incident related to confidential information being sent to the wrong recipient by email. The data did not leave the boundaries of the NHS and all data was retrieved. There was one category 3 Information Governance Serious Incident this year which related to a GP disposing of a patient record in an inappropriate manner.

Summary of Serious Untoward Incidents

Category	Nature of incident	Hastings and Rother PCT
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	0
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	0
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	1
IV	Unauthorised disclosure	1
V	Other	0
	Totals for the year	**2**

* *East Sussex Downs and Weald PCT and Hastings and Rother PCT work closely together, with staff working across both organisations, and incidents reported under East Sussex Downs and Weald PCT may reflect joint working arrangements.*

Subject Access Requests were dealt with effectively, within the time constraints set out by the Department of Health. A Subject Access Request and Caldicott Log were maintained and updated by the Information Governance Team to keep track of requests from members of the public and any queries raised by staff about the management of personal information.

Control and risk related to performance indicators

More than sixty key performance indicators were regularly monitored by the Board and past performance reports were available to the public on the NHS Sussex website. These reports included nationally agreed operating targets together with supporting measures and wider targets agreed locally. Performance outcomes for 2012/13 are disclosed in the annual report.

For the purpose of this statement the following table identifies those nationally recognised indicators (headline measures and supporting measures) that did not reach target for the full year 2012/13.

KPI Grouping	Indicator	Hasting & Rother	
		Full Year Plan	Full Year Actual
18 weeks	RTT - admitted - 95th percentile	23	24.4

Stroke	Proportion of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit		80.0%	**77.22%**
Primary Care	Number of patients receiving NHS primary dental services located within the PCT area within a 24 month period		120,518	**110,028**
Primary Care	QOF domain scores and exception reporting rate (PERFORMANCE COMPARED AGAINST NATIONAL AVERAGE)		94.7%	**92.37%**
Screening	SQU27: Coverage of NHS Health Checks - Offered - Reported Cumulatively		18.1%	**9.4%**
Screening	SQU27: Coverage of NHS Health Checks - screened - reported Cumulatively		7.2%	**4.5%**
Maternity	Prevalence of breastfeeding at 6-8 wks after birth		45.3%	**43.4%**
Health Improvement	Under 18 conception rate per 1,000 female aged 15 to 17		31	**35.3**
Health Improvement	Immunisation - Aged 1 immunized for DTaP/IPV/Hib (Sussex Cluster performance is average of the PCTs, actual cluster performance will be available in Q1 11/12)		95.0%	**93.78%**
Health Improvement	Immunisation - Aged 2 immunised for PCV (Sussex Cluster actual and plan is the average of the PCTs, actual cluster performance will be available in Q1 11/12)		95.0%	**91.82%**
Health Improvement	Immunisation - Aged 2 immunised for Hib/MenC (Sussex Cluster actual and plan is the average of the PCTs, actual cluster performance will be available in Q1 11/12)		95.0%	**92.67%**
Health Improvement	Immunisation - Aged 2 immunised for MMR (Sussex Cluster actual and plan is the average of the PCTs, actual cluster performance will be available in Q1 11/12)		95.0%	**92.37%**
Health Improvement	Immunisation - Aged 5 immunised for DTaP/IPV(Sussex Cluster actual and plan is the average of the PCTs)		95.0%	**89.44%**
Health Improvement	Immunisation - Aged 5 immunised for MMR (Sussex Cluster actual and plan is the average of the PCTs)		95.0%	**87.22%**
Health Improvement	Number of 4-week smoking quitters that have attended NHS Stop Smoking Services		957	**815**

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

As Accountable Officer, I had responsibility for reviewing the effectiveness of the system of internal control for the financial year ending 31 March 2013. My review was informed in a number of ways. The head of internal audit provided me with an opinion on the overall arrangements for gaining assurance through assessment of the assurance framework and on the controls reviewed as part of the internal auditor's work. Executive managers within the organisation with responsibility for the development and maintenance of the system of internal control provided me with assurance. The assurance framework itself provided me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives were reviewed.

My review was also informed by the work of our external auditors, BDO LLP (particularly in relation to audit of the financial statements 2012/13 and value for money conclusion 2012/13) and by the work of our internal auditors, South Coast Audit (particularly in relation to audit of risk and assurance processes 2012/13 and audits supporting the financial statements).

The Head of Internal Audit opinion states: "**Significant assurance** can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk."

Internal audit work covered a range of risk-based audit assignments throughout the year. Of the 28 audits and reviews reported against, one 'limited assurance' opinion was given, two 'split assurance' opinions were given, and fifteen 'significant assurance' opinions were given. A further ten consultancy and development reviews were undertaken where no assurance opinion was given. The Head of Internal Audit, in reaching an overall assessment for 2012/13 of 'significant assurance' took into account:

- the relative importance of the areas audited and the positive results from the core annual audit work on key financial systems;
- the number of risk based reviews where 'significant' assurance was provided; and
- the 'significant' assurance provided by the development, design and operation of the Board Assurance Framework and associated risk management processes.

Limited assurance was received regarding Commissioning Support Unit service requirements as no agreed indicators or targets were agreed with service users to assess performance and delivery.

Recommendations and action plans for these areas were managed through the NHS Sussex system of follow-up, and the implementation of audit recommendations was monitored by the Audit Committees. This system gave me assurance that control issues were dealt with effectively by executive directors.

I was advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board and the Audit Committee. A plan to address weaknesses and ensure continuous improvement of the system remained in place until the close of the PCT.

6. Significant Issues

Two areas were identified as significant issues:

- The non-delivery of national priority headline and supporting measures as set out in section 4. Performance Management processes were in place during 2012/13 to mitigate performance risks and the PCT has worked with emerging Clinical Commissioning Groups and other receiving organisations to develop future performance management regimes.

- A number of irregular payments were identified by the PCT and referred to NHS Protect in April 2013. The investigation is currently ongoing and NHS Protect is being supported by the Surrey and Sussex Commissioning Support Unit which is the main receiving body of the legacy PCT finance function.

Accountable Officer: Amanda Fadero

Organisation: Hastings and Rother PCT

7th June 2013

Amanda Fadero, Director, Surrey and Sussex Area Team, NHS England

Annual Governance Statement for East Sussex Downs and Weald PCT

1. Scope of responsibility

The Board was accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I had responsibility for maintaining a sound system of internal control that supported the achievement of the organisation's policies, aims and objectives until 31 March 2013. I also had responsibility for safeguarding the public funds and the organisation's assets for which I was personally responsible as set out in the Accountable Officer Memorandum.

East Sussex Downs and Weald Primary Care Trust (PCT) achieved its statutory financial duties to remain within its revenue, cash and capital resource limits in the financial year 2012/13. It reported a £732,000 surplus compared to the control total target surplus of £750,000. Capital expenditure in the year at £4.5 million was within the Capital Resource Limit of £4.7 million and cash spending was within the cash limit of £628m.

2. The governance framework of the organisation

Good corporate governance and the management of risk is a corporate responsibility and, accordingly, the Board took a leading role in ensuring that management strategies and supporting processes were in place. The Board did this through its own annual review of the risk management strategy, by regular review of its assurance framework and through the governance, internal control, risk and assurance work of its committees. The Board was committed to ensuring that good corporate governance and risk management were integral to the organisation's philosophy, practice and planning rather than being viewed or practiced as separate programmes, and to ensuring that responsibility for implementation was accepted at all levels of the organisation. A record of Board members' attendance at Board meetings is presented below.

NHS Sussex Board Meeting Attendance Log

Name	Role	22/05 2012	07/06 2012	24/7 2012	25/09 2012	25/09 2012 AGM	09/11 2012	23/11 2012	22/01 2013	26/03 2013
David Clayton-Smith	Chairman	✓	✓	✓	✓	✓	✓	✓	✓	✓
Amanda Fadero	Chief Executive	✓	✓	✓	✓	✓	✓	✓	✓	✓
Andrew Foulkes	Medical Director	✓	✓	✓	✓	✓	✓	✓	x	✓
Sue Braysher	Director of Commissioning Development	✓	x	x	✓	✓	✓	✓	✓	✓
Sarah Creamer	Director of Performance	✓	✓	✓	✓	✓	✓	✓	x	✓
Julia Dutchman-Bailey	Director of Quality and Chief Nurse	✓	✓	✓	✓	✓	x	✓	✓	✓
Amanda Philpott	Director of Strategy and Provider Development	✓	✓	✓	✓	✓	✓	✓	✓	✓
Claire Quigley	Director of Transition and Governance	✓	x	✓	✓	✓	✓	✓	x	✓
Michael Schofield	Director of Finance	✓	✓	✓	✓	✓	✓	✓	✓	✓
Frank Sims	Director of Commissioning Support Unit	✓	✓	✓	X	x	✓	X	x	✓
Jeremy Alford	Non Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	x

Peter Douglas	Non Executive Director	✓	x	✓	✓	✓	✓	✓	✓	✓
Charles Everett	Non Executive Director (Vice Chair)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rita Lewis	Non Executive Director	✓	✓	✓	✓	✓	✓	✓	x	✓
George Mack	Non Executive Director	✓	✓	x	✓	✓	✓	✓	✓	✓
Denise Stokoe	Non Executive Director	✓	✓	✓	✓	✓	✓	✓	x	✓

✓ = present, x = absent.

I was appointed as Chief Executive of NHS Sussex and each of the four statutory PCTs in Sussex. I led a single executive team across NHS Sussex. I had overall responsibility until 31 March 2013 for ensuring that effective governance and risk management systems were in place, meeting all statutory and legal requirements, and adhering to guidance issued by the Department of Health in respect of governance. My Director of Governance and Transition was accountable to me for the strategic development and implementation of organisational risk management and governance controls. All my executive directors were accountable to me for risk management and governance across the breadth of their functions.

In line with the recommendations of the Integrated Governance Handbook, NHS Sussex established committees responsible for reviewing the management of all types of risk, both clinical and non-clinical.

The Quality and Delivery Assurance Board, supported by the establishment of Clinical Commissioning Groups (CCGs) as committees of the Board with their own assurance processes, and developing through the CCG authorisation process, managed this agenda in 2012/13 in preparation for statutory establishment of CCGs from 1 April 2013.

A Transition Assurance Board (TAB) was established during 2012/13 to oversee the operational handover of current PCT functions to appropriate receiving organisations and provide supporting closure (legacy) documentation. The Director of Transition and Governance, an NHS Sussex board member, was the executive lead member of TAB. Specialist transition groups covering closedown, human resources and finance were also established to support the work of TAB. A transition and closedown report confirming that all PCT-critical closure activities had been covered was received at the final NHS Sussex board meeting.

The governance and risk systems ensured that the PCT discharged its statutory functions during 2012/13 and that these were legally compliant. The TAB had specific responsibility for ensuring the legal closure of the PCT on 31st March 2013 and completion of the necessary Transfer Schemes.

The Audit Committees of the four Sussex PCTs met jointly as NHS Sussex Audit Committee to enable a single senior overview of audit and internal control matters. The Audit Committees reported to the Board and reviewed the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) that supported the achievement of the organisation's objectives.

The Audit Committees ensured that there was an effective internal audit function that met mandatory NHS Internal Audit Standards and provided appropriate independent assurance to the Audit Committees, Chief Executive and Board. The Committees reviewed the work and findings of the external auditors, and considered the implications and managerial response to the auditors' work. The Committees satisfied themselves that the organisation had adequate arrangements in place for countering fraud and reviewed the outcomes of counter fraud work. Directly in relation to financial reporting, the Committees monitored the integrity of the financial statements of the PCTs and ensured that the systems for reporting to the Board, including those of budgetary control, were subject to review as to completeness and accuracy of the information provided to the Board until 31 March 2013. The

Committees reviewed the draft annual report and early working papers for the financial statements of the PCTs, including this Annual Governance Statement. Completion of the 2012/13 accounts and approval for these and the related statements took place after the closure of the PCTs via governance arrangements under the accountability of the NHS Business Services Authority.

In preparing this statement compliance with the five sections of the UK Corporate Governance Code was reviewed as follows:

Leadership
A.1 The Role of the Board. Every company should be headed by an effective board which is collectively responsible for the long-term success of the company. *Compliant. The types of decisions taken by the board or delegated to management were detailed in the published scheme of delegation.*
A.2 Division of Responsibilities. There should be a clear division of responsibilities at the head of the company between the running of the board and the executive responsibility for the running of the company's business. No one individual should have unfettered powers of decision. *Compliant. The roles of Chairman and Chief Executive were separate.*
A.3 The Chairman. The chairman is responsible for leadership of the board and ensuring its effectiveness on all aspects of its role. *Compliant.*
A.4 Non-executive directors. As part of their role as members of a unitary board, non-executive directors should constructively challenge and help develop proposals on strategy. *Compliant. A Senior Independent Director was formally designated.*

Effectiveness
B.1 The Composition of the Board. The board and its committees should have the appropriate balance of skills, experience, independence and knowledge of the company to enable them to discharge their respective duties and responsibilities effectively. *Compliant. Regulations were changed in 2010 enabling non-executive directors to be members of multiple PCTs. NHS Sussex directors held multiple membership of the four PCTs in Sussex. Non-executive directors were appointed independently by the Appointments Commission.*
B.2 Appointments to the Board. There should be a formal, rigorous and transparent procedure for the appointment of new directors to the board. *Compliant. Nominations were put to the Remuneration Committee as a result of transparent appointment processes.*
B.3 Commitment. All directors should be able to allocate sufficient time to the company to discharge their responsibilities effectively. *Compliant. Executive directors allocated time as per contract; non-executive directors complied with and were reviewed against applicable Appointments Commission guidance.*
B.4 Development. All directors should receive induction on joining the board and should regularly update and refresh their skills and knowledge. *Compliant. Mandatory training provided; in 2012/13 non-essential training was limited due to closure of the PCTs but development programmes for CCG senior staff were in place.*
B.5 Information and Support. The board should be supplied in a timely manner with information in a form and of a quality appropriate to enable it to discharge its duties. *Compliant.Adequate resources were available under the guidance of the Chief Executive and executive directors.*
B.6 Evaluation. The board should undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors. *Compliant. Individual performance reviews took place for executive and non-executive directors; the operation of the Board itself was reviewed in April 2012 with particular emphasis on how it would work in the final year of the existence of PCTs. Review and performance management by NHS South of England in place.*
B.7 Re-election. *Not applicable, the composition of PCT Boards was based on statute and followed NHS guidance.*

Accountability
C.1 Financial and Business Reporting. The board should present a balanced and understandable assessment of the company's position and prospects. *Compliant. Provided in annual report.*
C.2 Risk Management and Internal Control. 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 should maintain sound risk management and internal control systems. *Compliant. In 2012/13 there were*

significant changes to NHS commissioning organisations in preparation for new structures in 2013/14; such large scale change inherently carried risks which the Board mitigated as described and published in its board assurance framework.
C.3 Audit Committee and Auditors. The board should establish formal and transparent arrangements for considering how it should apply the corporate reporting and risk management and internal control principles and for maintaining an appropriate relationship with the company's auditor. *Compliant. Contained within the terms of reference of the Audit Committees and described in this Annual Governance Statement.*
Code schedule B. Disclosure on corporate governance arrangements. *Compliant. Described in this Annual Governance Statement.*

Remuneration
D.1 The Level and Components of Remuneration. The levels of remuneration should be sufficient to attract, retain and motivate directors of the quality required to run the company successfully, but a company should avoid paying more than is necessary for this purpose. A significant proportion of executive director's remuneration should be structured so as to link rewards to corporate and individual performance. *Compliant. Remuneration was paid in line with agreed NHS reward schemes.*
D.2 Remuneration Procedure. There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding his or her own remuneration. *Compliant. Remuneration for executives was set by the remuneration committee, not by individual directors.*
Code schedule A. *The design of performance-related remuneration for executive directors was not applicable under NHS schemes.*

Relations with Shareholders
E.1 Dialogue with Shareholders. There should be a dialogue with shareholders based on the mutual understanding of objectives. The board as a whole has responsibility for ensuring that a satisfactory dialogue with shareholders takes place. *Compliant. There were no shareholders but the organisation was accountable to the public for its activities and engaged patients, stakeholder organisations and the public in planning its objectives; particularly when considering larger scale service changes where it had a duty to consult.*
E.2 Constructive use of the AGM. The board should use the AGM to communicate with investors and encourage their participation. *Compliant. There were no investors but patients, stakeholder organisations and the public were encouraged to participate.*

3. The risk and control framework

The system of internal control was designed to manage risk to a reasonable level rather than eliminate all risk of failure to achieve policies, aims and objectives; it could therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control was in place in East Sussex Downs and Weald PCT throughout the year ended 31 March 2013.

The NHS Sussex Board operated harmonised risk management across its constituent PCTs. The risk management strategy was approved and reported to the Board. Mandatory risk management training, with a mandatory update every two years, was made available to all staff. A full range of health and safety and other mandatory training packages were made available to relevant staff. Records of attendances were kept and collated for reporting purposes

In line with the Risk Management Strategy the risk and control framework was designed to focus management attention on risks at the appropriate level in the organisation. In particular it was designed to set the most significant risks before the Board and its committees in order that resources could be applied to adjust controls that prevented or mitigated the risks, and gain assurances that those controls were effective. The key components of the risk management system - including the method of risk assessment, directorate risk registers, corporate risk register and the assurance framework - were described clearly in the PCT's Risk Management Strategy. Risk assessment enabled effective mitigating actions to be devised and encouraged the proactive identification and prevention of manifest risks and potential risks. Risk deterrents were also in place, for example through counter fraud work.

The Board assurance framework required high level risks with a score of 15 or above to be presented to the Board. This assurance framework was populated and reviewed at a lower level by the executive team and by CCG committees with responsibility for governance. The assurance framework was developed to provide assurance to the Board that the systems, policies and people it had put in place were operating in a way that supported the delivery of objectives by focusing on preventing and minimising risk. It ensured that the Board was informed of the principal risks which faced the organisation together with action plans to address them. It was a regularly updated or 'live' document linked to the more detailed corporate and departmental risk registers and to key business planning documents for the PCT. The assurance framework identified for each strategic objective of the Board:-

- Principal risks, being the highest risks in the corporate risk register.
- Key controls to assist in managing risks to secure the achievement of the objective.
- The sources of evidence on which reliance of the effectiveness of the systems was placed.
- The detailed assurances obtained showing the evidence presented to the Board including internal assurances on the effectiveness of systems from Board committees, staff, Internal Audit and external bodies (the Audit Commission, NHS Litigation Authority, Care Quality Commission etc).
- Any gaps in control i.e. systems not in place
- Any gaps in assurance i.e. systems in place but evidence not available.
- The detail of actions put in place to mitigate the risk including relevant milestones and target dates for removal.
- Progress on the actions
- Most recent review date
- Target removal date
- Executive ownership

4. Risk assessment

The PCT recognised that it is not possible to eliminate all risks and that systems of control should not be so rigid that they stifle imaginative use of limited resources in order to provide an effective service. In order to establish a consistent framework for assessing and managing risk, the organisation adapted a standard risk assessment tool from the National Patient Safety Agency and determined the levels of authority at which risks should be addressed. This provided a consistent approach across all of the different types of assessment that were undertaken. All identified risks were brought to the attention of Line Managers who had responsibility for making an initial assessment of the risk.

The organisation determined that risks identified as having a total score of 11 (moderate) or below would be managed at team/department level by Line Managers. These risks were considered small enough to have an immaterial effect on the organisation's objectives, or could be controlled effectively in order to minimise adverse consequences.

Those risks identified as scoring 12+ (high) or above, or where a manager could not immediately introduce control measures to reduce the level of risk to an acceptable level, were notified to an appropriate Director who determined how the risk would be addressed. Moderated risks with a score of 12+ formed part of the corporate risk register.

Risks determined with a score of 15+ as moderated by appropriate Directors were escalated to the assurance framework for attention of the Board.

The organisational risk profile was made clear through assurance framework reports presented at each ordinary Board meeting. The reports highlighted risks against principal objectives and included the level of risk, the balance of risks and the trend in risks.

During 2012/13 the emerging CCGs remained under the NHS Sussex risk system. Since 1 April 2013 CCGs run their own risk systems with their own risk management strategies, policies and procedures. A proposal was approved by the NHS Sussex Audit Committee regarding the closedown process for NHS Sussex risks and the transfer of risks to receiving organisations by 31 March 2013. The following table

highlights the key newly identified significant risks in terms of impact and likelihood reported in the final NHS Sussex Board Assurance Framework and the receiving body for these risks.

Key risks included in the Final Assurance Framework, March 2013

Risk No.	Risk description	Risk score	Actions taken
119	There is risk that current breast screening equipment in Worthing will be obsolete before the new West Sussex breast unit is complete.	20	*This risk was subsequently transferred to and accepted by the Surrey and Sussex Area Team, NHS England.*
217	There is a risk of a new strain of influenza pandemic virus developing, and we cannot predict with certainty when it will happen, the epidemiology of an emergent influenza pandemic virus or its clinical behaviour.	20	*This risk was subsequently transferred to and accepted by the Surrey and Sussex Area Team, NHS England, and some of the Sussex CCGs.*
312	There is a risk that there will be insufficient management capacity within the Clinical Commissioning Groups to achieve the scale and scope of change required and this may impact on the delivery of the QIPP plans across Sussex	20	*This risk was subsequently transferred to and accepted by some of the Sussex CCGs.*
314	There is a risk that the centralisation of arterial vascular surgery with 24/7services at BSUH will not be achieved by March 2013	20	*This risk was subsequently transferred to and accepted by the Surrey and Sussex Area Team, NHS England.*
571	DH Guidance relating to the timescales for making retrospective Continuing Healthcare claims has resulted in a significant rise in claims received by PCTs requiring assessment with consequent risk of service disruption.	20	*This risk was subsequently transferred to and accepted by Coastal West Sussex CCG as hosts of the future service.*
140	There is a risk that there is insufficient capacity to deliver core operational processes and there is a delay to operationalisation of the Surrey and Sussex Commissioning Support Unit	16	*This risk was subsequently transferred to and accepted by Surrey and Sussex Commissioning Support Unit*

The Board agreed its principal objectives in May 2012 and monitored them at each standard board meeting during the remainder of 2012/13. These objectives are set out in the table below as Strategic Goals (SG).

Strategic Goal 1. Quality, Delivery and Performance SG1.1 - Deliver the quality and safeguarding responsibilities including the quality standards outlined in the Sussex Plan SG1.2 - Deliver the performance improvements outlined in the Sussex Plan SG1.3 - Deliver the financial plans for 12/13 outlined in the 2 year Sussex plan
Strategic Goal 2. Transition SG2.1 - Supporting our staff through the transition and maximising their talents and capabilities SG2.2 - NHS Sussex responsibilities are transferred to successor organisations by end March 2013 SG2.3 - Establish effective Clinical Commissioning Groups and an effective Commissioning Support Service for the future
Strategic Goal 3. Strategy SG3.1 - Deliver the agreed outcomes from Sussex Together SG3.2 - Foster pan-Sussex working arrangements to improve services for patients SG3.3 - Strengthening our strategic partnerships to improve the health and wellbeing of our population
Strategic Goal 4. Health Outcomes SG4.1 - Reduce Health Inequalities within our population SG4.2 - Improve the health and wellbeing of our population

Information governance incidents

There were no Information Governance Serious Untoward Incidents (IG SUIs) this year (i.e. scored at level 5, the most serious level, on the IG SUI grading matrix.

There were two category 4 incidents relating to confidential information being sent to the wrong recipient by email or wrongly attached to the intended recipient by email. The data did not leave the boundaries of the NHS and all data was retrieved.

Summary of Serious Untoward Incidents

Category	Nature of incident	East Sussex Downs and Weald PCT
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	0
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	0
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	2
V	Other	0
	Totals for the year	**2**

* *East Sussex Downs and Weald PCT and Hastings and Rother PCT work closely together, with staff working across both organisations, and incidents reported under East Sussex Downs and Weald PCT may reflect joint working arrangements.*

Subject Access Requests were dealt with effectively, within the time constraints set out by the Department of Health. A Subject Access Request and Caldicott Log were maintained and updated by the Information Governance Team to keep track of requests from members of the public and any queries raised by staff about the management of personal information.

Control and risk related to performance indicators

More than sixty key performance indicators were regularly monitored by the Board and past performance reports were available to the public on the NHS Sussex website. These reports included nationally agreed operating targets together with supporting measures and wider targets agreed locally. Performance outcomes for 2012/13 are disclosed in the annual report.

For the purpose of this statement the following table identifies those nationally recognised indicators (headline measures and supporting measures) that did not reach target for the full year 2012/13.

KPI Grouping	Indicator		East Sussex Downs and Weald	
			Full Year Plan	Full Year Actual
HCAIs	Clostridium Difficile		94	**100**

18 weeks	Numbers waiting on an incomplete Referral to Treatment pathway		17,889	**20,118**
Emergency	Ambulance Response times to Cat A - % within 8 minutes (Cluster)		75.0%	**73.60%**
Cancer waits	Proportion of patients with suspected cancer, referred through GP who wait less than 62 days from referral to treatment		85.0%	**83.64%**
Primary Care	Number of patients receiving NHS primary dental services located within the PCT area within a 24 month period		202,389	**184,782**
Mental Health	The number of new cases of psychosis served by early intervention teams year to date		36	**31**
Screening	SQU27: Coverage of NHS Health Checks - Offered - Reported Cumulatively		19.4%	**8.7%**
Screening	SQU27: Coverage of NHS Health Checks - screened - reported Cumulatively		7.8%	**5.4%**
Maternity	Coverage of breast feeding		95.0%	**94.26%**
Health Improvement	Immunisation - Aged 2 immunised for PCV (Sussex Cluster actual and plan is the average of the PCTs, actual cluster performance will be available in Q1 11/12)		95.0%	**93.13%**
Health Improvement	Immunisation - Aged 2 immunised for Hib/MenC (Sussex Cluster actual and plan is the average of the PCTs, actual cluster performance will be available in Q1 11/12)		95.0%	**93.06%**
Health Improvement	Immunisation - Aged 2 immunised for MMR (Sussex Cluster actual and plan is the average of the PCTs, actual cluster performance will be available in Q1 11/12)		95.0%	**93.53%**
Health Improvement	Immunisation - Aged 5 immunised for DTaP/IPV(Sussex Cluster actual and plan is the average of the PCTs)		95.0%	**87.95%**
Health Improvement	Immunisation - Aged 5 immunised for MMR (Sussex Cluster actual and plan is the average of the PCTs)		95.0%	**86.49%**
Health Improvement	Number of 4-week smoking quitters that have attended NHS Stop Smoking Services		1,219	**1,015**

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

As Accountable Officer, I had responsibility for reviewing the effectiveness of the system of internal control for the financial year ending 31 March 2013. My review was informed in a number of ways. The head of internal audit provided me with an opinion on the overall arrangements for gaining assurance through assessment of the assurance framework and on the controls reviewed as part of the internal

auditor's work. Executive managers within the organisation with responsibility for the development and maintenance of the system of internal control provided me with assurance. The assurance framework itself provided me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives were reviewed.

My review was also informed by the work of our external auditors, BDO LLP (particularly in relation to audit of the financial statements 2012/13 and value for money conclusion 2012/13) and by the work of our internal auditors, South Coast Audit (particularly in relation to audit of risk and assurance processes 2012/13 and audits supporting the financial statements).

The Head of Internal Audit opinion states: "**Significant assurance** can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk."

Internal audit work covered a range of risk-based audit assignments throughout the year. Of the 28 audits and reviews reported against, one 'limited assurance' opinion was given, two 'split assurance' opinions were given, and fifteen 'significant assurance' opinions were given. A further ten consultancy and development reviews were undertaken where no assurance opinion was given. The Head of Internal Audit, in reaching an overall assessment for 2012/13 of 'significant assurance' took into account:

- the relative importance of the areas audited and the positive results from the core annual audit work on key financial systems;
- the number of risk based reviews where 'significant' assurance was provided; and
- the 'significant' assurance provided by the development, design and operation of the Board Assurance Framework and associated risk management processes.

Limited assurance was received regarding Commissioning Support Unit service requirements as no agreed indicators or targets were agreed with service users to assess performance and delivery.

Recommendations and action plans for these areas were managed through the NHS Sussex system of follow-up, and the implementation of audit recommendations was monitored by the Audit Committees. This system gave me assurance that control issues were dealt with effectively by executive directors.

I was advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board and the Audit Committee. A plan to address weaknesses and ensure continuous improvement of the system remained in place until the close of the PCT.

6. Significant Issues

Three areas were identified as significant issues:

- The non-delivery of national priority headline and supporting measures as set out in section 4. Performance Management processes were in place during 2012/13 to mitigate performance risks and the PCT has worked with emerging Clinical Commissioning Groups and other receiving organisations to develop future performance management regimes.

- The year end financial position has been reached only by the use of non-recurrent measures such as negotiating one year capped contracts with Sussex NHS provider organisations. This negated the in year financial impact of demand led over performance on contracted activity levels that was evident during the year. During 2012/13 the PCT worked with shadow Clinical Commissioning Groups in East Sussex to develop appropriate QIPP savings initiatives for 2013/14 and beyond to address the underlying issues.

- A number of irregular payments were identified by the PCT and referred to NHS Protect in April 2013. The investigation is currently ongoing and NHS Protect is being supported by the Surrey and Sussex Commissioning Support Unit which is the main receiving body of the legacy PCT finance function.

Accountable Officer: Amanda Fadero

Organisation: East Sussex Downs and Weald PCT

7th June 2013

Amanda Fadero, Director, Surrey and Sussex Area Team, NHS England

Annual Governance Statement for Brighton and Hove PCT

1. Scope of responsibility

The Board was accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I had responsibility for maintaining a sound system of internal control that supported the achievement of the organisation's policies, aims and objectives until 31 March 2013. I also had responsibility for safeguarding the public funds and the organisation's assets for which I was personally responsible as set out in the Accountable Officer Memorandum.

Brighton and Hove City Primary Care (PCT) achieved its statutory financial duties to remain within its revenue, cash and capital resource limits in the financial year 2012/13. It reported a £753,000 surplus compared to the control total target surplus of £750,000. Capital expenditure in the year at £270,000 was within the Capital Resource Limit of £391,000 and cash spending was within the cash limit of £524m.

2. The governance framework of the organisation

Good corporate governance and the management of risk is a corporate responsibility and, accordingly, the Board took a leading role in ensuring that management strategies and supporting processes were in place. The Board did this through its own annual review of the risk management strategy, by regular review of its assurance framework and through the governance, internal control, risk and assurance work of its committees. The Board was committed to ensuring that good corporate governance and risk management were integral to the organisation's philosophy, practice and planning rather than being viewed or practiced as separate programmes, and to ensuring that responsibility for implementation was accepted at all levels of the organisation. A record of Board members' attendance at Board meetings is presented below.

NHS Sussex Board Meeting Attendance Log

Name	Role	22/05 2012	07/06 2012	24/7 2012	25/09 2012	25/09 2012 AGM	09/11 2012	23/11 2012	22/01 2013	26/03 2013
David Clayton-Smith	Chairman	✓	✓	✓	✓	✓	✓	✓	✓	✓
Amanda Fadero	Chief Executive	✓	✓	✓	✓	✓	✓	✓	✓	✓
Andrew Foulkes	Medical Director	✓	✓	✓	✓	✓	✓	✓	x	✓
Sue Braysher	Director of Commissioning Development	✓	x	x	✓	✓	✓	✓	✓	✓
Sarah Creamer	Director of Performance	✓	✓	✓	✓	✓	✓	✓	x	✓
Julia Dutchman-Bailey	Director of Quality and Chief Nurse	✓	✓	✓	✓	✓	x	✓	✓	✓
Amanda Philpott	Director of Strategy and Provider Development	✓	✓	✓	✓	✓	✓	✓	✓	✓
Claire Quigley	Director of Transition and Governance	✓	x	✓	✓	✓	✓	✓	x	✓
Michael Schofield	Director of Finance	✓	✓	✓	✓	✓	✓	✓	✓	✓
Frank Sims	Director of Commissioning Support Unit	✓	✓	✓	X	x	✓	X	x	✓
Jeremy Alford	Non Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	x
Peter Douglas	Non Executive Director	✓	x	✓	✓	✓	✓	✓	✓	✓

Charles Everett	Non Executive Director (Vice Chair)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rita Lewis	Non Executive Director	✓	✓	✓	✓	✓	✓	✓	x	✓
George Mack	Non Executive Director	✓	✓	x	✓	✓	✓	✓	✓	✓
Denise Stokoe	Non Executive Director	✓	✓	✓	✓	✓	✓	✓	x	✓

✓ = present, x = absent.

I was appointed as Chief Executive of NHS Sussex and each of the four statutory PCTs in Sussex. I led a single executive team across NHS Sussex. I had overall responsibility until 31 March 2013 for ensuring that effective governance and risk management systems were in place, meeting all statutory and legal requirements, and adhering to guidance issued by the Department of Health in respect of governance. My Director of Governance and Transition was accountable to me for the strategic development and implementation of organisational risk management and governance controls. All my executive directors were accountable to me for risk management and governance across the breadth of their functions.

In line with the recommendations of the Integrated Governance Handbook, NHS Sussex established committees responsible for reviewing the management of all types of risk, both clinical and non-clinical.

The Quality and Delivery Assurance Board, supported by the establishment of Clinical Commissioning Groups (CCGs) as committees of the Board with their own assurance processes, and developing through the CCG authorisation process, managed this agenda in 2012/13 in preparation for statutory establishment of CCGs from 1 April 2013.

A Transition Assurance Board (TAB) was established during 2012/13 to oversee the operational handover of current PCT functions to appropriate receiving organisations and provide supporting closure (legacy) documentation. The Director of Transition and Governance, an NHS Sussex board member, was the executive lead member of TAB. Specialist transition groups covering closedown, human resources and finance were also established to support the work of TAB. A transition and closedown report confirming that all PCT-critical closure activities had been covered was received at the final NHS Sussex board meeting.

The governance and risk systems ensured that the PCT discharged its statutory functions during 2012/13 and that these were legally compliant. The TAB had specific responsibility for ensuring the legal closure of the PCT on 31st March 2013 and completion of the necessary Transfer Schemes.

The Audit Committees of the four Sussex PCTs met jointly as NHS Sussex Audit Committee to enable a single senior overview of audit and internal control matters. The Audit Committees reported to the Board and reviewed the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) that supported the achievement of the organisation's objectives.

The Audit Committees ensured that there was an effective internal audit function that met mandatory NHS Internal Audit Standards and provided appropriate independent assurance to the Audit Committees, Chief Executive and Board. The Committees reviewed the work and findings of the external auditors, and considered the implications and managerial response to the auditors' work. The Committees satisfied themselves that the organisation had adequate arrangements in place for countering fraud and reviewed the outcomes of counter fraud work. Directly in relation to financial reporting, the Committees monitored the integrity of the financial statements of the PCTs and ensured that the systems for reporting to the Board, including those of budgetary control, were subject to review as to completeness and accuracy of the information provided to the Board until 31 March 2013. The Committees reviewed the draft annual report and early working papers for the financial statements of the PCTs, including this Annual Governance Statement. Completion of the 2012/13 accounts and approval

for these and the related statements took place after the closure of the PCTs via governance arrangements under the accountability of the NHS Business Services Authority.

In preparing this statement compliance with the five sections of the UK Corporate Governance Code was reviewed as follows:

Leadership

A.1 The Role of the Board. Every company should be headed by an effective board which is collectively responsible for the long-term success of the company. *Compliant. The types of decisions taken by the board or delegated to management were detailed in the published scheme of delegation.*

A.2 Division of Responsibilities. There should be a clear division of responsibilities at the head of the company between the running of the board and the executive responsibility for the running of the company's business. No one individual should have unfettered powers of decision. *Compliant. The roles of Chairman and Chief Executive were separate.*

A.3 The Chairman. The chairman is responsible for leadership of the board and ensuring its effectiveness on all aspects of its role. *Compliant.*

A.4 Non-executive directors. As part of their role as members of a unitary board, non-executive directors should constructively challenge and help develop proposals on strategy. *Compliant. A Senior Independent Director was formally designated.*

Effectiveness

B.1 The Composition of the Board. The board and its committees should have the appropriate balance of skills, experience, independence and knowledge of the company to enable them to discharge their respective duties and responsibilities effectively. *Compliant. Regulations were changed in 2010 enabling non-executive directors to be members of multiple PCTs. NHS Sussex directors held multiple membership of the four PCTs in Sussex. Non-executive directors were appointed independently by the Appointments Commission.*

B.2 Appointments to the Board. There should be a formal, rigorous and transparent procedure for the appointment of new directors to the board. *Compliant. Nominations were put to the Remuneration Committee as a result of transparent appointment processes.*

B.3 Commitment. All directors should be able to allocate sufficient time to the company to discharge their responsibilities effectively. *Compliant. Executive directors allocated time as per contract; non-executive directors complied with and were reviewed against applicable Appointments Commission guidance.*

B.4 Development. All directors should receive induction on joining the board and should regularly update and refresh their skills and knowledge. *Compliant. Mandatory training provided; in 2012/13 non-essential training was limited due to closure of the PCTs but development programmes for CCG senior staff were in place.*

B.5 Information and Support. The board should be supplied in a timely manner with information in a form and of a quality appropriate to enable it to discharge its duties. *Compliant.Adequate resources were available under the guidance of the Chief Executive and executive directors.*

B.6 Evaluation. The board should undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors. *Compliant. Individual performance reviews took place for executive and non-executive directors; the operation of the Board itself was reviewed in April 2012 with particular emphasis on how it would work in the final year of the existence of PCTs. Review and performance management by NHS South of England in place.*

B.7 Re-election. *Not applicable, the composition of PCT Boards was based on statute and followed NHS guidance.*

Accountability

C.1 Financial and Business Reporting. The board should present a balanced and understandable assessment of the company's position and prospects. *Compliant. Provided in annual report.*

C.2 Risk Management and Internal Control. 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 should maintain sound risk management and internal control systems. *Compliant. In 2012/13 there were significant changes to NHS commissioning organisations in preparation for new structures in 2013/14;*

such large scale change inherently carried risks which the Board mitigated as described and published in its board assurance framework.

C.3 Audit Committee and Auditors. The board should establish formal and transparent arrangements for considering how it should apply the corporate reporting and risk management and internal control principles and for maintaining an appropriate relationship with the company's auditor. *Compliant. Contained within the terms of reference of the Audit Committees and described in this Annual Governance Statement.*

Code schedule B. Disclosure on corporate governance arrangements. *Compliant. Described in this Annual Governance Statement.*

Remuneration

D.1 The Level and Components of Remuneration. The levels of remuneration should be sufficient to attract, retain and motivate directors of the quality required to run the company successfully, but a company should avoid paying more than is necessary for this purpose. A significant proportion of executive director's remuneration should be structured so as to link rewards to corporate and individual performance. *Compliant. Remuneration was paid in line with agreed NHS reward schemes.*

D.2 Remuneration Procedure. There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding his or her own remuneration. *Compliant. Remuneration for executives was set by the remuneration committee, not by individual directors.*

Code schedule A. *The design of performance-related remuneration for executive directors was not applicable under NHS schemes.*

Relations with Shareholders

E.1 Dialogue with Shareholders. There should be a dialogue with shareholders based on the mutual understanding of objectives. The board as a whole has responsibility for ensuring that a satisfactory dialogue with shareholders takes place. *Compliant. There were no shareholders but the organisation was accountable to the public for its activities and engaged patients, stakeholder organisations and the public in planning its objectives; particularly when considering larger scale service changes where it had a duty to consult.*

E.2 Constructive use of the AGM. The board should use the AGM to communicate with investors and encourage their participation. *Compliant. There were no investors but patients, stakeholder organisations and the public were encouraged to participate.*

3. The risk and control framework

The system of internal control was designed to manage risk to a reasonable level rather than eliminate all risk of failure to achieve policies, aims and objectives; it could therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control was in place in Brighton and Hove City PCT throughout the year ended 31 March 2013.

The NHS Sussex Board operated harmonised risk management across its constituent PCTs. The risk management strategy was approved and reported to the Board. Mandatory risk management training, with a mandatory update every two years, was made available to all staff. A full range of health and safety and other mandatory training packages were made available to relevant staff. Records of attendances were kept and collated for reporting purposes

In line with the Risk Management Strategy the risk and control framework was designed to focus management attention on risks at the appropriate level in the organisation. In particular it was designed to set the most significant risks before the Board and its committees in order that resources could be applied to adjust controls that prevented or mitigated the risks, and gain assurances that those controls were effective. The key components of the risk management system - including the method of risk assessment, directorate risk registers, corporate risk register and the assurance framework - were described clearly in the PCT's Risk Management Strategy. Risk assessment enabled effective mitigating actions to be devised and encouraged the proactive identification and prevention of manifest risks and potential risks. Risk deterrents were also in place, for example through counter fraud work.

The Board assurance framework required high level risks with a score of 15 or above to be presented to the Board. This assurance framework was populated and reviewed at a lower level by the executive team and by CCG committees with responsibility for governance. The assurance framework was developed to provide assurance to the Board that the systems, policies and people it had put in place were operating in a way that supported the delivery of objectives by focusing on preventing and minimising risk. It ensured that the Board was informed of the principal risks which faced the organisation together with action plans to address them. It was a regularly updated or 'live' document linked to the more detailed corporate and departmental risk registers and to key business planning documents for the PCT. The assurance framework identified for each strategic objective of the Board:-

- Principal risks, being the highest risks in the corporate risk register.
- Key controls to assist in managing risks to secure the achievement of the objective.
- The sources of evidence on which reliance of the effectiveness of the systems was placed.
- The detailed assurances obtained showing the evidence presented to the Board including internal assurances on the effectiveness of systems from Board committees, staff, Internal Audit and external bodies (the Audit Commission, NHS Litigation Authority, Care Quality Commission etc).
- Any gaps in control i.e. systems not in place
- Any gaps in assurance i.e. systems in place but evidence not available.
- The detail of actions put in place to mitigate the risk including relevant milestones and target dates for removal.
- Progress on the actions
- Most recent review date
- Target removal date
- Executive ownership

4. Risk assessment

The PCT recognised that it is not possible to eliminate all risks and that systems of control should not be so rigid that they stifle imaginative use of limited resources in order to provide an effective service. In order to establish a consistent framework for assessing and managing risk, the organisation adapted a standard risk assessment tool from the National Patient Safety Agency and determined the levels of authority at which risks should be addressed. This provided a consistent approach across all of the different types of assessment that were undertaken. All identified risks were brought to the attention of Line Managers who had responsibility for making an initial assessment of the risk.

The organisation determined that risks identified as having a total score of 11 (moderate) or below would be managed at team/department level by Line Managers. These risks were considered small enough to have an immaterial effect on the organisation's objectives, or could be controlled effectively in order to minimise adverse consequences.

Those risks identified as scoring 12+ (high) or above, or where a manager could not immediately introduce control measures to reduce the level of risk to an acceptable level, were notified to an appropriate Director who determined how the risk would be addressed. Moderated risks with a score of 12+ formed part of the corporate risk register.

Risks determined with a score of 15+ as moderated by appropriate Directors were escalated to the assurance framework for attention of the Board.

The organisational risk profile was made clear through assurance framework reports presented at each ordinary Board meeting. The reports highlighted risks against principal objectives and included the level of risk, the balance of risks and the trend in risks.

During 2012/13 the emerging CCGs remained under the NHS Sussex risk system. Since 1 April 2013 CCGs run their own risk systems with their own risk management strategies, policies and procedures. A proposal was approved by the NHS Sussex Audit Committee regarding the closedown process for NHS Sussex risks and the transfer of risks to receiving organisations by 31 March 2013. The following table

highlights the key newly identified significant risks in terms of impact and likelihood reported in the final NHS Sussex Board Assurance Framework and the receiving body for these risks.

Key risks included in the Final Assurance Framework, March 2013

Risk No.	Risk description	Risk score	Actions taken
119	There is risk that current breast screening equipment in Worthing will be obsolete before the new West Sussex breast unit is complete.	20	*This risk was subsequently transferred to and accepted by the Surrey and Sussex Area Team, NHS England.*
217	There is a risk of a new strain of influenza pandemic virus developing, and we cannot predict with certainty when it will happen, the epidemiology of an emergent influenza pandemic virus or its clinical behaviour.	20	*This risk was subsequently transferred to and accepted by the Surrey and Sussex Area Team, NHS England, and some of the Sussex CCGs.*
312	There is a risk that there will be insufficient management capacity within the Clinical Commissioning Groups to achieve the scale and scope of change required and this may impact on the delivery of the QIPP plans across Sussex	20	*This risk was subsequently transferred to and accepted by some of the Sussex CCGs.*
314	There is a risk that the centralisation of arterial vascular surgery with 24/7services at BSUH will not be achieved by March 2013	20	*This risk was subsequently transferred to and accepted by the Surrey and Sussex Area Team, NHS England.*
571	DH Guidance relating to the timescales for making retrospective Continuing Healthcare claims has resulted in a significant rise in claims received by PCTs requiring assessment with consequent risk of service disruption.	20	*This risk was subsequently transferred to and accepted by Coastal West Sussex CCG as hosts of the future service.*
140	There is a risk that there is insufficient capacity to deliver core operational processes and there is a delay to operationalisation of the Surrey and Sussex Commissioning Support Unit	16	*This risk was subsequently transferred to and accepted by Surrey and Sussex Commissioning Support Unit*

The Board agreed its principal objectives in May 2012 and monitored them at each standard board meeting during the remainder of 2012/13. These objectives are set out in the table below as Strategic Goals (SG).

Strategic Goal 1. Quality, Delivery and Performance SG1.1 - Deliver the quality and safeguarding responsibilities including the quality standards outlined in the Sussex Plan SG1.2 - Deliver the performance improvements outlined in the Sussex Plan SG1.3 - Deliver the financial plans for 12/13 outlined in the 2 year Sussex plan
Strategic Goal 2. Transition SG2.1 - Supporting our staff through the transition and maximising their talents and capabilities SG2.2 - NHS Sussex responsibilities are transferred to successor organisations by end March 2013 SG2.3 - Establish effective Clinical Commissioning Groups and an effective Commissioning Support Service for the future
Strategic Goal 3. Strategy SG3.1 - Deliver the agreed outcomes from Sussex Together SG3.2 - Foster pan-Sussex working arrangements to improve services for patients SG3.3 - Strengthening our strategic partnerships to improve the health and wellbeing of our population
Strategic Goal 4. Health Outcomes SG4.1 - Reduce Health Inequalities within our population SG4.2 - Improve the health and wellbeing of our population

Information governance incidents

There were no Information Governance Serious Untoward Incidents or Information Governance Serious Incidents this year.

There was one Information Governance incident of a less significant nature relating to the loss of inadequately protected electronic equipment, devices or paper

Subject Access Requests were dealt with effectively, within the time constraints set out by the Department of Health. A Subject Access Request and Caldicott Log were maintained and updated by the Information Governance Team to keep track of requests from members of the public and any queries raised by staff about the management of personal information.

Control and risk related to performance indicators

More than sixty key performance indicators were regularly monitored by the Board and past performance reports were available to the public on the NHS Sussex website. These reports included nationally agreed operating targets together with supporting measures and wider targets agreed locally. Performance outcomes for 2012/13 are disclosed in the annual report.

For the purpose of this statement the following table identifies those nationally recognised indicators (headline measures and supporting measures) that did not reach target for the full year 2012/13.

KPI Grouping	Indicator	Brighton & Hove	
		Plan YTD	**Actual YTD**
HCAIs	MRSA Infections	3	**8**
Cancer waits	Proportion of patients waiting no more than 31 days for subsequent cancer treatment (Radiotherapy)	94.0%	**87.64%**
Acute General	Referral rates per 100,000 population for 1st OP attendances by referral source	436	**467.21**
Primary Care	Number of patients receiving NHS primary dental services located within the PCT area within a 24 month period	159,903	**148,116**
Primary Care	QOF domain scores and exception reporting rate (PERFORMANCE COMPARED AGAINST NATIONAL AVERAGE)	94.7%	**90.46%**
Screening	All Women to receive results of cervical screening tests within 2 weeks	98.0%	**93.62%**
Screening	SQU27: Coverage of NHS Health Checks - Offered - Reported Cumulatively	18.3%	**13.9%**
Screening	SQU27: Coverage of NHS Health Checks - screened - reported Cumulatively	7.6%	**6.2%**
Maternity	Coverage of breast feeding	95.0%	**94.37%**
Maternity	Prevalence of breastfeeding at 6-8 wks after birth	69.3%	**68.9%**

Health Improvement	Under 18 conception rate per 1,000 female aged 15 to 17		31	**36.5**
Health Improvement	Number of 4-week smoking quitters that have attended NHS Stop Smoking Services		1,800	**1,755**

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

As Accountable Officer, I had responsibility for reviewing the effectiveness of the system of internal control for the financial year ending 31 March 2013. My review was informed in a number of ways. The head of internal audit provided me with an opinion on the overall arrangements for gaining assurance through assessment of the assurance framework and on the controls reviewed as part of the internal auditor's work. Executive managers within the organisation with responsibility for the development and maintenance of the system of internal control provided me with assurance. The assurance framework itself provided me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives were reviewed.

My review was also informed by the work of our external auditors, Ernst and Young LLP (particularly in relation to audit of the financial statements 2012/13 and value for money conclusion 2012/13) and by the work of our internal auditors, South Coast Audit (particularly in relation to audit of risk and assurance processes 2012/13 and audits supporting the financial statements).

The Head of Internal Audit opinion states: "**Significant assurance** can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk."

Internal audit work covered a range of risk-based audit assignments throughout the year. Of the 28 audits and reviews reported against, one 'limited assurance' opinion was given, two 'split assurance' opinions were given, and fifteen 'significant assurance' opinions were given. A further ten consultancy and development reviews were undertaken where no assurance opinion was given. The Head of Internal Audit, in reaching an overall assessment for 2012/13 of 'significant assurance' took into account:

- the relative importance of the areas audited and the positive results from the core annual audit work on key financial systems;
- the number of risk based reviews where 'significant' assurance was provided; and
- the 'significant' assurance provided by the development, design and operation of the Board Assurance Framework and associated risk management processes.

Limited assurance was received regarding Commissioning Support Unit service requirements as no agreed indicators or targets were agreed with service users to assess performance and delivery.

Recommendations and action plans for these areas were managed through the NHS Sussex system of follow-up, and the implementation of audit recommendations was monitored by the Audit Committees. This system gave me assurance that control issues were dealt with effectively by executive directors.

I was advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board and the Audit Committee. A plan to address weaknesses and ensure continuous improvement of the system remained in place until the close of the PCT.

6. Significant Issues

One area was identified as a significant issue:

- The non-delivery of national priority headline and supporting measures as set out in section 4. Performance Management processes were in place during 2012/13 to mitigate performance risks

and the PCT has worked with emerging Clinical Commissioning Groups and other receiving organisations to develop future performance management regimes.

Accountable Officer: Amanda Fadero

Organisation: Brighton and Hove City PCT

7th June 2013

Amanda Fadero, Director, Surrey and Sussex Area Team, NHS England

Department
of Health

Brighton and Hove City Teaching Primary Care Trust

2012-13 Accounts

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

© Crown copyright

Published to gov.uk, in PDF format only.

www.gov.uk/dh

Brighton and Hove City Teaching Primary Care Trust

2012-13 Accounts

NHS
Brighton and Hove

2012-13 Annual Accounts of NHS Brighton and Hove

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.

nb: sign and date in any colour ink except black

Signed...Designated Signing Officer

Name: A. FADERO

Date....07/06/2013

NHS
Brighton and Hove

2012-13 Annual Accounts of NHS Brighton and Hove

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.

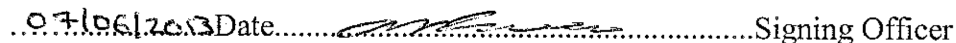
- ensure that the PCT kept proper accounting records which disclosed with reasonable accuracy at any time the financial position of the primary care trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State.

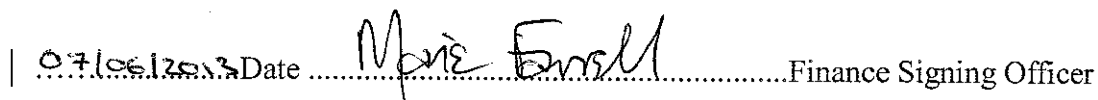
- have taken reasonable steps for the prevention and detection of fraud and other irregularities.

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.

nb: sign and date in any colour ink except black


..07/06/2013 Date..Signing Officer


07/06/2013 Date ....Finance Signing Officer

2012/13 Annual Governance Statement
Brighton and Hove PCT

1. Scope of responsibility

The Board was accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I had responsibility for maintaining a sound system of internal control that supported the achievement of the organisation's policies, aims and objectives until 31 March 2013. I also had responsibility for safeguarding the public funds and the organisation's assets for which I was personally responsible as set out in the Accountable Officer Memorandum.

Brighton and Hove City Primary Care (PCT) achieved its statutory financial duties in the financial year 2012/13 of remaining within its revenue, cash and capital resource limits. It reported a £753,000 surplus compared to the control total target surplus of £750,000. Capital expenditure in the year at £270,000 was within the Capital Resource Limit set of £391,000 and cash spending was within the cash limit set of £524m.

2. The governance framework of the organisation

Good corporate governance and the management of risk is a corporate responsibility and, accordingly, the Board took a leading role in ensuring that management strategies and supporting processes were in place. The Board did this through its own annual review of the risk management strategy, by regular review of its assurance framework and through the governance, internal control, risk and assurance work of its committees. The Board was committed to ensuring that good corporate governance and risk management were integral to the organisation's philosophy, practice and planning rather than being viewed or practiced as separate programmes, and to ensuring that responsibility for implementation was accepted at all levels of the organisation. A record of Board members' attendance at Board meetings is presented below.

NHS Sussex Board Meeting Attendance Log

Name	Role	22/05 2012	07/06 2012	24/7 2012	25/09 2012	25/09 2012 AGM	09/11 2012	23/11 2012	22/01 2013	26/03 2013
David Clayton-Smith	Chairman	✓	✓	✓	✓	✓	✓	✓	✓	✓
Amanda Fadero	Chief Executive	✓	✓	✓	✓	✓	✓	✓	✓	✓
Andrew Foulkes	Medical Director	✓	✓	✓	✓	✓	✓	✓	x	✓
Sue Braysher	Director of Commissioning Development	✓	x	x	✓	✓	✓	✓	✓	✓
Sarah Creamer	Director of Performance	✓	✓	✓	✓	✓	✓	✓	x	✓
Julia Dutchman-Bailey	Director of Quality and Chief Nurse	✓	✓	✓	✓	✓	x	✓	✓	✓
Amanda Philpott	Director of Strategy and Provider Development	✓	✓	✓	✓	✓	✓	✓	✓	✓
Claire Quigley	Director of Transition	✓	x	✓	✓	✓	✓	✓	x	✓

	and Governance									
Michael Schofield	Director of Finance	✓	✓	✓	✓	✓	✓	✓	✓	✓
Frank Sims	Director of Commissioning Support Unit	✓	✓	✓	x	x	✓	x	x	✓
Jeremy Alford	Non Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	x
Peter Douglas	Non Executive Director	✓	x	✓	✓	✓	✓	✓	✓	✓
Charles Everett	Non Executive Director (Vice Chair)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rita Lewis	Non Executive Director	✓	✓	✓	✓	✓	✓	✓	x	✓
George Mack	Non Executive Director	✓	✓	x	✓	✓	✓	✓	✓	✓
Denise Stokoe	Non Executive Director	✓	✓	✓	✓	✓	✓	✓	x	✓

✓ = present, x = absent.

I was appointed as Chief Executive of NHS Sussex and each of the four statutory PCTs in Sussex. I led a single executive team across NHS Sussex. I had overall responsibility for ensuring that effective governance and risk management systems were in place and for meeting all statutory requirements and adhering to guidance issued by the Department of Health in respect of governance until 31 March 2013. My director of Governance and Transition was accountable to me for the strategic development and implementation of organisational risk management and governance controls. All my executive directors were accountable to me for risk management and governance across the breadth of their functions.

In line with the recommendations of the Integrated Governance Handbook, NHS Sussex established committees responsible for reviewing the management of all types of risk both clinical and non-clinical. The Quality and Delivery Assurance Board, supported by the establishment of Clinical Commissioning Groups (CCGs) as committees of the Board with their own assurance processes, and developing through the CCG authorisation process, managed this agenda in 2012/13 in preparation for statutory establishment of CCGs from 1 April 2013.

A Transition Assurance Board (TAB) was established during 2012/13 to oversee the operational handover of current PCT functions to appropriate receiving organisations and provide supporting closure (legacy) documentation. The Director of Transition and Governance, an NHS Sussex Board member was the executive lead member of TAB. To support the work of TAB specialist Transition Groups covering Closedown, Human Resources and Finance were also established. A Transition and Closedown Report was received by the final Board of NHS Sussex confirming that all PCT critical closure activities had been covered.

The governance and risk systems ensured the PCT discharged its statutory functions during 2012/13 and that these were legally compliant. The TAB had specific responsibility for ensuring that the legal closure of the PCT on 31st March 2013 and completion of the necessary Transfer Schemes.

The Audit Committees of the PCTs met jointly as the NHS Sussex Audit Committee to enable a single senior overview of NHS Sussex audit and internal control matters. The Audit Committees reported to the Board and reviewed the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the

organisation's activities (both clinical and non-clinical), that supported the achievement of the organisation's objectives.

The Audit Committees ensured that there was an effective internal audit function that met mandatory NHS Internal Audit Standards and provided appropriate independent assurance to the Audit Committees, Chief Executive and Board. The Committees reviewed the work and findings of the external auditors and considered the implications and management's response to their work. The Committees satisfied themselves that the organisation had adequate arrangements in place for countering fraud and they reviewed the outcomes of counter fraud work. Directly in relation to financial reporting, the Committees monitored the integrity of the financial statements of the PCTs and ensured that the systems for reporting to the Board, including those of budgetary control, were subject to review as to completeness and accuracy of the information provided to the Board until 31 March 2013. The Committees reviewed the draft annual report and early working papers for the financial statements of the PCTs, including this Annual Governance Statement. Completion of the 2012/13 accounts and approval for these and the related statements took place after the closure of the PCTs via governance arrangements under the accountability of the NHS Business Services Authority.

In preparing this statement compliance with the five sections of the UK Corporate Governance Code was reviewed as follows:

Leadership
A.1 The Role of the Board. Every company should be headed by an effective board which is collectively responsible for the long-terms success of the company. *Compliant; the types of decisions taken by the board or delegated to management were detailed in the published scheme of delegation.*
A.2 Division of Responsibilities. There should be a clear division of responsibilities at the head of the company between the running of the board and the executive responsibility for the running of the company's business. No one individual should have unfettered powers of decision. *Compliant. The roles of Chairman and Chief Executive were separate appointments.*
A.3 The Chairman. The chairman is responsible for leadership of the board and ensuring its effectiveness on all aspects of its role. *Compliant.*
A.4 Non-executive Directors. As part of their role as members of a unitary board, non-executive directors should constructively challenge and help develop proposals on strategy. *Compliant; a Senior Independent Director was formally designated.*

Effectiveness
B.1 The Composition of the Board. The board and its committees should have the appropriate balance of skills, experience, independence and knowledge of the company to enable them to discharge their respective duties and responsibilities effectively. *Compliant; regulations were changed in 2010 enabling Non-executive Directors to be members of multiple PCTs, NHS Sussex Directors held multiple membership of the four PCTs in Sussex. Non-executive directors were appointed independently by the Appointments Commission.*
B.2 Appointments to the Board. There should be a formal, rigorous and transparent procedure for the appointment of new directors to the board. *Compliant; nominations were put to the Remuneration Committee as a result of transparent appointment processes.*
B.3 Commitment. All directors should be able to allocate sufficient time to the company to discharge their responsibilities effectively. *Compliant. Executive Directors allocated time as per contract; Non-executive Directors complied with and were reviewed against applicable Appointments Commission guidance.*
B.4 Development. All directors should receive induction on joining the board and should regularly update and refresh their skills and knowledge. *Compliant; mandatory training*

provided; in 2012/13 non-essential training was limited due to closure of the PCTs, development programmes for CCG senior staff were in place.
B.5 Information and Support. The board should be supplied in a timely manner with information in a form and of a quality appropriate to enable it to discharge its duties. *Compliant. Adequate resources were available under the guidance of the Chief Executive and Executive Directors.*
B.6 Evaluation. The board should undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors. *Compliant; individual performance reviews for Executive and Non-executive directors; the operation of the Board itself was reviewed in April 2012 with particular emphasis on how the Board would work in the final year of the existence of PCTs. Review and performance management by NHS South of England in place.*
B.7 Re-election. Not applicable, the composition of PCT Boards was based on statute and followed NHS guidance.

Accountability
C.1 Financial and Business Reporting. The board should present a balanced and understandable assessment of the company's position and prospects. *Compliant. Provided in annual report.*
C.2 Risk Management and Internal Control. 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 should maintain sound risk management and internal control systems. *Compliant; iin 2012/13 there were significant changes to NHS commissioning organisations in preparation for new structures in 2013/14, such large scale change inherently carried risks which the Board mitigated as described and published in its board assurance framework.*
C.3 Audit Committee and Auditors. The board should establish formal and transparent arrangements for considering how it should apply the corporate reporting and risk management and internal control principles and for maintaining an appropriate relationship with the company's auditor. *Compliant. Contained within the terms of reference of the Audit Committees and described in this Annual Governance Statement.*
Code schedule B. Disclosure on corporate governance arrangements. *Compliant. Described in this Annual Governance Statement.*

Remuneration
D.1 The Level and Components of Remuneration. The levels of remuneration should be sufficient to attract, retain and motivate directors of the quality required to run the company successfully, but a company should avoid paying more than is necessary for this purpose. A significant proportion of executive director's remuneration should be structured so as to link rewards to corporate and individual performance. *Compliant; remuneration was paid in line with agreed NHS reward schemes.*
D.2 Remuneration Procedure. There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding his or her own remuneration. *Compliant. Remuneration for executives was set by the remuneration committee, not by individual directors.*
Code schedule A. The design of performance-related remuneration for executive directors, was not applicable under NHS schemes.

Relations with Shareholders

E.1 Dialogue with Shareholders. There should be a dialogue with shareholders based on the mutual understanding of objectives. The board as a whole has responsibility for ensuring that a satisfactory dialogue with shareholders takes place. *Compliant; there were no shareholders but the organisation was accountable to the public for its activities and engaged patients, stakeholder organisations and the public in planning its objectives; particularly when considering larger scale service changes where it had a duty to consult.*
E.2 Constructive use of the AGM. The board should use the AGM to communicate with investors and encourage their participation. *Compliant; there were no investors however, patients, stakeholder organisations and the public were encouraged to participate.*

3. The risk and control framework

The system of internal control was designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it could therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control was in place in the Brighton and Hove City PCT throughout the year ended 31 March 2013 when the PCT closed.

The NHS Sussex Board operated a harmonised risk management processes across the component PCTs. The risk management strategy was approved and reported to the Board. Risk management training was made available to all staff, was mandatory and an update was required to be attended every two years. A full range of health and safety and other mandatory training packages were made available to all relevant staff. Records of attendances were kept and collated for reporting purposes

In line with the Risk Management Strategy the risk and control framework was designed to focus management attention on risks at the appropriate level in the organisation. In particular it was designed to set the most significant risks before the Board and its committees in order that resources could be applied to adjust controls that prevented or mitigated the risks, and to gain assurances that those controls were effective. The key components of the risk management system including the method of risk assessment, directorate risk registers, corporate risk register and the assurance framework were described clearly in the PCT's Risk Management Strategy. Risk assessment enabled effective mitigating actions to be devised and encouraged the proactive identification and prevention both of manifest risks and also of potential risks. Risk deterrents were also in place, for example through the work of counter fraud.

The Board used an assurance framework to present high level risks with a score of 15 or above to the Board. This assurance framework was populated and reviewed at a lower level by the executive and by CCG committees with responsibility for governance. The assurance framework was developed to provide assurance to the Board that the systems, policies and people it had put in place were operating in a way that was effective in driving the delivery of objectives by focusing on preventing and minimising risk. It ensured that the Board was informed of the principal risks which faced the organisation together with action plans to address them. It was a regularly updated or 'live' document linked to the more detailed corporate and departmental risk registers and to key business planning documents for the PCT. The assurance framework identified for each strategic objective of the Board:-

- The principal risks, being the highest risks in the corporate risk register.
- The key controls to assist in managing the risk to secure the achievement of the objective.

- The sources of evidence on which reliance of the effectiveness of the systems was placed.
- The detailed assurances obtained showing the evidence presented to the Board. Included in the detailed assurances were internal assurances on the effectiveness of systems, from the Board committees and staff, from Internal Audit and from external bodies; the Audit Commission, NHS Litigation Authority, Care Quality Commission, etc.
- Any gaps in control i.e. systems not in place
- Any gaps in assurance i.e. systems in place but evidence not available.
- The detail of actions put in place to mitigate the risk including relevant milestones and target dates for removal.
- Progress on the actions
- Most recent review date
- Target removal date
- Executive Ownership

4. Risk assessment

The PCT recognised that it is not possible to totally eliminate all risks and that systems of control should not be so rigid that they stifle imaginative use of limited resources in order to provide an effective service. However, in order to establish a consistent framework for the assessment and management of risk, the organisation adapted a standard risk assessment tool from the National Patient Safety Agency and determined the levels of authority at which risks should be addressed. This provided a consistent approach across all of the different types of assessment that were undertaken and all identified risks were brought to the attention of Line Managers who had responsibility for making an initial assessment of the risk.

The organisation determined that those risks identified as having a total score of 11 (moderate) or below would be regarded as risks managed at team/department level by Line Managers. These risks were considered small enough to have an immaterial effect on the organisation's objectives or controlled effectively in order to minimise adverse consequences.

Those risks identified as scoring 12+ (high) or above were regarded as significant risks or where a manager could not immediately introduce control measures to reduce the level of risk to an acceptable level, these were notified within the organisation to an appropriate Director who determined how the risk would be addressed. Moderated risks with a score of 12+ formed part of the corporate risk register.

Risks determined with a score of 15+ as moderated by appropriate Directors were escalated to the assurance framework for attention of the Board.

The organisational risk profile was made clear through assurance framework reports presented at each ordinary Board meeting. The reports highlighted the level of risk against principal objectives, including the level of risk, the balance of risks and the trend in risks.

During 2012/13 CCG's have continued to remain under the NHS Sussex Risk System. From 1st April 2013 the CCG's will run their own risk systems under their approved Risk Management Strategies and Risk Management Policy and Procedures. A proposal was approved by the NHS

Sussex Audit Committee regarding the closedown process for NHS Sussex risks and the transfer of risks to receiving organisations by 31st March 2013. The following table highlights the key newly identified significant risks in terms of impact and likelihood reported in the final NHS Sussex Board Assurance Framework and the receiving body for these risks.

Key risks included in the Final Assurance Framework, March 2013

Risk No.	Risk description	Risk score	Actions taken
119	There is risk that current breast screening equipment in Worthing will be obsolete before the new West Sussex breast unit is complete.	20	*This risk was subsequently transferred to and accepted by the Surrey and Sussex Area Team, NHS England.*
217	There is a risk of a new strain of influenza pandemic virus developing, and we cannot predict with certainty when it will happen, the epidemiology of an emergent influenza pandemic virus or its clinical behaviour.	20	*This risk was subsequently transferred to and accepted by the Surrey and Sussex Area Team, NHS England, and some of the Sussex CCGs.*
312	There is a risk that there will be insufficient management capacity within the Clinical Commissioning Groups to achieve the scale and scope of change required and this may impact on the delivery of the QIPP plans across Sussex	20	*This risk was subsequently transferred to and accepted by some of the Sussex CCGs.*
314	There is a risk that the centralisation of arterial vascular surgery with 24/7services at BSUH will not be achieved by March 2013	20	*This risk was subsequently transferred to and accepted by the Surrey and Sussex Area Team, NHS England.*
571	DH Guidance relating to the timescales for making retrospective Continuing Healthcare claims has resulted in a significant rise in claims received by PCTs requiring assessment with consequent risk of service disruption.	20	*This risk was subsequently transferred to and accepted by Coastal West Sussex CCG as hosts of the future service.*
140	There is a risk that there is insufficient capacity to deliver core operational processes and there is a delay to operationalization of the Surrey and Sussex Commissioning Support Unit	16	*This risk was subsequently transferred to and accepted by Surrey and Sussex Commissioning Support Unit*

The Board agreed its principle objectives in May 2013 (set out in the table below) describing them as Strategic Goals (SG) and monitored these at every ordinary board meeting until the close of 2012/13.

Strategic Goal 1. Quality, Delivery and Performance SG1.1 - Deliver the quality and safeguarding responsibilities including the quality standards outlined in the Sussex Plan SG1.2 - Deliver the performance improvements outlined in the Sussex Plan SG1.3 - Deliver the financial plans for 12/13 outlined in the 2 year Sussex plan
Strategic Goal 2. Transition SG2.1 - Supporting our staff through the transition and maximising their talents and capabilities SG2.2 - NHS Sussex responsibilities are transferred to successor organisations by end March 2013 SG2.3 - Establish effective Clinical Commissioning Groups and an effective

Commissioning Support Service for the future
Strategic Goal 3. Strategy SG3.1 - Deliver the agreed outcomes from Sussex Together SG3.2 - Foster pan-Sussex working arrangements to improve services for patients SG3.3 - Strengthening our strategic partnerships to improve the health and wellbeing of our population
Strategic Goal 4. Health Outcomes SG4.1 - Reduce Health Inequalities within our population SG4.2 - Improve the health and wellbeing of our population

In 2013/14 CCGs will identify and align risks with their principal objectives and govern risks as required under the terms of their authorisation. In 2012/13 NHS Sussex has supported CCGs in establishing their risk management processes.

Information governance incidents

There were no Information Governance (IG) Serious Untoward Incidents (SUI) reported this year as none scored at level 5 on the IG SUI grading matrix (the most serious score on a grading from 1-5).

There were no Information Governance (IG) Serious Incident (SI) this year. There was one Information Governance incident of a less significant nature relating to the loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises.

Subject Access Requests were dealt with effectively, within the time constraints set out by the Department of Health. A 'Subject Access Request' (SAR) and 'Caldicott Log' were maintained and updated by the Information Governance Team to keep track of any requests from members of the public and any queries raised by staff about the management of personal information.

Control and risk related to performance indicators

More than sixty key performance indicators were regularly monitored by the Board and past performance reports were available to the public on the NHS Sussex website. These reports included nationally agreed operating targets as 'headline measures' and their 'supporting measures' along with wider targets agreed locally. Performance outcomes for 2012/13 are disclosed in the annual report.

For the purpose of this statement the following table identifies those nationally recognised indicators (headline measures and supporting measures) that did not reach target for the full year 2012/13.

KPI	Indicator	Brighton & Hove

Grouping		Plan YTD	Actual YTD
HCAIs	MRSA Infections	3	8
Cancer waits	Proportion of patients waiting no more than 31 days for subsequent cancer treatment (Radiotherapy)	94.0%	87.64%
Acute General	Referral rates per 100,000 population for 1st OP attendances by referral source	436	467.21
Primary Care	Number of patients receiving NHS primary dental services located within the PCT area within a 24 month period	159,903	148,116
Primary Care	QOF domain scores and exception reporting rate (PERFORMANCE COMPARED AGAINST NATIONAL AVERAGE)	94.7%	90.46%
Screening	All Women to receive results of cervical screening tests within 2 weeks	98.0%	93.62%
Screening	SQU27: Coverage of NHS Health Checks - Offered - Reported Cumulatively	18.3%	13.9%
Screening	SQU27: Coverage of NHS Health Checks - screened - reported Cumulatively	7.6%	6.2%
Maternity	Coverage of breast feeding	95.0%	94.37%
Maternity	Prevalence of breastfeeding at 6-8 wks after birth	69.3%	68.9%
Health Improvement	Under 18 conception rate per 1,000 female aged 15 to 17	31	36.5
Health Improvement	Number of 4-week smoking quitters that have attended NHS Stop Smoking Services	1,800	1,755

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

As Accountable Officer, I had responsibility for reviewing the effectiveness of the system of internal control for the financial year ending 31 March 2013. My review was informed in a number of ways. The head of internal audit provided me with an opinion on the overall arrangements for gaining assurance through assessment of the assurance framework and on the controls reviewed as part of the internal auditor's work. Executive managers within the organisation with responsibility for the development and maintenance of the system of internal control provided me with assurance. The assurance framework itself provided me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives were reviewed. My review was also informed by the work of our external auditors, Ernst and Young LLP, particularly in the following areas:

- audit of the financial statements 2012/13
- value for money conclusion 2012/13

And by the work of our internal auditors, South Coast Audit, particularly in the following areas:

- audit of risk and assurance processes 2012/13
- audits supporting the financial statements

In addition, the Head of Internal Audit opinion which states:

"**Significant assurance** can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk."

Internal audit work covered a range of risk-based audit assignments throughout the year. Of the 28 audits and reviews reported against, 1 'Limited' assurance opinion was given, 2 'split' assurance opinions were given and 15 'Significant' assurance opinions were given. A further 10 consultancy and development reviews were undertaken were no assurance opinion was given. The Head of Internal Audit, in reaching an overall assessment for 2012/13 of 'significant assurance' took into account:

- the relative importance of the areas audited and the positive results from the core annual audit work on key financial systems;
- the number of risk based reviews where 'significant' assurance was provided; and
- the 'significant' assurance provided by the development, design and operation of the Board Assurance Framework and associated risk management processes.

Limited assurance was received regarding Commissioning Support Unit (CSU) service requirements were no agreed KPI's or targets were agreed with users of the services to assess performance and delivery.

Recommendations and action plans for these areas were managed through the NHS Sussex system of follow-up and the implementation of audit recommendations was monitored by the Audit Committees. This system gave me assurance that control issues were dealt with effectively by executive directors.

I was advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, and the Audit Committee. A plan to address weaknesses and ensure continuous improvement of the system remained in place until the close of the PCT.

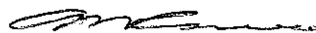
6. Significant Issues

1 area was identified as significant issues:

- The non-delivery of national priority headline and supporting measures as set out in section 4. Performance Management processes were in place during 2012/13 to mitigate performance risks and the PCT has worked with shadow Clinical Commissioning Groups and other receiving organisations to develop future performance management regimes.

Accountable Officer: Amanda Fadero

Organisation: Brighton and Hove City PCT



7th June 2013

Amanda Fadero, Director, Surrey and Sussex Area Team, NHS England

INDEPENDENT AUDITORS' REPORT TO THE ACCOUNTABLE OFFICER FOR BRIGHTON AND HOVE CITY TEACHING PRIMARY CARE TRUST

We have audited the financial statements of Brighton and Hove City Teaching Primary Care Trust for the year ended 31 March 2013 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 42. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

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

- the table of salaries and allowances of senior managers and related narrative notes on page 28;
- the table of pension benefits of senior managers and related narrative notes on page 29; and
- the narrative notes on pay multiples on page 31.

This report is made solely to the Accountable Officer for Brighton and Hove City Teaching Primary Care Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Accountable Officer, for our audit work, for this report, or for the opinions we have formed.

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

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

Scope of the audit of the financial statements

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

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

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

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

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of Brighton and Hove City Teaching 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 on:
    - the level of progress made by the Primary Care Trust in partnership with its main providers to successfully manage acute demand via the Sussex Together programme and associated 2 year financial plan;
    - the recovery plans put in place by the Primary Care Trust to manage its 2012/13 financial position, and the financial planning as part of the transition from Primary Care Trust to clinical commissioning groups; and
    - review of the Primary Care Trust's arrangements and processes to ensure a smooth closedown and effective transition of its functions to successor bodies for 2013/14.

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 Brighton and Hove City Teaching 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.

Helen Thompson
for and on behalf of Ernst & Young LLP
Southampton
Date: 10 June 2013

Final Accounts 2012/13

Prepared under International Financial Reporting Standards

NHS Brighton and Hove
Level 4, Lanchester House, Trafalgar Place, Brighton BN1 4FU
Tel: 01273 574745 | Fax: 01273 574737
www.sussex.nhs.uk

FOREWORD TO THE ACCOUNTS

NHS Brighton and Hove
Annual Accounts and Supporting Notes as at 31st March 2013

These accounts for the year ending 31st March 2013 have been prepared by NHS Brighton and Hove under direction of the Secretary of State for Health in exercise of powers conferred on him by Section 232 (Schedule 15, 3(1)) of the National Health Service Act 2006.

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	**9,209**	7,689
Other costs	5.1	**521,497**	494,699
Income	4	**(24,520)**	(12,855)
Net operating costs before interest		**506,186**	489,533
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**134**	117
Net operating costs for the financial year		**506,320**	489,650
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		**506,320**	**489,650**
Of which:			
Administration Costs			
Gross employee benefits	7.1	**9,209**	7,689
Other costs	5.1	**9,813**	7,639
Income	4	**(7,586)**	(2,495)
Net administration costs before interest		**11,436**	**12,833**
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**0**	117
Net administration costs for the financial year		**11,436**	**12,950**
Programme Expenditure			
Gross employee benefits	7.1	**0**	0
Other costs	5.1	**511,684**	487,060
Income	4	**(16,934)**	(10,360)
Net programme expenditure before interest		**494,750**	**476,700**
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**134**	0
Net programme expenditure for the financial year		**494,884**	**476,700**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**214**	0
Net (gain) on revaluation of property, plant & equipment	**0**	(214)
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*	**506,534**	**489,436**

*This is the sum of the rows above plus net operating costs for the financial year after absorption accounting adjustments.

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	**13,140**	13,743
Intangible assets	13	**0**	0
investment property	15	**0**	0
Other financial assets	21	**0**	0
Trade and other receivables	19	**0**	0
Total non-current assets		**13,140**	13,743
Current assets:			
Inventories	18	**3**	3
Trade and other receivables	19	**8,821**	7,675
Other financial assets	36	**0**	0
Other current assets	22	**0**	0
Cash and cash equivalents	23	**249**	49
Total current assets		**9,073**	7,727
Non-current assets held for sale	24	**0**	0
Total current assets		**9,073**	7,727
Total assets		**22,213**	21,470
Current liabilities			
Trade and other payables	25	**(25,594)**	(43,373)
Other liabilities	26,28	**0**	0
Provisions	32	**0**	(600)
Borrowings	27	**0**	0
Other financial liabilities	36.2	**0**	0
Total current liabilities		**(25,594)**	(43,973)
Non-current assets plus/less net current assets/liabilities		**(3,381)**	(22,503)
Non-current liabilities			
Trade and other payables	25	0	0
Other Liabilities	28	0	0
Provisions	32	(3,534)	(1,761)
Borrowings	27	0	0
Other financial liabilities	36.2	0	0
Total non-current liabilities		**(3,534)**	(1,761)
Total Assets Employed:		**(6,915)**	(24,264)
Financed by taxpayers' equity:			
General fund		(6,915)	(24,478)
Revaluation reserve		0	214
Other reserves		0	0
Total taxpayers' equity:		**(6,915)**	(24,264)

The financial statements on pages 4 to 45 were approved by the Audit Committee on behalf of the Department of Health and signed on 7th June 2013

Chief Executive: **Date: 7th June 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	**(24,478)**	**214**	**0**	**(24,264)**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(506,320)	0	0	**(506,320)**
Net gain on revaluation of property, plant, equipment	0	0	0	**0**
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	(214)	0	**(214)**
Movements in other reserves	0	0	0	**0**
Transfers between reserves*	0	0	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	**(506,320)**	**(214)**	**0**	**(506,534)**
Net Parliamentary funding	523,883	0	0	**523,883**
Balance at 31 March 2013	**(6,915)**	**0**	**0**	**(6,915)**
Balance at 1 April 2011	**(35,969)**	**387**	**0**	**(35,582)**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(489,650)	0	0	(489,650)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment	0	214	0	214
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	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves*	387	(387)	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
Total recognised income and expense for 2011-12	(489,263)	(173)	0	(489,436)
Net Parliamentary funding	500,754	0	0	500,754
Balance at 31 March 2012	**(24,478)**	**214**	**0**	**(24,264)**

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	**(506,186)**	(489,533)
Depreciation and Amortisation	**595**	551
Impairments and Reversals	**64**	(371)
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	**0**	0
Release of PFI/deferred credit	**0**	0
(Increase)/Decrease in Inventories	**0**	0
(Increase)/Decrease in Trade and Other Receivables	**(1,146)**	(4,102)
(Increase)/Decrease in Other Current Assets	**0**	0
Increase/(Decrease) in Trade and Other Payables	**(17,837)**	5,068
(Increase)/Decrease in Other Current Liabilities	**0**	0
Provisions Utilised	**(461)**	(211)
Increase/(Decrease) in Provisions	**1,486**	(156)
Net Cash Inflow/(Outflow) from Operating Activities	**(523,485)**	**(488,754)**
Cash flows from investing activities		
Interest Received	**14**	0
(Payments) for Property, Plant and Equipment	**(212)**	(11,711)
(Payments) for Intangible Assets	**0**	0
(Payments) for Other Financial Assets	**0**	0
(Payments) for Financial Assets (LIFT)	**0**	0
Proceeds of disposal of assets held for sale (PPE)	**0**	0
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)	**0**	0
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	**(198)**	**(11,711)**
Net cash inflow/(outflow) before financing	**(523,683)**	**(500,465)**
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**0**	(296)
Net Parliamentary Funding	**523,883**	500,754
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	**523,883**	**500,458**
Net increase/(decrease) in cash and cash equivalents	**200**	**(7)**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**49**	**56**
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	**249**	**49**

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.

The value of the NHS charitable fund, for which the PCT is the corporate trustee, is less than £100k and is not considered material. The PCT has, therefore, not consolidated the funds into its financial statements. This course of action is also in accordance with the directed accounting policy from the Secretary of State which states that NHS Bodies should not consolidate NHS Charitable Funds for which it is the corporate trustee.

1.1 Accounting Conventions

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

Transforming Community Services (TCS) transactions

Under the TCS initiative, services historically provided by PCTs have transferred to other providers - notably NHS Trusts and NHS Foundation Trusts. The Manual for Accounts sets out guidance for transfers which have taken place. However, NHS Brighton and Hove has not held a provider arm and has always been a “commissioning-only” PCT. Therefore, the guidance does not apply to the PCT.

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

Key areas of judgement and uncertainty in the accounts are as follows:

Non-Current Assets

Fixed assets are depreciated on a straight-line basis over their useful economic life. Included within the PCT’s non-current assets of £13,140k (See Statement of Financial Position) is a property owned by the PCT valued at £11,831k (90% of total non-current assets). This is the Independent Sector Treatment Centre located at Princess Royal Hospital in Haywards Heath. An independent, professional valuation has been obtained for this asset as at 31st March for the past five years.

Current Assets

Included in the receivables (see note 19) are a number of prepayments and accrued income. These may inevitably require an element of judgement. Where estimates have been applied, the PCT has adhered to guidance stipulated in the NHS Manual for Accounts and relevant financial standards.

The PCT has considered the likely collectability of its debts and whether a risk provision for doubtful debts should be raised. The PCT has concluded that a provision for doubtful debts is not required for 31st March 2013.

The PCT applies a robust approach to dental contract management and debts for underperformance are enforceable and will be reflected in the financial statements.

Payables

Trade payables include a number of NHS and non-NHS accruals which will require an element of judgement (see note 25). Where applicable, the PCT adheres to guidance set out in the NHS Manual for Accounts and relevant financial standards.

For each area of expenditure, the Director of Finance and the Finance teams form a judgement on the extent to which the full amount of the expenditure is reflected in the year and raise accruals as considered appropriate. These judgements are based upon the knowledge of a contract and historic experience of the expenditure.

The Family Health Services (FHS) Payables in note 25 includes an accrual for prescribing. Information in relation to prescribing is sent to the PCT monthly in arrears by the relevant prescribing authorities. This is always at least two months behind the current month. Each month, the PCT has to estimate the year to date expenditure – including at the year end – based on the last set of available data. At the year end, the PCT estimates prescribing expenditure based on 10 months' data, but with information about profiling and extrapolated trends.

The FHS Payables also includes an accrual for dental. The PCT receives information from the Dental Practice Board on a monthly basis. This information is based upon historic data and, accordingly, the PCT is required to estimate the amount of total expenditure for the final months of the financial year.

Primary Care accruals are also included in the FHS Payables. There are two main complex elements of accruing for primary care. The first relates to The Quality and Outcomes Framework (QOF), which is a payment to practices for performance against a set of indicators. The PCT has to collate full year contract monitoring information, and then audit this, before agreeing the total amount of the in-year QOF payment. Inevitably, this involves a significant element of estimation. The PCT has formed a view, as at the time

The second key element of the accrual process for the primary care area relates to the provision of enhanced services. These are complex contracts, and they can sometimes extend over a number of years. The PCT collates information from practices which is audited before arrangement is made for payment. This exercise will not be completed by the time of the accounts preparation and the accrual is based on the judgement of the Director of Finance on the likely level of payments required.

Contract Monitoring

Several of the PCT's contracts with provider Trusts are relatively straightforward as "block" payments are agreed at the start of the year. However, contracts with acute providers can be complex and information in relation to performance on the contracts may not be fully available when the accounts are being prepared. Negotiations take place with the provider Trusts at year-end and payments / accruals for any over-performance are agreed. NHS agreements are binding once made reducing the risk of bad debts / spurious accruals.

The process is facilitated by an NHS Agreement of Balances (AoB) process at year end whereby respective debit/credit balances between NHS bodies are reconciled on a national level.

Provisions:

Provisions (note 32) includes a calculation for pensions for staff who retired early or for injury benefits. The calculation includes Back-to-Back provisions where the PCT 'holds' the provision in respect of relevant staff costs on behalf of NHS Trusts in accordance with standard NHS arrangements. The provisions are calculated based on the life expectancy of the individuals to whom the provisions relate to. As a result, the uncertainty over this life expectancy leads to uncertainty over how long the provision will remain with the PCT. The PCT receives statements from the other local organisations on a yearly basis that details the amount of the provision that is utilised, the portion of the provision that will be unused, and any revised values for the provision based on their assumptions of how long the provision will remain.

The Provisions figure also includes a calculation for continuing health care (CHC) claims. These are claims from members of the public who assert they have personally paid for health care that should have been provided by the NHS. Some of these claims can be speculative in nature and the PCT must make an estimation of the likely success of the claims received.

A provision of approximately £1 million has been created representing the estimated cost of settling 225 outstanding claims for retrospective continuing health care funding.

The following judgements and assumptions have been made at NHS Sussex level to arrive at the provisions disclosed in the annual accounts of NHS Brighton and Hove:

- An assessment of success rate has been made based on the historic success rate for claims pan-Sussex of approximately 30 per cent. This has been adjusted to 15 per cent to inform the calculation of the provision as the PCT considers the very considerable increase in volume of claims received in 2012/13 increases the probability of the claims being significantly more speculative than in previous periods.

- Work has been undertaken at NHS Sussex level to show that a significant majority of claims where questionnaires had not been returned as at 31 March 2013 had been received prior to 30 September 2012. The PCT considers these claims were highly likely to be speculative given the length of time between issue of the questionnaire and financial year end. It is therefore considered appropriate to completely discount these claims from the population of claims used to calculate the provision.

Going Concern

As a consequence of the Health and Social Care Act 2012, NHS Brighton and Hove will be dissolved on 31 March 2013. Its functions will be transferred to various new or existing public sector entities.

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

As a result, the Board of NHS Brighton and Hove has prepared these financial statements on a going concern basis.

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 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.

1.4 Administration and Programme Costs

Treasury has set performance targets in respect of non-frontline expenditure (administration expenditure).
From 2011-12, PCTs therefore analyse and report revenue income and expenditure by "admin and programme"
For PCTs, the Department has defined "admin and programme" in terms of running costs.

The broad definition of running costs includes any cost incurred that is not a direct payment for the provision of healthcare or healthcare related services.
Expense incurred under NHS transition redundancy programmes is however classed as "programme" under Treasury budgetary control arrrangements and so is recorded as such in the financial statements.

1. Accounting policies (continued)

1.5 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)

1.6 Intangible Assets

The PCT has no intangible assets.

1.7 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)

1.8 Donated assets

The Treasury Department introduced a change in account policy in its Financial Reporting Manual (FReM) whereby PCTs would no longer maintain a donated asset reserve. The FReM sets out the policy to be applied. NHS Brighton and Hove has no donated assets and, therefore, the change in accounting policy does not apply to the PCT.

1.9 Government grants

Following the change in accounting policy detailed in section 1.9, government grant reserves should no longer be maintained. The PCT has held no Government grants.

1.10 Non-current assets held for sale

The PCT currently has no non-current assets held for sale.

1.11 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.12 Cash and cash equivalents

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

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

1.13 Losses and Special Payments

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

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

1.14 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)

1.15 Employee benefits

Short-term employee benefits

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

Retirement benefit costs

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

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

There are no employees in pension schemes other than the NHS pension scheme.

1.16 Research and Development

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

1.17 Other expenses

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

1.18 Grant making

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

1. Accounting policies (continued)

1.19 Contingencies

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

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

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

1.20 Leases

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

The PCT as lessee

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

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

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

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

The PCT as lessor

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

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

1.21 Foreign exchange

Transactions which are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the date of each transaction, except where rates do not fluctuate significantly, in which case an average rate for a period is used. Resulting exchange gains and losses are taken to the Statement of Comprehensive Net Expenditure.

1.22 Provisions

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

1.23 Financial Instruments

Financial assets

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

Financial assets are initially recognised at fair value.

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

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.

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.

1.24 Private Finance Initiative (PFI) and NHS LIFT transactions

The PCT has no Private Finance Initiatives (PFI) or NHS LIFT schemes.

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

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

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

2. Operating Segments

		Commissioning		Total	
		2012/13	2011/12	**2012/13**	2011/12
		£'000	£'000	£'000	£'000
Net Operating Cost		**506,320**	489,650	**506,320**	489,650
Surplus/(Deficit)					
	Surplus before Interest	**753**	4,721	**753**	4,721
	Common Costs	**0**	(117)	**0**	(117)
	Surplus after Interest	**753**	4,604	**753**	4,604
Net Assets					
	Segment Net Assets	**(6,915)**	(24,264)	**(6,915)**	(24,264)

NHS Brighton and Hove is a commissioning-only PCT and it has been determined that it has only one operating segment. Healthcare commissioning is managed as a single segment and reported as such to the Chief Operating Decision Maker (CODM). IFRS 8 “Operating Segments” requires disclosure of what the CODM uses to make decisions. In the PCT’s case, the CODM is the Board.

The PCT has formed two s75 partnerships with Brighton and Hove City Council for the provision of health and social care services; one for Adults and Older People and the other for Children’s Services. Partnership performances are reported to Joint Commissioning Boards (JCBs), whose membership includes PCT employees. The PCT considered showing the s75 partnerships as segments. However, it was concluded that, as the partnership budgets are not separately identified and are included within the single segment reported to the Board, it would be inappropriate to show them separately under IFRS 8. In addition, the PCT’s contributions to the s75 partnership arrangements individually are less than 10% of the PCT’s turnover. IFRS 8 does not require disclosure of segments below 10%.

3. Financial Performance Targets

3.1 Revenue Resource Limit

	2012-13 £000	2011-12 £000
The PCTs' performance for the year ended 2012-13 is as follows:		
Total Net Operating Cost for the Financial Year		489,650
Net operating cost plus (gain)/loss on transfers by absorption	**506,320**	
Adjusted for prior period adjustments in respect of errors	**0**	0
Revenue Resource Limit	**507,073**	494,254
Under/(Over)spend Against Revenue Resource Limit (RRL)	753	4,604

3.2 Capital Resource Limit

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

	2012-13 £000	2011-12 £000
Capital Resource Limit	**391**	50
Charge to Capital Resource Limit	**270**	49
(Over)/Underspend Against CRL	**121**	**1**

3.3 Provider full cost recovery duty

PCTs with provider arms are required have a duty to recover full provider costs. NHS Brighton and Hove is a commissioning-only PCT.

3.4 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**523,883**	500,754
Cash Limit	**(524,183)**	(500,754)
Under/(Over)spend Against Cash Limit	**300**	**0**

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

	2012-13 £000
Total cash received from DH (Gross)	466,088
Less: Trade Income from DH	0
Less/(Plus): movement in DH working balances	0
Sub total: net advances	**466,088**
(Less)/plus: transfers (to)/from other resource account bodies (free text note required)	0
Plus: cost of Dentistry Schemes (central charge to cash limits)	12,324
Plus: drugs reimbursement (central charge to cash limits)	45,471
Parliamentary funding credited to General Fund	**523,883**

4 Miscellaneous Revenue

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Fees and Charges	**15**	15	0	17
Dental Charge income from Contractor-Led GDS & PDS	**3,160**	0	3,160	3,059
Dental Charge income from Trust-Led GDS & PDS	**0**	0	0	0
Prescription Charge income	**2,084**	0	2,084	1,985
Strategic Health Authorities	**209**	0	209	350
NHS Trusts	**439**	439	0	507
NHS Foundation Trusts	**98**	0	98	91
Primary Care Trusts Contributions to DATs	**0**	0	0	0
Primary Care Trusts - Other	**0**	0	0	0
Primary Care Trusts - Lead Commissioning	**14,963**	6,457	8,506	5,126
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	**0**	0	0	20
Recoveries in respect of employee benefits	**0**	0	0	0
Local Authorities	**289**	289	0	206
Patient Transport Services	**122**	0	122	0
Education, Training and Research	**1**	1	0	0
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	0
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	**1,020**	97	923	821
Other revenue	**2,120**	288	1,832	673
Total miscellaneous revenue	**24,520**	**7,586**	**16,934**	**12,855**

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	**310,207**	0	310,207	260,362
Non-Healthcare	**1,190**	1,190	0	1,900
Total	311,397	1,190	310,207	262,262
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	**18,950**	679 #	18,271	50,352
Goods and services (other, excl Trusts, FT and PCT))	**94**	0	94	0
Total	19,044	679	18,365	50,352
Goods and Services from Foundation Trusts	**17,921**	0	17,921	4,276
Purchase of Healthcare from Non-NHS bodies	**58,184**	0	58,184	61,367
Social Care from Independent Providers	**0**	0	0	0
Expenditure on Drugs Action Teams	**1,985**	0	1,985	2,198
Non-GMS Services from GPs	**531**	0	531	963
Contractor Led GDS & PDS (excluding employee benefits)	**15,190**	0	15,190	15,056
Salaried Trust-Led PDS & PCT DS (excluding employee benefits)	**340**	0	340	0
Chair, Non-executive Directors & PEC remuneration	**249**	249	0	369
Executive committee members costs	**188**	188	0	146
Consultancy Services	**1,314**	1,314	0	585
Prescribing Costs	**42,919**	0	42,919	45,493
G/PMS, APMS and PCTMS (excluding employee benefits)	**41,153**	2,081	39,072	39,808
Pharmaceutical Services	**4,341**	0	4,341	4,414
Local Pharmaceutical Services Pilots	**0**	0	0	0
New Pharmacy Contract	**86**	0	86	104
General Ophthalmic Services	**1,901**	0	1,901	2,022
Supplies and Services - Clinical	**405**	0	405	449
Supplies and Services - General	**38**	38	0	39
Establishment	**869**	869	0	1,668
Transport	**0**	0	0	0
Premises	**1,630**	1,630	0	1,896
Impairments & Reversals of Property, plant and equipment	**64**	0	64	(371)
Impairments and Reversals of non-current assets held for sale	**0**	0	0	0
Depreciation	**595**	595	0	551
Amortisation	**0**	0	0	0
Impairment & Reversals Intangible non-current assets	**0**	0	0	0
Impairment and Reversals of Financial Assets	**0**	0	0	0
Impairment of Receivables	**0**	0	0	0
Inventory write offs	**0**	0	0	0
Research and Development Expenditure	**0**	0	0	0
Audit Fees	**120**	120	0	221
Other Auditors Remuneration	**32**	32	0	0
Clinical Negligence Costs	**0**	0	0	0
Education and Training	**333**	333	0	154
Grants for capital purposes	**436**	436	0	0
Grants for revenue purposes	**0**	0	0	0
Impairments and reversals for investment properties	**0**	0	0	0
Other	**232**	59	173	677
Total Operating costs charged to Statement of Comprehensive Net Expenditure	521,497	9,813	511,684	494,699
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	**430**	430	0	56
Other Employee Benefits	**8,779**	8,779	0	7,633
Total Employee Benefits charged to SOCNE	**9,209**	**9,209**	**0**	**7,689**
Total Operating Costs	530,706	19,022	511,684	502,388
Analysis of grants reported in total operating costs				
For capital purposes				
Grants to fund Capital Projects - GMS	**0**	0	0	0
Grants to Local Authorities to Fund Capital Projects	**0**	0	0	0
Grants to Private Sector to Fund Capital Projects	**436**	436	0	0
Grants to Fund Capital Projects - Dental	**0**	0	0	0
Grants to Fund Capital Projects - Other	**0**	0	0	0
Total Capital Grants	436	436	0	0
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	436	436	0	0

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**11,436**	10,339	1,097
Weighted population (number in units)	**268,404**	268,404	268,404
Running costs per head of population (£ per head)	**43**	**39**	**4**
PCT Running Costs 2011-12			
Running costs (£000s)	**12,950**	11,865	1,085
Weighted population (number in units)	**268,404**	268,404	268,404
Running costs per head of population (£ per head)	**48**	**44**	**4**

5.2 Analysis of operating expenditure by expenditure classification

	2012-13 £000	2011-12 £000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	39,072	39,808
Prescribing costs	42,919	45,493
Contractor led GDS & PDS	15,190	15,056
Trust led GDS & PDS	340	0
General Ophthalmic Services	1,901	2,022
Department of Health Initiative Funding	0	0
Pharmaceutical services	4,341	4,414
Local Pharmaceutical Services Pilots	0	0
New Pharmacy Contract	86	104
Non-GMS Services from GPs	531	963
Other	2,390	2,628
Total Primary Healthcare purchased	**106,770**	110,488
Purchase of Secondary Healthcare		
Learning Difficulties	6,293	5,570
Mental Illness	59,775	53,153
Maternity	11,705	10,051
General and Acute	217,401	186,814
Accident and emergency	17,130	14,720
Community Health Services	49,524	61,089
Other Contractual	44,495	46,859
Total Secondary Healthcare Purchased	**406,323**	378,256
Grant Funding		
Grants for capital purposes	436	0
Grants for revenue purposes	0	0
Total Healthcare Purchased by PCT	**513,529**	**488,744**

6. Operating Leases

The PCT has entered into arrangements to lease a building - the Wellsbourne Centre. The lease is for a term of 25 years with annual lease payments of £148,566. The lease commenced in April 2010 and the PCT leases the building without security of tenure. i.e. The PCT has no right to stay in, or purchase, the premises when the lease expires, unless the landlord chooses to offer a new lease, the PCT will be required to vacate the building.

Parts of the building are being subleased for the provision of podiatry and dental services. Sub-leases to the Sussex Community Trust (formally South Downs Health NHS Trust) and Southern Dental Limited commenced on 1st April 2010 and 1st October 2010 respectively.

The PCT also moved to a new head office in 2010/11. A lease for the rental of Lanchester House commenced on 16th June 2010 for a term of 10 years with a 5 year tenant-only break clause. The rent is £404,813 per annum.

During 2007/08, Sussex Community NHS Trust acquired 177 Preston Road, Brighton, with an annual value of £266k over 25 years on behalf of the PCT. The PCT has given full indemnity that it will meet all the costs associated with the lease and reimburses the Trust for the cost of the lease.

The PCT also leases photocopiers and holds a contract with a company for 60 months with a commencement date of 10th September 2009.

In respect of lease income, the PCT sub-leases parts of the Wellsbourne Centre to Sussex Community NHS Trust and a dental practice. In addition, with effect from 1st July 2011, the ISTC is being sub-let to Brighton and Sussex University Hospitals NHS Trust (BSUH). The PCT charges BSUH for both the buildings and the land. The income is included in 6.2.

6.1 PCT as lessee

	Land	Buildings	Other	2012-13 Total	2011-12
	£000	£000	£000	£000	£000
Payments recognised as an expense					
Minimum lease payments	0	553	76	**629**	623
Contingent rents	0	0	0	**0**	0
Sub-lease payments	0	0	0	**0**	0
Total	0	553	76	**629**	**623**
Payable:					
No later than one year	**0**	553	76	**630**	623
Between one and five years	**0**	2,214	35	**2,249**	2,297
After five years	**0**	3,436	0	**3,436**	4,274
Total	**0**	6,203	111	**6,315**	**7,194**
Total future sublease payments expected to be received				0	0

6.2 PCT as lessor

	2012-13	2011-12
	£000	£000
Recognised as income		
Rental Revenue	**1,021**	821
Contingent rents	**0**	0
Total	**1021**	821
Receivable:		
No later than one year	**990**	821
Between one and five years	**3,219**	3,854
After five years	**44**	67
Total	**4,253**	4,742

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	**7,045**	7,045	0	**6,776**	6,776	0	**269**	269	0
Social security costs	**596**	596	0	**596**	596	0	**0**	0	0
Employer Contributions to NHS BSA - Pensions Division	**772**	772	0	**772**	772	0	**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	**796**	796	0	**796**	796	0	**0**	0	0
Total employee benefits	**9,209**	**9,209**	**0**	**8,940**	**8,940**	**0**	**269**	**269**	**0**
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	**9,209**	**9,209**	**0**	**8,940**	**8,940**	**0**	**269**	**269**	**0**
Employee costs capitalised	**0**	0	0	**0**	0	0	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**9,209**	**9,209**	**0**	**8,940**	**8,940**	**0**	**269**	**269**	**0**
Recognised as:									
Commissioning employee benefits	**9,209**			**8,940**			**269**		
Provider employee benefits	**0**			**0**			**0**		
Gross Employee Benefits excluding capitalised costs	**9,209**			**8,940**			**269**		

	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 - Revenue									
Salaries and wages	**0**	0	0	**0**	0	0	**0**	0	0
Social Security costs	**0**	0	0	**0**	0	0	**0**	0	0
Employer Contributions to NHS BSA - Pensions Division	**0**	0	0	**0**	0	0	**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	**0**	0	0	**0**	0	0	**0**	0	0
TOTAL excluding capitalised costs	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	**6,496**	6,364	132
Social security costs	**500**	500	0
Employer Contributions to NHS BSA - Pensions Division	**693**	693	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	**7,689**	**7,557**	**132**
Less recoveries in respect of employee benefits	**0**	0	0
Total - Net Employee Benefits including capitalised costs	**7,689**	**7,557**	**132**
Employee costs capitalised	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**7,689**	**7,557**	**132**
Recognised as:			
Commissioning employee benefits	**7,689**		
Provider employee benefits	**0**		
Gross Employee Benefits excluding capitalised costs	**7,689**		

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	**3**	3	0	**3**	3	0
Ambulance staff	**0**	0	0	**0**	0	0
Administration and estates	**128**	123	5	**120**	117	3
Healthcare assistants and other support staff	**0**	0	0	**0**	0	0
Nursing, midwifery and health visiting staff	**17**	17	0	**8**	8	0
Nursing, midwifery and health visiting learners	**0**	0	0	**0**	0	0
Scientific, therapeutic and technical staff	**4**	4	0	**4**	4	0
Social Care Staff	**0**	0	0	**0**	0	0
Other	**0**	0	0	**0**	0	0
TOTAL	**152**	**147**	**5**	**135**	**132**	**3**
Of the above - staff engaged on capital projects	**0**	0	0	**0**	0	0

During 2012/13, there were no retirements due to ill health (2011/12 - nil).

7.3 Exit Packages agreed during 2012-13

Exit package cost band (including any special payment element)	2012-13 Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	2011-12 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	**1**	**0**	**1**	3	0	**3**
£10,001-£25,000	**6**	**0**	**6**	5	0	**5**
£25,001-£50,000	**2**	**0**	**2**	14	0	**14**
£50,001-£100,000	**2**	**0**	**2**	3	0	**3**
£100,001 - £150,000	**2**	**0**	**2**	1	0	**1**
£150,001 - £200,000	**1**	**0**	**1**	1	0	**1**
>£200,000	**0**	**0**	**0**	0	0	**0**
Total number of exit packages by type (total cost)	**14**	**0**	**14**	**27**	**0**	**27**
	£s	**£s**	**£s**	**£s**	**£s**	**£s**
Total resource cost	714,812	0	**714,812**	989,000	0	**989,000**

This note provides an analysis of Exit Packages agreed during the year. Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Where the 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.

7.4 Pension costs

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

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	**13,144**	**78,287**	11,316	95,261
Total Non-NHS Trade Invoices Paid Within Target	**12,116**	**68,222**	10,652	86,789
Percentage of NHS Trade Invoices Paid Within Target	92.18%	87.14%	94.13%	91.11%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3,256**	**360,567**	2,634	310,014
Total NHS Trade Invoices Paid Within Target	**2,799**	**352,882**	2,004	300,906
Percentage of NHS Trade Invoices Paid Within Target	85.96%	97.87%	76.08%	97.06%

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 against the PCT under this legislation in either 2011/12 or 2012/13.

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	0	0	0	0
LIFT: loan interest receivable	0	0	0	0
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	0	0	0	0
Total investment income	0	0	0	0

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	0
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	0	0	0	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	0	0	0	0

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	0	0	0	0
- contingent finance cost	0	0	0	0
Interest on late payment of commercial debt	0	0	0	0
Other interest expense	0	0	0	7
Total interest expense	0	0	0	7
Other finance costs	0	0	0	0
Provisions - unwinding of discount	134		134	110
Total	134	0	134	117

12.1 Property, plant and equipment

2012-13	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:									
At 1 April 2012	**133**	**12,308**	**0**	**0**	**0**	**0**	**842**	**1,645**	**14,928**
Additions of Assets Under Construction				0					**0**
Additions Purchased	0	0	0		0	0	270	0	**270**
Additions Donated	0	0	0	0	0	0	0	0	**0**
Additions Government Granted	0	0	0	0	0	0	0	0	**0**
Additions Leased	0	0	0		0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassifications as Held for Sale	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	0	0	0	0	**0**
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	**0**
Impairments/negative indexation	0	(214)	0	0	0	0	0	0	**(214)**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	**0**
At 31 March 2013	**133**	**12,094**	**0**	**0**	**0**	**0**	**1,112**	**1,645**	**14,984**
Depreciation									
At 1 April 2012	**0**	**(196)**	**0**	**0**	**0**	**0**	**645**	**736**	**1,185**
Reclassifications	0	0	0		0	0	0	0	**0**
Reclassifications as Held for Sale	0	0	0		0	0	0	0	**0**
Disposals other than for sale	0	0	0		0	0	0	0	**0**
Upward revaluation/positive indexation	0	0	0		0	0	0	0	**0**
Impairments	0	64	0	0	0	0	0	0	**64**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Charged During the Year	0	237	0		0	0	96	262	**595**
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	**0**
At 31 March 2013	**0**	**105**	**0**	**0**	**0**	**0**	**741**	**998**	**1,844**
Net Book Value at 31 March 2013	**133**	**11,989**	**0**	**0**	**0**	**0**	**371**	**647**	**13,140**
Purchased	133	11,989	0	0	0	0	371	647	**13,140**
Donated	0	0	0	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2013	**133**	**11,989**	**0**	**0**	**0**	**0**	**371**	**647**	**13,140**
Asset financing:									
Owned	133	11,989	0	0	0	0	371	647	**13,140**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2013	**133**	**11,989**	**0**	**0**	**0**	**0**	**371**	**647**	**13,140**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	**0**	**214**	**0**	**0**	**0**	**0**	**0**	**0**	**214**
Movements (specify)	0	(214)	0	0	0	0	0	0	**(214)**
At 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Additions to Assets Under Construction in 2012-13

	£000
Land	0
Buildings excl Dwellings	0
Dwellings	0
Plant & Machinery	0
Balance as at YTD	**0**

The impairment relates to the Sussex Orthopaedic Centre. A valuation is obtained annually and was obtained as at 31st March 2013. The valuation showed a small impairment to the value of the asset. The total impairment was £278k. This cost was initially charged to the revaluation reserve relating to previous revaluations of the assets. A residual amount of £64k was charged to expenditure.

12.2 Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	**£000**
Cost or valuation:									
At 1 April 2011	**133**	**12,141**	**0**	**0**	**0**	**0**	**834**	**1,604**	**14,712**
Additions - purchased	0	11,709	0	0	0	0	8	41	**11,758**
Additions - donated	0	0	0	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals other than by sale	0	(11,709)	0	0	0	0	0	0	**(11,709)**
Revaluation & indexation gains	0	167	0	0	0	0	0	0	**167**
Impairments	0	0	0	0	0	0	0	0	**0**
Reversals of impairments	0	0	0	0	0	0	0	0	**0**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluatio	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**133**	**12,308**	**0**	**0**	**0**	**0**	**842**	**1,645**	**14,928**
Depreciation									
At 1 April 2011	**0**	**0**	**0**		**0**	**0**	**537**	**468**	**1,005**
Reclassifications		0	0		0	0	0	0	**0**
Reclassifications as Held for Sale	0	0	0		0	0	0	0	**0**
Disposals other than for sale	0	0	0		0	0	0	0	**0**
Upward revaluation/positive indexation	0	0	0		0	0	0	0	**0**
Impairments	0	(371)	0	0	0	0	0	0	**(371)**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Charged During the Year	0	175	0		0	0	108	268	**551**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluatio	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**0**	**(196)**	**0**	**0**	**0**	**0**	**645**	**736**	**1,185**
Net Book Value at 31 March 2012	**133**	**12,504**	**0**	**0**	**0**	**0**	**197**	**909**	**13,743**
Purchased	133	12,504	0	0	0	0	197	909	**13,743**
Donated	0	0	0	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**133**	**12,504**	**0**	**0**	**0**	**0**	**197**	**909**	**13,743**
Asset financing:									
Owned	133	12,504	0	0	0	0	197	909	**13,743**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**133**	**12,504**	**0**	**0**	**0**	**0**	**197**	**909**	**13,743**

13.1 Intangible non-current assets

2012-13	Software internally generated £000	Software purchased £000	Licences & trademarks £000	Patents £000	Development expenditure £000	Total £000
At 1 April 2012	**0**	**0**	**0**	**0**	**0**	**0**
Additions - purchased	0	0	0	0	0	**0**
Additions - internally generated	0	0	0	0	0	**0**
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**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation & indexation gains	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	**0**
In-year transfers to/from NHS bodies	0	0	0	0	0	**0**
At 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**
Amortisation						
At 1 April 2012	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation or indexation gains	0	0	0	0	0	**0**
Impairments charged to operating expenses	0	0	0	0	0	**0**
Reversal of impairments charged to operating expenses	0	0	0	0	0	**0**
Charged during the year	0	0	0	0	0	**0**
In-year transfers to NHS bodies	0	0	0	0	0	**0**
At 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**
Net Book Value at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**
Net Book Value at 31 March 2013 comprises						
Purchased	0	0	0	0	0	**0**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	**0**
Total at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**

Revaluation reserve balance for intangible non-current assets

	Software internally generated £000's	Software purchased £000's	Licences & trademarks £000's	Patents £000's	Development expenditure £000's	Total £000's
At 1 April 2012	**0**	**0**	**0**	**0**	**0**	**0**
Movements	0	0	0	0	0	**0**
At 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**

13.2 Intangible non-current assets

2011-12	Software internally generated	Software purchased	Licences & trademarks	Patents	Development expenditure	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2011	**0**	**0**	**0**	**0**	**0**	**0**
Additions - purchased	0	0	0	0	0	**0**
Additions - internally generated	0	0	0	0	0	**0**
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	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation & indexation gains	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	**0**
Reversal 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 revaluation	0	0	0	0	0	**0**
At 31 March 2012	**0**	**0**	**0**	**0**	**0**	**0**
Amortisation						
At 1 April 2011	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation or indexation gains	0	0	0	0	0	**0**
Impairments charged to operating expenses	0	0	0	0	0	**0**
Reversal of impairments charged to operating expenses	0	0	0	0	0	**0**
Charged during the year	0	0	0	0	0	**0**
In-year transfers to NHS bodies	0	0	0	0	0	**0**
Less cumulative dep written down on revaluation	0	0	0	0	0	**0**
At 31 March 2012	**0**	**0**	**0**	**0**	**0**	**0**
Net Book Value at 31 March 2012	**0**	**0**	**0**	**0**	**0**	**0**
Net Book Value at 31 March 2012 comprises						
Purchased	0	0	0	0	0	**0**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	**0**
Total at 31 March 2012	**0**	**0**	**0**	**0**	**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
Loss as a result of catastrophe	0		0
Other	0		0
Changes in market price	64		64
Total charged to Annually Managed Expenditure	**64**		**64**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Loss or damage resulting from normal operations	0		
Over Specification of Assets	0		
Abandonment of assets in the course of construction	0		
Unforeseen obsolescence	0		
Loss as a result of catastrophe	0		
Other	0		
Changes in market price	214		
Total impairments for PPE charged to reserves	**214**		
Total Impairments of Property, Plant and Equipment	**278**	**0**	**64**
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
Loss as a result of catastrophe	0		0
Other	0		0
Changes in market price	0		0
Total charged to Annually Managed Expenditure	**0**		**0**
Intangible Assets impairments and reversals charged to the Revaluation Reserve			
Loss or damage resulting from normal operations	0		
Over-specification of assets	0		
Abandonment of assets in the course of construction	0		
Unforeseen obsolescence	0		
Loss as a result of catastrophe	0		
Other	0		
Changes in market price	0		
Total impairments for Intangible Assets charged to Reserves	**0**		
Total Impairments of Intangibles	**0**	**0**	**0**
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
Other	0		0
Total charged to Annually Managed Expenditure	**0**		**0**
Financial Assets impairments and reversals charged to the Revaluation Reserve			
Loss or damage resulting from normal operations	0		
Loss as a result of catastrophe	0		
Other	0		
TOTAL impairments for Financial Assets charged to reserves	**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
Loss as a result of catastrophe	0		0
Other	0		0
Changes in market price	0		0
Total charged to Annually Managed Expenditure	**0**		**0**
Total impairments of non-current assets held for sale	**0**	**0**	**0**
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
Loss as a Result of a Catastrophe	0		0
Other (Free text note required)*	0		0
Changes in Market Price	0		0
Total charged to Annually Managed Expenditure	**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
Loss as a Result of a Catastrophe	0		0
Other (Free text note required)*	0		0
Changes in Market Price	0		0
Total charged to Annually Managed Expenditure	**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		
Over Specification of Assets	0		
Abandonment of Assets in the Course of Construction	0		
Unforeseen Obsolescence	0		
Loss as a Result of a Catastrophe	0		
Other (Free text note required)*	0		
Changes in Market Price	0		
TOTAL impairments for Investment Property charged to Reserves	**0**		
Total Investment Property Impairments	**0**	**0**	**0**
Total Impairments charged to Revaluation Reserve	214		
Total Impairments charged to SoCNE - DEL	0	0	0
Total Impairments charged to SoCNE - AME	64		64
Overall Total Impairments	**278**	**0**	**64**
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

	31 March 2013 £000	31 March 2012 £000
At fair value		
Balance at 1 April 2012	**0**	0
Additions Through Subsequent Expenditure	**0**	0
Other Acquisitions	**0**	0
Disposals	**0**	0
Property Reclassified as Held for Sale	**0**	0
Loss from Fair Value Adjustments - Impairments	**0**	0
Gain from Fair Value Adjustments - Reversal of Impairments	**0**	
Gain from Fair Value Adjustments	**0**	0
Transfers (to)/from Other Public Sector Bodies	**0**	
Other Changes	**0**	0
Balance at 31 March 2013	**0**	0
Investment property capital transactions in 2012-13		
Capital expenditure	**0**	0
Capital income	**0**	0
	0	0

16 Commitments

16.1 Capital commitments

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

	31 March 2013 £000	31 March 2012 £000
Property, plant and equipment	**0**	841
Intangible assets	**0**	0
Total	**0**	841

16.2 Other financial commitments

	31 March 2013 £000	31 March 2012 £000
Not later than one year	**0**	0
Later than one year and not later than five year	**0**	0
Later than five years	**0**	0
Total	**0**	0

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	6,960	0	1,251	0
Balances with Local Authorities	36	0	989	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	317	0	7,181	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	1,508	0	16,173	0
At 31 March 2013	**8,821**	**0**	**25,594**	**0**
prior period:				
Balances with other Central Government Bodies	4,676	0	8,489	0
Balances with Local Authorities	120	0	174	0
Balances with NHS Trusts and Foundation Trusts	329	0	15,950	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	2,550	0	18,760	0
At 31 March 2012	**7,675**	**0**	**43,373**	**0**

18 Inventories

	Drugs £000	Consumables £000	Energy £000	Work in progress £000	Loan Equipment £000	Other £000	Total £000	Of which held at NRV £000
Balance at 1 April 2012	**0**	**3**	**0**	**0**	**0**	**0**	**3**	0
Additions	0	3	0	0	0	0	**3**	0
Inventories recognised as an expense in the period	0	(3)	0	0	0	0	**(3)**	0
Write-down of inventories (including losses)	0	0	0	0	0	0	**0**	0
Reversal of write-down previously taken to SoCNE	0	0	0	0	0	0	**0**	0
Transfers (to)/from other public sector bodies	0	0	0	0	0	0	**0**	0
Balance at 31 March 2013	**0**	**3**	**0**	**0**	**0**	**0**	**3**	**0**

19.1 Trade and other receivables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
NHS receivables - revenue	**2,184**	2,614	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**5,093**	2,391	**0**	0
Non-NHS receivables - revenue	**210**	236	**0**	0
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**1,207**	2,317	**0**	0
Provision for the impairment of receivables	**0**	0	**0**	0
VAT	**54**	43	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	**0**	0	**0**	0
Interest receivables	**0**	0	**0**	0
Finance lease receivables	**0**	0	**0**	0
Operating lease receivables	**0**	0	**0**	0
Other receivables	**73**	74	**0**	0
Total	**8,821**	7,675	**0**	0
Total current and non current	**8,821**	7,675		
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	**488**	204
By three to six months	**1,207**	229
By more than six months	**148**	136
Total	**1,843**	569

19.3 Provision for impairment of receivables

	2012-13 £000	**2011-12 £000**
Balance at 1 April 2012	**0**	(776)
Amount written off during the year	**0**	776
Amount recovered during the year	**0**	0
(Increase)/decrease in receivables impaired	**0**	0
Balance at 31 March 2013	**0**	0

20 NHS LIFT investments

	Loan £000	Share capital £000	Total £000
Balance at 1 April 2012	**0**	**0**	**0**
Additions	**0**	**0**	**0**
Disposals	**0**	**0**	**0**
Loan repayments	**0**	**0**	**0**
Revaluations	**0**	**0**	**0**
Loans repayable within 12 months	**0**	**0**	**0**
Balance at 31 March 2013	**0**	**0**	**0**
Balance at 1 April 2011	0	0	0
Additions	0	0	0
Disposals	0	0	0
Loan repayments	0	0	0
Revaluations	0	0	0
Loans repayable within 12 months	0	0	0
Balance at 31 March 2012	**0**	**0**	**0**

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	**0**	0
Additions	0	0
Revaluation	0	0
Impairments	0	0
Impairment Reversals	0	0
Transferred to current financial assets	0	0
Disposals	0	0
Transfers (to)/from Other Public Sector Bodies in year	0	0
Total Other Financial Assets - Non Current	**0**	0

21.3 Other Financial Assets - Capital Analysis

	31 March 2013 £000	31 March 2012 £000
Capital Expenditure	**0**	0
Capital Income	**0**	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	**49**	56
Net change in year	**200**	(7)
Closing balance	**249**	49
Made up of		
Cash with Government Banking Service	**249**	49
Commercial banks	**0**	0
Cash in hand	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**249**	49
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**249**	49
Patients' money held by the PCT, not included above	**0**	0

24 Non-current assets held for sale

	Land	Buildings, excl. dwellings	Dwellings	Asset Under Construction and Payments on Account	Plant and Machinery	Transport and Equipment	Information Technology	Furniture and Fittings	Intangible Assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Balance at 1 April 2012	0	0	0	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	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	0	0	**0**
Transfers (to)/from other public sector bodies	0	0	0	0	0	0	0	0	0	**0**
Revaluation	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
										0
Balance at 1 April 2011	0	0	0	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	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	0	0	**0**
Balance at 31 March 2012	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2012	0	0	0	0	0	0	0	0	0	**0**

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

At 31 March 2012	0
At 31 March 2013	0

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		
NHS payables - revenue	**3,112**	9,644	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**5,320**	14,795	**0**	0
Family Health Services (FHS) payables	**10,840**	11,170		
Non-NHS payables - revenue	**3,427**	2,646	**0**	0
Non-NHS payables - capital	**58**	0	**0**	0
Non-NHS accruals and deferred income	**2,050**	4,750	**0**	0
Social security costs	**2**	74		
VAT	**0**	0	**0**	0
Tax	**95**	93		
Payments received on account	**0**	0	**0**	0
Other	**690**	201	**0**	0
Total	**25,594**	**43,373**	**0**	0
Total payables (current and non-current)	**25,594**	**43,373**		

26 Other liabilities

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
PFI/LIFT deferred credit	**0**	0	**0**	0
Lease incentives	**0**	0	**0**	0
Other	**0**	0	**0**	0
Total	**0**	**0**	**0**	**0**
Total other liabilities (current and non-current)	**0**	**0**		

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	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**0**	0	**0**	0
Other (describe)	**0**	0	**0**	0
Total	**0**	**0**	**0**	**0**

Borrowings/Loans - Payment of Principal Falling Due in:

	DH	Other	Total
	£000s	£000s	£000s
0 - 1 Years	0	0	**0**
1 - 2 Years	0	0	**0**
2 - 5 Years	0	0	**0**
Over 5 Years	0	0	**0**
TOTAL	**0**	**0**	**0**

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	**0**	0	**0**	0
Deferred income addition	**0**	0	**0**	0
Transfer of deferred income	**0**	0	**0**	0
Current deferred Income at 31 March 2013	**0**	0	**0**	0
Total other liabilities (current and non-current)	**0**	**0**		

30 Finance lease obligations

The PCT has no Finance Lease obligations.

31 Finance lease receivables as lessor

n/a

32 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	**2,361**	0	639	0	0	0	0	0	1,722	0
Arising During the Year	**1,540**	0	0	0	0	1,040	0	0	500	0
Utilised During the Year	**(461)**	0	(98)	0	0	0	0	0	(363)	0
Reversed Unused	**(54)**	0	0	0	0	0	0	0	(54)	0
Unwinding of Discount	**134**	0	35	0	0	0	0	0	99	0
Change in Discount Rate	**14**	0	0	0	0	0	0	0	14	0
Transferred (to)/from otherPublic Sector bodies	**0**	0	0	0	0	0	0	0	0	0
Balance at 31 March 2013	**3,534**	**0**	**576**	**0**	**0**	**1,040**	**0**	**0**	**1,918**	**0**
Expected Timing of Cash Flows:										
No Later than One Year	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Later than One Year and not later than Five Years	**1,484**	**0**	**393**	**0**	**0**	**500**	**0**	**0**	**591**	**0**
Later than Five Years	**2,050**	**0**	**183**	**0**	**0**	**540**	**0**	**0**	**1,327**	**0**

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

The majority of the other provisions figure relates to provisions in respect of early retirements and pension costs arising in prior years. Pensions relating to "other staff" provisions are "back to back" provisions with provider organisations, where the PCT 'holds' the provision in respect of relevant staff costs in accordance with standard NHS arrangements.

Under previous accounting arrangements, Brighton and Hove City PCT (and its predecessor organisation, East Sussex, Brighton and Hove Health Authority) was responsible for the early retirement, clinical negligence and injury benefit provisions for other local organisations (or their historical predecessors). Several years ago, the funding arrangements for these provisions changed and the funding was given to these organisations directly. At this point, it was agreed that these organisations would account for any new provisions that arise, and the liability for existing provisions would remain with Brighton and Hove City PCT but paid through the organisation that they relate to.

The provisions were calculated based on the life expectancy of the individuals to whom the provisions relate to. As a result, the uncertainty over this life expectancy leads to uncertainty over how long the provision will remain with the PCT. The PCT receives statements from the other local organisations on a yearly basis that details the amount of the provision that is utilised, the portion of the provision that will be unused, and any revised values for the provision based on their assumptions of how long the provision will remain.

There is a continuing care provision in 2012/13. The Department of Health has published guidelines to the public in respect of continuing healthcare funding with set deadlines for claims.
This resulted in a significant increase in claims from the public. These claims are still being assessed by management and the level of provision provided has been set in accordance with accounting standards.

33 Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities		
Equal Pay	**0**	0
Other	**0**	0
Amounts Recoverable Against Contingent Liabilities	**0**	0
Net Value of Contingent Liabilities	**0**	0
Contingent Assets		
Contingent Assets	**2,581**	2,581
Net Value of Contingent Assets	**2,581**	2,581

During 2010/11, five properties were transferred to Brighton and Hove City Council at open market value for £2.581m. This was in support of the national Valuing People Now policy which transferred the commissioning and funding of social care for people with learning disabilities from health bodies to local authorities.

The transfer was supported by a s28a capital grant made to Brighton and Hove City Council for £2.581m. The PCT retains legal charges over each of the properties which are supported by memorandum of agreements which set out the ongoing rights and obligations of the PCT and the Council in relation to the use and disposal of the properties. If certain future events materialize, the PCT may exercise the right to seek reimbursement of all or some of the £2.581m grant paid to Brighton and Hove City Council. The PCT considers the occurrence of these events to be remote and it is therefore relevant to disclose this transaction as a contingent asset.

There were no other contingent assets as at each of the accounting dates.

There are no contingent liabilities as at 31st March 2013.

34 PFI and LIFT - additional information

The PCT has no PFI or LIFT Schemes.

35 Impact of IFRS treatment - 2012-13

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

36 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/Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The PCT/Trust has no overseas operations. The PCT/Trust 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.

36.1 Financial Assets	**At 'fair value through profit and loss'**	**Loans and receivables**	**Available for sale**	**Total**
	£000	**£000**	**£000**	**£000**
Embedded derivatives	0			**0**
Receivables - NHS		7,277		**7,277**
Receivables - non-NHS		1,545		**1,545**
Cash at bank and in hand		249		**249**
Other financial assets	0	0	0	**0**
Total at 31 March 2013	**0**	**9,071**	**0**	**9,071**
Embedded derivatives	0			0
Receivables - NHS		5,005		5,005
Receivables - non-NHS		2,670		2,670
Cash at bank and in hand		49		49
Other financial assets	0	0	0	0
Total at 31 March 2012	0	7,724	0	7,724

36.2 Financial Liabilities	**At 'fair value through profit and loss'**	**Other**	**Total**
	£000	**£000**	**£000**
Embedded derivatives	0		**0**
NHS payables		8,433	**8,433**
Non-NHS payables		17,161	**17,161**
Other borrowings		0	**0**
PFI & finance lease obligations		0	**0**
Other financial liabilities	0	0	**0**
Total at 31 March 2013	**0**	**25,594**	**25,594**
Embedded derivatives	0		0
NHS payables		24,439	24,439
Non-NHS payables		18,934	18,934
Other borrowings		0	0
PFI & finance lease obligations		0	0
Other financial liabilities	0	0	0
Total at 31 March 2012	**0**	43,373	43,373

37 Related party transactions

During the year none of the Department of Health Ministers or parties related to any of them, has undertaken any material transactions with the PCT. Claire Quigley (PCT Director of Governance and Transition) was a Governor of Sussex Partnership Foundation Trust and Charles Everett (PCT Non Executive Director) was a trustee of St Michaels Hospice. Details of related party transactions for these individuals are recorded in the table below. During 2012/13 Brighton and Hove Clinical Commissioning Group (CCG) was established in shadow form as sub committees of the Board. The table below records related party transactions with organisations where Governing Body members of shadow CCG's have declared an interest. Where the related party is a General Medical Practice, payments were made under the standard terms and conditions of General Medical Services or Personal Medical Services contracts.

	Payments to Related Party £
Claire Quigley, Director of Governance and Transition - Governor of Sussex Partnership Foundation Trust	6,802,653
Charles Everett, Non Executive Director - Trustee of St Michaels Hospice	125
Xavier Nalletamby, Governing Body Member, Brighton and Hove CCG - St Peters Medical Practice	1,397,263
Naseer Khan, Governing Body Member, Brighton and Hove CCG - Warmdene Medical Practice	1,075,706
Anne Miners, Governing Body Member, Brighton and Hove CCG - Portslade Medical Centre	1,466,892
Darren Emilianus, Governing Body Member, Brighton and Hove CCG - Woodingdean Medical Practice	626,200
Jonny Coxon, Governing Body Member, Brighton and Hove CCG - Beaconsfield Medical Practice	1,348,852

The Department of Health is regarded as a related party. During the year. 2012/13, the 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. The NHS organisations listed below are those where transactions over the year 2012/13 have exceeded £300k:

Supplier Name:	£'000
West Sussex PCT	287,709
Sussex Community NHS Trust	9,514
Brighton and Sussex University Hospitals NHS Trust	6,198
West Kent PCT	22,976
East Sussex Downs and Weald NHS Trust	577
Chelsea and Westminster Hospital NHS Foundation Trust	629
South East Coast Ambulance service NHS Trust	8,503

In addition, the NHS Brighton and Hove has had a significant number of transactions with other Government Departments and other central and local Government bodies. Most of these transactions have been with Brighton and Hove City Council. There were also a number of material transactions with Brighton and Hove Integrated Care Service (BICS), HMRC and NHS Pensions.

38 Losses and special payments

There have been no losses or special payments during the year.

39 Third party assets

The PCT does not hold any third party assets

40 s75 Partnerships

The PCT has formed two s75 partnerships with Brighton and Hove City Council for the provision of health and social care services; one for Adults and Older People and the other for Children's Services. PCT and council employees are members of Joint Commissioning Boards for each partnership which plan and determine their strategic direction.

The Adults and Older People partnership is hosted by the PCT and the City Council jointly. The Children's Services pool is hosted by Brighton and Hove City Council. Detailed financial information is included in the financial statements of the city council.

Following a detailed review of the accounting arrangements in place, the PCT has concluded that the s75 partnerships do not fall under IAS 31"Interests in Joint Ventures". The standard requires partnerships within pools to recognise its share of the income and expenditure and its share of the pooled assets and liabilities. The PCT has concluded that, although arrangements are in place to agree the sharing of risks, formal pooling does not take place. The PCT accounts for its shares of the assets, liabilities, income and expenditure separately.

The table below shows the contributions from each party:

Contributions to Adults and Older People

	PCT Health Care £'000	Council Social Care £'000
Intermediate Care Services	4,564	452
HIV/AIDS Services	373	336
Learning Disabilities Services	791	29,251
Integrated Equipment Store	789	714
Mental Health	37,188	11,601
Substance Misuse Services	420	102
	44,125	**42,456**
Contributions to Children and Young People Partnership	**1,372**	**69,111**

41 Cashflows relating to exceptional items

There have been no cashflows relating to exceptional items.

42 Events after the end of the reporting period

NHS Brighton and Hove was abolished as at 31st March 2013 and its responsibilities were split amongst new statutory successor organisations. The bulk of the commissioning responsibilities have been passed to Brighton and Hove City Clinical Commissioning Group (CCG).

GLOSSARY OF FINANCIAL TERMS

Term	Definition
Accruals	An accounting concept. In addition to payments and receipts of cash, adjustment is made for outstanding payments, debts to be collected and stock. This means that the accounts show all of the income and expenditure that related to the financial year.
Assets	An item that has a value in the future. For example, a Receivable (someone who owes money) is an asset, as they will in future pay. A building is an asset, because it houses activity that will provide a future income stream.
Audit	The process of validation of the accuracy, completeness and adequacy of disclosure of financial records.
Capital	Land, buildings, equipment and other long-term assets owned by the Trust, the cost of which exceeds £5,000 and has an expected life of more than one year.
Cash Limit	A limit set by the Department of Health which restricts the amount of cash drawings that the Trust can make in the financial year. There is a combined cash limit for both revenue and capital.
Commissioning	Purchase of healthcare from external service providers (NHS, other public sector, private and voluntary) to meet the needs of the population.
Current Assets	Receivables, stocks, cash or similar, whose value is, or can be converted into, cash within the next twelve months.
Non-Current Assets	Land, buildings, equipment and other long term assets that are expected to have a life of more than one year.
Governance	Governance is the system by which organisations are directed and controlled . It is concerned with how the organisation is run, how it is structured and how it is led. Corporate governance should underpin all that an organisation does. In the NHS, this means it must encompass clinical, financial and organisational aspects.
Gross Operating Costs	This is the total revenue expenditure, including accruals and provisions, incurred in the course of performing all aspects of the Trust's functions during the year.
Intangible Assets	Brand value or some other right (for example, a software licence), which although invisible is likely to derive financial benefit for its owner in the future, and for which you might be willing to pay.
Liabilities	Obligations which the PCT has incurred in the course of business. This includes outstanding payments to suppliers (NHS and non-NHS) as well as obligations arising under longer term arrangements, such as finance leases.
Miscellaneous Income	Income that relates directly to the operating activities of the Trust. This excludes cash voted by Parliament and drawn down by the Trust from the Department of Health, which is credited to the general fund.
Payment by Results	A financial framework in which providers are paid according to the level of activity undertaken. Payment is based on a national tariff.
Practice Based Commissioning	A framework which engages GP practices and other primary care professionals in the redesign of services for the benefit of patients, through the provision of resources, information and support.
Primary Care Trust	Primary care organisations that provide and manage services delivered within the primary and community care sector, as well as commission acute and other services for its population.

Provider	Provision of healthcare from within the Trust to meet the needs of the population.
Resource limit	Expenditure limits are determined for each NHS organisation by the Department of Health for both revenue and capital, which limit the amount that may be expended on revenue purchases, as assessed on an accruals basis (that is, after adjusting for Receivables and payables).
Revenue	Ongoing or recurring running costs or funding for the general provision of services.
Tangible Assets	A sub-classification of non-current assets, which include land, buildings, equipment, and fixtures and fittings.

East Sussex Downs and Weald Primary Care Trust

2012-13 Accounts

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

© Crown copyright

Published to gov.uk, in PDF format only.

www.gov.uk/dh

East Sussex Downs and Weald Primary Care Trust

2012-13 Accounts

2012-13 Annual Accounts of East Sussex Downs and Weald Primary Care Trust

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: AMANDA FADERO

Date..7/6/13..........

2012-13 Annual Accounts of East Sussex Downs and Weald 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.

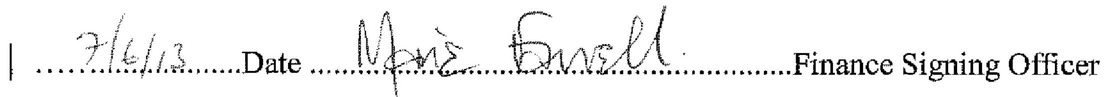
- ensure that the PCT kept proper accounting records which disclosed with reasonable accuracy at any time the financial position of the primary care trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State.

- 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.

...7/6/13.........Date..Signing Officer


...7/6/13.......Date ....Finance Signing Officer

2012/13 Annual Governance Statement
East Sussex Downs and Weald PCT

1. Scope of responsibility

The Board was accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I had responsibility for maintaining a sound system of internal control that supported the achievement of the organisation's policies, aims and objectives until 31 March 2013. I also had responsibility for safeguarding the public funds and the organisation's assets for which I was personally responsible as set out in the Accountable Officer Memorandum.

East Sussex Downs and Weald Primary Care Trust (PCT) achieved its statutory financial duties in the financial year 2012/13 of remaining within its revenue, cash and capital resource limits. It reported a £732,000 surplus compared to the control total target surplus of £750,000. Capital expenditure in the year at £4.5 million was within the Capital Resource Limit set of £4.7 million and cash spending was within the cash limit set of £628m.

2. The governance framework of the organisation

Good corporate governance and the management of risk is a corporate responsibility and, accordingly, the Board took a leading role in ensuring that management strategies and supporting processes were in place. The Board did this through its own annual review of the risk management strategy, by regular review of its assurance framework and through the governance, internal control, risk and assurance work of its committees. The Board was committed to ensuring that good corporate governance and risk management were integral to the organisation's philosophy, practice and planning rather than being viewed or practiced as separate programmes, and to ensuring that responsibility for implementation was accepted at all levels of the organisation. A record of Board members' attendance at Board meetings is presented below.

NHS Sussex Board Meeting Attendance Log

Name	Role	22/05 2012	07/06 2012	24/7 2012	25/09 2012	25/09 2012 AGM	09/11 2012	23/11 2012	22/01 2013	26/03 2013
David Clayton-Smith	Chairman	✓	✓	✓	✓	✓	✓	✓	✓	✓
Amanda Fadero	Chief Executive	✓	✓	✓	✓	✓	✓	✓	✓	✓
Andrew Foulkes	Medical Director	✓	✓	✓	✓	✓	✓	✓	x	✓
Sue Braysher	Director of Commissioning Development	✓	x	x	✓	✓	✓	✓	✓	✓
Sarah Creamer	Director of Performance	✓	✓	✓	✓	✓	✓	✓	x	✓
Julia Dutchman-Bailey	Director of Quality and Chief Nurse	✓	✓	✓	✓	✓	x	✓	✓	✓
Amanda Philpott	Director of Strategy and Provider Development	✓	✓	✓	✓	✓	✓	✓	✓	✓
Claire Quigley	Director of Transition and Governance	✓	x	✓	✓	✓	✓	✓	x	✓

Michael Schofield	Director of Finance	✓	✓	✓	✓	✓	✓	✓	✓	✓
Frank Sims	Director of Commissioning Support Unit	✓	✓	✓	x	x	✓	x	x	✓
Jeremy Alford	Non Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	x
Peter Douglas	Non Executive Director	✓	x	✓	✓	✓	✓	✓	✓	✓
Charles Everett	Non Executive Director (Vice Chair)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rita Lewis	Non Executive Director	✓	✓	✓	✓	✓	✓	✓	x	✓
George Mack	Non Executive Director	✓	✓	x	✓	✓	✓	✓	✓	✓
Denise Stokoe	Non Executive Director	✓	✓	✓	✓	✓	✓	✓	x	✓

✓ = present, x = absent.

I was appointed as Chief Executive of NHS Sussex and each of the four statutory PCTs in Sussex. I led a single executive team across NHS Sussex. I had overall responsibility for ensuring that effective governance and risk management systems were in place and for meeting all statutory requirements and adhering to guidance issued by the Department of Health in respect of governance until 31 March 2013. My director of Governance and Transition was accountable to me for the strategic development and implementation of organisational risk management and governance controls. All my executive directors were accountable to me for risk management and governance across the breadth of their functions.

In line with the recommendations of the Integrated Governance Handbook, NHS Sussex established committees responsible for reviewing the management of all types of risk both clinical and non-clinical. The Quality and Delivery Assurance Board, supported by the establishment of Clinical Commissioning Groups (CCGs) as committees of the Board with their own assurance processes, and developing through the CCG authorisation process, managed this agenda in 2012/13 in preparation for statutory establishment of CCGs from 1 April 2013.

A Transition Assurance Board (TAB) was established during 2012/13 to oversee the operational handover of current PCT functions to appropriate receiving organisations and provide supporting closure (legacy) documentation. The Director of Transition and Governance, an NHS Sussex Board member was the executive lead member of TAB. To support the work of TAB specialist Transition Groups covering Closedown, Human Resources and Finance were also established. A Transition and Closedown Report was received by the final Board of NHS Sussex confirming that all PCT critical closure activities had been covered.
The governance and risk systems ensured the PCT discharged its statutory functions during 2012/13 and that these were legally compliant. The TAB had specific responsibility for ensuring that the legal closure of the PCT on 31st March 2013 and completion of the necessary Transfer Schemes.

The Audit Committees of the PCTs met jointly as the NHS Sussex Audit Committee to enable a single senior overview of NHS Sussex audit and internal control matters. The Audit Committees reported to the Board and reviewed the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supported the achievement of the organisation's objectives.

The Audit Committees ensured that there was an effective internal audit function that met mandatory NHS Internal Audit Standards and provided appropriate independent assurance to the Audit Committees, Chief Executive and Board. The Committees reviewed the work and findings of the external auditors and considered the implications and management's response to their work. The Committees satisfied themselves that the organisation had adequate arrangements in place for countering fraud and they reviewed the outcomes of counter fraud work. Directly in relation to financial reporting, the Committees monitored the integrity of the financial statements of the PCTs and ensured that the systems for reporting to the Board, including those of budgetary control, were subject to review as to completeness and accuracy of the information provided to the Board until 31 March 2013. The Committees reviewed the draft annual report and early working papers for the financial statements of the PCTs, including this Annual Governance Statement. Completion of the 2012/13 accounts and approval for these and the related statements took place after the closure of the PCTs via governance arrangements under the accountability of the NHS Business Services Authority.

In preparing this statement compliance with the five sections of the UK Corporate Governance Code was reviewed as follows:

Leadership
A.1 The Role of the Board. Every company should be headed by an effective board which is collectively responsible for the long-terms success of the company. *Compliant; the types of decisions taken by the board or delegated to management were detailed in the published scheme of delegation.*
A.2 Division of Responsibilities. There should be a clear division of responsibilities at the head of the company between the running of the board and the executive responsibility for the running of the company's business. No one individual should have unfettered powers of decision. *Compliant. The roles of Chairman and Chief Executive were separate appointments.*
A.3 The Chairman. The chairman is responsible for leadership of the board and ensuring its effectiveness on all aspects of its role. *Compliant.*
A.4 Non-executive Directors. As part of their role as members of a unitary board, non-executive directors should constructively challenge and help develop proposals on strategy. *Compliant; a Senior Independent Director was formally designated.*

Effectiveness
B.1 The Composition of the Board. The board and its committees should have the appropriate balance of skills, experience, independence and knowledge of the company to enable them to discharge their respective duties and responsibilities effectively. *Compliant; regulations were changed in 2010 enabling Non-executive Directors to be members of multiple PCTs, NHS Sussex Directors held multiple membership of the four PCTs in Sussex. Non-executive directors were appointed independently by the Appointments Commission.*
B.2 Appointments to the Board. There should be a formal, rigorous and transparent procedure for the appointment of new directors to the board. *Compliant; nominations were put to the Remuneration Committee as a result of transparent appointment processes.*
B.3 Commitment. All directors should be able to allocate sufficient time to the company to discharge their responsibilities effectively. *Compliant. Executive Directors allocated time as per contract; Non-executive Directors complied with and were reviewed against applicable Appointments Commission guidance.*
B.4 Development. All directors should receive induction on joining the board and should regularly update and refresh their skills and knowledge. *Compliant; mandatory training provided; in 2012/13 non-essential training was limited due to closure of the PCTs, development programmes for CCG senior staff were in place.*

B.5 Information and Support. The board should be supplied in a timely manner with information in a form and of a quality appropriate to enable it to discharge its duties. *Compliant. Adequate resources were available under the guidance of the Chief Executive and Executive Directors.*
B.6 Evaluation. The board should undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors. *Compliant; individual performance reviews for Executive and Non-executive directors; the operation of the Board itself was reviewed in April 2012 with particular emphasis on how the Board would work in the final year of the existence of PCTs. Review and performance management by NHS South of England in place.*
B.7 Re-election. Not applicable, the composition of PCT Boards was based on statute and followed NHS guidance.

Accountability
C.1 Financial and Business Reporting. The board should present a balanced and understandable assessment of the company's position and prospects. *Compliant. Provided in annual report.*
C.2 Risk Management and Internal Control. 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 should maintain sound risk management and internal control systems. *Compliant; in 2012/13 there were significant changes to NHS commissioning organisations in preparation for new structures in 2013/14, such large scale change inherently carried risks which the Board mitigated as described and published in its board assurance framework.*
C.3 Audit Committee and Auditors. The board should establish formal and transparent arrangements for considering how it should apply the corporate reporting and risk management and internal control principles and for maintaining an appropriate relationship with the company's auditor. *Compliant. Contained within the terms of reference of the Audit Committees and described in this Annual Governance Statement.*
Code schedule B. Disclosure on corporate governance arrangements. *Compliant. Described in this Annual Governance Statement.*

Remuneration
D.1 The Level and Components of Remuneration. The levels of remuneration should be sufficient to attract, retain and motivate directors of the quality required to run the company successfully, but a company should avoid paying more than is necessary for this purpose. A significant proportion of executive director's remuneration should be structured so as to link rewards to corporate and individual performance. *Compliant; remuneration was paid in line with agreed NHS reward schemes.*
D.2 Remuneration Procedure. There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding his or her own remuneration. *Compliant. Remuneration for executives was set by the remuneration committee, not by individual directors.*
Code schedule A. The design of performance-related remuneration for executive directors, was not applicable under NHS schemes.

Relations with Shareholders
E.1 Dialogue with Shareholders. There should be a dialogue with shareholders based on the mutual understanding of objectives. The board as a whole has responsibility for ensuring that a satisfactory dialogue with shareholders takes place. *Compliant; there were no shareholders but the organisation was accountable to the public for its activities and engaged patients,*

stakeholder organisations and the public in planning its objectives; particularly when considering larger scale service changes where it had a duty to consult.
E.2 Constructive use of the AGM. The board should use the AGM to communicate with investors and encourage their participation. *Compliant; there were no investors however, patients, stakeholder organisations and the public were encouraged to participate.*

3. The risk and control framework

The system of internal control was designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it could therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control was in place in the East Sussex Downs and Weald PCT throughout the year ended 31 March 2013 when the PCT closed.

The NHS Sussex Board operated a harmonised risk management processes across the component PCTs. The risk management strategy was approved and reported to the Board. Risk management training was made available to all staff, was mandatory and an update was required to be attended every two years. A full range of health and safety and other mandatory training packages were made available to all relevant staff. Records of attendances were kept and collated for reporting purposes

In line with the Risk Management Strategy the risk and control framework was designed to focus management attention on risks at the appropriate level in the organisation. In particular it was designed to set the most significant risks before the Board and its committees in order that resources could be applied to adjust controls that prevented or mitigated the risks, and to gain assurances that those controls were effective. The key components of the risk management system including the method of risk assessment, directorate risk registers, corporate risk register and the assurance framework were described clearly in the PCT's Risk Management Strategy. Risk assessment enabled effective mitigating actions to be devised and encouraged the proactive identification and prevention both of manifest risks and also of potential risks. Risk deterrents were also in place, for example through the work of counter fraud.

The Board used an assurance framework to present high level risks with a score of 15 or above to the Board. This assurance framework was populated and reviewed at a lower level by the executive and by CCG committees with responsibility for governance. The assurance framework was developed to provide assurance to the Board that the systems, policies and people it had put in place were operating in a way that was effective in driving the delivery of objectives by focusing on preventing and minimising risk. It ensured that the Board was informed of the principal risks which faced the organisation together with action plans to address them. It was a regularly updated or 'live' document linked to the more detailed corporate and departmental risk registers and to key business planning documents for the PCT. The assurance framework identified for each strategic objective of the Board:-

- The principal risks, being the highest risks in the corporate risk register.
- The key controls to assist in managing the risk to secure the achievement of the objective.
- The sources of evidence on which reliance of the effectiveness of the systems was placed.
- The detailed assurances obtained showing the evidence presented to the Board. Included in the detailed assurances were internal assurances on the effectiveness of

systems, from the Board committees and staff, from Internal Audit and from external bodies; the Audit Commission, NHS Litigation Authority, Care Quality Commission, etc.

- Any gaps in control i.e. systems not in place
- Any gaps in assurance i.e. systems in place but evidence not available.
- The detail of actions put in place to mitigate the risk including relevant milestones and target dates for removal.
- Progress on the actions
- Most recent review date
- Target removal date
- Executive Ownership

4. Risk assessment

The PCT recognised that it is not possible to totally eliminate all risks and that systems of control should not be so rigid that they stifle imaginative use of limited resources in order to provide an effective service. However, in order to establish a consistent framework for the assessment and management of risk, the organisation adapted a standard risk assessment tool from the National Patient Safety Agency and determined the levels of authority at which risks should be addressed. This provided a consistent approach across all of the different types of assessment that were undertaken and all identified risks were brought to the attention of Line Managers who had responsibility for making an initial assessment of the risk.

The organisation determined that those risks identified as having a total score of 11 (moderate) or below would be regarded as risks managed at team/department level by Line Managers. These risks were considered small enough to have an immaterial effect on the organisation's objectives or controlled effectively in order to minimise adverse consequences.

Those risks identified as scoring 12+ (high) or above were regarded as significant risks or where a manager could not immediately introduce control measures to reduce the level of risk to an acceptable level, these were notified within the organisation to an appropriate Director who determined how the risk would be addressed. Moderated risks with a score of 12+ formed part of the corporate risk register.

Risks determined with a score of 15+ as moderated by appropriate Directors were escalated to the assurance framework for attention of the Board.

The organisational risk profile was made clear through assurance framework reports presented at each ordinary Board meeting. The reports highlighted the level of risk against principal objectives, including the level of risk, the balance of risks and the trend in risks.

During 2012/13 CCG's have continued to remain under the NHS Sussex Risk System. From 1st April 2013 the CCG's will run their own risk systems under their approved Risk Management Strategies and Risk Management Policy and Procedures. A proposal was approved by the NHS Sussex Audit Committee regarding the closedown process for NHS Sussex risks and the transfer of risks to receiving organisations by 31st March 2013. The following table highlights the key newly identified significant risks in terms of impact and likelihood reported in the final NHS Sussex Board Assurance Framework and the receiving body for these risks.

Key risks included in the Final Assurance Framework, March 2013

Risk No.	Risk description	Risk score	Actions taken
119	There is risk that current breast screening equipment in Worthing will be obsolete before the new West Sussex breast unit is complete.	20	*This risk was subsequently transferred to and accepted by the Surrey and Sussex Area Team, NHS England.*
217	There is a risk of a new strain of influenza pandemic virus developing, and we cannot predict with certainty when it will happen, the epidemiology of an emergent influenza pandemic virus or its clinical behaviour.	20	*This risk was subsequently transferred to and accepted by the Surrey and Sussex Area Team, NHS England, and some of the Sussex CCGs.*
312	There is a risk that there will be insufficient management capacity within the Clinical Commissioning Groups to achieve the scale and scope of change required and this may impact on the delivery of the QIPP plans across Sussex	20	*This risk was subsequently transferred to and accepted by some of the Sussex CCGs.*
314	There is a risk that the centralisation of arterial vascular surgery with 24/7services at BSUH will not be achieved by March 2013	20	*This risk was subsequently transferred to and accepted by the Surrey and Sussex Area Team, NHS England.*
571	DH Guidance relating to the timescales for making retrospective Continuing Healthcare claims has resulted in a significant rise in claims received by PCTs requiring assessment with consequent risk of service disruption.	20	*This risk was subsequently transferred to and accepted by Coastal West Sussex CCG as hosts of the future service.*
140	There is a risk that there is insufficient capacity to deliver core operational processes and there is a delay to operationalization of the Surrey and Sussex Commissioning Support Unit	16	*This risk was subsequently transferred to and accepted by Surrey and Sussex Commissioning Support Unit*

The Board agreed its principle objectives in May 2013 (set out in the table below) describing them as Strategic Goals (SG) and monitored these at every ordinary board meeting until the close of 2012/13.

Strategic Goal 1. Quality, Delivery and Performance SG1.1 - Deliver the quality and safeguarding responsibilities including the quality standards outlined in the Sussex Plan SG1.2 - Deliver the performance improvements outlined in the Sussex Plan SG1.3 - Deliver the financial plans for 12/13 outlined in the 2 year Sussex plan
Strategic Goal 2. Transition SG2.1 - Supporting our staff through the transition and maximising their talents and capabilities SG2.2 - NHS Sussex responsibilities are transferred to successor organisations by end March 2013 SG2.3 - Establish effective Clinical Commissioning Groups and an effective Commissioning Support Service for the future
Strategic Goal 3. Strategy SG3.1 - Deliver the agreed outcomes from Sussex Together

SG3.2 - Foster pan-Sussex working arrangements to improve services for patients SG3.3 - Strengthening our strategic partnerships to improve the health and wellbeing of our population
Strategic Goal 4. Health Outcomes SG4.1 - Reduce Health Inequalities within our population SG4.2 - Improve the health and wellbeing of our population

In 2013/14 CCGs will identify and align risks with their principal objectives and govern risks as required under the terms of their authorisation. In 2012/13 NHS Sussex has supported CCGs in establishing their risk management processes.

Information governance incidents

There were no Information Governance (IG) Serious Untoward Incidents (SUI) reported this year as none scored at level 5 on the IG SUI grading matrix (the most serious score on a grading from 1-5).

There were 2 category 4 incidents relating to confidential information being sent to the wrong recipient by email or being wrongly attached to the intended recipient by email. In these cases, the data did not leave the boundaries of the NHS and all data was retrieved.

Summary of Serious Untoward Incidents

Category	Nature of incident	East Sx Downs and Weald PCT
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	0
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	0
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	2
V	Other	0
	Totals for the year	**2**

* *It should be noted that as East Sussex Downs and Weald PCT and Hastings and Rother PCT work closely together, with staff working across both organisations, and incidents reported under East Sussex Downs and Weald PCT may reflect joint working arrangements.*

Subject Access Requests were dealt with effectively, within the time constraints set out by the Department of Health. A 'Subject Access Request' (SAR) and 'Caldicott Log' were maintained and updated by the Information Governance Team to keep track of any requests from members of the public and any queries raised by staff about the management of personal information.

Control and risk related to performance indicators

More than sixty key performance indicators were regularly monitored by the Board and past performance reports were available to the public on the NHS Sussex website. These reports included nationally agreed operating targets as 'headline measures' and their 'supporting measures' along with wider targets agreed locally. Performance outcomes for 2012/13 are disclosed in the annual report.

For the purpose of this statement the following table identifies those nationally recognised indicators (headline measures and supporting measures) that did not reach target for the full year 2012/13.

KPI Grouping	Indicator	ESDW	
		Full Year Plan	Full Year Actual
HCAIs	Clostridium Difficile	94	**100**
18 weeks	Numbers waiting on an incomplete Referral to Treatment pathway	17,889	**20,118**
Emergency	Ambulance Response times to Cat A - % within 8 minutes (Cluster)	75.0%	**73.60%**
Cancer waits	Proportion of patients with suspected cancer, referred through GP who wait less than 62 days from referral to treatment	85.0%	**83.64%**
Primary Care	Number of patients receiving NHS primary dental services located within the PCT area within a 24 month period	202,389	**184,782**
Mental Health	The number of new cases of psychosis served by early intervention teams year to date	36	**31**
Screening	SQU27: Coverage of NHS Health Checks - Offered - Reported Cumulatively	19.4%	**8.7%**
Screening	SQU27: Coverage of NHS Health Checks - screened - reported Cumulatively	7.8%	**5.4%**
Maternity	Coverage of breast feeding	95.0%	**94.26%**
Health Improvement	Immunisation - Aged 2 immunised for PCV (Sussex Cluster actual and plan is the average of the PCTs, actual cluster performance will be available in Q1 11/12)	95.0%	**93.13%**
Health Improvement	Immunisation - Aged 2 immunised for Hib/MenC (Sussex Cluster actual and plan is the average of the PCTs, actual cluster performance will be available in Q1 11/12)	95.0%	**93.06%**

Health Improvement	Immunisation - Aged 2 immunised for MMR (Sussex Cluster actual and plan is the average of the PCTs, actual cluster performance will be available in Q1 11/12)		95.0%	93.53%
Health Improvement	Immunisation - Aged 5 immunised for DTaP/IPV(Sussex Cluster actual and plan is the average of the PCTs)		95.0%	87.95%
Health Improvement	Immunisation - Aged 5 immunised for MMR (Sussex Cluster actual and plan is the average of the PCTs)		95.0%	86.49%
Health Improvement	Number of 4-week smoking quitters that have attended NHS Stop Smoking Services		1,219	1,015

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

As Accountable Officer, I had responsibility for reviewing the effectiveness of the system of internal control for the financial year ending 31 March 2013. My review was informed in a number of ways. The head of internal audit provided me with an opinion on the overall arrangements for gaining assurance through assessment of the assurance framework and on the controls reviewed as part of the internal auditor's work. Executive managers within the organisation with responsibility for the development and maintenance of the system of internal control provided me with assurance. The assurance framework itself provided me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives were reviewed. My review was also informed by the work of our external auditors, BDO LLP, particularly in the following areas:

- audit of the financial statements 2012/13
- value for money conclusion 2012/13

And by the work of our internal auditors, South Coast Audit, particularly in the following areas:

- audit of risk and assurance processes 2012/13
- audits supporting the financial statements

In addition, the Head of Internal Audit opinion which states:

"**Significant assurance** can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk."

Internal audit work covered a range of risk-based audit assignments throughout the year. Of the 28 audits and reviews reported against, 1 'Limited' assurance opinion was given, 2 'split' assurance opinions were given and 15 'Significant' assurance opinions were given. A further 10 consultancy and development reviews were undertaken were no assurance opinion was given. The Head of Internal Audit, in reaching an overall assessment for 2012/13 of 'significant assurance' took into account:

- the relative importance of the areas audited and the positive results from the core annual audit work on key financial systems;
- the number of risk based reviews where 'significant' assurance was provided; and
- the 'significant' assurance provided by the development, design and operation of the Board Assurance Framework and associated risk management processes.

Limited assurance was received regarding Commissioning Support Unit (CSU) service requirements were no agreed KPI's or targets were agreed with users of the services to assess performance and delivery.

Recommendations and action plans for these areas were managed through the NHS Sussex system of follow-up and the implementation of audit recommendations was monitored by the Audit Committees. This system gave me assurance that control issues were dealt with effectively by executive directors.

I was advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, and the Audit Committee. A plan to address weaknesses and ensure continuous improvement of the system remained in place until the close of the PCT.

6. Significant Issues

There were 3 areas identified as significant issues:

- The non-delivery of national priority headline and supporting measures as set out in section 4. Performance Management processes were in place during 2012/13 to mitigate performance risks and the PCT has worked with shadow Clinical Commissioning Groups and other receiving organisations to develop future performance management regimes.

- The year end financial position has been reached only by the use of non-recurrent measures such as negotiating one year capped contracts with Sussex NHS provider organisations. This negated the in year financial impact of demand led over performance on contracted activity levels that was evident during the year. During 2012/13 the PCT worked with shadow Clinical Commissioning Groups in East Sussex to develop appropriate QIPP savings initiatives for 2013/14 and beyond to address the underlying issues.

- A number of irregular payments were identified by the PCT and referred to NHS Protect in April 2013. The investigation is currently ongoing and NHS Protect is being supported by the Surrey and Sussex Commissioning Support Unit which is the main receiving body of the legacy PCT finance function.

Accountable Officer: Amanda Fadero

Organisation: East Sussex Downs and Weald PCT

7th June 2013

Amanda Fadero, Director, Surrey and Sussex Area Team, NHS England

INDEPENDENT AUDITOR'S REPORT TO THE ACCOUNTABLE OFFICER FOR EAST SUSSEX DOWNS AND WEALD PRIMARY CARE TRUST

Financial statements

We have audited the financial statements of East Sussex Downs and Weald 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.

This report is made solely to the Accountable Officer for East Sussex Downs and Weald 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 auditor

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 Primary Care Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Primary Care 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.

Qualified opinion on regularity arising from non-compliance with governing authorities

As disclosed in Note 38 to the financial statements, expenditure includes £513,000 of payments during 2012/13 and additional amounts in excess of £175,000 in previous years, where the Primary Care Trust had no powers to make such payments. These payments have been reported to NHS Protect to seek recovery of amounts paid.

Accordingly, we have concluded that this expenditure has not been applied to the purposes intended by Parliament and is not in conformity with the authorities which govern it.

In our opinion, except for the irregular payments reported above, in all material respects the expenditure and income have been applied to the purposes intended by Parliament and 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 state of affairs of East Sussex Downs and Weald 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 to be audited 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 Operating and Financial review section within the annual report relating to East Sussex Downs and Weald Primary Care Trust, excluding information which is specific to the other NHS Sussex cluster Primary Care Trusts, 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 have nothing to report in respect of the following other matters which the Code of audit practice for local NHS bodies (March 2010) requires us to report to you if:

- we have been unable to satisfy ourselves that the annual governance statement meets the disclosure requirements set out in the guidance provided by the Department of Health or is misleading or inconsistent with other information that is forthcoming from the audit; or
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

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

Respective responsibilities of the Primary Care Trust and auditor

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

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Primary Care Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. For 2012/13, auditors of Primary Care Trusts will consider the risks relating to PCT abolition and the transition to new local commissioning arrangements, rather than giving their conclusion based on specified reporting criteria. 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.

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

We have undertaken our review 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 Annual 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 Primary Care Trust; and
- our locally determined risk-based work on demise of the Primary Care Trust and transition to successor bodies and delivering Quality, Innovation, Productivity and Prevention (QIPP) plans.

Conclusion

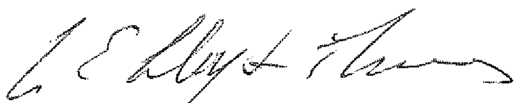
As a result, we have concluded that there are the following matters to report:

The Primary Care Trust has been unable to demonstrate that it has adequate arrangements in place to plan finances effectively and deliver sustainable outcomes and value for money for the following reasons:

- financial targets for the year ended 31 March 2013 were achieved only with the support of non-recurrent funding from the NHS Sussex risk pooling reserve and the agreement of capped contracts with key providers, which undermines the ability of the Primary Care Trust to manage its financial risks and secure a stable financial position for successor organisations
- the Primary Care Trust has not been able to show that it is able to influence its main providers to have a positive effect on acute demand and costs through it QIPP plans and the Sussex Together programme
- the Primary Care Trust has not been able to demonstrate sufficient transformation change through its QIPP plans and use of additional non-recurrent funding
- the two successor Clinical Commissioning Groups have not been able to develop clear and credible financial plans, with the result that they are both under the direction of NHS England.

Certificate

We certify that we have completed the audit of the accounts of East Sussex Downs and Weald 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.



Leigh Lloyd-Thomas
for and on behalf of BDO LLP
London, UK
25 July 2013

East Sussex Downs and Weald

Final Accounts 2012/13

Prepared under International Financial Reporting Standards

East Sussex Downs and Weald PCT
36-38 Friars Walk, Lewes, East Sussex, BN7 2PB
Tel: 01273 403704 | Fax: 01273 403682
www.sussex.nhs.uk

ACCOUNTS FOR 2012/13

FOREWORD TO THE ACCOUNTS

East Sussex Downs and Weald PCT
Annual Accounts and Supporting Notes as at 31 March 2013

These accounts for the year ended 31st March 2013 have been prepared by East Sussex Downs and Weald PCT under direction of the Secretary of State for Health in exercise of powers conferred on him by Section 232 (Schedule 15, 3(1)) of the National Health Service Act 2006

Statement of Comprehensive Net Expenditure for year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000 restated
Administration Costs and Programme Expenditure			
Gross employee benefits	7.1	**11,726**	12,016
Other costs	5.1	**631,166**	605,177
Income	4	**(26,526)**	(31,417)
Net operating costs before interest		**616,366**	585,776
Other gains	10	**(12)**	0
Finance costs	11	**67**	74
Net operating costs for the financial year		**616,421**	585,850
Of which:			
Administration Costs			
Gross employee benefits	7.1	**10,309**	11,938
Other costs	5.1	**8,044**	6,880
Income	4	**(7,319)**	(9,367)
Net administration costs for the financial year		**11,034**	**9,451**
Programme Expenditure			
Gross employee benefits	7.1	**1,417**	78
Other costs	5.1	**623,122**	598,297
Income	4	**(19,207)**	(22,050)
Net programme expenditure before interest		**605,332**	**576,325**
Other gains	10	**(12)**	0
Finance costs	11	**67**	74
Net programme expenditure for the financial year		**605,387**	**576,399**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**516**	0
Net gain on revaluation of property, plant & equipment	**0**	(497)
Total comprehensive net expenditure for the year*	**616,937**	**585,353**

*This is the sum of the rows above plus net operating costs for the financial year.
The notes on pages 7 to 42 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	**56,914**	54,786
Current assets:			
Trade and other receivables	19	**8,169**	12,449
Cash and cash equivalents	23	**75**	9
Total current assets		**8,244**	12,458
Non-current assets held for sale	24	**0**	0
Total current assets		**8,244**	12,458
Total assets		**65,158**	67,244
Current liabilities			
Trade and other payables	25	**(35,923)**	(45,997)
Provisions	32	**(980)**	(331)
Total current liabilities		**(36,903)**	(46,328)
Non-current assets less net current liabilities		**28,255**	20,916
Non-current liabilities			
Provisions	32	(2,874)	(1,191)
Total Assets Employed:		**25,381**	19,725
Financed by taxpayers' equity:			
General fund		6,851	669
Revaluation reserve		18,530	19,056
Total taxpayers' equity:		**25,381**	19,725

The notes on pages 7 to 42 form part of this account.

The financial statements on pages *3 to 42* were approved by the Audit Committee on behalf of the Department of Health and signed on 7th June 2013.

Signing Officer: Date: 7/6/13

Director - Surrey and Sussex Area Team

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

	General fund	Revaluation reserve	Total reserves
	£000	£000	£000
Balance at 1 April 2012	**669**	**19,056**	**19,725**
Changes in taxpayers' equity for 2012-13			
Net operating cost for the year	(616,421)	0	**(616,421)**
Impairments and reversals	0	(516)	**(516)**
Transfers between reserves	10	(10)	**0**
Total recognised income and expense for 2012-13	**(616,411)**	**(526)**	**(616,937)**
Net Parliamentary funding	622,593	0	**622,593**
Balance at 31 March 2013	**6,851**	**18,530**	**25,381**
Balance at 1 April 2011	**5,689**	**18,660**	**24,349**
Changes in taxpayers' equity for 2011-12			
Net operating cost for the year	(585,850)	0	(585,850)
Net gain on revaluation of Property, Plant and Equipment	0	497	497
Transfers between reserves	101	(101)	0
Total recognised income and expense for 2011-12	(585,749)	396	(585,353)
Net Parliamentary funding	580,729	0	580,729
Balance at 31 March 2012	**669**	**19,056**	**19,725**

Statement of cash flows for the year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities			
Net Operating Cost Before Interest		**(616,366)**	(585,776)
Depreciation and Amortisation		**1,890**	1,691
Impairments and Reversals		**10**	0
Decrease in Inventories		**0**	141
Decrease in Trade and Other Receivables		**4,259**	2,783
Increase/(Decrease) in Trade and Other Payables		**(8,676)**	1,208
Provisions Utilised		**(394)**	(237)
Increase in Provisions		**2,659**	163
Net Cash Outflow from Operating Activities		**(616,618)**	**(580,027)**
Cash flows from investing activities			
Payments for Property, Plant and Equipment		**(6,050)**	(3,120)
Proceeds of disposal of assets held for sale (PPE)		**120**	2,418
Net Cash Outflow from Investing Activities		**(5,930)**	**(702)**
Net cash outflow before financing		**(622,548)**	**(580,729)**
Cash flows from financing activities			
Net Parliamentary Funding		**622,593**	580,729
Capital grants and other capital receipts		**21**	0
Net Cash Inflow from Financing Activities		**622,614**	**580,729**
Net increase in cash and cash equivalents	**23**	**66**	**0**
Cash and Cash Equivalents at Beginning of the Year	**23**	**9**	**9**
Cash and Cash Equivalents at year end	**23**	**75**	**9**

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.

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 and certain financial assets and financial liabilities.

Under the provisions of The Health and Social Care Act 2012 (Commencement No.4. Transitional, Savings and Transitory Provisions) Order 2013, East Sussex Downs and Weald PCT was dissolved on 1st April 2013. The PCT's functions, assets and liabilities transferred to other public sector entities as outlined in Note 39 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 Statement of Financial Position has therefore been drawn up at 31 March 2013 on the same basis as in previous years, reporting balances on the same basis as would a continuing entity. 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.

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.

A change in 2011-12 PCT Manual for Accounts meant that the treatment of the management costs recharges between Hastings and Rother PCT and East Sussex Downs and Weald PCT had to change. The statements reflect the shared income and expenditure on a net, rather than gross, basis.
There has been a change in the accounting treament of the Continuing Healthcare recharge between East Sussex Downs and Weald PCT and Hastings and Rother PCT. The statements now show expenditure on a net basis, prior year comparatives have also been amended (£11.265m that was previously disclosed within Purchase of Healthcare from non nhs bodies has now been netted off against income from PCTs in the comparatives for 2011-12).

The PCT hosts PCSS (Primary Care Support Services) on behalf of other PCTs in the South East. The hosting arrangements require PCSS to comply with the PCT's governance. PCSS are a full cost recovery service and therefore the PCT only picks up its proportion of the PCSS costs. The remaining costs are covered by income from other PCTs.

Critical judgements in applying accounting policies
Critical judgements and key sources of estimation uncertainty are disclosed, where relevant, under the notes to the accounts.

Key sources of estimation uncertainty
Where uncertainty exists in the preparation of these accounts, the PCT makes reasonable efforts to make estimations based on the information available to it at the time the accounts are prepared. Many estimations have to be made in the production of these accounts which relate to the delay between activities happening and the financial impact of those activities being confirmed. When the cost of known commitments is available estimations are based on those costs. When the cost of known commitments is not available estimations are based on actual spend for a period of time, forecasted to represent a twelve month cost or latest information available to us in respect of indexation.

The following are the key assumptions used at the Statement of Financial Position date, that may have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.
- Agreements have been reached with local NHS acute providers regarding the expected outturn of agreements ending 31st March 2013. Where agreements haven't been reached the PCT has relied on information received from the Sussex Commissioning Support Unit and West Kent PCT as host of the specialist commissioning function.
- Accruals for the Prescription Pricing Authority creditor : - Information in relation to prescribing is sent to the PCT monthly in arrears by the relavent prescribing authorities. This is always at least two months behind the current month. Each month, the PCT has to estimate the year to date expenditure - including at year end - based on the last set of available data. At year end, the PCT estimates prescribing based on 10 months' data, but with information about profiling and extrapolated trends.
- Accruals for the Quality and Outcomes Framework creditor : - This is a payment to practices for performance against a set of indicators. The PCT has to collate full year contract monitoring information, and then audit this, before agreeing the total amount of the in-year QOF payment. Inevitably this involves a significant element of estimation. The PCT has formed a view, as at the time of preparation of the financial statements, on the likely deliverability of improved performance across the practices and this forms the basis of the relevant accrual.

- The NHS has a policy of revaluing its fixed assets on a five year basis. For the years in between the latest available market value based indices (the BCIS All in Tender prices) are used when material.
- Fixed asset lives are assessed based on expert assessment in relation to remaining useful life of the asset.

- Provisions for Continuing Healthcare (CHC) retrospective claims have been estimated by reviewing all completed questionnaires and categorising into care groups. An estimated conversion rate of 15% has been applied to each of the groups for claims received , based on previous experience (30%) and adjusted down to take account of our expectations of potential payments, and a financial value calculated based on average bed prices for the relevant care category.

- The PCT has made an allowance for impairment of non NHS debts based on a review of outstanding NHS debtors and the expectation that those debts will be met. The PCT has a policy of debt collection and instructs third parties to act on its behalf to recover overdue debts.

1.2 Revenue and Funding

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

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

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

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

1.3 Pooled budgets

The PCT has entered into pooled budgets with East Sussex County Council and Hastings and Rother PCT. Under the arrangement funds are pooled under S75 of the NHS Act 2006 for:

- the provision of care services for carers
- the provision of an integrated community equipment loan service
- the provision of services for Children.

The pools are hosted by East Sussex County Council. The PCT makes contributions to the care services for carers pool as part of its commissioning role.

1.4 Taxation

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

1.5 Administration and Programme Costs

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

1.6 Property, Plant & Equipment

Recognition

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

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

Valuation

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

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

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

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

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

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

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

IAS 16 Property, plant and equipment require that the carrying value of replaced components are derecognised when the cost of replacement works are capitalised. The PCT has not followed this policy where it is not possible to calculate the carrying value of the replaced components due to insufficient information on these components.

1.7 Depreciation and impairments

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

Otherwise, depreciation is charged to write off the costs or valuation of property, plant and equipment, 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 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.

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.

1.8 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.

1.9 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.

1.10 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.

1.11 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).

1.12 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.

1.13 Employee benefits

Short-term employee benefits

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

Retirement benefit costs

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

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

1.14 Other expenses

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

1.15 Grant making

Under section 256 of the National Health Service Act 2006, the 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.

1.16 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 PCT. 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.

1.17 Leases

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

The PCT as lessee

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.

1.18 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.

1.19 Financial Instruments

Financial assets

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

Financial assets are initially recognised at fair value.

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

The PCT has classified all financial assets as 'loans and receivables' and does not hold any other types of financial assets.

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.

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

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

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

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

Financial liabilities are initially recognised at fair value.

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

The PCT has classified alll financial liabilities as 'other financial liabilities' and does not hold any other types of 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.

1.20 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

	Corporate Services		Primary Care		Commissioning		Primary Care Support Service		Total	
	2012-13	2011-12	**2012-13**	2011-12	**2012-13**	2011-12	**2012-13**	2011-12	**2012-13**	2011-12
	£000	£000	**£000**	£000	**£000**	£000 restated	**£000**	£000	**£000**	£000 restated
Statement of Comprehensive Net Expenditure										
Employee benefits	**6,553**	6,919	**0**	0	**0**	0	**5,173**	5,097	**11,726**	12,016
Other Costs	**10,963**	9,463	**142,787**	143,156	**475,177**	450,158	**2,239**	2,400	**631,166**	605,177
Total Operating Costs	**17,516**	16,382	**142,787**	143,156	**475,177**	450,158	**7,412**	7,497	**642,892**	617,193
Income	**(3,863)**	(6,094)	**(10,174)**	(11,501)	**(5,077)**	(6,324)	**(7,412)**	(7,498)	**(26,526)**	(31,417)
Other Gains	**(12)**	0	**0**	0	**0**	0	**0**	0	**(12)**	0
Finance Costs	**67**	74	**0**	0	**0**	0	**0**	0	**67**	74
Segmental net operating costs / (surplus)	**13,708**	10,362	**132,613**	131,655	**470,100**	443,834	**0**	(1)	**616,421**	**585,850**
Revenue Resource Limit									**617,153**	586,326
PCT Operating Surplus									**732**	**476**

PCT management reviews balance sheet performance and investment decisions on a holistic basis. The net assets are therefore not split in the above segmental analysis.

Commissioning expenditure includes amounts with other PCTs that exceed 10 per cent of total operating costs - refer to note 5.1.

2011-12 comparatives for commissioning income and costs have been restated by £11.265m to reflect continuing healthcare recharges between the two East Sussex PCTs on a net rather than gross basis.

3 Financial Performance Targets

3.1 Revenue Resource Limit

The PCTs' performance for the year ended 2012-13 is as follows:

	2012-13 £000	2011-12 £000
Total Net Operating Cost for the Financial Year	**616,421**	585,850
Revenue Resource Limit	**617,153**	586,326
Underspend Against Revenue Resource Limit (RRL)	**732**	**476**

3.2 Capital Resource Limit

The PCT is required to keep within its Capital Resource Limit (CRL)

	2012-13 £000	2011-12 £000
Capital Resource Limit	**4,657**	1,568
Charge to Capital Resource Limit	**4,544**	1,545
Underspend Against CRL	**113**	**23**

3.3 Provider full cost recovery duty

The PCT had no provider functions in 2012-13 or 2011-12.

3.4 Underspend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**622,593**	580,729
Cash Limit	**628,393**	580,729
Underspend Against Cash Limit	**5,800**	**0**

An additional cash resource of £5.463m was given to the PCT in line with Department of Health guidance around reducing year end balances. This was only notified in March 2013 which was too late for the PCT to fully utilise hence the under spend against the cash limit.

3.5 Reconciliation of Cash Drawings to Parliamentary Funding

	2012-13 £000	2011-12 £000
Total cash received from Department of Health (Gross)	**547,637**	503,708
Plus: cost of Dentistry Schemes (central charge to cash limits)	**11,809**	11,931
Plus: drugs reimbursement (central charge to cash limits)	**63,147**	65,090
Parliamentary funding credited to General Fund	**622,593**	**580,729**

4 Miscellaneous Revenue

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Restated £000
Dental Charge income from Contractor-Led GDS & PDS	**5,275**	0	5,275	5,348
Prescription Charge income	**3,178**	0	3,178	3,055
Strategic Health Authorities	**53**	53	0	303
NHS Trusts	**1,409**	68	1,341	1,637
Primary Care Trusts - Other	**7,282**	6,718	564	15,500 *
English RAB Special Health Authorities	**53**	53	0	0
Local Authorities	**4,300**	166	4,134	370
Education, Training and Research	**0**	0	0	1
Rental revenue from operating leases	**3,995**	0	3,995	4,195
Other revenue	**981**	261	720	1,008
Total miscellaneous revenue	**26,526**	**7,319**	**19,207**	**31,417**

* Income from Primary Care Trusts for 2011-12 has been restated (reduced) by £11.265m to reflect continuing healthcare recharges between the two East Sussex PCTs on a net rather than gross basis.

5 Operating Costs

5.1 Analysis of operating costs:

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12 Total Restated
	£000	£000	£000	£000
Goods and Services from Other PCTs				
Healthcare	**391,745**	0	391,745	357,814
Non-Healthcare	**651**	651	0	(1,180)
Total	**392,396**	**651**	**391,745**	**356,634**
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	**9,358**	172	9,186	21,489
Goods and services (other, excl Trusts, FT and PCT))	**0**	0	0	1,648
Total	**9,358**	**172**	**9,186**	**23,137**
Goods and Services from Foundation Trusts	**5,727**	27	5,700	5,453
Purchase of Healthcare from Non-NHS bodies	**59,438**	0	59,438	55,299 *
Non-GMS Services from GPs	**550**	550	0	0
Contractor Led GDS & PDS (excluding employee benefits)	**17,586**	0	17,586	17,627
Chair, Non-executive Directors & PEC remuneration	**30**	30	0	57
Executive committee members costs	**9**	9	0	52
Consultancy Services	**927**	595	332	541
Prescribing Costs	**56,083**	0	56,083	58,840
G/PMS, APMS and PCTMS (excluding employee benefits)	**45,245**	0	45,245	45,415
Pharmaceutical Services	**1,097**	0	1,097	1,036
New Pharmacy Contract	**13,796**	0	13,796	13,515
General Ophthalmic Services	**2,853**	0	2,853	2,874
Supplies and Services - Clinical	**906**	333	573	1,091
Supplies and Services - General	**91**	76	15	63
Establishment	**2,044**	2,019	25	1,698
Transport	**170**	170	0	55
Premises	**3,327**	1,281	2,046	3,513
Impairments & Reversals of Property, plant and equipment	**10**	0	10	0
Depreciation	**1,890**	565	1,325	1,691
Impairment of Receivables	**(94)**	(94)	0	161
Audit Fees	**123**	123	0	194
Other Auditors Remuneration	**61**	61	0	77
Clinical Negligence Costs	**193**	193	0	125
Education and Training	**60**	60	0	109
Grants for capital purposes	**439**	0	439	471
Other	**16,851**	1,223 **	15,628	15,449
Total Operating costs charged to Statement of Comprehensive Net Expenditure	**631,166**	**8,044**	**623,122**	**605,177**
Employee Benefits (excluding capitalised costs)				
PCT Officer Board Members	**479**	479	0	609
Other Employee Benefits	**11,247**	9,830	1,417	11,407
Total Employee Benefits charged to SOCNE	**11,726**	**10,309**	**1,417**	**12,016**
Total Operating Costs	**642,892**	**18,353**	**624,539**	**617,193**

* Purchase of healthcare from Non-NHS bodies for 2011-12 has been restated (reduced) by £11.265m to reflect continuing healthcare recharges between the two East Sussex PCTs on a net rather than gross basis.

** Other operating costs include £0.51m relating to a series of transactions currently subject to examination and investigation by NHS Protect – see note 38 to these accounts for further information.

5 Operating Costs

5.1 Analysis of operating costs: (cont)

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
Analysis of grants reported in total operating costs				
For capital purposes				
Grants to fund Capital Projects - GMS	**39**	0	39	0
Grants to Fund Capital Projects - Dental	**400**	0	400	471
Total Capital Grants	**439**	**0**	**439**	**471**
Grants to fund revenue expenditure	0	0	0	0
Total Grants	**439**	**0**	**439**	**471**

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**11,034**	9,979	1,055
Weighted population (number in units)*	**331,532**	331,532	331,532
Running costs per head of population (£ per head)	**33**	**30**	**3**
PCT Running Costs 2011-12			
Running costs (£000s)	**9,451**	8,292	1,159
Weighted population (number in units)	**331,532**	331,532	331,532
Running costs per head of population (£ per head)	**29**	**25**	**3**

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

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

5.2 Analysis of operating expenditure by expenditure classification

	2012-13	2011-12
	£000	£000
		restated
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	45,245	45,415
Prescribing costs	56,083	58,840
Contractor led GDS & PDS	17,586	17,627
General Ophthalmic Services	2,853	2,874
Pharmaceutical services	1,097	1,036
New Pharmacy Contract	13,796	13,515
Non-GMS Services from GPs	550	0
Total Primary Healthcare purchased	**137,210**	139,307
Purchase of Secondary Healthcare		
Learning Difficulties	11,660	8,426
Mental Illness	43,483	40,693
Maternity	14,585	14,114
General and Acute	294,843	273,280
Accident and emergency	21,429	23,076
Community Health Services	37,532	40,393
Other Contractual	34,179	32,585
Total Secondary Healthcare Purchased	**457,711**	432,567
Grant Funding		
Grants for capital purposes	439	471
Total Healthcare Purchased by PCT	**595,360**	**572,345**
PCT self-provided secondary healthcare included above	0	0
Social Care from Independent Providers	0	0
Healthcare from NHS FTs included above	5,700	5,453

6 Operating Leases

6.1 PCT as lessee

	Buildings	Other	2012-13 Total	2011-12
	£000	£000	£000	£000
Payments recognised as an expense				
Minimum lease payments	**1,177**	**0**	**1,177**	1,051
Payable:				
No later than one year	**890**	**0**	**890**	720
Between one and five years	**3,153**	**0**	**3,153**	2,707
After five years	**3,576**	**0**	**3,576**	2,989
Total	**7,619**	**0**	**7,619**	**6,416**

6.2 PCT as lessor

	2012-13	2011-12
	£000	£000
Recognised as income		
Rental Revenue	**3,995**	4,195
Receivable:		
No later than one year	**3,489**	3,449
Between one and five years	**0**	0
After five years	**0**	0
Total	**3,489**	3,449

This rental income is from the PCT owned community properties that are rented to East Sussex Healthcare NHS Trust who run Provider Services. Rent income relates to receipts under cancellable at no notice arrangements, which are not required to be analysed across financial years.

7 Employee benefits and staff numbers

7.1 Employee benefits

2012-13

	Total	Admin	Programme	Permanently employed Total	Permanently employed Admin	Permanently employed Programme	Other Total	Other Admin	Other Programme
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Employee Benefits - Gross Expenditure									
Salaries and wages	**9,549**	8,624	925	**8,818**	7,967	851	**731**	657	74
Social security costs	**734**	666	68	**718**	650	68	**16**	16	0
Employer Contributions to NHS BSA - Pensions Division	**1,123**	1,019	104	**1,098**	994	104	**25**	25	0
Termination benefits	**320**	0	320	**320**	0	320	**0**	0	0
Total employee benefits	**11,726**	**10,309**	**1,417**	**10,954**	**9,611**	**1,343**	**772**	**698**	**74**
Less recoveries in respect of employee benefits	**0**	0	0	**0**	**0**	**0**	**0**	**0**	**0**
Total - Net Employee Benefits including capitalised costs	**11,726**	**10,309**	**1,417**	**10,954**	**9,611**	**1,343**	**772**	**698**	**74**
Employee costs capitalised	**0**	0	0	**0**	0	0	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**11,726**	**10,309**	**1,417**	**10,954**	**9,611**	**1,343**	**772**	**698**	**74**
Recognised as:									
Commissioning employee benefits	**11,726**			**10,954**			**772**		

Employee Benefits - Prior- year

	Total	Permanently employed	Other
	£000	£000	£000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	**10,095**	9,744	351
Social security costs	**746**	746	0
Employer Contributions to NHS BSA - Pensions Division	**1,175**	1,175	0
Total gross employee benefits	**12,016**	**11,665**	**351**
Less recoveries in respect of employee benefits	**0**	0	0
Total - Net Employee Benefits including capitalised costs	**12,016**	**11,665**	**351**
Employee costs capitalised	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**12,016**	**11,665**	**351**
Recognised as:			
Commissioning employee benefits	**12,016**		

7 Employee benefits and staff numbers

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	**0**	0	0	**1**	1	0
Administration and estates	**263**	255	8	**276**	271	5
Nursing, midwifery and health visiting staff	**20**	20	0	**16**	15	1
Scientific, therapeutic and technical staff	**8**	8	0	**8**	8	0
TOTAL	**291**	**283**	**8**	**301**	**295**	**6**

Of the above - no staff engaged on capital projects

7.3 Ill health retirements

	2012-13 Number	2011-12 Number
Number of persons retired early on ill health grounds	**1**	1
	£000s	£000s
Total additional pensions liabilities accrued in the year	**46**	83

7.4 Exit Packages agreed during the year

Exit package cost band (including any special payment element)	2012-13 Number of compulsory redundancies	2012-13 Number of other departures agreed	2012-13 Total number of exit packages by cost band	2011-12 Number of compulsory redundancies	2011-12 Number of other departures agreed	2011-12 Total number of exit packages by cost band
	Number	Number	Number	Number	Number	Number
Lees than £10,000	**1**	**0**	**1**	0	3	**3**
£10,001-£25,000	**0**	**0**	**0**	1	4	**5**
£25,001-£50,000	**2**	**0**	**2**	3	0	**3**
£50,001-£100,000	**0**	**0**	**0**	5	0	**5**
Total number of exit packages by type (total cost)	**3**	**0**	**3**	**9**	**7**	**16**
	£s	**£s**	**£s**	**£s**	**£s**	**£s**
Total resource cost	92,104	0	**92,104**	406,000	65,000	**471,000**

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

The above numbers relate to named individuals employed by the PCT.

7.5 Pension costs

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

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

a) Accounting valuation

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

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

b) Full actuarial (funding) valuation

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

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

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

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

c) Scheme provisions

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

The Scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as “pension commutation”.

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

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

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

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

8 Better Payment Practice Code

8.1 Measure of compliance

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	16,627	74,582	19,006	75,003
Total Non-NHS Trade Invoices Paid Within Target	14,884	56,092	17,182	68,102
Percentage of NHS Trade Invoices Paid Within Target	89.52%	75.21%	90.40%	90.80%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,508	428,760	2,925	405,946
Total NHS Trade Invoices Paid Within Target	2,854	406,968	2,408	392,160
Percentage of NHS Trade Invoices Paid Within Target	81.36%	94.92%	82.32%	96.60%

The Better Payment Practice Code requires the PCT to aim to pay all valid invoices within 30 days of receipt of a valid invoice or receipt of goods, whichever is later, or within other agreed payment terms.

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

No amounts included in finance costs from claims made under this legislation and
No compensation paid to cover debt recovery costs under this legislation (2011-12: £nil)

9 Investment Income

The PCT had no investment income in 2012-13 or 2011-12.

10 Other Gains and Losses

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Gain on disposal of assets held for sale	**12**	**0**	**12**	0

11 Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Provisions - unwinding of discount	**67**	**0**	**67**	74

12.1 Property, plant and equipment

	Land	Buildings excluding dwellings	Plant & machinery	Information technology	Furniture & fittings	Total
2012-13						
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Cost or valuation:						
At 1 April 2012	**14,365**	**40,335**	**1,639**	**2,623**	**110**	**59,072**
Additions Purchased	0	4,381	33	238	0	**4,652**
Reclassifications as Held for Sale	(25)	(83)	0	0	0	**(108)**
Impairments/negative indexation	0	(516)	0	0	0	**(516)**
At 31 March 2013	**14,340**	**44,117**	**1,672**	**2,861**	**110**	**63,100**
Depreciation						
At 1 April 2012	**0**	**1,321**	**1,136**	**1,757**	**72**	**4,286**
Impairments	0	10	0	0	0	**10**
Charged During the Year	0	1,471	135	270	14	**1,890**
At 31 March 2013	**0**	**2,802**	**1,271**	**2,027**	**86**	**6,186**
Net Book Value at 31 March 2013	**14,340**	**41,315**	**401**	**834**	**24**	**56,914**
Purchased	11,840	36,217	401	834	24	**49,316**
Donated	2,500	5,098	0	0	0	**7,598**
Total at 31 March 2013	**14,340**	**41,315**	**401**	**834**	**24**	**56,914**
Asset financing:						
Owned	14,340	41,315	401	834	24	**56,914**

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	**6,564**	**12,477**	**15**	**0**	**0**	**19,056**
Impairments	0	(516)	0	0	0	**(516)**
Transfer to general fund	0	(10)	0	0	0	**(10)**
At 31 March 2013	**6,564**	**11,951**	**15**	**0**	**0**	**18,530**

12.2 Property, plant and equipment

	Land	Buildings excluding dwellings	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
2011-12							
	£000	£000	£000	£000	£000	£000	**£000**
Cost or valuation:							
At 1 April 2011	**14,365**	**36,513**	**5,363**	**120**	**4,205**	**595**	**61,161**
Additions - purchased	0	3,325	167	0	492	0	**3,984**
Reclassified as held for sale	0	0	(3,891)	(120)	(2,074)	(485)	**(6,570)**
Revaluation & indexation gains	0	497	0	0	0	0	**497**
At 31 March 2012	**14,365**	**40,335**	**1,639**	**0**	**2,623**	**110**	**59,072**
Depreciation							
At 1 April 2011	**0**	**0**	**3,653**	**103**	**2,437**	**533**	**6,726**
Reclassifications as Held for Sale	0	0	(2,639)	(103)	(914)	(475)	**(4,131)**
Charged During the Year	0	1,321	122	0	234	14	**1,691**
At 31 March 2012	**0**	**1,321**	**1,136**	**0**	**1,757**	**72**	**4,286**
Net Book Value at 31 March 2012	**14,365**	**39,014**	**503**	**0**	**866**	**38**	**54,786**
Purchased	11,865	33,660	503	0	866	38	**46,932**
Donated	2,500	5,354	0	0	0	0	**7,854**
At 31 March 2012	**14,365**	**39,014**	**503**	**0**	**866**	**38**	**54,786**
Asset financing:							
Owned	14,365	39,014	503	0	866	38	**54,786**

12.3 Property, plant and equipment

Land, buildings and dwellings were last revalued by an independent valuer with specialist knowledge of the NHS Estate during January and February 2010 with a Valuation Date as the 1st April 2010. This valuation was applied as at 31st March 2010 in the Statement of Financial Position and has subsequently been revalued in accordance with the valuation policy described in note 1.6.

The valuations have been undertaken having regard to International Financial Reporting Standards (IFRS) as applied to the United Kingdom public sector and in accordance with HM Treasury guidance, International Valuation Standards and the requirements of the Royal Institution of Chartered Surveyors (RICS) Valuation Standards 6th Edition.
The PCT decreased the valuation of the buildings by a net £526,000 based on the latest available market value based indices. This was a decrease of 1.4% on last year. The indices incicated no significant movement for Land.

Bases of Valuation

The valuation report was prepared in accordance with the terms of the Royal Institution of Chartered Surveyors' Valuation Standards, 6th Edition, insofar as these terms are consistent with the requirements of HM Treasury, the National Health Service, and the Department of Health.

Public sector bodies including the NHS are required to apply the Revaluation model set out in IAS 16 and value their capital assets to fair value.

Fair value is defined in IAS16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. The fair value of land, buildings and dwellings is usually determined from market-based evidence by appraisal undertaken by professionally qualified valuers.

The remaining economic lives of each class of fixed asset is assessed as follows:
Buildings excluding Dwellings - between 0 years minimum and 40 years maximum
Plant and machinery - between 0 years minimum and 13 years maximum.
Information technology - between 0 years minimum and 9 years maximum.
Furniture and Furnishings - between 1 years minimum and 8 years maximum.

13.1 Intangible non-current assets

2012-13	Software purchased
	£000
Cost / Valuation	
At 1 April 2012	**133**
Movement	0
At 31 March 2013	**133**
Amortisation	
At 1 April 2012	**133**
Movement	0
At 31 March 2013	**133**
Net Book Value at 31 March 2013	**0**

13.2 Intangible non-current assets

2011-12	Software purchased
	£000
At 1 April 2011	**133**
Movement	0
At 31 March 2012	**133**
Amortisation	
At 1 April 2011	**133**
Movement	0
At 31 March 2012	**133**
Net Book Value at 31 March 2012	**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			
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Changes in market price	10	0	10
Total charged to Annually Managed Expenditure	**10**	**0**	**10**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Changes in market price	516		
Total Impairments of Property, Plant and Equipment	**526**	**0**	**10**
Total Impairments charged to Revaluation Reserve	516		
Total Impairments charged to SoCNE - DEL	0	0	0
Total Impairments charged to SoCNE - AME	10		10
Overall Total Impairments	**526**	**0**	**10**

Of which:

No impairment on revaluation to "modern equivalent asset" basis (2011-12 £nil)

No Donated and Gov Granted Assets, included above (2011-12 £nil)

15 Investment property

The PCT has no investment property at 31 March 2013 (31 March 2012 £nil).

16 Commitments

16.1 Capital commitments

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

	31 March 2013	31 March 2012
	£000	£000
Property, plant and equipment	**0**	908

16.2 Other financial commitments

The PCT has not entered into any non-cancellable contracts (which are not leases or PFI contracts or other service concession arrangements) at 31 March 2013 (31 March 2012 £nil).

17 Intra-Government and other balances

	Current receivables £000s	**Current payables £000s**
Balances with other Central Government Bodies	4,330	4,394
Balances with Local Authorities	391	3,217
Balances with NHS Trusts and Foundation Trusts	2,838	5,610
Balances with bodies external to government	610	22,702
At 31 March 2013	**8,169**	**35,923**
prior period:		
Balances with other Central Government Bodies	7,403	3,843
Balances with Local Authorities	35	54
Balances with NHS Trusts and Foundation Trusts	3,175	13,011
Balances with bodies external to government	1,836	29,089
At 31 March 2012	**12,449**	**45,997**

18 Inventories

The PCT has no inventory at 31 March 2013 (31 March 2012: £nil).

19.1 Trade and other receivables

	Current		
	31 March 2013	31 March 2012 Restated	
	£000	£000	
NHS receivables - revenue	**3,339**	4,950	*
NHS receivables - capital	**0**	21	
NHS prepayments and accrued income	**3,732**	5,533	*
Non-NHS receivables - revenue	**583**	206	
Non-NHS prepayments and accrued income	**424**	1,731	
Provision for the impairment of receivables	**(6)**	(100)	
VAT	**97**	74	
Other receivables	**0**	34	
Total	**8,169**	12,449	

No Prepaid pensions contributions included above.

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

* The balances for 31 March 2012 have been restated to reclassify £5.533m from NHS revenue receivables to NHS prepayments and accrued income, to reflect the new disclosure requirements this year.

19.2 Receivables past their due date but not impaired

	31 March 2013	31 March 2012
	£000	£000
By up to three months	**2,745**	**1,213**
By three to six months	**118**	**215**
By more than six months	**108**	**2,071**
Total	**2,971**	**3,499**

19.3 Provision for impairment of receivables

	2012-13	**2011-12**
	£000	**£000**
Balance at 1 April 2012	**(100)**	**(100)**
Amount written off during the year	**0**	**161**
(Increase)/decrease in receivables impaired	**94**	**(161)**
Balance at 31 March 2013	**(6)**	**(100)**

20 NHS LIFT investments

The PCT has no NHS LIFT investments at 31 March 2013 (31 March 2012: £nil).

21 Other financial assets - Current and Non Current

The PCT has no other financial assets at 31 March 2013 (31 March 2012: £nil).

22 Other current assets

The PCT has no other current assets at 31 March 2013 (31 March 2012: £nil).

23 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**9**	9
Net change in year	**66**	0
Closing balance	**75**	9
Made up of		
Cash with Government Banking Service	**75**	8
Cash in hand	**0**	1
Cash and cash equivalents as in statement of cash flows and statement of financial position	**75**	9

No Patients' money held by the PCT.

24 Non-current assets held for sale

	Land	Buildings, excl. dwellings	Plant and Machinery	Transport and Equipment	Information Technology	Furniture and Fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Balance at 1 April 2012	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	25	83	0	0	0	0	**108**
Less assets sold in the year	(25)	(83)	0	0	0	0	**(108)**
Balance at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**

No Liabilities associated with assets held for sale at 31 March 2013

	Land	Buildings, excl. dwellings	Plant and Machinery	Transport and Equipment	Information Technology	Furniture and Fittings	Total
Balance at 1 April 2011	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	1,252	17	1,160	10	**2,439**
Less assets sold in the year	0	0	(1,252)	(17)	(1,160)	(10)	**(2,439)**
Balance at 31 March 2012	**0**	**0**	**0**	**0**	**0**	**0**	**0**

No Liabilities associated with assets held for sale at 31 March 2012.

No Revaluation reserve balances in respect of non-current assets held for sale at 31 March 2013 (31 March 2012 £nil).

25 Trade and other payables

	Current 31 March 2013 £000	31 March 2012 Restated £000
NHS payables - revenue	**3,647**	4,001 *
NHS payables - capital	**162**	0
NHS accruals and deferred income	**6,195**	12,806 *
Family Health Services (FHS) payables	**14,995**	17,048
Non-NHS payables - revenue	**2,720**	7,429
Non-NHS payables - capital	**85**	1,645
Non-NHS accruals and deferred income	**7,549**	2,199
Tax	**0**	47
Other	**570**	822
Total	**35,923**	45,997

* The balances for 31 March 2012 have been restated to reclassify £12.806m from NHS revenue payables to NHS accruals and deferred income, to reflect the new disclosure requirements this year.

26 Other liabilities
The PCT has no other liabilities at 31 March 2013 (31 March 2012: £nil).

27 Borrowings
The PCT has no borrowings at 31 March 2013 (31 March 2012: £nil).

28 Other financial liabilities
The PCT has no other financial liabilities at 31 March 2013 (31 March 2012: £nil).

29 Deferred income

	Current 31 March 2013 £000	31 March 2012 £000
Opening balance at 1 April 2012	**0**	4
Transfer of deferred income	**180**	(4)
Current deferred Income at 31 March 2013	**180**	0

30 Finance lease obligations
The PCT has no finance lease obligations at 31 March 2013 (31 March 2012: £nil).

31 Finance lease receivables as lessor
The PCT has no finance lease receivables at 31 March 2013 (31 March 2012: £nil).

32 Provisions

Comprising:

	Total £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Continuing Care £000s	Other £000s
Balance at 1 April 2012	**1,522**	1,134	11	201	176
Arising During the Year	**2,660**	21	0	2,634	5
Utilised During the Year	**(394)**	(133)	0	(223)	(38)
Reversed Unused	**(1)**	0	(1)	0	0
Unwinding of Discount	**67**	62	0	0	5
Balance at 31 March 2013	**3,854**	**1,084**	**10**	**2,612**	**148**
Expected Timing of Cash Flows:					
No Later than One Year	**980**	**91**	**10**	**871**	**8**
Later than One Year and not later than Five Years	**2,138**	**364**	**0**	**1,741**	**33**
Later than Five Years	**736**	**629**	**0**	**0**	**107**
Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:					
As at 31 March 2013	417				
As at 31 March 2012	714				

The provisions carried by the PCT include:

1) Pensions which relate mainly to inherited pre 95 early retirements which are now a liability of the PCT.
2) Legal claims includes a provision for staff and third party non clinical claims.

3) Continuing care provision for retrospective claims which are currently under assessment to establish whether or not the costs should be borne by the NHS following publication of findings by the Health Ombudsman.

The East Sussex PCTs received 1,017 claims by mid March 2013. 749 of these claims were considered to be highly unlikely to result in any payment. The excluded claims relate mainly to claims from residential homes, previously rejected claims and cases where the claimant has failed to return sufficient documentation within a reasonable period, despite reminders sent by the PCT. The remaining 268 claims were included in the calculation of the provision, of which 143 relate to the PCT, 111 relate to Hastings and Rother PCT and 14 claims are ‘unknowns’ and split between the two PCTs. Of the 143 claims for the PCT, and a proportion of the unknown claims, the PCT applied a probability of 15 per cent in calculating a provision of £2.6 million. An estimated conversion rate of 15% has been applied to each of the groups, based on previous experience (30%) and adjusted down to take account of our expectations of potential payments, and a financial value calculated based on average bed prices for the relevant care category.

4) £10,000 is included in the PCT's provisions relating to the NHS Litigation Authority at 31 March 2013 in respect of Legal Claims liabilities (31 March 2012: £11,375).

33 Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities		
Continuing healthcare claims	**(16,684)**	(1,058)

The liabilities are an estimate based on the number of potential claims for reimbursement of continuing care costs following publication of findings by the Health Ombudsman.

As reported in the provisions note, the East Sussex PCTs received 1,017 claims by mid March 2013. A further 31 claims were received by the end of May 2013 and 48 returned questionnaires for claims that had been excluded from the provision and contingent liablity. After excluding the claims that are considered highly unlikely to result in any payment the PCT has estimated a contingent liability based on 85 per cent of the value of the remaining claims.

34 PFI and LIFT - additional information

The PCT has no PFI or LIFT Schemes.

35 Impact of IFRS treatment - 2012-13

No Impact of IFRS treatment 2012-13.

36 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 all transactions, assets and liabilities being in the UK and Sterling based. The PCT has no overseas operations. The PCT therefore has no 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.

36.1 Financial Assets	**Loans and receivables**
	£000
Receivables - NHS	7,071
Receivables - non-NHS	607
Cash at bank and in hand	75
Total at 31 March 2013	**7,753**
Receivables - NHS	10,504
Receivables - non-NHS	254
Cash at bank and in hand	9
Total at 31 March 2012	10,767

36.2 Financial Liabilities	**Other**
	£000
NHS payables	10,004
Non-NHS payables	25,919
Total at 31 March 2013	**35,923**
NHS payables	16,807
Non-NHS payables	29,143
Total at 31 March 2012	45,950

37 Related party transactions

During the year none of the Department of Health Ministers or parties related to any of them, has undertaken any material transactions with the PCT. Claire Quigley (PCT Director of Governance and Transition) was a Governor of Sussex Partnership Foundation Trust and Charles Everett (PCT Non-Executive Director) was a trustee of St Michaels Hospice. Details of related party transactions for these individuals are recorded in the table below. During 2012/13 Eastbourne, Seaford and Hailsham and High Weald Lewes Havens Clinical Commissioning Groups (CCG's) were established in shadow form as sub committees of the Board. The table below records related party transactions with organisations where Governing Body members of shadow CCG's have declared an interest. Where the related party is a General Medical Practice, payments were made under the standard terms and conditions of General Medical Services or Personal Medical Services contracts.

Details of related party transactions with individuals are as follows:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£	£	£	£
Claire Quigley, Director of Governance and Transition - Governor of Sussex Partnership Foundation Trust	4,308,000	0	580,000	27,000
Charles Everett, Non Executive Director - Trustee of St Michaels Hospice	98,616	0	0	0
Elizabeth Gill, Governing Body Member, High Weald Lewes Havens CCG - Buxton and East Hoathly Surgery	1,478,474	0	0	0
Peter Birtles, Governing Body Member, High Weald Lewes Havens CCG - Saxonbury House Practice, Crowborough	1,206,462	0	0	0
Vince Elliot, Governing Body Member, High Weald Lewes Havens CCG - Mid Downs Medical Practice	1,101,288	0	0	0
Sarah Richards, Governing Body Member, High Weald Lewes Havens CCG - River Lodge Surgery	1,384,086	0	0	0
David Roche, Governing Body Member, High Weald Lewes Havens CCG - Belmont Surgery	1,113,123	0	0	0
Howard Wright, Governing Body Member, High Weald Lewes Havens CCG - Quayside Medical Practice	1,294,628	0	0	0
Michael Rymer, Governing Body Member, High Weald Lewes Havens CCG - Western Sussex Hospitals Foundation Trust	0	0	0	0
Karen Ford, Governing Body Member, High Weald Lewes Havens CCG - Quayside Medical Practice	1,294,628	0	0	0
Frank Powell, Governing Body Member, High Weald Lewes Havens CCG - Beacon Surgery	1,133,944	0	0	0
Martin Writer, Governing Body Member, Eastbourne, Hailsham and Seaford CCG - Park Practice	1,412,586	0	0	0
Mark Barnes, Governing Body Member, Eastbourne, Hailsham and Seaford CCG - Seaford Medical Practice	2,281,769	0	0	0
Mathew Jackson, Governing Body Member, Eastbourne, Hailsham and Seaford CCG - Seaforth Farm Surgery	1,448,397	0	0	0
Michael Von Fraunhofer, Governing Body Member, Eastbourne, Hailsham and Seaford CCG - Lighthouse Medical Practice	193,195	0	0	0
Phil Abbott, Governing Body Member, Eastbourne, Hailsham and Seaford CCG - Seaford Medical Practice	2,281,769	0	0	0

The Department of Health is regarded as a related party. During the year the 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 listed below;

East Sussex Healthcare NHS Trust
Brighton and Sussex University Hospitals NHS Trust
Maidstone and Tunbridge Wells NHS Trust
Sussex Community NHS Trust
West Sussex Primary Care Trust - Sussex Acute Commissioning Service, Sussex HIS
Brighton and Hove City Primary Care Trust
West Kent Primary Care Trust - Specialist Commissioning
Sussex Partnership NHS Foundation Trust
South East Coast Ambulance Services NHS Trust
Hastings and Rother Primary Care Trust

In addition, the PCT has had a significant number of material transactions with other Government Departments and other central and local Government bodies. Most of these transactions have been with:

East Sussex County Council for joint enterprises
HM Revenue and Customs for payment of VAT, employees income tax and national insurance contributions
HM Prison Service for support services
Lewes District Council for business rates and other joint services
Wealden District Council for business rates and other joint services
Eastbourne District Council for business rates and other joint services

The PCT has also received revenue payments from charitable funds, none of the Trustees for which are members of the PCT Board.

38 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	513,196	1
Special payments - PCT management costs	0	0
Losses in respect of the provision of family practitioner services	0	0
Special payments in respect of the provision of family practitioner services	0	0
Total losses	513,196	1
Total special payments	0	0
Total losses and special payments	513,196	1

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

	Total Value of Cases £s restated	**Total Number of Cases restated**
Losses - PCT management costs	342,384	18
Special payments - PCT management costs	14,430	2
Losses in respect of the provision of family practitioner services	0	0
Special payments in respect of the provision of family practitioner services	0	0
Total losses	342,384	18
Total special payments	14,430	2
Total losses and special payments	356,814	20

During 2012/13 a series of potentially irregular payments were identified and reported to NHS Protect for further examination and investigation. The potential irregular payments identified to date are in excess of £0.68m and occurred over the accounting periods 2010/11 to 2012/13 with £0.51m identified as relating to 2012-13 and £0.18m relating 2011-12 (comparatives have been restated to reflect this).
The total value of the potential irregular payments identified to date is reported under "Losses – PCT management costs" in the table above. The payments identified in 2012-13 are also reported under "other " in note 5.1 to these accounts (Analysis of operating costs).

39 Events after the end of the reporting period

East Sussex Downs and Weald PCT was abolished on 31st March 2013 and its responsibilities split in to programmes and these passed to new statutory organisations and East Sussex County Council from 1st April 2013. The bulk of the commissioning responsibilities have been passed to High Weald Lewes Havens Clinical Commissioning Group and Eastbourne, Hailsham and Seaford Clinical Commissioning Group dependent upon the geographic identification of the PCT's commissioning for the services within the responsibilities of these new statutory organisations. High Weald Lewes Havens Clinical Commissioning Group has an allocation of £195.9m for 2013/14 and Eastbourne, Hailsham and Seaford Clinical Commissioning Group has an allocation of £225.3m for 2013/14.

Certain assets have transferred to NHS Property Services and East Sussex Healthcare NHS Trust on 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 bodies to consider whether, in 2013-14, it is necessary to review these for impairment.

Hastings and Rother Primary Care Trust

2012-13 Accounts

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

© Crown copyright

Published to gov.uk, in PDF format only.

www.gov.uk/dh

Hastings and Rother Primary Care Trusts

2012-13 Accounts

2012-13 Annual Accounts of Hastings and Rother Primary Care Trust

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: AMANDA LADERO

Date...7/6/13......

2012-13 Annual Accounts of Hastings and Rother 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.

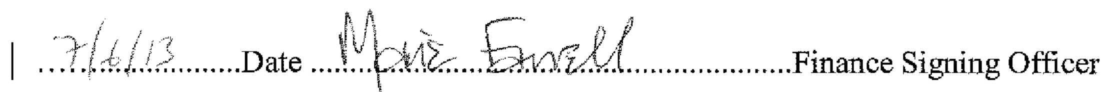
- ensure that the PCT kept proper accounting records which disclosed with reasonable accuracy at any time the financial position of the primary care trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State.

- 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.

7/6/13 ....Date..Signing Officer



7/6/13 ....Date ....Finance Signing Officer

2012/13 Annual Governance Statement
Hastings and Rother PCT

1. Scope of responsibility

The Board was accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I had responsibility for maintaining a sound system of internal control that supported the achievement of the organisation's policies, aims and objectives until 31 March 2013. I also had responsibility for safeguarding the public funds and the organisation's assets for which I was personally responsible as set out in the Accountable Officer Memorandum.

Hastings and Rother Primary Care Trust (PCT) achieved its statutory financial duties in the financial year 2012/13 of remaining within its revenue, cash and capital resource limits. It reported a £878,000 surplus compared to the control total target surplus of £750,000. Capital expenditure in the year at £2.1 million was within the Capital Resource Limit set of £2.6m and cash spending was within the cash limit set of £345m.

2. The governance framework of the organisation

Good corporate governance and the management of risk is a corporate responsibility and, accordingly, the Board took a leading role in ensuring that management strategies and supporting processes were in place. The Board did this through its own annual review of the risk management strategy, by regular review of its assurance framework and through the governance, internal control, risk and assurance work of its committees. The Board was committed to ensuring that good corporate governance and risk management were integral to the organisation's philosophy, practice and planning rather than being viewed or practiced as separate programmes, and to ensuring that responsibility for implementation was accepted at all levels of the organisation. A record of Board members' attendance at Board meetings is presented below.

NHS Sussex Board Meeting Attendance Log

Name	Role	22/05 2012	07/06 2012	24/7 2012	25/09 2012	25/09 2012 AGM	09/11 2012	23/11 2012	22/01 2013	26/03 2013
David Clayton-Smith	Chairman	✓	✓	✓	✓	✓	✓	✓	✓	✓
Amanda Fadero	Chief Executive	✓	✓	✓	✓	✓	✓	✓	✓	✓
Andrew Foulkes	Medical Director	✓	✓	✓	✓	✓	✓	✓	x	✓
Sue Braysher	Director of Commissioning Development	✓	x	x	✓	✓	✓	✓	✓	✓
Sarah Creamer	Director of Performance	✓	✓	✓	✓	✓	✓	✓	x	✓
Julia Dutchman-	Director of Quality and Chief Nurse	✓	✓	✓	✓	✓	x	✓	✓	✓

Bailey										
Amanda Philpott	Director of Strategy and Provider Development	✓	✓	✓	✓	✓	✓	✓	✓	✓
Claire Quigley	Director of Transition and Governance	✓	x	✓	✓	✓	✓	✓	x	✓
Michael Schofield	Director of Finance	✓	✓	✓	✓	✓	✓	✓	✓	✓
Frank Sims	Director of Commissioning Support Unit	✓	✓	✓	x	x	✓	x	x	✓
Jeremy Alford	Non Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	x
Peter Douglas	Non Executive Director	✓	x	✓	✓	✓	✓	✓	✓	✓
Charles Everett	Non Executive Director (Vice Chair)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rita Lewis	Non Executive Director	✓	✓	✓	✓	✓	✓	✓	x	✓
George Mack	Non Executive Director	✓	✓	x	✓	✓	✓	✓	✓	✓
Denise Stokoe	Non Executive Director	✓	✓	✓	✓	✓	✓	✓	x	✓

✓ = present, x = absent.

I was appointed as Chief Executive of NHS Sussex and each of the four statutory PCTs in Sussex. I led a single executive team across NHS Sussex. I had overall responsibility for ensuring that effective governance and risk management systems were in place and for meeting all statutory requirements and adhering to guidance issued by the Department of Health in respect of governance until 31 March 2013. My director of Governance and Transition was accountable to me for the strategic development and implementation of organisational risk management and governance controls. All my executive directors were accountable to me for risk management and governance across the breadth of their functions.

In line with the recommendations of the Integrated Governance Handbook, NHS Sussex established committees responsible for reviewing the management of all types of risk both clinical and non-clinical. The Quality and Delivery Assurance Board, supported by the establishment of Clinical Commissioning Groups (CCGs) as committees of the Board with their own assurance processes, and developing through the CCG authorisation process, managed this agenda in 2012/13 in preparation for statutory establishment of CCGs from 1 April 2013.

A Transition Assurance Board (TAB) was established during 2012/13 to oversee the operational handover of current PCT functions to appropriate receiving organisations and provide supporting closure (legacy) documentation. The Director of Transition and Governance, an NHS Sussex Board member was the executive lead member of TAB. To support the work of TAB specialist Transition Groups covering Closedown, Human Resources and Finance were also established. A Transition and Closedown Report was received by the final Board of NHS Sussex confirming that all PCT critical closure activities had been covered.

The governance and risk systems ensured the PCT discharged its statutory functions during 2012/13 and that these were legally compliant. The TAB had specific responsibility for ensuring that the legal closure of the PCT on 31st March 2013 and completion of the necessary Transfer Schemes.

The Audit Committees of the PCTs met jointly as the NHS Sussex Audit Committee to enable a single senior overview of NHS Sussex audit and internal control matters. The Audit Committees reported to the Board and reviewed the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supported the achievement of the organisation's objectives.

The Audit Committees ensured that there was an effective internal audit function that met mandatory NHS Internal Audit Standards and provided appropriate independent assurance to the Audit Committees, Chief Executive and Board. The Committees reviewed the work and findings of the external auditors and considered the implications and management's response to their work. The Committees satisfied themselves that the organisation had adequate arrangements in place for countering fraud and they reviewed the outcomes of counter fraud work. Directly in relation to financial reporting, the Committees monitored the integrity of the financial statements of the PCTs and ensured that the systems for reporting to the Board, including those of budgetary control, were subject to review as to completeness and accuracy of the information provided to the Board until 31 March 2013. The Committees reviewed the draft annual report and early working papers for the financial statements of the PCTs, including this Annual Governance Statement. Completion of the 2012/13 accounts and approval for these and the related statements took place after the closure of the PCTs via governance arrangements under the accountability of the NHS Business Services Authority.

In preparing this statement compliance with the five sections of the UK Corporate Governance Code was reviewed as follows:

Leadership
A.1 The Role of the Board. Every company should be headed by an effective board which is collectively responsible for the long-terms success of the company. *Compliant; the types of decisions taken by the board or delegated to management were detailed in the published scheme of delegation.*
A.2 Division of Responsibilities. There should be a clear division of responsibilities at the head of the company between the running of the board and the executive responsibility for the running of the company's business. No one individual should have unfettered powers of decision. *Compliant. The roles of Chairman and Chief Executive were separate appointments.*
A.3 The Chairman. The chairman is responsible for leadership of the board and ensuring its effectiveness on all aspects of its role. *Compliant.*
A.4 Non-executive Directors. As part of their role as members of a unitary board, non-executive directors should constructively challenge and help develop proposals on strategy. *Compliant; a Senior Independent Director was formally designated.*

Effectiveness
B.1 The Composition of the Board. The board and its committees should have the appropriate balance of skills, experience, independence and knowledge of the company to enable them to discharge their respective duties and responsibilities effectively. *Compliant; regulations were changed in 2010 enabling Non-executive Directors to be members of multiple PCTs, NHS Sussex Directors held multiple membership of the four PCTs in Sussex. Non-executive directors were appointed independently by the Appointments Commission.*
B.2 Appointments to the Board. There should be a formal, rigorous and transparent procedure for the appointment of new directors to the board. *Compliant; nominations were put to the Remuneration Committee as a result of transparent appointment processes.*
B.3 Commitment. All directors should be able to allocate sufficient time to the company to discharge their responsibilities effectively. *Compliant. Executive Directors allocated time as per*

contract; Non-executive Directors complied with and were reviewed against applicable Appointments Commission guidance.

B.4 Development. All directors should receive induction on joining the board and should regularly update and refresh their skills and knowledge. *Compliant; mandatory training provided; in 2012/13 non-essential training was limited due to closure of the PCTs, development programmes for CCG senior staff were in place.*

B.5 Information and Support. The board should be supplied in a timely manner with information in a form and of a quality appropriate to enable it to discharge its duties. *Compliant. Adequate resources were available under the guidance of the Chief Executive and Executive Directors.*

B.6 Evaluation. The board should undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors. *Compliant; individual performance reviews for Executive and Non-executive directors; the operation of the Board itself was reviewed in April 2012 with particular emphasis on how the Board would work in the final year of the existence of PCTs. Review and performance management by NHS South of England in place.*

B.7 Re-election. Not applicable, the composition of PCT Boards was based on statute and followed NHS guidance.

Accountability

C.1 Financial and Business Reporting. The board should present a balanced and understandable assessment of the company's position and prospects. *Compliant. Provided in annual report.*

C.2 Risk Management and Internal Control. 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 should maintain sound risk management and internal control systems. *Compliant; iin 2012/13 there were significant changes to NHS commissioning organisations in preparation for new structures in 2013/14, such large scale change inherently carried risks which the Board mitigated as described and published in its board assurance framework.*

C.3 Audit Committee and Auditors. The board should establish formal and transparent arrangements for considering how it should apply the corporate reporting and risk management and internal control principles and for maintaining an appropriate relationship with the company's auditor. *Compliant. Contained within the terms of reference of the Audit Committees and described in this Annual Governance Statement.*

Code schedule B. Disclosure on corporate governance arrangements. *Compliant. Described in this Annual Governance Statement.*

Remuneration

D.1 The Level and Components of Remuneration. The levels of remuneration should be sufficient to attract, retain and motivate directors of the quality required to run the company successfully, but a company should avoid paying more than is necessary for this purpose. A significant proportion of executive director's remuneration should be structured so as to link rewards to corporate and individual performance. *Compliant; remuneration was paid in line with agreed NHS reward schemes.*

D.2 Remuneration Procedure. There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding his or her own remuneration. *Compliant. Remuneration for executives was set by the remuneration committee, not by individual directors.*

Code schedule A. The design of performance-related remuneration for executive directors, was not applicable under NHS schemes.

Relations with Shareholders

E.1 Dialogue with Shareholders. There should be a dialogue with shareholders based on the mutual understanding of objectives. The board as a whole has responsibility for ensuring that a satisfactory dialogue with shareholders takes place. *Compliant; there were no shareholders but the organisation was accountable to the public for its activities and engaged patients, stakeholder organisations and the public in planning its objectives; particularly when considering larger scale service changes where it had a duty to consult.*

E.2 Constructive use of the AGM. The board should use the AGM to communicate with investors and encourage their participation. *Compliant; there were no investors however, patients, stakeholder organisations and the public were encouraged to participate.*

3. The risk and control framework

The system of internal control was designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it could therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control was in place in the Hastings and Rother PCT throughout the year ended 31 March 2013 when the PCT closed.

The NHS Sussex Board operated a harmonised risk management processes across the component PCTs. The risk management strategy was approved and reported to the Board. Risk management training was made available to all staff, was mandatory and an update was required to be attended every two years. A full range of health and safety and other mandatory training packages were made available to all relevant staff. Records of attendances were kept and collated for reporting purposes

In line with the Risk Management Strategy the risk and control framework was designed to focus management attention on risks at the appropriate level in the organisation. In particular it was designed to set the most significant risks before the Board and its committees in order that resources could be applied to adjust controls that prevented or mitigated the risks, and to gain assurances that those controls were effective. The key components of the risk management system including the method of risk assessment, directorate risk registers, corporate risk register and the assurance framework were described clearly in the PCT's Risk Management Strategy. Risk assessment enabled effective mitigating actions to be devised and encouraged the proactive identification and prevention both of manifest risks and also of potential risks. Risk deterrents were also in place, for example through the work of counter fraud.

The Board used an assurance framework to present high level risks with a score of 15 or above to the Board. This assurance framework was populated and reviewed at a lower level by the executive and by CCG committees with responsibility for governance. The assurance framework was developed to provide assurance to the Board that the systems, policies and people it had put in place were operating in a way that was effective in driving the delivery of objectives by focusing on preventing and minimising risk. It ensured that the Board was informed of the principal risks which faced the organisation together with action plans to address them. It was a regularly updated or 'live' document linked to the more detailed corporate and departmental risk registers and to key business planning documents for the PCT. The assurance framework identified for each strategic objective of the Board:-

- The principal risks, being the highest risks in the corporate risk register.

- The key controls to assist in managing the risk to secure the achievement of the objective.
- The sources of evidence on which reliance of the effectiveness of the systems was placed.
- The detailed assurances obtained showing the evidence presented to the Board. Included in the detailed assurances were internal assurances on the effectiveness of systems, from the Board committees and staff, from Internal Audit and from external bodies; the Audit Commission, NHS Litigation Authority, Care Quality Commission, etc.
- Any gaps in control i.e. systems not in place
- Any gaps in assurance i.e. systems in place but evidence not available.
- The detail of actions put in place to mitigate the risk including relevant milestones and target dates for removal.
- Progress on the actions
- Most recent review date
- Target removal date
- Executive Ownership

4. Risk assessment

The PCT recognised that it is not possible to totally eliminate all risks and that systems of control should not be so rigid that they stifle imaginative use of limited resources in order to provide an effective service. However, in order to establish a consistent framework for the assessment and management of risk, the organisation adapted a standard risk assessment tool from the National Patient Safety Agency and determined the levels of authority at which risks should be addressed. This provided a consistent approach across all of the different types of assessment that were undertaken and all identified risks were brought to the attention of Line Managers who had responsibility for making an initial assessment of the risk.

The organisation determined that those risks identified as having a total score of 11 (moderate) or below would be regarded as risks managed at team/department level by Line Managers. These risks were considered small enough to have an immaterial effect on the organisation's objectives or controlled effectively in order to minimise adverse consequences.

Those risks identified as scoring 12+ (high) or above were regarded as significant risks or where a manager could not immediately introduce control measures to reduce the level of risk to an acceptable level, these were notified within the organisation to an appropriate Director who determined how the risk would be addressed. Moderated risks with a score of 12+ formed part of the corporate risk register.

Risks determined with a score of 15+ as moderated by appropriate Directors were escalated to the assurance framework for attention of the Board.

The organisational risk profile was made clear through assurance framework reports presented at each ordinary Board meeting. The reports highlighted the level of risk against principal objectives, including the level of risk, the balance of risks and the trend in risks.

During 2012/13 CCG's have continued to remain under the NHS Sussex Risk System. From 1st April 2013 the CCG's will run their own risk systems under their approved Risk Management Strategies and Risk Management Policy and Procedures. A proposal was approved by the NHS Sussex Audit Committee regarding the closedown process for NHS Sussex risks and the transfer of risks to receiving organisations by 31st March 2013. The following table highlights the key newly identified significant risks in terms of impact and likelihood reported in the final NHS Sussex Board Assurance Framework and the receiving body for these risks.

Key risks included in the Final Assurance Framework, March 2013

Risk No.	Risk description	Risk score	Actions taken
119	There is risk that current breast screening equipment in Worthing will be obsolete before the new West Sussex breast unit is complete.	20	*This risk was subsequently transferred to and accepted by the Surrey and Sussex Area Team, NHS England.*
217	There is a risk of a new strain of influenza pandemic virus developing, and we cannot predict with certainty when it will happen, the epidemiology of an emergent influenza pandemic virus or its clinical behaviour.	20	*This risk was subsequently transferred to and accepted by the Surrey and Sussex Area Team, NHS England, and some of the Sussex CCGs.*
312	There is a risk that there will be insufficient management capacity within the Clinical Commissioning Groups to achieve the scale and scope of change required and this may impact on the delivery of the QIPP plans across Sussex	20	*This risk was subsequently transferred to and accepted by some of the Sussex CCGs.*
314	There is a risk that the centralisation of arterial vascular surgery with 24/7services at BSUH will not be achieved by March 2013	20	*This risk was subsequently transferred to and accepted by the Surrey and Sussex Area Team, NHS England.*
571	DH Guidance relating to the timescales for making retrospective Continuing Healthcare claims has resulted in a significant rise in claims received by PCTs requiring assessment with consequent risk of service disruption.	20	*This risk was subsequently transferred to and accepted by Coastal West Sussex CCG as hosts of the future service.*
140	There is a risk that there is insufficient capacity to deliver core operational processes and there is a delay to operationalization of the Surrey and Sussex Commissioning Support Unit	16	*This risk was subsequently transferred to and accepted by Surrey and Sussex Commissioning Support Unit*

The Board agreed its principle objectives in May 2013 (set out in the table below) describing them as Strategic Goals (SG) and monitored these at every ordinary board meeting until the close of 2012/13.

Strategic Goal 1. Quality, Delivery and Performance
SG1.1 - Deliver the quality and safeguarding responsibilities including the quality standards outlined in the Sussex Plan
SG1.2 - Deliver the performance improvements outlined in the Sussex Plan
SG1.3 - Deliver the financial plans for 12/13 outlined in the 2 year Sussex plan

Strategic Goal 2. Transition
SG2.1 - Supporting our staff through the transition and maximising their talents and capabilities
SG2.2 - NHS Sussex responsibilities are transferred to successor organisations by end March 2013
SG2.3 - Establish effective Clinical Commissioning Groups and an effective Commissioning Support Service for the future

Strategic Goal 3. Strategy
SG3.1 - Deliver the agreed outcomes from Sussex Together
SG3.2 - Foster pan-Sussex working arrangements to improve services for patients
SG3.3 - Strengthening our strategic partnerships to improve the health and wellbeing of our population

Strategic Goal 4. Health Outcomes
SG4.1 - Reduce Health Inequalities within our population
SG4.2 - Improve the health and wellbeing of our population

In 2013/14 CCGs will identify and align risks with their principal objectives and govern risks as required under the terms of their authorisation. In 2012/13 NHS Sussex has supported CCGs in establishing their risk management processes.

Information governance incidents

There were no Information Governance (IG) Serious Untoward Incidents (SUI) reported this year as none scored at level 5 on the IG SUI grading matrix (the most serious score on a grading from 1-5).

There was one category 3 Information Governance (IG) Serious Incident (SI) this year which related to a GP disposing of a patient record in an inappropriate manner. The category 4 incident related to confidential information being sent to the wrong recipient by email. The data did not leave the boundaries of the NHS and all data was retrieved.

Summary of Serious Untoward Incidents

Category	Nature of incident	Hastings and Rother PCT
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	0
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	0
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	1
IV	Unauthorised disclosure	1
V	Other	0
	Totals for the year	**2**

** It should be noted that as East Sussex Downs and Weald PCT and Hastings and Rother PCT work closely together, with staff working across both organisations, and incidents reported under East Sussex Downs and Weald PCT may reflect joint working arrangements.*

Subject Access Requests were dealt with effectively, within the time constraints set out by the Department of Health. A 'Subject Access Request' (SAR) and 'Caldicott Log' were maintained and updated by the Information Governance Team to keep track of any requests from members of the public and any queries raised by staff about the management of personal information.

Control and risk related to performance indicators
More than sixty key performance indicators were regularly monitored by the Board and past performance reports were available to the public on the NHS Sussex website. These reports included nationally agreed operating targets as 'headline measures' and their 'supporting measures' along with wider targets agreed locally. Performance outcomes for 2012/13 are disclosed in the annual report.

For the purpose of this statement the following table identifies those nationally recognised indicators (headline measures and supporting measures) that did not reach target for the full year 2012/13.

KPI Grouping	Indicator	Hasting & Rother	
		Full Year Plan	Full Year Actual
18 weeks	RTT - admitted - 95th percentile	23	24.4
Stroke	Proportion of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit	80.0%	77.22%
Primary Care	Number of patients receiving NHS primary dental services located within the PCT area within a 24 month period	120,518	110,028
Primary Care	QOF domain scores and exception reporting rate (PERFORMANCE COMPARED AGAINST NATIONAL AVERAGE)	94.7%	92.37%
Screening	SQU27: Coverage of NHS Health Checks - Offered - Reported Cumulatively	18.1%	9.4%
Screening	SQU27: Coverage of NHS Health Checks - screened - reported Cumulatively	7.2%	4.5%
Maternity	Prevalence of breastfeeding at 6-8 wks after birth	45.3%	43.4%
Health Improvement	Under 18 conception rate per 1,000 female aged 15 to 17	31	35.3

Health Improvement	Immunisation - Aged 1 immunized for DTaP/IPV/Hib (Sussex Cluster performance is average of the PCTs, actual cluster performance will be available in Q1 11/12)		95.0%	93.78%
Health Improvement	Immunisation - Aged 2 immunised for PCV (Sussex Cluster actual and plan is the average of the PCTs, actual cluster performance will be available in Q1 11/12)		95.0%	91.82%
Health Improvement	Immunisation - Aged 2 immunised for Hib/MenC (Sussex Cluster actual and plan is the average of the PCTs, actual cluster performance will be available in Q1 11/12)		95.0%	92.67%
Health Improvement	Immunisation - Aged 2 immunised for MMR (Sussex Cluster actual and plan is the average of the PCTs, actual cluster performance will be available in Q1 11/12)		95.0%	92.37%
Health Improvement	Immunisation - Aged 5 immunised for DTaP/IPV(Sussex Cluster actual and plan is the average of the PCTs)		95.0%	89.44%
Health Improvement	Immunisation - Aged 5 immunised for MMR (Sussex Cluster actual and plan is the average of the PCTs)		95.0%	87.22%
Health Improvement	Number of 4-week smoking quitters that have attended NHS Stop Smoking Services		957	815

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

As Accountable Officer, I had responsibility for reviewing the effectiveness of the system of internal control for the financial year ending 31 March 2013. My review was informed in a number of ways. The head of internal audit provided me with an opinion on the overall arrangements for gaining assurance through assessment of the assurance framework and on the controls reviewed as part of the internal auditor's work. Executive managers within the organisation with responsibility for the development and maintenance of the system of internal control provided me with assurance. The assurance framework itself provided me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives were reviewed. My review was also informed by the work of our external auditors, BDO LLP, particularly in the following areas:

- audit of the financial statements 2012/13
- value for money conclusion 2012/13

And by the work of our internal auditors, South Coast Audit, particularly in the following areas:

- audit of risk and assurance processes 2012/13

- audits supporting the financial statements

In addition, the Head of Internal Audit opinion which states:

"**Significant assurance** can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk."

Internal audit work covered a range of risk-based audit assignments throughout the year. Of the 28 audits and reviews reported against, 1 'Limited' assurance opinion was given, 2 'split' assurance opinions were given and 15 'Significant' assurance opinions were given. A further 10 consultancy and development reviews were undertaken were no assurance opinion was given. The Head of Internal Audit, in reaching an overall assessment for 2012/13 of 'significant assurance' took into account:

- the relative importance of the areas audited and the positive results from the core annual audit work on key financial systems;
- the number of risk based reviews where 'significant' assurance was provided; and
- the 'significant' assurance provided by the development, design and operation of the Board Assurance Framework and associated risk management processes.

Limited assurance was received regarding Commissioning Support Unit (CSU) service requirements were no agreed KPI's or targets were agreed with users of the services to assess performance and delivery.

Recommendations and action plans for these areas were managed through the NHS Sussex system of follow-up and the implementation of audit recommendations was monitored by the Audit Committees. This system gave me assurance that control issues were dealt with effectively by executive directors.

I was advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, and the Audit Committee. A plan to address weaknesses and ensure continuous improvement of the system remained in place until the close of the PCT.

6. Significant Issues

2 areas were identified as significant issues:

- The non-delivery of national priority headline and supporting measures as set out in section 4. Performance Management processes were in place during 2012/13 to mitigate performance risks and the PCT has worked with shadow Clinical Commissioning Groups and other receiving organisations to develop future performance management regimes.

- A number of irregular payments were identified by the PCT and referred to NHS Protect in April 2013. The investigation is currently ongoing and NHS Protect is being supported by the Surrey and Sussex Commissioning Support Unit which is the main receiving body of the legacy PCT finance function.

Accountable Officer: Amanda Fadero

Organisation: Hastings and Rother PCT

7th June 2013

Amanda Fadero, Director, Surrey and Sussex Area Team, NHS England

INDEPENDENT AUDITOR'S REPORT TO THE ACCOUNTABLE OFFICER FOR HASTINGS AND ROTHER PRIMARY CARE TRUST

Financial statements

We have audited the financial statements of Hastings and Rother 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.

This report is made solely to the Accountable Officer for Hastings and Rother 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 auditor

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 Primary Care Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Primary Care 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.

Qualified opinion on regularity arising from non-compliance with governing authorities

As disclosed in Note 38 to the financial statements, expenditure includes £568,000 of payments during 2012/13 and additional amounts in excess of £1.1 million in previous years, where the Primary Care Trust had no powers to make such payments. These payments have been reported to NHS Protect to seek recovery of amounts paid.

Accordingly, we have concluded that this expenditure has not been applied to the purposes intended by Parliament and is not in conformity with the authorities which govern it.

In our opinion, except for the irregular payments reported above, in all material respects the expenditure and income have been applied to the purposes intended by Parliament and 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 state of affairs of Hastings and Rother 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 to be audited 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 Operating and Financial review section within the annual report relating to Hastings and Rother Primary Care Trust, excluding information which is specific to the other NHS Sussex cluster Primary Care Trusts, 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 have nothing to report in respect of the following other matters which the Code of audit practice for local NHS bodies (March 2010) requires us to report to you if:

- we have been unable to satisfy ourselves that the annual governance statement meets the disclosure requirements set out in the guidance provided by the Department of Health or is misleading or inconsistent with other information that is forthcoming from the audit; or
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

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

Respective responsibilities of the Primary Care Trust and auditor

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

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Primary Care Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. For 2012/13, auditors of Primary Care Trusts will consider the risks relating to PCT abolition and the transition to new local commissioning arrangements, rather than giving their conclusion based on specified reporting criteria. 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.

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

We have undertaken our review 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 Annual Governance Statement;

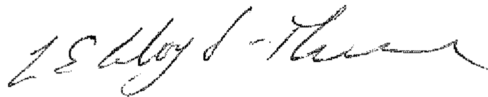
- the work of other relevant regulatory bodies or inspectorates, to the extent that the results of this work impact on our responsibilities at the Primary Care Trust; and
- our locally determined risk-based work on demise of the Primary Care Trust and transition to successor bodies and delivering Quality, Innovation, Productivity and Prevention (QIPP) plans.

Conclusion

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 Hastings and Rother 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.



Leigh Lloyd-Thomas
for and on behalf of BDO LLP
London, UK
25 July 2013

Hastings and Rother

Final Accounts 2012/13

Prepared under International Financial Reporting Standards

Hastings and Rother PCT
36-38 Friars Walk, Lewes, East Sussex, BN7 2PB
Tel: 01273 403704 | Fax: 01273 403682
www.sussex.nhs.uk

ACCOUNTS FOR 2012/13

FOREWORD TO THE ACCOUNTS

Hastings And Rother PCT
Annual Accounts and Supporting Notes as at 31 March 2013

These accounts for the year ended 31st March 2013 have been prepared by Hastings and Rother PCT under direction of the Secretary of State for Health in exercise of powers conferred on him by Section 232 (Schedule 15, 3(1)) of the National Health Service Act 2006

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	**4,206**	6,090
Other costs	5.1	**343,803**	344,374
Income	4	**(10,009)**	(14,759)
Net operating costs before interest		**338,000**	335,705
Other (gains)/losses	10	**(4)**	6
Finance costs	11	**21**	22
Net operating costs for the financial year		**338,017**	335,733
Of which:			
Administration Costs			
Gross employee benefits	7.1	**3,428**	2,669
Other costs	5.1	**3,479**	3,390
Income	4	**(503)**	(1,044)
Net administration costs for the financial year		**6,404**	**5,015**
Programme Expenditure			
Gross employee benefits	7.1	**778**	3,421
Other costs	5.1	**340,324**	340,984
Income	4	**(9,506)**	(13,715)
Net programme expenditure before interest		**331,596**	**330,690**
Other (gains)/losses	10	**(4)**	6
Finance costs	11	**21**	22
Net programme expenditure for the financial year		**331,613**	**330,718**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**329**	0
Net gain on revaluation of property, plant & equipment	**0**	(324)
Total comprehensive net expenditure for the year*	**338,346**	**335,409**

*This is the sum of the rows above plus net operating costs for the financial year.
The notes on pages 7 to 41 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	**32,149**	30,928
Current assets:			
Trade and other receivables	19	**3,045**	4,234
Cash and cash equivalents	23	**91**	15
Total current assets		**3,136**	4,249
Non-current assets held for sale	24	**0**	371
Total current assets		**3,136**	4,620
Total assets		**35,285**	35,548
Current liabilities			
Trade and other payables	25	**(23,065)**	(27,974)
Provisions	32	**(772)**	(254)
Total current liabilities		**(23,837)**	(28,228)
Non-current assets less net current liabilities		**11,448**	7,320
Non-current liabilities			
Provisions	32	**(1,875)**	(465)
Total Assets Employed:		**9,573**	6,855
Financed by taxpayers' equity:			
General fund		2,558	(489)
Revaluation reserve		7,015	7,344
Total taxpayers' equity:		9,573	6,855

The notes on pages 7 to 41 form part of this account.

The financial statements on pages *3 to 41* were approved by the Audit Committee on behalf of the Department of Health and signed on 7th June 2013.

Signing Officer:

Date: 7/6/13

Director - Surrey and Sussex Area Team

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

	General fund	Revaluation reserve	Total reserves
	£000	£000	£000
Balance at 1 April 2012	**(489)**	**7,344**	**6,855**
Changes in taxpayers' equity for 2012-13			
Net operating cost for the year	(338,017)	0	**(338,017)**
Impairments and reversals	0	(329)	**(329)**
Total recognised income and expense for 2012-13	**(338,017)**	**(329)**	**(338,346)**
Net Parliamentary funding	341,064	0	**341,064**
Balance at 31 March 2013	**2,558**	**7,015**	**9,573**
Balance at 1 April 2011	**4,362**	**7,062**	**11,424**
Changes in taxpayers' equity for 2011-12			
Net operating cost for the year	(335,733)	0	(335,733)
Net gain on revaluation of Property, Plant and Equipment	0	324	324
Transfers between reserves	42	(42)	0
Total recognised income and expense for 2011-12	(335,691)	282	(335,409)
Net Parliamentary funding	330,840	0	330,840
Balance at 31 March 2012	**(489)**	**7,344**	**6,855**

Statement of cash flows for the year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities			
Net Operating Cost Before Interest		**(338,000)**	(335,705)
Depreciation and Amortisation		**959**	847
Impairments and Reversals		**5**	800
Decrease in Trade and Other Receivables		**1,189**	3,839
Decrease in Trade and Other Payables		**(3,579)**	(327)
Provisions Utilised		**(122)**	(113)
Increase in Provisions		**2,029**	93
Net Cash Outflow from Operating Activities		**(337,519)**	**(330,566)**
Cash flows from investing activities			
Payments for Property, Plant and Equipment		**(3,844)**	(2,872)
Proceeds of disposal of assets held for sale (PPE)		**375**	751
Net Cash Outflow from Investing Activities		**(3,469)**	**(2,121)**
Net cash outflow before financing		**(340,988)**	**(332,687)**
Cash flows from financing activities			
Net Parliamentary Funding		**341,064**	330,840
Capital grants and other capital receipts		**0**	1,855
Net Cash Inflow from Financing Activities		**341,064**	**332,695**
Net increase in cash and cash equivalents	**23**	**76**	**8**
Cash and Cash Equivalents at Beginning of the Year	**23**	**15**	**7**
Cash and Cash Equivalents at year end	**23**	**91**	**15**

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.

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 and certain financial assets and financial liabilities.

Under the provisions of The Health and Social Care Act 2012 (Commencement No.4. Transitional, Savings and Transitory Provisions) Order 2013, Hastings and Rother PCT was dissolved on 1st April 2013. The PCT's functions, assets and liabilities transferred to other public sector entities as outlined in Note 39 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 Statement of Financial Position has therefore been drawn up at 31 March 2013 on the same basis as in previous years, reporting balances on the same basis as would a continuing entity. 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.

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.

A change in 2011-12 PCT Manual for Accounts meant that the treatment of the management costs recharges between Hastings and Rother PCT and East Sussex Downs and Weald PCT had to change. The statements reflect the shared income and expenditure on a net, rather than gross, basis.
There has been a change in the accounting treament of the Continuing Healthcare recharge between East Sussex Downs and Weald PCT and Hastings and Rother PCT. The statements now show expenditure on a net basis, prior year comparatives have also been amended (expenditure of £11.265m is now included in Purchaase of healthcare from non nhs bodies rather than goods and services from Other PCTs in the comparatives for 2011-12).

Critical judgements in applying accounting policies
Critical judgements and key sources of estimation uncertainty are disclosed, where relevant, under the notes to the accounts.

Key sources of estimation uncertainty
Where uncertainty exists in the preparation of these accounts, the PCT makes reasonable efforts to make estimations based on the information available to it at the time the accounts are prepared. Many estimations have to be made in the production of these accounts which relate to the delay between activities happening and the financial impact of those activities being confirmed. When the cost of known commitments is available estimations are based on those costs. When the cost of known commitments is not available estimations are based on actual spend for a period of time, forecasted to represent a twelve month cost or latest information available to us in respect of indexation.

The following are the key assumptions used at the Statement of Financial Position date, that may have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.
- Agreements have been reached with local NHS acute providers regarding the expected outturn of agreements ending 31st March 2013. Where agreements haven't been reached the PCT has relied on information received from the Sussex Commissioning Support Unit and West Kent PCT as host of the specialist commissioning function.
- Accruals for the Prescription Pricing Authority creditor : - Information in relation to prescribing is sent to the PCT monthly in arrears by the relavent prescribing authorities. This is always at least two months behind the current month. Each month, the PCT has to estimate the year to date expenditure - including at year end - based on the last set of available data. At year end, the PCT estimates prescribing based on 10 months' data, but with information about profiling and extrapolated trends.
- Accruals for the Quality and Outcomes Framework creditor : - This is a payment to practices for performance against a set of indicators. The PCT has to collate full year contract monitoring information, and then audit this, before agreeing the total amount of the in-year QOF payment. Inevitably this involves a significant element of estimation. The PCT has formed a view, as at the time of preparation of the financial statements, on the likely deliverability of improved performance across the practices and this forms the basis of the relevant accrual.

- The NHS has a policy of revaluing its fixed assets on a five year basis. For the years in between the latest available market value based indices (the BCIS All in Tender prices) are used when material.
- Fixed asset lives are assessed based on expert assessment in relation to remaining useful life of the asset.

- Provisions for Continuing Healthcare (CHC) retrospective claims have been estimated by reviewing all completed questionnaires and categorising into care groups. An estimated conversion rate of 15% has been applied to each of the groups for claims received, based on previous experience (30%) and adjusted down to take account of our expectations of potential payments, and a financial value calculated based on average bed prices for the relevant care category.
- The PCT has made no allowance for impairment of non NHS debts based on its review of outstanding non NHS debtors and the expectation that those debts will all be met. The PCT has a policy of debt collection and instructs third parties to act on its behalf to recover overdue debts.

1.2 Revenue and Funding

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

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

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

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

1.3 Pooled budgets

The PCT has entered into pooled budgets with East Sussex County Council and East Sussex Downs and Weald PCT. Under the arrangement funds are pooled under S75 of the NHS Act 2006 for:

- the provision of care services for carers
- the provision of an integrated community equipment loan service
- the provision of services for Children.

The pools are hosted by East Sussex County Council. The PCT makes contributions to the care services for carers pool as part of its commissioning role.

1.4 Taxation

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

1.5 Administration and Programme Costs

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

1.6 Property, Plant & Equipment

Recognition

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

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

Valuation

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

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

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

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

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

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

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

IAS 16 Property, plant and equipment require that the carrying value of replaced components are derecognised when the cost of replacement works are capitalised. The PCT has not followed this policy where it is not possible to calculate the carrying value of the replaced components due to insufficient information on these components.

1.7 Depreciation and impairments

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

Otherwise, depreciation is charged to write off the costs or valuation of property, plant and equipment, 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 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.

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.

1.8 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.

1.9 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.

1.10 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.

1.11 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).

1.12 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.

1.13 Employee benefits

Short-term employee benefits

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

Retirement benefit costs

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

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

1.14 Other expenses

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

1.15 Grant making

Under section 256 of the National Health Service Act 2006, the 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.

1.16 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 PCT. 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.

1.17 Leases

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

The PCT as lessee

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.

1.18 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.

1.19 Financial Instruments

Financial assets

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

Financial assets are initially recognised at fair value.

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

The PCT has classified all financial assets as 'loans and receivables' and does not hold any other types of financial assets.

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.

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

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

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

Financial liabilities

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

Financial liabilities are initially recognised at fair value.

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

The PCT has classified alll financial liabilities as 'other financial liabilities' and does not hold any other types of 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.

1.20 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's responsibility for the provision of learning disabilities (provider services) transferred to Affinity Trust for the financial year commencing 1st April 2012.

	Corporate Services		Primary Care		Commissioning		Provider Services		Total	
	2012-13	2011-12	**2012-13**	2011-12	**2012-13**	2011-12	**2012-13**	2011-12	**2012-13**	2011-12
	£000	£000	**£000**	£000	**£000**	£000	**£000**	£000	**£000**	£000
Statement of Comprehensive Net Expenditure										
Employee benefits	**4,206**	2,745	**0**	0	**0**	0	**0**	3,345	**4,206**	6,090
Other Costs	**5,544**	7,921	**81,642**	82,965	**256,617**	253,111	**0**	377	**343,803**	344,374
Total Operating Costs	**9,750**	10,666	**81,642**	82,965	**256,617**	253,111	**0**	3,722	**348,009**	350,464
Income	**(2,387)**	(3,674)	**(5,986)**	(5,896)	**(1,636)**	(1,461)	**0**	(3,728)	**(10,009)**	(14,759)
Other (Gains) / Losses	**(4)**	0	**0**	0	**0**	0	**0**	6	**(4)**	6
Finance Costs	**21**	22	**0**	0	**0**	0	**0**	0	**21**	22
Segmental Net Operating Costs	**7,380**	7,014	**75,656**	77,069	**254,981**	251,650	**0**	0	**338,017**	**335,733**
Revenue Resource Limit									**338,895**	338,440
PCT Operating Surplus									**878**	**2,707**

PCT management reviews balance sheet performance and investment decisions on a holistic basis. The net assets are therefore not split in the above segmental analysis.

Commissioning expenditure includes amounts with other PCTs that exceed 10 per cent of total operating costs - refer to note 5.1.

3 Financial Performance Targets

3.1 Revenue Resource Limit

The PCTs' performance for the year ended 2012-13 is as follows:

	2012-13 £000	2011-12 £000
Total Net Operating Cost for the Financial Year	**338,017**	335,733
Revenue Resource Limit	**338,895**	338,440
Underspend Against Revenue Resource Limit (RRL)	**878**	**2,707**

3.2 Capital Resource Limit

The PCT is required to keep within its Capital Resource Limit (CRL)

	2012-13 £000	2011-12 £000
Capital Resource Limit	**2,628**	1,435
Charge to Capital Resource Limit	**2,143**	1,412
Underspend Against CRL	**485**	**23**

3.3 Provider full cost recovery duty

The PCT is required to recover full costs in relation to its provider functions.

	2012-13 £000	2011-12 £000
Provider gross operating costs	**0**	3,728
Provider Operating Revenue	**0**	(3,728)
Net Provider Operating Costs	**0**	0
Costs Met Within PCTs Own Allocation	**0**	0
Recovery of Costs	**0**	0

3.4 Underspend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**341,064**	330,840
Cash Limit	**344,964**	330,840
Underspend Against Cash Limit	**3,900**	**0**

An additional cash resource of £4.440m was given to the PCT in line with Department of Health guidance around reducing year end balances. This was only notified in March 2013 which was too late for the PCT to fully utilise hence the under spend against the cash limit.

3.5 Reconciliation of Cash Drawings to Parliamentary Funding

	2012-13 £000	2011-12 £000
Total cash received from the Department of Health (Gross)	**298,135**	286,235
Plus: cost of Dentistry Schemes (central charge to cash limits)	**7,693**	7,755
Plus: drugs reimbursement (central charge to cash limits)	**35,236**	36,850
Parliamentary funding credited to General Fund	**341,064**	**330,840**

4 Miscellaneous Revenue

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Dental Charge income from Contractor-Led GDS & PDS	**2,903**	0	2,903	2,815
Prescription Charge income	**1,826**	0	1,826	1,675
Strategic Health Authorities	**52**	37	15	416
NHS Trusts	**382**	28	354	343
NHS Foundation Trusts	**191**	0	191	0
Primary Care Trusts - Other	**1,400**	218	1,182	2,970
English RAB Special Health Authorities	**30**	30	0	0
Local Authorities	**569**	188	381	4,072
Education, Training and Research	**0**	0	0	1
Rental revenue from operating leases	**1,884**	0	1,884	1,650
Other revenue	**772**	2	770	817
Total miscellaneous revenue	**10,009**	**503**	**9,506**	**14,759**

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 restated	
Goods and Services from Other PCTs					
Healthcare	**210,122**	0	210,122	206,850	*
Non-Healthcare	**653**	595	58	2,491	
Total	**210,775**	**595**	**210,180**	**209,341**	
Goods and Services from Other NHS Bodies other than FTs					
Goods and services from NHS Trusts	**1,806**	156	1,650	3,405	
Goods and services (other, excl Trusts, FT and PCT))	**0**	0	0	654	
Total	**1,806**	**156**	**1,650**	**4,059**	
Goods and Services from Foundation Trusts	**3,379**	16	3,363	3,812	
Purchase of Healthcare from Non-NHS bodies	**27,672**	0	27,672	25,637	*
Expenditure on Drugs Action Teams	**4,599**	0	4,599	5,005	
Non-GMS Services from GPs	**82**	82	0	0	
Contractor Led GDS & PDS (excluding employee benefits)	**10,813**	0	10,813	11,106	
Chair, Non-executive Directors & PEC remuneration	**14**	14	0	13	
Executive committee members costs	**24**	24	0	66	
Consultancy Services	**347**	304	43	440	
Prescribing Costs	**34,163**	0	34,163	35,528	
G/PMS, APMS and PCTMS (excluding employee benefits)	**25,404**	0	25,404	25,037	
Pharmaceutical Services	**1,299**	0	1,299	1,364	
New Pharmacy Contract	**7,510**	0	7,510	7,276	
General Ophthalmic Services	**1,718**	0	1,718	1,709	
Supplies and Services - Clinical	**215**	208	7	246	
Supplies and Services - General	**13**	0	13	111	
Establishment	**588**	444	144	533	
Transport	**7**	7	0	34	
Premises	**1,047**	148	899	1,138	
Impairments & Reversals of Property, plant and equipment	**5**	0	5	0	
Impairments and Reversals of non-current assets held for sale	**0**	0	0	800	
Depreciation	**959**	291	668	847	
Impairment of Receivables	**(25)**	(25)	0	0	
Audit Fees	**103**	103	0	166	
Other Auditors Remuneration	**25**	25	0	36	
Clinical Negligence Costs	**38**	38	0	24	
Education and Training	**61**	61	0	109	
Grants for capital purposes	**344**	0	344	341	
Other	**10,818**	988 **	9,830	9,596	
Total Operating costs charged to Statement of Comprehensive Net Expenditure	**343,803**	**3,479**	**340,324**	**344,374**	
Employee Benefits (excluding capitalised costs)					
PCT Officer Board Members	**272**	272	0	394	
Other Employee Benefits	**3,934**	3,156	778	5,696	
Total Employee Benefits charged to SOCNE	**4,206**	**3,428**	**778**	**6,090**	
Total Operating Costs	**348,009**	**6,907**	**341,102**	**350,464**	

* 2011-12 has been restated to reclassify continuing healthcare costs of £11.265m from 'Goods and services from other PCTs' to 'Goods and services from Non-NHS bodies' to reflect the recharging arrangement for continuing healthcare costs rather than the purchase of services from East Sussex Downs and Weald PCT.

** Other operating costs include £0.57m relating to a series of transactions currently subject to examination and investigation by NHS Protect – see note 38 to these accounts for further information.

5 Operating Costs

5.1 Analysis of operating costs: (cont)

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
Analysis of grants reported in total operating costs				
For capital purposes				
Grants to fund Capital Projects - GMS	**22**	0	22	0
Grants to Fund Capital Projects - Dental	**322**	0	322	341
Total Capital Grants	**344**	**0**	**344**	**341**
Grants to fund revenue expenditure	0	0	0	0
Total Grants	**344**	**0**	**344**	**341**

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**6,404**	5,800	604
Weighted population (number in units)*	**195,983**	195,983	195,983
Running costs per head of population (£ per head)	**33**	**30**	**3**
PCT Running Costs 2011-12			
Running costs (£000s)	**5,015**	4,423	592
Weighted population (number in units)	**195,983**	195,983	195,983
Running costs per head of population (£ per head)	**26**	**23**	**3**

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

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

5.2 Analysis of operating expenditure by expenditure classification

	2012-13	2011-12
	£000	£000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	25,404	25,037
Prescribing costs	34,163	35,528
Contractor led GDS & PDS	10,813	11,106
General Ophthalmic Services	1,718	1,709
Pharmaceutical services	1,299	1,364
New Pharmacy Contract	7,510	7,276
Non-GMS Services from GPs	82	0
Total Primary Healthcare purchased	**80,989**	82,020
Purchase of Secondary Healthcare		
Learning Difficulties	7,308	5,595
Mental Illness	25,776	24,712
Maternity	8,359	8,340
General and Acute	148,761	144,382
Accident and emergency	13,213	13,763
Community Health Services	22,925	24,143
Other Contractual	28,071	30,598
Total Secondary Healthcare Purchased	**254,413**	251,533
Grant Funding		
Grants for capital purposes	344	341
Total Healthcare Purchased by PCT	**335,746**	**333,894**
PCT self-provided secondary healthcare included above	0	0
Social Care from Independent Providers	0	0
Healthcare from NHS FTs included above	3,363	7,063

6 Operating Leases

6.1 PCT as lessee

	Buildings	Other	2012-13 Total	2011-12
	£000	£000	£000	£000
Payments recognised as an expense				
Minimum lease payments	**124**	**0**	**124**	205
Payable:				
No later than one year	**7**	**0**	**7**	7
Between one and five years	**5**	**0**	**5**	11
After five years	**0**	**0**	**0**	0
Total	**12**	**0**	**12**	**18**

6.2 PCT as lessor

	2012-13	2011-12
	£000	£000
Recognised as income		
Rental Revenue	**1,884**	1,650
Receivable:		
No later than one year	**1,201**	1,065
Between one and five years	**0**	0
After five years	**0**	0
Total	**1,201**	1,065

This rental income is from the PCT owned community properties that are rented to East Sussex Healthcare NHS Trust who run Provider Services. Rent income relates to receipts under cancellable at no notice arrangements, which are not required to be analysed across financial years.

7 Employee benefits and staff numbers

7.1 Employee benefits

2012-13	Total £000	Admin £000	Programme £000	Permanently employed Total £000	Permanently employed Admin £000	Permanently employed Programme £000	Other Total £000	Other Admin £000	Other Programme £000
Employee Benefits - Gross Expenditure									
Salaries and wages	**3,366**	2,871	495	**3,071**	2,581	490	**295**	290	5
Social security costs	**259**	220	39	**244**	205	39	**15**	15	0
Employer Contributions to NHS BSA - Pensions Division	**397**	337	60	**374**	314	60	**23**	23	0
Termination benefits	**184**	0	184	**184**	0	184	**0**	0	0
Total employee benefits	**4,206**	**3,428**	**778**	**3,873**	**3,100**	**773**	**333**	**328**	**5**
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	**4,206**	**3,428**	**778**	**3,873**	**3,100**	**773**	**333**	**328**	**5**
Employee costs capitalised	**0**	0	0	**0**	0	0	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**4,206**	**3,428**	**778**	**3,873**	**3,100**	**773**	**333**	**328**	**5**
Recognised as:									
Commissioning employee benefits	**4,206**			**3,873**			**333**		

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	**4,842**	4,423	419
Social security costs	**412**	378	34
Employer Contributions to NHS BSA - Pensions Division	**657**	606	51
Termination benefits	**179**	179	0
Total gross employee benefits	**6,090**	**5,586**	**504**
Less recoveries in respect of employee benefits	**0**	0	0
Total - Net Employee Benefits including capitalised costs	**6,090**	**5,586**	**504**
Employee costs capitalised	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**6,090**	**5,586**	**504**
Recognised as:			
Commissioning employee benefits	**2,745**		
Provider employee benefits	**3,345**		
Gross Employee Benefits excluding capitalised costs	**6,090**		

7 Employee benefits and staff numbers

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	**0**	0	0	**1**	1	0
Administration and estates	**54**	53	1	**33**	33	0
Healthcare assistants and other support staff	**0**	0	0	**88**	85	3
Nursing, midwifery and health visiting staff	**12**	12	0	**15**	14	1
Scientific, therapeutic and technical staff	**5**	5	0	**5**	5	0
TOTAL	**71**	**70**	**1**	**142**	**138**	**4**

Of the above - no staff engaged on capital projects

7.3 Ill health retirements

No persons retired early on ill health grounds in 2012-13 or 2011-12.

No additional pensions liabilities accrued in 2012-13 or 2011-12.

7.4 Exit Packages agreed during the year

	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	**1**	**0**	**1**	0	0	**0**
£10,001-£25,000	**3**	**0**	**3**	5	1	**6**
£25,001-£50,000	**6**	**0**	**6**	2	0	**2**
£50,001-£100,000	**5**	**0**	**5**	0	2	**2**
£100,001 - £150,000	**2**	**0**	**2**	0	0	**0**
£150,001 - £200,000	**0**	**0**	**0**	0	0	**0**
>£200,000	**1**	**0**	**1**	0	0	**0**
Total number of exit packages by type (total cost)	**18**	**0**	**18**	**7**	**3**	**10**
	£s	**£s**	**£s**	**£s**	**£s**	**£s**
Total resource cost	1,121,289	0	**1,121,289**	138,000	177,000	**315,000**

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

The above numbers relate to named individuals employed by the PCT.

7.5 Pension costs

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

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

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

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

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

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

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

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

c) Scheme provisions
The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:
The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.
With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".
Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

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

8 Better Payment Practice Code

8.1 Measure of compliance

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**3,699**	**27,696**	4,071	25,289
Total Non-NHS Trade Invoices Paid Within Target	**3,423**	**22,268**	3,623	22,016
Percentage of NHS Trade Invoices Paid Within Target	92.54%	80.40%	89.00%	87.06%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,144**	**242,118**	2,108	242,183
Total NHS Trade Invoices Paid Within Target	**1,784**	**237,199**	1,846	232,699
Percentage of NHS Trade Invoices Paid Within Target	83.21%	97.97%	87.57%	96.08%

The Better Payment Practice Code requires the PCT to aim to pay all valid invoices within 30 days of receipt of a valid invoice or receipt of goods, whichever is later, or within other agreed payment terms.

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

No amounts included in finance costs from claims made under this legislation.
No compensation paid to cover debt recovery costs under this legislation (2011-12: £nil)

9 Investment Income

The PCT had no investment income in 2012-13 or 2011-12.

10 Other Gains and Losses

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Loss on disposal of assets other than by sale (PPE)	**0**	**0**	**0**	(6)
Gain on disposal of assets held for sale	**4**	**0**	**4**	0
Total	**4**	**0**	**4**	(6)

11 Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Provisions - unwinding of discount	**21**	**0**	**21**	22

12.1 Property, plant and equipment

	Land	Buildings excluding dwellings	Dwellings	Plant & machinery	Information technology	Total
2012-13						
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Cost or valuation:						
At 1 April 2012	**5,315**	**24,826**	**620**	**540**	**1,463**	**32,764**
Additions Purchased	0	2,203	20	148	143	**2,514**
Impairments/negative indexation	0	(319)	(10)	0	0	**(329)**
At 31 March 2013	**5,315**	**26,710**	**630**	**688**	**1,606**	**34,949**
Depreciation						
At 1 April 2012	**0**	**677**	**10**	**68**	**1,081**	**1,836**
Impairments	0	5	0	0	0	**5**
Charged During the Year	0	730	10	80	139	**959**
At 31 March 2013	**0**	**1,412**	**20**	**148**	**1,220**	**2,800**
Net Book Value at 31 March 2013	**5,315**	**25,298**	**610**	**540**	**386**	**32,149**
Purchased	5,315	23,200	610	540	386	**30,051**
Donated	0	2,098	0	0	0	**2,098**
Total at 31 March 2013	**5,315**	**25,298**	**610**	**540**	**386**	**32,149**
Asset financing:						
Owned	5,315	25,298	610	540	386	**32,149**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Plant & machinery	Information technology	Total
	£000's	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
At 1 April 2012	**3,943**	**3,375**	**12**	**14**	**0**	**7,344**
Impairments	0	(319)	(10)	0	0	**(329)**
At 31 March 2013	**3,943**	**3,056**	**2**	**14**	**0**	**7,015**

12.2 Property, plant and equipment

	Land	Buildings excluding dwellings	Dwellings	Plant & machinery	Transport equipment	Information technology	Total
2011-12							
	£000	£000	£000	£000	£000	£000	**£000**
Cost or valuation:							
At 1 April 2011	**5,453**	**23,996**	**567**	**971**	**126**	**1,766**	**32,879**
Additions - purchased	0	1,546	46	450	0	121	**2,163**
Reclassified as held for sale	(138)	(1,033)	0	(881)	(126)	(424)	**(2,602)**
Revaluation & indexation gains	0	317	7	0	0	0	**324**
At 31 March 2012	**5,315**	**24,826**	**620**	**540**	**0**	**1,463**	**32,764**
Depreciation							
At 1 April 2011	**0**	**0**	**0**	**569**	**71**	**1,023**	**1,663**
Reclassifications as Held for Sale	0	0	0	(507)	(91)	(76)	**(674)**
Charged During the Year	0	677	10	6	20	134	**847**
At 31 March 2012	**0**	**677**	**10**	**68**	**0**	**1,081**	**1,836**
Net Book Value at 31 March 2012	**5,315**	**24,149**	**610**	**472**	**0**	**382**	**30,928**
Purchased	5,315	21,953	610	472	0	382	**28,732**
Donated	0	2,196	0	0	0	0	**2,196**
At 31 March 2012	**5,315**	**24,149**	**610**	**472**	**0**	**382**	**30,928**
Asset financing:							
Owned	5,315	24,149	610	472	0	382	**30,928**

12.3 Property, plant and equipment

Land, buildings and dwellings were last revalued by an independent valuer with specialist knowledge of the NHS Estate during January and February 2010 with a Valuation Date as the 1st April 2010. This valuation was applied as at 31st March 2010 in the Statement of Financial Position and has subsequently been revalued in accordance with the valuation policy described in note 1.6.

The valuations have been undertaken having regard to International Financial Reporting Standards (IFRS) as applied to the United Kingdom public sector and in accordance with HM Treasury guidance, International Valuation Standards and the requirements of the Royal Institution of Chartered Surveyors (RICS) Valuation Standards 6th Edition.

The PCT decreased the valuation of the buildings by a net £329,000 based on the latest available market value based indices. This was a decrease of 1.4% on last year. The indices incicated no significant movement for Land.

Bases of Valuation

The valuation report was prepared in accordance with the terms of the Royal Institution of Chartered Surveyors' Valuation Standards, 6th Edition, insofar as these terms are consistent with the requirements of HM Treasury, the National Health Service, and the Department of Health.

Public sector bodies including the NHS are required to apply the Revaluation model set out in IAS 16 and value their capital assets to fair value.

Fair value is defined in IAS16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. The fair value of land, buildings and dwellings is usually determined from market-based evidence by appraisal undertaken by professionally qualified valuers.

The remaining economic lives of each class of fixed asset is assessed as follows:
Buildings and Dwellings - between 9 years minimum and 54 years maximum
Plant and machinery - between 0 years minimum and 7 years maximum
Information technology - between 0 years minimum and 5 years maximum.

13 Intangible non-current assets

The PCT has no intangible assets at 31st March 2013 (31st March 2012 £nil)

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			
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Changes in market price	5	0	5
Total charged to Annually Managed Expenditure	**5**	**0**	**5**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Changes in market price	329		
Total Impairments of Property, Plant and Equipment	**334**	**0**	**5**
Total Impairments charged to Revaluation Reserve	329		
Total Impairments charged to SoCNE - DEL	0	0	0
Total Impairments charged to SoCNE - AME	5		5
Overall Total Impairments	**334**	**0**	**5**

Of which:
No impairment on revaluation to "modern equivalent asset" basis (2011-12 £nil)

No Donated and Gov Granted Assets, included above (2011-12 £nil)

15 Investment property

The PCT has no investment property at 31 March 2013 (31 March 2012 £nil).

16 Commitments

16.1 Capital commitments

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

	31 March 2013	31 March 2012
	£000	£000
Property, plant and equipment	**0**	326

16.2 Other financial commitments

The PCT has not entered into any non-cancellable contracts (which are not leases or PFI contracts or other service concession arrangements) at 31 March 2013 (31 March 2012 £nil).

17 Intra-Government and other balances

	Current receivables £000s	**Current payables £000s**
Balances with other Central Government Bodies	1,595	8,362
Balances with Local Authorities	107	1,055
Balances with NHS Trusts and Foundation Trusts	949	2,503
Balances with bodies external to government	394	11,145
At 31 March 2013	**3,045**	**23,065**
prior period:		
Balances with other Central Government Bodies	841	6,720
Balances with Local Authorities	91	390
Balances with NHS Trusts and Foundation Trusts	1,945	5,303
Balances with bodies external to government	1,357	15,561
At 31 March 2012	**4,234**	**27,974**

18 Inventories

The PCT has no inventory at 31 March 2013 (31 March 2012: £nil).

19.1 Trade and other receivables

	Current		
	31 March 2013	31 March 2012 Restated	
	£000	£000	
NHS receivables - revenue	**1,733**	1,898	*
NHS prepayments and accrued income	**811**	888	*
Non-NHS receivables - revenue	**272**	269	
Non-NHS prepayments and accrued income	**191**	1,156	
Provision for the impairment of receivables	**0**	(25)	
Other receivables	**38**	48	
Total	**3,045**	4,234	

No Prepaid pensions contributions included above.

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

* The balances for 31 March 2012 have been restated to reclassify £0.888m from NHS revenue receivables to NHS prepayments and accrued income to reflect the new disclosure requirement this year.

19.2 Receivables past their due date but not impaired

	31 March 2013	31 March 2012
	£000	£000
By up to three months	**1,626**	**1,381**
By three to six months	**395**	**135**
By more than six months	**29**	**659**
Total	**2,050**	**2,175**

19.3 Provision for impairment of receivables

	2012-13	**2011-12**
	£000	**£000**
Balance at 1 April 2012	**(25)**	**(25)**
Decrease in receivables impaired	**25**	**0**
Balance at 31 March 2013	**0**	**(25)**

20 NHS LIFT investments

The PCT has no NHS LIFT investments at 31 March 2013 (31 March 2012: £nil).

21 Other financial assets - Current and Non Current

The PCT has no other financial assets at 31 March 2013 (31 March 2012: £nil).

22 Other current assets

The PCT has no other current assets at 31 March 2013 (31 March 2012: £nil).

23 Cash and Cash Equivalents

	31 March 2013	31 March 2012
	£000	£000
Opening balance	**15**	7
Net change in year	**76**	8
Closing balance	**91**	15
Made up of		
Cash with Government Banking Service	**91**	15

No Patients' money held by the PCT.

24 Non-current assets held for sale

	Land	Buildings, excl. dwellings	Plant and Machinery	Transport and Equipment	Information Technology	Total
	£000	£000	£000	£000	£000	£000
Balance at 1 April 2012	138	233	0	0	0	**371**
Less assets sold in the year	(138)	(233)	0	0	0	**(371)**
Balance at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**

No Liabilities associated with assets held for sale at 31 March 2013

	Land	Buildings, excl. dwellings	Plant and Machinery	Transport and Equipment	Information Technology	Total
						0
Balance at 1 April 2011	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	138	1,033	374	35	348	**1,928**
Less assets sold in the year	0	0	(374)	(35)	(348)	**(757)**
Less impairment of assets held for sale	0	(800)	0	0	0	**(800)**
Balance at 31 March 2012	**138**	**233**	**0**	**0**	**0**	**371**

No Liabilities associated with assets held for sale at 31 March 2012.

No Revaluation reserve balances in respect of non-current assets held for sale at 31 March 2013 (31 March 2012 £nil).

25 Trade and other payables

	Current 31 March 2013 £000	31 March 2012 Restated £000	
NHS payables - revenue	**1,951**	638	*
NHS payables - capital	**18**	0	
NHS accruals and deferred income	**8,501**	11,108	*
Family Health Services (FHS) payables	**8,408**	10,407	
Non-NHS payables - revenue	**1,234**	2,090	
Non-NHS payables - capital	**50**	1,398	
Non-NHS accruals and deferred income	**2,006**	1,902	
Social security costs	**105**	123	
VAT	**64**	15	
Tax	**226**	139	
Other	**502**	154	
Total	**23,065**	27,974	

* The balances for 31 March 2012 have been restated to reclassify £11.108m from NHS revenue payables to NHS accruals and deferred income, to reflect the new disclosure requirement this year.

26 Other liabilities
The PCT has no other liabilities at 31 March 2013 (31 March 2012: £nil).

27 Borrowings
The PCT has no borrowings at 31 March 2013 (31 March 2012: £nil).

28 Other financial liabilities
The PCT has no other financial liabilities at 31 March 2013 (31 March 2012: £nil).

29 Deferred income
The PCT has no deferred income at 31 March 2013 (31 March 2012: £nil).

30 Finance lease obligations
The PCT has no finance lease obligations at 31 March 2013 (31 March 2012: £nil).

31 Finance lease receivables as lessor
The PCT has no finance lease receivables at 31 March 2013 (31 March 2012: £nil).

32 Provisions

	Total £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Continuing Care £000s	Other £000s
		Comprising:			
Balance at 1 April 2012	**719**	496	19	97	107
Arising During the Year	**2,029**	12	17	1,997	3
Utilised During the Year	**(122)**	(75)	0	(33)	(14)
Unwinding of Discount	**21**	18	0	0	3
Balance at 31 March 2013	**2,647**	**451**	**36**	**2,061**	**99**
Expected Timing of Cash Flows:					
No Later than One Year	**772**	**43**	**36**	**687**	**6**
Later than One Year and not later than Five Years	**1,570**	**172**	**0**	**1,374**	**24**
Later than Five Years	**305**	**236**	**0**	**0**	**69**

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at 31 March 2013	1
As at 31 March 2012	0

The provisions carried by the PCT include:

1) Pensions which relate mainly to inherited pre 95 early retirements which are now a liability of the PCT.
2) Legal claims includes a provision for staff and third party non clinical claims.
3) Continuing care provision for retrospective claims which are currently under assessment to establish whether or not the costs should be borne by the NHS following publication of findings by the Health Ombudsman.
The East Sussex PCTs received 1,017 claims by mid March 2013. 749 of these claims were considered to be highly unlikely to result in any payment. The excluded claims relate mainly to claims from residential homes, previously rejected claims and cases where the claimant has failed to return sufficient documentation within a reasonable period, despite reminders sent by the PCT. The remaining 268 claims were included in the calculation of the provision, of which 111 relate to the PCT, 143 relate to East Sussex Downs and Weald PCT and 14 claims are ‘unknowns’ and split between the two PCTs. Of the 111 claims for the PCT, and a proportion of the unknown claims, the PCT applied a probability of 15 per cent in calculating a provision of £2 million. An estimated conversion rate of 15% has been applied to each of the groups, based on previous experience (30%) and adjusted down to take account of our expectations of potential payments, and a financial value calculated based on average bed prices for the relevant care category.

4) £36,000 is included in the PCT's provisions relating to the NHS Litigation Authority at 31 March 2013 in respect of Legal Claims liabilities (31 March 2012: £18,950).

33 Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities		
Continuing healthcare claims	**(11,838)**	(233)

The liabilities are an estimate based on the number of potential claims for reimbursement of continuing care costs following publication of findings by the Health Ombudsman.

As reported in the provisions note, the East Sussex PCTs received 1,017 claims by mid March 2013. A further 31 claims were received by the end of May 2013 and 48 returned questionnaires for claims that had been excluded from the provision and contingent liablity. After excluding the claims that are considered highly unlikely to result in any payment the PCT has estimated a contingent liability based on 85 per cent of the value of the remaining claims.

34 PFI and LIFT - additional information

The PCT has no PFI or LIFT Schemes.

35 Impact of IFRS treatment - 2012-13

No Impact of IFRS treatment 2012-13.

36 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 all transactions, assets and liabilities being in the UK and Sterling based. The PCT has no overseas operations. The PCT therefore has no 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.

36.1 Financial Assets	Loans and receivables
	£000
Receivables - NHS	2,544
Receivables - non-NHS	322
Cash at bank and in hand	91
Total at 31 March 2013	**2,957**
Receivables - NHS	2,786
Receivables - non-NHS	791
Cash at bank and in hand	15
Total at 31 March 2012	3,592

36.2 Financial Liabilities	Other
	£000
NHS payables	10,470
Non-NHS payables	12,220
Total at 31 March 2013	**22,690**
NHS payables	11,746
Non-NHS payables	15,951
Total at 31 March 2012	27,697

37 Related party transactions

During the year none of the Department of Health Ministers or parties related to any of them, has undertaken any material transactions with the PCT. Claire Quigley (PCT Director of Governance and Transition) was a Governor of Sussex Partnership Foundation Trust and Charles Everett (PCT Non-Executive Director) was a trustee of St Michaels Hospice. Details of related party transactions for these individuals are recorded in the table below. During 2012/13 Hastings and Rother Clinical Commissioning Group (CCG) was established in shadow form as a sub committee of the Board. The table below records related party transactions with organisations where Governing Body members of the shadow CCG have declared an interest. Where the related party is a General Medical Practice, payments were made under the standard terms and conditions of General Medical Services or Personal Medical Services contracts.

Details of related party transactions with individuals are as follows:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£	£	£	£
Claire Quigley, Director of Governance and Transition - Governor of Sussex Partnership Foundation Trust	5,625,000	191,000	237,000	191,000
Charles Everett, Non Executive Director - Trustee of St Michaels Hospice	1,557,457	0	0	0
Roger Elias, Chair of Governing Body, Hastings and Rother CCG - Pebsham Surgery Medical Practice	1,381,244	0	0	0
Susan Rae, Governing Body Member, Hastings and Rother CCG - Silver Springs Medical Practice	976,834	0	0	0
David Warden, Governing Body Member, Hastings and Rother CCG - Collington Surgery Medical Practice	941,647	0	0	0
Greg Wilcox, Chief Clinical Officer, Hastings and Rother CCG - Harold Road Surgery Medical Practice	1,219,109	0	0	0

The Department of Health is regarded as a related party. During the year the 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 listed below;

East Sussex Healthcare NHS Trust
Brighton and Sussex University Hospitals NHS Trust
Maidstone and Tunbridge Wells NHS Trust
Sussex Community NHS Trust
West Sussex Primary Care Trust - Sussex Acute Commissioning Service, Sussex HIS
Brighton and Hove City Primary Care Trust
West Kent Primary Care Trust - Specialist Commissioning
Sussex Partnership NHS Foundation Trust
South East Coast Ambulance Services NHS Trust
East Sussex Downs and Weald Primary Care Trust

In addition, the PCT has had a significant number of material transactions with other Government Departments and other central and local Government bodies. Most of these transactions have been with:

East Sussex County Council for joint enterprises
HM Revenue and Customs for payment of VAT, employees income tax and national insurance contributions
Hastings District Council for business rates and other joint services
Rother District Council for business rates and other joint services

The PCT has also received revenue payments from charitable funds, none of the Trustees for which are members of the PCT Board.

38 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	578,557	5
Special payments - PCT management costs	0	0
Losses in respect of the provision of family practitioner services	0	0
Special payments in respect of the provision of family practitioner services	0	0
Total losses	578,557	5
Total special payments	0	0
Total losses and special payments	578,557	5

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

	Total Value of Cases £s restated	**Total Number of Cases restated**
Losses - PCT management costs	525,580	10
Special payments - PCT management costs	30637	3
Losses in respect of the provision of family practitioner services	0	0
Special payments in respect of the provision of family practitioner services	0	0
Total losses	525,580	10
Total special payments	30,637	3
Total losses and special payments	556,217	13

During 2012/13 a series of potentially irregular payments were identified and reported to NHS Protect for further examination and investigation. The potential irregular payments identified to date are in excess of £1.3m and occurred over the accounting periods 2010/11 to 2012/13, with £0.57m identified as relating to 2012/13 and £0.53m relating 2011-12 (comparatives have been restated to reflect this).
The total value of the potential irregular payments identified to date is reported under “Losses – PCT management costs” in the table above. The payments identified in 2012/13 are also reported under “other ” in note 5.1 to these accounts (Analysis of operating costs).

39 Events after the end of the reporting period

Hastings and Rother PCT was abolished on 31st March 2013 and its responsibilities split in to programmes and these passed to new statutory organisations and East Sussex County Council from 1st April 2013. The bulk of the commissioning responsibilities have been passed to Hastings and Rother Clinical Commissioning Group. Hastings and Rother Clinical Commissioning Group has an allocation of £254.2m for 2013/14.

Certain assets have transferred to NHS Property Services and East Sussex Healthcare NHS Trust on 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 bodies to consider whether, in 2013-14, it is necessary to review these for impairment.

West Sussex Primary Care Trust

2012-13 Accounts

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

© Crown copyright

Published to gov.uk, in PDF format only.

www.gov.uk/dh

West Sussex Primary Care Trust

2012-13 Accounts

2012-13 Annual Accounts of NHS West Sussex

NHS West Sussex

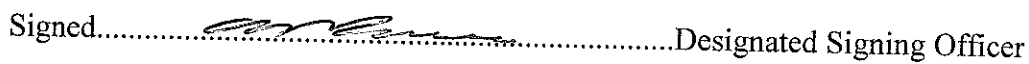
STATEMENT OF THE RESPONSIBILITIES OF THE SIGNING OFFICER OF THE PRIMARY CARE TRUST

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.

nb: sign and date in any colour ink except black



Signed..Designated Signing Officer

Name: AMANDA FADERO

Date....07\06\2013

STATEMENT OF RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

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

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

- make judgements and estimates which are reasonable and prudent;

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

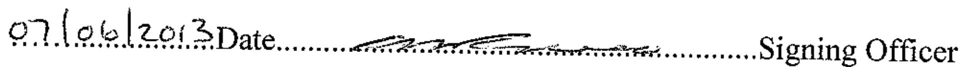
- ensure that the PCT kept proper accounting records which disclosed with reasonable accuracy at any time the financial position of the primary care trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State.

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

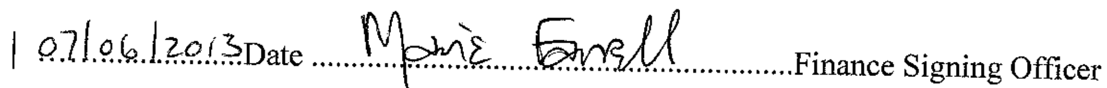
The Signing Officer and the Finance Signing Officer confirm to the best of their knowledge and belief, they have complied with the above requirements in preparing the accounts.

By order of the Permanent Secretary.

nb: sign and date in any colour ink except black



07/06/2013 Date...Signing Officer



07/06/2013 Date ....Finance Signing Officer

2012/13 Annual Governance Statement
West Sussex PCT

1. Scope of responsibility

The Board was accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I had responsibility for maintaining a sound system of internal control that supported the achievement of the organisation's policies, aims and objectives until 31 March 2013. I also had responsibility for safeguarding the public funds and the organisation's assets for which I was personally responsible as set out in the Accountable Officer Memorandum.

West Sussex Primary Care Trust (PCT) achieved its statutory financial duties in the financial year 2012/13 of remaining within its revenue, cash and capital resource limits. It reported a £777,000 surplus compared to the control total target surplus of £750,000. Capital expenditure in the year was £13.3m with capital receipts of £0.7m resulting in net capital expenditure of £12.6m which was within the Capital Resource Limit set of £13.8m. Cash spending was within the cash limit set of £1,369m.

2. The governance framework of the organisation

Good corporate governance and the management of risk is a corporate responsibility and, accordingly, the Board took a leading role in ensuring that management strategies and supporting processes were in place. The Board did this through its own annual review of the risk management strategy, by regular review of its assurance framework and through the governance, internal control, risk and assurance work of its committees. The Board was committed to ensuring that good corporate governance and risk management were integral to the organisation's philosophy, practice and planning rather than being viewed or practiced as separate programmes, and to ensuring that responsibility for implementation was accepted at all levels of the organisation. A record of Board members' attendance at Board meetings is presented below.

NHS Sussex Board Meeting Attendance Log

Name	Role	22/05 2012	07/06 2012	24/7 2012	25/09 2012	25/09 2012 AGM	09/11 2012	23/11 2012	22/01 2013	26/03 2013
David Clayton-Smith	Chairman	✓	✓	✓	✓	✓	✓	✓	✓	✓
Amanda Fadero	Chief Executive	✓	✓	✓	✓	✓	✓	✓	✓	✓
Andrew Foulkes	Medical Director	✓	✓	✓	✓	✓	✓	✓	x	✓
Sue Braysher	Director of Commissioning Development	✓	x	x	✓	✓	✓	✓	✓	✓
Sarah Creamer	Director of Performance	✓	✓	✓	✓	✓	✓	✓	x	✓
Julia Dutchman-Bailey	Director of Quality and Chief Nurse	✓	✓	✓	✓	✓	x	✓	✓	✓
Amanda Philpott	Director of Strategy and Provider Development	✓	✓	✓	✓	✓	✓	✓	✓	✓
Claire Quigley	Director of Transition	✓	x	✓	✓	✓	✓	✓	x	✓

	and Governance									
Michael Schofield	Director of Finance	✓	✓	✓	✓	✓	✓	✓	✓	✓
Frank Sims	Director of Commissioning Support Unit	✓	✓	✓	X	x	✓	X	x	✓
Jeremy Alford	Non Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	x
Peter Douglas	Non Executive Director	✓	x	✓	✓	✓	✓	✓	✓	✓
Charles Everett	Non Executive Director (Vice Chair)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rita Lewis	Non Executive Director	✓	✓	✓	✓	✓	✓	✓	x	✓
George Mack	Non Executive Director	✓	✓	x	✓	✓	✓	✓	✓	✓
Denise Stokoe	Non Executive Director	✓	✓	✓	✓	✓	✓	✓	x	✓

✓ = present, x = absent.

I was appointed as Chief Executive of NHS Sussex and each of the four statutory PCTs in Sussex. I led a single executive team across NHS Sussex. I had overall responsibility for ensuring that effective governance and risk management systems were in place and for meeting all statutory and legal requirements and adhering to guidance issued by the Department of Health in respect of governance until 31 March 2013. My director of Governance and Transition was accountable to me for the strategic development and implementation of organisational risk management and governance controls. All my executive directors were accountable to me for risk management and governance across the breadth of their functions.

In line with the recommendations of the Integrated Governance Handbook, NHS Sussex established committees responsible for reviewing the management of all types of risk both clinical and non-clinical.

The Quality and Delivery Assurance Board, supported by the establishment of Clinical Commissioning Groups (CCGs) as committees of the Board with their own assurance processes, and developing through the CCG authorisation process, managed this agenda in 2012/13 in preparation for statutory establishment of CCGs from 1 April 2013.

A Transition Assurance Board (TAB) was established during 2012/13 to oversee the operational handover of current PCT functions to appropriate receiving organisations and provide supporting closure (legacy) documentation. The Director of Transition and Governance, an NHS Sussex Board member was the executive lead member of TAB. To support the work of TAB specialist Transition Groups covering Closedown, Human Resources and Finance were also established. A Transition and Closedown Report was received by the final Board of NHS Sussex confirming that all PCT critical closure activities had been covered.

The governance and risk systems ensured the PCT discharged its statutory functions during 2012/13 and that these were legally compliant. The TAB had specific responsibility for ensuring that the legal closure of the PCT on 31st March 2013 and completion of the necessary Transfer Schemes.

The Audit Committees of the PCTs met jointly as the NHS Sussex Audit Committee to enable a single senior overview of NHS Sussex audit and internal control matters. The Audit Committees reported to the Board and reviewed the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supported the achievement of the organisation's objectives.

The Audit Committees ensured that there was an effective internal audit function that met mandatory NHS Internal Audit Standards and provided appropriate independent assurance to the Audit Committees, Chief Executive and Board. The Committees reviewed the work and findings of the external auditors and considered the implications and management's response to their work. The Committees satisfied themselves that the organisation had adequate arrangements in place for countering fraud and they reviewed the outcomes of counter fraud work. Directly in relation to financial reporting, the Committees monitored the integrity of the financial statements of the PCTs and ensured that the systems for reporting to the Board, including those of budgetary control, were subject to review as to completeness and accuracy of the information provided to the Board until 31 March 2013. The Committees reviewed the draft annual report and early working papers for the financial statements of the PCTs, including this Annual Governance Statement. Completion of the 2012/13 accounts and approval for these and the related statements took place after the closure of the PCTs via governance arrangements under the accountability of the NHS Business Services Authority.

In preparing this statement compliance with the five sections of the UK Corporate Governance Code was reviewed as follows:

Leadership
A.1 The Role of the Board. Every company should be headed by an effective board which is collectively responsible for the long-terms success of the company. *Compliant; the types of decisions taken by the board or delegated to management were detailed in the published scheme of delegation.*
A.2 Division of Responsibilities. There should be a clear division of responsibilities at the head of the company between the running of the board and the executive responsibility for the running of the company's business. No one individual should have unfettered powers of decision. *Compliant. The roles of Chairman and Chief Executive were separate appointments.*
A.3 The Chairman. The chairman is responsible for leadership of the board and ensuring its effectiveness on all aspects of its role. *Compliant.*
A.4 Non-executive Directors. As part of their role as members of a unitary board, non-executive directors should constructively challenge and help develop proposals on strategy. *Compliant; a Senior Independent Director was formally designated.*

Effectiveness
B.1 The Composition of the Board. The board and its committees should have the appropriate balance of skills, experience, independence and knowledge of the company to enable them to discharge their respective duties and responsibilities effectively. *Compliant; regulations were changed in 2010 enabling Non-executive Directors to be members of multiple PCTs, NHS Sussex Directors held multiple membership of the four PCTs in Sussex. Non-executive directors were appointed independently by the Appointments Commission.*
B.2 Appointments to the Board. There should be a formal, rigorous and transparent procedure for the appointment of new directors to the board. *Compliant; nominations were put to the Remuneration Committee as a result of transparent appointment processes.*
B.3 Commitment. All directors should be able to allocate sufficient time to the company to discharge their responsibilities effectively. *Compliant. Executive Directors allocated time as per*

contract; Non-executive Directors complied with and were reviewed against applicable Appointments Commission guidance.

B.4 Development. All directors should receive induction on joining the board and should regularly update and refresh their skills and knowledge. *Compliant; mandatory training provided; in 2012/13 non-essential training was limited due to closure of the PCTs, development programmes for CCG senior staff were in place.*

B.5 Information and Support. The board should be supplied in a timely manner with information in a form and of a quality appropriate to enable it to discharge its duties. *Compliant. Adequate resources were available under the guidance of the Chief Executive and Executive Directors.*

B.6 Evaluation. The board should undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors. *Compliant; individual performance reviews for Executive and Non-executive directors; the operation of the Board itself was reviewed in April 2012 with particular emphasis on how the Board would work in the final year of the existence of PCTs. Review and performance management by NHS South of England in place.*

B.7 Re-election. Not applicable, the composition of PCT Boards was based on statute and followed NHS guidance.

Accountability

C.1 Financial and Business Reporting. The board should present a balanced and understandable assessment of the company's position and prospects. *Compliant. Provided in annual report.*

C.2 Risk Management and Internal Control. 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 should maintain sound risk management and internal control systems. *Compliant; in 2012/13 there were significant changes to NHS commissioning organisations in preparation for new structures in 2013/14, such large scale change inherently carried risks which the Board mitigated as described and published in its board assurance framework.*

C.3 Audit Committee and Auditors. The board should establish formal and transparent arrangements for considering how it should apply the corporate reporting and risk management and internal control principles and for maintaining an appropriate relationship with the company's auditor. *Compliant. Contained within the terms of reference of the Audit Committees and described in this Annual Governance Statement.*

Code schedule B. Disclosure on corporate governance arrangements. *Compliant. Described in this Annual Governance Statement.*

Remuneration

D.1 The Level and Components of Remuneration. The levels of remuneration should be sufficient to attract, retain and motivate directors of the quality required to run the company successfully, but a company should avoid paying more than is necessary for this purpose. A significant proportion of executive director's remuneration should be structured so as to link rewards to corporate and individual performance. *Compliant; remuneration was paid in line with agreed NHS reward schemes.*

D.2 Remuneration Procedure. There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding his or her own remuneration. *Compliant. Remuneration for executives was set by the remuneration committee, not by individual directors.*

Code schedule A. The design of performance-related remuneration for executive directors, was not applicable under NHS schemes.

Relations with Shareholders

E.1 Dialogue with Shareholders. There should be a dialogue with shareholders based on the mutual understanding of objectives. The board as a whole has responsibility for ensuring that a satisfactory dialogue with shareholders takes place. *Compliant; there were no shareholders but the organisation was accountable to the public for its activities and engaged patients, stakeholder organisations and the public in planning its objectives; particularly when considering larger scale service changes where it had a duty to consult.*

E.2 Constructive use of the AGM. The board should use the AGM to communicate with investors and encourage their participation. *Compliant; there were no investors however, patients, stakeholder organisations and the public were encouraged to participate.*

3. The risk and control framework

The system of internal control was designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it could therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control was in place in the West Sussex PCT throughout the year ended 31 March 2013 when the PCT closed.

The NHS Sussex Board operated a harmonised risk management processes across the component PCTs. The risk management strategy was approved and reported to the Board. Risk management training was made available to all staff, was mandatory and an update was required to be attended every two years. A full range of health and safety and other mandatory training packages were made available to all relevant staff. Records of attendances were kept and collated for reporting purposes

In line with the Risk Management Strategy the risk and control framework was designed to focus management attention on risks at the appropriate level in the organisation. In particular it was designed to set the most significant risks before the Board and its committees in order that resources could be applied to adjust controls that prevented or mitigated the risks, and to gain assurances that those controls were effective. The key components of the risk management system including the method of risk assessment, directorate risk registers, corporate risk register and the assurance framework were described clearly in the PCT's Risk Management Strategy. Risk assessment enabled effective mitigating actions to be devised and encouraged the proactive identification and prevention both of manifest risks and also of potential risks. Risk deterrents were also in place, for example through the work of counter fraud.

The Board used an assurance framework to present high level risks with a score of 15 or above to the Board. This assurance framework was populated and reviewed at a lower level by the executive and by CCG committees with responsibility for governance. The assurance framework was developed to provide assurance to the Board that the systems, policies and people it had put in place were operating in a way that was effective in driving the delivery of objectives by focusing on preventing and minimising risk. It ensured that the Board was informed of the principal risks which faced the organisation together with action plans to address them. It was a regularly updated or 'live' document linked to the more detailed corporate and departmental risk registers and to key business planning documents for the PCT. The assurance framework identified for each strategic objective of the Board:-

- The principal risks, being the highest risks in the corporate risk register.
- The key controls to assist in managing the risk to secure the achievement of the objective.
- The sources of evidence on which reliance of the effectiveness of the systems was placed.
- The detailed assurances obtained showing the evidence presented to the Board. Included in the detailed assurances were internal assurances on the effectiveness of systems, from the Board committees and staff, from Internal Audit and from external bodies; the Audit Commission, NHS Litigation Authority, Care Quality Commission, etc.
- Any gaps in control i.e. systems not in place
- Any gaps in assurance i.e. systems in place but evidence not available.
- The detail of actions put in place to mitigate the risk including relevant milestones and target dates for removal.
- Progress on the actions
- Most recent review date
- Target removal date
- Executive Ownership

4. Risk assessment

The PCT recognised that it is not possible to totally eliminate all risks and that systems of control should not be so rigid that they stifle imaginative use of limited resources in order to provide an effective service. However, in order to establish a consistent framework for the assessment and management of risk, the organisation adapted a standard risk assessment tool from the National Patient Safety Agency and determined the levels of authority at which risks should be addressed. This provided a consistent approach across all of the different types of assessment that were undertaken and all identified risks were brought to the attention of Line Managers who had responsibility for making an initial assessment of the risk.

The organisation determined that those risks identified as having a total score of 11 (moderate) or below would be regarded as risks managed at team/department level by Line Managers. These risks were considered small enough to have an immaterial effect on the organisation's objectives or controlled effectively in order to minimise adverse consequences.

Those risks identified as scoring 12+ (high) or above were regarded as significant risks or where a manager could not immediately introduce control measures to reduce the level of risk to an acceptable level, these were notified within the organisation to an appropriate Director who determined how the risk would be addressed. Moderated risks with a score of 12+ formed part of the corporate risk register.

Risks determined with a score of 15+ as moderated by appropriate Directors were escalated to the assurance framework for attention of the Board.

The organisational risk profile was made clear through assurance framework reports presented at each ordinary Board meeting. The reports highlighted the level of risk against principal objectives, including the level of risk, the balance of risks and the trend in risks.

During 2012/13 CCG's have continued to remain under the NHS Sussex Risk System. From 1st April 2013 the CCG's will run their own risk systems under their approved Risk Management Strategies and Risk Management Policy and Procedures. A proposal was approved by the NHS Sussex Audit Committee regarding the closedown process for NHS Sussex risks and the transfer of risks to receiving organisations by 31st March 2013. The following table highlights the key newly identified significant risks in terms of impact and likelihood reported in the final NHS Sussex Board Assurance Framework and the receiving body for these risks.

Key risks included in the Final Assurance Framework, March 2013

Risk No.	Risk description	Risk score	Actions taken
119	There is risk that current breast screening equipment in Worthing will be obsolete before the new West Sussex breast unit is complete.	20	*This risk was subsequently transferred to and accepted by the Surrey and Sussex Area Team, NHS England.*
217	There is a risk of a new strain of influenza pandemic virus developing, and we cannot predict with certainty when it will happen, the epidemiology of an emergent influenza pandemic virus or its clinical behaviour.	20	*This risk was subsequently transferred to and accepted by the Surrey and Sussex Area Team, NHS England, and some of the Sussex CCGs.*
312	There is a risk that there will be insufficient management capacity within the Clinical Commissioning Groups to achieve the scale and scope of change required and this may impact on the delivery of the QIPP plans across Sussex	20	*This risk was subsequently transferred to and accepted by some of the Sussex CCGs.*
314	There is a risk that the centralisation of arterial vascular surgery with 24/7services at BSUH will not be achieved by March 2013	20	*This risk was subsequently transferred to and accepted by the Surrey and Sussex Area Team, NHS England.*
571	DH Guidance relating to the timescales for making retrospective Continuing Healthcare claims has resulted in a significant rise in claims received by PCTs requiring assessment with consequent risk of service disruption.	20	*This risk was subsequently transferred to and accepted by Coastal West Sussex CCG as hosts of the future service.*
140	There is a risk that there is insufficient capacity to deliver core operational processes and there is a delay to operationalization of the Surrey and Sussex Commissioning Support Unit	16	*This risk was subsequently transferred to and accepted by Surrey and Sussex Commissioning Support Unit*

The Board agreed its principle objectives in May 2013 (set out in the table below) describing them as Strategic Goals (SG) and monitored these at every ordinary board meeting until the close of 2012/13.

Strategic Goal 1. Quality, Delivery and Performance
SG1.1 - Deliver the quality and safeguarding responsibilities including the quality standards outlined in the Sussex Plan
SG1.2 - Deliver the performance improvements outlined in the Sussex Plan

SG1.3 - Deliver the financial plans for 12/13 outlined in the 2 year Sussex plan
Strategic Goal 2. Transition SG2.1 - Supporting our staff through the transition and maximising their talents and capabilities SG2.2 - NHS Sussex responsibilities are transferred to successor organisations by end March 2013 SG2.3 - Establish effective Clinical Commissioning Groups and an effective Commissioning Support Service for the future
Strategic Goal 3. Strategy SG3.1 - Deliver the agreed outcomes from Sussex Together SG3.2 - Foster pan-Sussex working arrangements to improve services for patients SG3.3 - Strengthening our strategic partnerships to improve the health and wellbeing of our population
Strategic Goal 4. Health Outcomes SG4.1 - Reduce Health Inequalities within our population SG4.2 - Improve the health and wellbeing of our population

In 2013/14 CCGs will identify and align risks with their principal objectives and govern risks as required under the terms of their authorisation. In 2012/13 NHS Sussex has supported CCGs in establishing their risk management processes.

Information governance incidents

There were no Information Governance (IG) Serious Untoward Incidents (SUI) reported this year as none scored at level 5 on the IG SUI grading matrix (the most serious score on a grading from 1-5).

There was one category 4 Information Governance (IG) Serious Incident (SI) this year which related to confidential information being sent to the wrong recipient by email. The data did not leave the boundaries of the NHS and all data was retrieved.

Summary of Serious Untoward Incidents

Category	Nature of incident	West Sussex PCT
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	0
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	0
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	1
V	Other	0
	Totals for the year	**1**

Information governance incidents of a less significant nature are listed by category in the table below:-

Summary of other personal data related incidents

Category	Nature of incident	West Sussex PCT
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	0
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	0
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	5
V	Other	0
	Totals for the year	**5**

Subject Access Requests were dealt with effectively, within the time constraints set out by the Department of Health. A 'Subject Access Request' (SAR) and 'Caldicott Log' were maintained and updated by the Information Governance Team to keep track of any requests from members of the public and any queries raised by staff about the management of personal information.

Control and risk related to performance indicators

More than sixty key performance indicators were regularly monitored by the Board and past performance reports were available to the public on the NHS Sussex website. These reports included nationally agreed operating targets as 'headline measures' and their 'supporting measures' along with wider targets agreed locally. Performance outcomes for 2012/13 are disclosed in the annual report.

For the purpose of this statement the following table identifies those nationally recognised indicators (headline measures and supporting measures) that did not reach target for the full year 2012/13.

KPI Grouping	**Indicator**		**West Sussex**	
			Full Year Plan	**Full Year Actual**
HCAIs	MRSA Infections		14	17
HCAIs	Clostridium Difficile		252	285
18 weeks	Numbers waiting on an incomplete Referral to Treatment pathway		42,529	47,912

Primary Care	Number of patients receiving NHS primary dental services located within the PCT area within a 24 month period		456,893	433,972
Mental Health	The number of Home Treatment episodes carried out by Crisis Resolution/Home Treatment teams - Reported Cumulatively		1228	1,095
Screening	All Women to receive results of cervical screening tests within 2 weeks		98.0%	95.10%
Screening	SQU27: Coverage of NHS Health Checks - Offered - Reported Cumulatively		18.2%	10.9%
Screening	SQU27: Coverage of NHS Health Checks - screened - reported Cumulatively		8.0%	5.5%
Maternity	Coverage of breast feeding		95.0%	90.21%
Health Improvement	Under 18 conception rate per 1,000 female aged 15 to 17		23	29.1
Health Improvement	Immunisation - Aged 2 immunised for PCV (Sussex Cluster actual and plan is the average of the PCTs, actual cluster performance will be available in Q1 11/12)		95.0%	92.39%
Health Improvement	Immunisation - Aged 2 immunised for Hib/MenC (Sussex Cluster actual and plan is the average of the PCTs, actual cluster performance will be available in Q1 11/12)		96.0%	94.12%
Health Improvement	Immunisation - Aged 5 immunised for DTaP/IPV(Sussex Cluster actual and plan is the average of the PCTs)		96.2%	90.09%
Health Improvement	Immunisation - Aged 5 immunised for MMR (Sussex Cluster actual and plan is the average of the PCTs)		95.0%	87.53%
Health Improvement	Number of 4-week smoking quitters that have attended NHS Stop Smoking Services		2,664	2,356

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

As Accountable Officer, I had responsibility for reviewing the effectiveness of the system of internal control for the financial year ending 31 March 2013. My review was informed in a number of ways. The head of internal audit provided me with an opinion on the overall arrangements for gaining assurance through assessment of the assurance framework and on the controls reviewed as part of the internal auditor's work. Executive managers within the organisation with responsibility for the development and maintenance of the system of internal control provided me with assurance. The assurance framework itself provided me with evidence that the effectiveness of controls that manage the risks to the organisation achieving

its principal objectives were reviewed. My review was also informed by the work of our external auditors, Ernst and Young LLP, particularly in the following areas:

- audit of the financial statements 2012/13
- value for money conclusion 2012/13

And by the work of our internal auditors, South Coast Audit, particularly in the following areas:

- audit of risk and assurance processes 2012/13
- audits supporting the financial statements

In addition, the Head of Internal Audit opinion which states:

"**Significant assurance** can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk."

Internal audit work covered a range of risk-based audit assignments throughout the year. Of the 28 audits and reviews reported against, 1 'Limited' assurance opinion was given, 2 'split' assurance opinions were given and 15 'Significant' assurance opinions were given. A further 10 consultancy and development reviews were undertaken were no assurance opinion was given. The Head of Internal Audit, in reaching an overall assessment for 2012/13 of 'significant assurance' took into account:

- the relative importance of the areas audited and the positive results from the core annual audit work on key financial systems;
- the number of risk based reviews where 'significant' assurance was provided; and
- the 'significant' assurance provided by the development, design and operation of the Board Assurance Framework and associated risk management processes.

Limited assurance was received regarding Commissioning Support Unit (CSU) service requirements were no agreed KPI's or targets were agreed with users of the services to assess performance and delivery.

Recommendations and action plans for these areas were managed through the NHS Sussex system of follow-up and the implementation of audit recommendations was monitored by the Audit Committees. This system gave me assurance that control issues were dealt with effectively by executive directors.

I was advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, and the Audit Committee. A plan to address weaknesses and ensure continuous improvement of the system remained in place until the close of the PCT.

6. Significant Issues

2 areas were identified as significant issues:

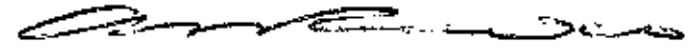
- The non-delivery of national priority headline and supporting measures as set out in section 4. Performance Management processes were in place during 2012/13 to

mitigate performance risks and the PCT has worked with shadow Clinical Commissioning Groups and other receiving organisations to develop future performance management regimes.

- The PCT will receive a qualified value for money conclusion from External Audit. The year end financial position has been reached only by the use of non-recurrent measures and the PCT was not able to demonstrate the required reduction of acute demand and costs planned by the Sussex Together programme. During 2012/13 the PCT worked with shadow Clinical Commissioning Groups in West Sussex to develop appropriate QIPP savings initiatives for 2013/14 and beyond to address the underlying issues.

Accountable Officer: Amanda Fadero

Organisation: West Sussex PCT



7th June 2013

Amanda Fadero, Director, Surrey and Sussex Area Team, NHS England

INDEPENDENT AUDITORS' REPORT TO THE ACCOUNTABLE OFFICER FOR WEST SUSSEX PRIMARY CARE TRUST

We have audited the financial statements of West Sussex Primary Care Trust for the year ended 31 March 2013 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 42. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

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

- the table of salaries and allowances of senior managers and related narrative notes on page 40;
- the table of pension benefits of senior managers and related narrative notes on page 41; and
- narrative notes on pay multiples on page 43.

This report is made solely to the Accountable Officer for West Sussex Primary Care Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Accountable Officer, for our audit work, for this report, or for the opinions we have formed.

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

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

Scope of the audit of the financial statements

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

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

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

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

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of West Sussex 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 on:
  - the level of progress made by the Primary Care Trust in partnership with its main providers to successfully manage acute demand via the Sussex Together programme and associated 2 year financial plan;
  - the recovery plans put in place by the Primary Care Trust to manage its 2012/13 financial position, and the financial planning as part of the transition from Primary Care Trust to clinical commissioning groups; and
  - review of the Primary Care Trust's arrangements and processes to ensure a smooth closedown and effective transition of its functions to successor bodies for 2013/14.

As a result, we have concluded that there is the following matter to report:

The Primary Care Trust has been unable to demonstrate that it has adequate arrangements in place to plan finances effectively to deliver strategic priorities and sound financial health, or to commission and procure quality services and supplies that are tailored to local needs and deliver sustainable outcomes and value for money for the following reasons:

- the Primary Care Trust was not able to demonstrate that it was able to influence its main providers to have a positive effect on acute demand and costs through the Sussex Together programme; and
- financial targets within the health economy for the year ended 31 March 2013 would not have been delivered without support of £44 million from the Strategic Health Authority. The Primary Care Trust could not demonstrate that this funding has been used only for non-recurrent expenditure.

Certificate

We certify that we have completed the audit of the accounts of West Sussex PCT in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Helen Thompson
for and on behalf of Ernst & Young LLP
Southampton
Date: 10 June 2013

NHS
West Sussex

Final Accounts 2012/13

Prepared under International Financial Reporting Standards

NHS West Sussex
Level 4, Lanchester House, Trafalgar Place, Brighton BN1 4FU
Tel: 01273 574745 | Fax: 01273 574737
www.sussex.nhs.uk

FOREWORD TO THE ACCOUNTS

NHS West Sussex
Annual Accounts and Supporting Notes as at 31st March 2013

These accounts for the year ending 31st March 2013 have been prepared by NHS West Sussex under direction of the Secretary of State for Health in exercise of powers conferred on him by Section 232 (Schedule 15, 3(1)) of the National Health Service Act 2006

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	**26,258**	26,944
Other costs	5.1	**2,228,214**	2,122,506
Income	4	**(895,163)**	(824,495)
Net operating costs before interest		**1,359,309**	1,324,955
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	(150)
Finance costs	11	**54**	110
Net operating costs for the financial year		**1,359,363**	1,324,915
Transfers by absorption -(gains)		**0**	
Transfers by absorption - losses		**0**	
Net (gain)/loss on transfers by absorption		**0**	
Net Operating Costs for the Financial Year including absorption transfers		**1,359,363**	**1,324,915**
Of which:			
Administration Costs			
Gross employee benefits	7.1	**24,412**	25,293
Other costs	5.1	**11,214**	20,732
Income	4	**(16,209)**	(25,892)
Net administration costs before interest		**19,417**	**20,133**
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	(150)
Finance costs	11	**0**	110
Net administration costs for the financial year		**19,417**	**20,093**
Programme Expenditure			
Gross employee benefits	7.1	**1,846**	1,651
Other costs	5.1	**2,217,000**	2,101,774
Income	4	**(878,954)**	(798,603)
Net programme expenditure before interest		**1,339,892**	**1,304,822**
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**54**	0
Net programme expenditure for the financial year		**1,339,946**	**1,304,822**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**0**	475
Net (gain) on revaluation of property, plant & equipment	**0**	(273)
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**	
Release of Reserves to Statement of Comprehensive Net Expenditure	**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*	**1,359,363**	**1,325,117**

*This is the sum of the rows above plus net operating costs for the financial year after absorption accounting adjustments.

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	**105,709**	104,753
Intangible assets	13	**0**	61
investment property	15	**0**	0
Other financial assets	21	**0**	0
Trade and other receivables	19	**0**	0
Total non-current assets		**105,709**	104,814
Current assets:			
Inventories	18	**88**	88
Trade and other receivables	19	**20,094**	25,174
Other financial assets	36.1	**0**	0
Other current assets	22	**0**	0
Cash and cash equivalents	23	**438**	280
Total current assets		**20,620**	25,542
Non-current assets held for sale	24	**0**	0
Total current assets		**20,620**	25,542
Total assets		**126,329**	130,356
Current liabilities			
Trade and other payables	25	**(68,176)**	(82,322)
Other liabilities	26,28	**0**	0
Provisions	32	**(965)**	(2,023)
Borrowings	27	**0**	0
Other financial liabilities	36.2	**0**	0
Total current liabilities		**(69,141)**	(84,345)
Non-current assets plus/less net current assets/liabilities		**57,188**	46,011
Non-current liabilities			
Trade and other payables	25	0	0
Other Liabilities	28	0	0
Provisions	32	(8,488)	(4,508)
Borrowings	27	0	0
Other financial liabilities	36.2	0	0
Total non-current liabilities		**(8,488)**	(4,508)
Total Assets Employed:		**48,700**	41,503
Financed by taxpayers' equity:			
General fund		31,860	24,662
Revaluation reserve		16,840	16,840
Other reserves		0	0
Total taxpayers' equity:		**48,700**	41,502

The financial statements on pages 4 to 45 were approved by the Audit Committee on behalf of the Department of Health and signed on 7th June 2013

Chief Executive: **Date: 7th June 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	**24,662**	**16,840**	**0**	**41,502**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(1,359,363)	0	0	**(1,359,363)**
Net gain on revaluation of property, plant, equipment	0	0	0	**0**
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	0	0	**0**
Movements in other reserves	0	0	0	**0**
Transfers between reserves*	0	0	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	**(1,359,363)**	**0**	**0**	**(1,359,363)**
Net Parliamentary funding	1,366,561	0	0	**1,366,561**
Balance at 31 March 2013	**31,860**	**16,840**	**0**	**48,700**
Balance at 1 April 2011	**12142**	**17363**	**0**	**29,505**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(1,324,915)	0	0	(1,324,915)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment	0	273	0	273
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	(475)	0	(475)
Movements in other reserves	0	0	0	0
Transfers between reserves*	321	(321)	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	(1,324,594)	(523)	0	(1,325,117)
Net Parliamentary funding	1,337,114	0	0	1,337,114
Balance at 31 March 2012	**24,662**	**16,840**	**0**	**41,502**

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	**(1,359,309)**	(1,324,955)
Depreciation and Amortisation	**4,822**	4,636
Impairments and Reversals	**6,881**	8,323
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	**0**	0
Release of PFI/deferred credit	**0**	0
(Increase)/Decrease in Inventories	**0**	5
(Increase)/Decrease in Trade and Other Receivables	**5,424**	(4,733)
(Increase)/Decrease in Other Current Assets	**0**	0
Increase/(Decrease) in Trade and Other Payables	**(10,366)**	(13,062)
(Increase)/Decrease in Other Current Liabilities	**0**	0
Provisions Utilised	**(715)**	(3,024)
Increase/(Decrease) in Provisions	**3,524**	2,596
Net Cash Inflow/(Outflow) from Operating Activities	**(1,349,739)**	**(1,330,214)**
Cash flows from investing activities		
Interest Received	**0**	0
(Payments) for Property, Plant and Equipment	**(17,082)**	(9,526)
(Payments) for Intangible Assets	**0**	0
(Payments) for Other Financial Assets	**0**	0
(Payments) for Financial Assets (LIFT)	**0**	0
Proceeds of disposal of assets held for sale (PPE)	**418**	2,678
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)	**0**	0
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	**(16,664)**	**(6,848)**
Net cash inflow/(outflow) before financing	**(1,366,403)**	**(1,337,062)**
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**0**	0
Net Parliamentary Funding	**1,366,561**	1,337,114
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	**1,366,561**	**1,337,114**
Net increase/(decrease) in cash and cash equivalents	**158**	**52**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**280**	**228**
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	**438**	**280**

1. Accounting policies

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

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

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

1.1 Accounting Conventions

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

Acquisitions and Discontinued Operations

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

Critical accounting judgements and key sources of estimation uncertainty

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

Key areas of judgement and uncertainty in the accounts are as follows:

Non-Current Assets:
Fixed assets are depreciated on a straight-line basis over their useful economic life.

Current Assets:
Included in the receivables (see note 19) are a number of prepayments and accrued income. These may inevitably require an element of judgement. Where estimates have been applied, the PCT has adhered to guidance stipulated in the NHS Manual for Accounts and relevant financial standards.

The PCT has considered the likely collectability of its debts and whether a risk provision for doubtful debts should be raised. The PCT has concluded that a provision for doubtful debts is not required for 31st March 2013.

The PCT applies a robust approach to dental contract management and debts for underperformance are enforceable and will be reflected in the financial statements.

Payables:
Trade payables include a number of NHS and non-NHS accruals which will require an element of judgement (see note tbc). Where applicable, the PCT adheres to guidance set out in the NHS Manual for Accounts and relevant financial standards.

For each area of expenditure, the Director of Finance and the Finance teams form a judgement on the extent to which the full amount of the expenditure is reflected in the year and raise accruals as considered appropriate. These judgements are based upon the knowledge of a contract and historic experience of the expenditure.

The Family Health Services (FHS) Payables in note 25 includes an accrual for prescribing. Information in relation to prescribing is sent to the PCT monthly in arrears by the relevant prescribing authorities. This is always at least two months behind the current month. Each month, the PCT has to estimate the year to date expenditure – including at the year end – based on the last set of available data. At the year end, the PCT estimates prescribing expenditure based on 10 months' data, but with information about profiling and extrapolated trends.

The FHS Payables also includes an accrual for dental. The PCT receives information from the Dental Practice Board on a monthly basis. This information is based upon historic data and, accordingly, the PCT is required to estimate the amount of total expenditure for the final months of the financial year.

Primary Care accruals are also included in the FHS Payables. There are two main complex elements of accruing for primary care. The first relates to The Quality and Outcomes Framework (QOF), which is a payment to practices for performance against a set of indicators. The PCT has to collate full year contract monitoring information, and then audit this, before agreeing the total amount of the in-year QOF payment. Inevitably, this involves a significant element of estimation. The PCT has formed a view, as at the time of preparation of the financial statements, on the likely deliverability of improved performance across the practices and this forms the basis of the relevant accrual.

The second key element of the accrual process for the primary care area relates to the provision of enhanced services. These are complex contracts, and they can sometimes extend over a number of years. The PCT collates information from practices which is audited before arrangement is made for payment. This exercise will not be completed by the time of the accounts preparation and the accrual is based on the judgement of the Director of Finance on the likely level of payments required.

Contract Monitoring:
Several of the PCT's contracts with provider Trusts are relatively straightforward as "block" payments are agreed at the start of the year. However, contracts with acute providers can be complex and information in relation to performance on the contracts may not be fully available when the accounts are being prepared. Negotiations take place with the provider Trusts at year-end and payments / accruals for any over-performance are agreed. NHS agreements are binding once made reducing the risk of bad debts / spurious accruals.

The process is facilitated by an NHS Agreement of Balances (AoB) process at year end whereby respective debit/credit balances between NHS bodies are reconciled on a national level.

Provisions:
Provisions (note 32) includes a calculation for pensions for staff who retired early or for injury benefits. The calculation includes Back-to-Back provisions where the PCT 'holds' the provision in respect of relevant staff costs on behalf of NHS Trusts in accordance with standard NHS arrangements. The provisions are calculated based on the life expectancy of the individuals to whom the provisions relate to. As a result, the uncertainty over this life expectancy leads to uncertainty over how long the provision will remain with the PCT. The PCT receives statements from the other local organisations on a yearly basis that details the amount of the provision that is utilised, the portion of the provision that will be unused, and any revised values for the provision based on their

The Provisions figure also includes a calculation for continuing health care (CHC) claims. These are claims from members of the public who assert they have personally paid for health care that should have been provided by the NHS. Some of these claims can be speculative in nature and the PCT must make an estimation of the likely success of the claims received.
A provision of approximately £6.8 million has been created representing the estimated cost of settling 1,262 outstanding claims for retrospective continuing health care funding.

The following judgements and assumptions have been made at NHS Sussex level to arrive at the provisions disclosed in the annual accounts of NHS West Sussex:
• An assessment of success rate has been made based on the historic success rate for claims pan-Sussex of approximately 30 per cent. This has been adjusted to 15 per cent to inform the calculation of the provision as the PCT considers the very considerable increase in volume of claims received in 2012/13 increases the probability of the claims being significantly more speculative than in previous periods.

• Work has been undertaken at NHS Sussex level to show that a significant majority of claims where questionnaires had not been returned as at 31 March 2013 had been received prior to 30 September 2012. The PCT considers these claims were highly likely to be speculative given the length of time between issue of the questionnaire and financial year end. It is therefore considered appropriate to completely discount these claims from the population of claims used to calculate the provision

Going Concern
As a consequence of the Health and Social Care Act 2012, NHS West Sussex dissolved on 31 March 2013. Its functions have transferred to various new or existing public sector entities.

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

As a result, the Board of NHS West Sussex has prepared these financial statements on a going concern basis.

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 Pooled budgets

The PCT has entered into a pooled budget with West Sussex County Council. Under the arrangement funds are pooled under S75 of the NHS Act 2006 for Mental Health Commissioning, Learning Difficulties Services and Telecare activities and a memorandum note to the accounts provides details of the joint income and expenditure.

The Mental Health pool is hosted by West Sussex Primary Care Trust.

The Learning Difficulties and Telecare pools are hosted by West Sussex County Council.

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

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

1.5 Administration and Programme Costs
Treasury has set performance targets in respect of non-frontline expenditure (administration expenditure).
From 2011-12, PCTs therefore analyse and report revenue income and expenditure by "admin and programme"
For PCTs, the Department has defined "admin and programme" in terms of running costs.

The broad definition of running costs includes any cost incurred that is not a direct payment for the provision of healthcare or healthcare related services.
Expense incurred under NHS transition redundancy programmes is however classed as "programme" under Treasury budgetary control arrrangements and so is recorded as such in the financial statements.

1. Accounting policies (continued)

1.6 Property, Plant & Equipment

Recognition

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

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

Valuation

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

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

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

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

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

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

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

Subsequent expenditure

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

1. Accounting policies (continued)

1.7 Intangible Assets

Recognition

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

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:
- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement

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

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

1.8 Depreciation, amortisation and impairments

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

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

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

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)

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

1.10 Government grants
The Treasury FREM referred to in note 1.9 also stipulated that Government Grants should no longer be maintained.

1.11 Non-current assets held for sale

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

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

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

1.12 Inventories
Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

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)

1.16 Employee benefits

Short-term employee benefits

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

Retirement benefit costs

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

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

1.17 Research and Development

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

1.18 Other expenses

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

1.19 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.

1.20 EU Emissions Trading Scheme

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

1. Accounting policies (continued)

1.21 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.

1.22 Leases

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

The PCT as lessee

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

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

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

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

The PCT as lessor

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

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

1.23 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.

1.24 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)

1.25 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.

1.26 Private Finance Initiative (PFI) and NHS LIFT transactions
The PCT has not Private Finance Initiative or NHS LIFT schemes.

1.27 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

2 Operating segments

IFRS 8 Operating Segments. defines an operating segment as a component of an entity:

• that engages in activities from which it may earn revenues and incur expenses (including revenue and expenses generated internally),

• whose operating results are regularly reviewed by the entity's 'chief operating decision maker' to make decisions about resource allocation to the segment and assess its performance, and

• for which discrete financial information is available.

The PCT's chief operating decision maker is the Board. In 2012/13, for the first time, the Director of Finance reported to the Board against the following components. As a consequence, there are no comparative figures for 2011/12:

	Coastal West Sussex CCG **2012-13 £000**	Crawley CCG **2012-13 £000**	Horsham and Mid Sussex CCG **2012-13 £000**	Public Health **2012-13 £000**	NCB / NHS Sussex **2012-13 £000**	Total **2012-13 £000**
Expenditure	**673,927**	**162,367**	**275,430**	**22,407**	**225,178**	**1,359,309**
Surplus/(Deficit)						
Segment surplus/(deficit)	**610**	**233**	**462**	**2,010**	**(2,484)**	**831**
Common costs	**0**	**0**	**0**	**0**	**0**	**(54)**
Surplus/(deficit) before interest	**610**	**233**	**462**	**2,010**	**(2,484)**	**777**
Net Assets						**48,700**

3. Financial Performance Targets

3.1 Revenue Resource Limit

	2012-13 £000	2011-12 £000
The PCTs' performance for the year ended 2012-13 is as follows:		
Total Net Operating Cost for the Financial Year	**1,359,363**	1,324,915
Adjusted for prior period adjustments in respect of errors	**0**	0
Revenue Resource Limit	**1,360,140**	1,325,427
Under/(Over)spend Against Revenue Resource Limit (RRL)	777	512

3.2 Capital Resource Limit

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

	2012-13 £000	2011-12 £000
Capital Resource Limit	**13,769**	11,449
Charge to Capital Resource Limit	**12,598**	11,449
(Over)/Underspend Against CRL	**1,171**	**0**

3.3 Provider full cost recovery duty

The PCT is required to recover full costs in relation to its provider functions.

	2012-13 £000	2011-12 £000
Provider gross operating costs	**0**	0
Provider Operating Revenue	**0**	0
Net Provider Operating Costs	**0**	0
Costs Met Within PCTs Own Allocation	**0**	0
Under/(Over) Recovery of Costs	**0**	0

3.4 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**1,366,561**	1,337,114
Cash Limit	**1,369,261**	1,337,114
Under/(Over)spend Against Cash Limit	**2,700**	**0**

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

	2012-13 £000
Total cash received from DH (Gross)	1,191,984
Less: Trade Income from DH	0
Less/(Plus): movement in DH working balances	0
Sub total: net advances	**1,191,984**
(Less)/plus: transfers (to)/from other resource account bodies (free text note required)	0
Plus: cost of Dentistry Schemes (central charge to cash limits)	32,855
Plus: drugs reimbursement (central charge to cash limits)	141,722
Parliamentary funding credited to General Fund	**1,366,561**

4 Miscellaneous Revenue

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Fees and Charges	**479**	479	0	342
Dental Charge income from Contractor-Led GDS & PDS	**10,837**	0	10,837	10,415
Dental Charge income from Trust-Led GDS & PDS	**150**	0	150	131
Prescription Charge income	**6,832**	0	6,832	6,519
Strategic Health Authorities	**343**	343	0	1,180
NHS Trusts	**14,353**	12,280	2,073	19,837
NHS Foundation Trusts	**1,937**	1,937	0	2,407
Primary Care Trusts Contributions to DATs	**0**	0	0	0
Primary Care Trusts - Other	**0**	0	0	3,358
Primary Care Trusts - Lead Commissioning	**837,870**	989	836,881	766,002
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	**0**	0	0	0
Recoveries in respect of employee benefits	**0**	0	0	0
Local Authorities	**8,520**	0	8,520	917
Patient Transport Services	**0**	0	0	0
Education, Training and Research	**22**	22	0	18
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	0
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	**13,668**	7	13,661	13,356
Other revenue	**152**	152	0	13
Total miscellaneous revenue	**895,163**	**16,209**	**878,954**	**824,495**

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	**64,338**		64,338	54,821
Non-Healthcare	**4,462**	4,462	0	2,691
Total	**68,800**	**4,462**	**64,338**	**57,512**
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	**1,369,091**	1,528	1,367,563	1,279,080
Goods and services (other, excl Trusts, FT and PCT))	**0**	0	0	0
Total	**1,369,091**	**1,528**	**1,367,563**	**1,279,080**
Goods and Services from Foundation Trusts	**282,615**	0	282,615	283,012
Purchase of Healthcare from Non-NHS bodies	**134,406**	0	134,406	125,439
Social Care from Independent Providers	**0**	0	0	0
Expenditure on Drugs Action Teams	**6,074**	0	6,074	5,809
Non-GMS Services from GPs	**1,875**	0	1,875	2,068
Contractor Led GDS & PDS (excluding employee benefits)	**41,683**	0	41,683	39,899
Salaried Trust-Led PDS & PCT DS (excluding employee benefits)	**3,144**	0	3,144	3,127
Chair, Non-executive Directors & PEC remuneration	**30**	30	0	101
Executive committee members costs	**36**	36	0	0
Consultancy Services	**781**	781	0	2,928
Prescribing Costs	**128,197**	0	128,197	135,117
G/PMS, APMS and PCTMS (excluding employee benefits)	**120,898**	0	120,898	115,402
Pharmaceutical Services	**2,309**	0	2,309	2,640
Local Pharmaceutical Services Pilots	**0**	0	0	0
New Pharmacy Contract	**28,754**	0	28,754	27,905
General Ophthalmic Services	**6,838**	0	6,838	6,852
Supplies and Services - Clinical	**888**	0	888	1,032
Supplies and Services - General	**69**	69	0	77
Establishment	**2,077**	2,077	0	2,183
Transport	**108**	108	0	98
Premises	**9,909**	0	9,909	10,180
Impairments & Reversals of Property, plant and equipment	**6,869**	0	6,869	8,323
Impairments and Reversals of non-current assets held for sale	**0**	0	0	0
Depreciation	**4,773**	0	4,773	4,604
Amortisation	**49**	0	49	32
Impairment & Reversals Intangible non-current assets	**12**	0	12	0
Impairment and Reversals of Financial Assets	**0**	0	0	0
Impairment of Receivables	**816**	0	816	0
Inventory write offs	**0**	0	0	0
Research and Development Expenditure	**0**	0	0	0
Audit Fees	**171**	171	0	239
Other Auditors Remuneration	**11**	11	0	38
Clinical Negligence Costs	**221**	221	0	190
Education and Training	**792**	792	0	506
Grants for capital purposes	**1,477**	0	1,477	3,378
Grants for revenue purposes	**0**	0	0	0
Impairments and reversals for investment properties	**0**	0	0	0
Other	**4,441**	928	3,513	4,735
Total Operating costs charged to Statement of Comprehensive Net Expenditure	**2,228,214**	**11,214**	**2,217,000**	**2,122,506**
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	**465**	465	0	791
Other Employee Benefits	**25,793**	23,947	1,846	26,153
Total Employee Benefits charged to SOCNE	**26,258**	**24,412**	**1,846**	**26,944**
Total Operating Costs	**2,254,472**	**35,626**	**2,218,846**	**2,149,450**

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
Analysis of grants reported in total operating costs				
For capital purposes				
Grants to fund Capital Projects - GMS	**0**	0	0	0
Grants to Local Authorities to Fund Capital Projects	**705**	0	705	3,378
Grants to Private Sector to Fund Capital Projects	**0**	0	0	0
Grants to Fund Capital Projects - Dental	**772**	0	772	0
Grants to Fund Capital Projects - Other	**0**	0	0	0
Total Capital Grants	**1,477**	**0**	**1,477**	**3,378**
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	**1,477**	**0**	**1,477**	**3,378**

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**19,417**	18,997	420
Weighted population (number in units)*	**764,904**	764,904	764,904
Running costs per head of population (£ per head)	**25**	**25**	**1**
PCT Running Costs 2011-12			
Running costs (£000s)	**20,093**	19,573	520
Weighted population (number in units)	**764,904**	764,904	764,904
Running costs per head of population (£ per head)	**26**	**26**	**1**

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

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

5.2 Analysis of operating expenditure by expenditure classification

	2012-13	2011-12
	£000	£000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	120,898	115,402
Prescribing costs	128,197	135,117
Contractor led GDS & PDS	41,683	39,899
Trust led GDS & PDS	3,144	3,127
General Ophthalmic Services	6,838	6,852
Department of Health Initiative Funding	0	0
Pharmaceutical services	2,309	2,640
Local Pharmaceutical Services Pilots	0	0
New Pharmacy Contract	28,754	27,905
Non-GMS Services from GPs	1,875	2,068
Other	888	428
Total Primary Healthcare purchased	**334,586**	333,438
Purchase of Secondary Healthcare		
Learning Difficulties	15,127	15,009
Mental Illness	127,237	99,857
Maternity	34,251	34,251
General and Acute	662,426	655,640
Accident and emergency	17,957	16,941
Community Health Services	123,714	112,805
Other Contractual	55,469	40,393
Total Secondary Healthcare Purchased	**1,036,181**	974,896
Grant Funding		
Grants for capital purposes	1,477	3,378
Grants for revenue purposes	0	0
Total Healthcare Purchased by PCT	**1,372,244**	**1,311,712**
PCT self-provided secondary healthcare included above	0	0
Social Care from Independent Providers	0	0
Healthcare from NHS FTs included above	114,521	116,327

6. Operating Leases

The main operating lease contracts are held in relation to Primary Care properties. The largest single Lease is for Steyning Health Centre held with Horsham District Council.

Included in Note 6.1 below are payments of £1,274k per annum in respect of a number of properties leased from Sussex Partnership NHS Foundation Trust. These properties are leased under a Service Level Agreement with the Trust where six months notice is required to terminate the leases.

The PCT also leases the following:

- Durston House. Office accommodation leased from Anstone Properties. The lease term is four years, commencing September 2008. Annual payments are made of £100k.
- Broadwater Medical Centre. The PCT leases the accommodation from a private landlord and then subleases to the GP practice. The lease term is 20 years, commencing March 2006. The annual payments are £138k.
- Steyning Health Centre. The property is leased from Horsham District Council at an annual rent of £393k. The lease term is 24 years commencing September 2008. The property is subleased to a GP practice. There is an option to extend this lease at the end of the contract.
- Crawley Down Health Centre. The property is leased from GP Group. The lease term is 24 years, commencing September 2007. The Annual Rent is £232k.
- Southgate House Chichester. Leased from Mapeley Steps Limited at an annual rent of £145k. The lease term is six years commencing June 2009.
- A property in Westhampnett Road, Chichester is rented from BNP Paribas Securities Trust Co Ltd. The annual rent is £151k. The lease commenced August 2009 for a term of 15 years.
- Nightingale Primary Care Centre. This property is rented from GP Group at an annual rent of £183k. The lease term is 20 years commencing January 2007.
- A property in West Street, Chichester is rented from Store Property Investments Limited at an annual rent of £109k. The lease term is ten years commencing June 2009.
- Sydney West PCC, Burgess Hill. The property is leased from GPG at an annual rent of £126k. The leased commenced July 2008 and is for 24 years.

There are a number of further leases, all with an annual lease below £100k.

6.1 PCT as lessee

	Land	Buildings	Other	2012-13 Total	2011-12
	£000	£000	£000	£000	£000
Payments recognised as an expense					
Minimum lease payments	**0**	**2,636**	**0**	**2,636**	3,713
Contingent rents	**0**	**0**	**0**	**0**	0
Sub-lease payments	**0**	**0**	**0**	**0**	0
Total	**0**	**2,636**	**0**	**2,636**	**3,713**
Payable:					
No later than one year		**2,184**	**0**	**2,184**	2,562
Between one and five years		**6,253**	**0**	**6,253**	8,032
After five years		**15,598**	**0**	**15,598**	15,599
Total	**0**	**24,035**	**0**	**24,035**	**26,193**
Total future sublease payments expected to be received				0	0

The PCT transferred its provider service to Sussex Community NHS Trust (SCT) in 2009/10. However, it still holds the assets relating to the services provided by SCT. The PCT has a Memorandum of Understanding with the Trust for use of the buildings. The income relating to the payments made by SCT for use of the building is recognised as an Operating Lease following a review of the relevant accounting standards - IAS 16 Property, Plant and Equipment, IAS 17 Leases and IFRIC 12 Service Concession Arrangements. The total income from SCT in 2012/13 was £9.4m.

The largest amounts by value relate to Crawley Hospital, Bognor Regis War Memorial Hospital and Horsham Hospital.

6.2 PCT as lessor

	2012-13	2011-12
	£000	£000
Recognised as income		
Rental Revenue	**13,668**	13,356
Contingent rents	**0**	0
Total	**13,668**	13,356
Receivable:		
No later than one year	**14,052**	11,739
Between one and five years	**56,208**	8,024
After five years	**70,260**	18,025
Total	**140,520**	37,788

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	**19,456**	17,944	1,512	**17,714**	16,202	1,512	**1,742**	1,742	0
Social security costs	**1,631**	1,493	138	**1,626**	1,488	138	**5**	5	0
Employer Contributions to NHS BSA - Pensions Division	**2,312**	2,116	196	**2,304**	2,108	196	**8**	8	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	**2,859**	2,859	0	**2,859**	2,859	0	**0**	0	0
Total employee benefits	**26,258**	**24,412**	**1,846**	**24,503**	**22,657**	**1,846**	**1,755**	**1,755**	**0**
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	**26,258**	**24,412**	**1,846**	**24,503**	**22,657**	**1,846**	**1,755**	**1,755**	**0**
Employee costs capitalised	**0**	0	0	**0**	0	0	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**26,258**	**24,412**	**1,846**	**24,503**	**22,657**	**1,846**	**1,755**	**1,755**	**0**
Recognised as:									
Commissioning employee benefits	**26,258**			**24,503**			**1,755**		
Provider employee benefits	**0**			**0**			**0**		
Gross Employee Benefits excluding capitalised costs	**26,258**			**24,503**			**1,755**		

	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 - Revenue									
Salaries and wages	**0**	0	0	**0**	0	0	**0**	0	0
Social Security costs	**0**	0	0	**0**	0	0	**0**	0	0
Employer Contributions to NHS BSA - Pensions Division	**0**	0	0	**0**	0	0	**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	**0**	0	0	**0**	0	0	**0**	0	0
TOTAL excluding capitalised costs	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	**22,842**	22,085	757
Social security costs	**1,645**	1,640	5
Employer Contributions to NHS BSA - Pensions Division	**2,430**	2,423	7
Other pension costs	**0**	0	0
Other post-employment benefits	**0**	0	0
Other employment benefits	**0**	0	0
Termination benefits	**27**	27	0
Total gross employee benefits	**26,944**	**26,175**	**769**
Less recoveries in respect of employee benefits	**0**	0	0
Total - Net Employee Benefits including capitalised costs	**26,944**	**26,175**	**769**
Employee costs capitalised	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**26,944**	**26,175**	**769**
Recognised as:			
Commissioning employee benefits	**26,944**		
Provider employee benefits	**0**		
Gross Employee Benefits excluding capitalised costs	**26,944**		

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	**9**	9	0	**10**	10	0
Ambulance staff	**1**	1	0	**2**	2	0
Administration and estates	**488**	449	39	**603**	571	32
Healthcare assistants and other support staff	**0**	0	0	**0**	0	0
Nursing, midwifery and health visiting staff	**22**	22	0	**21**	21	0
Nursing, midwifery and health visiting learners	**0**	0	0	**0**	0	0
Scientific, therapeutic and technical staff	**14**	13	1	**14**	14	0
Social Care Staff	**0**	0	0	**0**	0	0
Other	**0**	0	0	**0**	0	0
TOTAL	**534**	**494**	**40**	**650**	**618**	**32**
Of the above - staff engaged on capital projects	**0**	0	0	**0**	0	0

During 2012/13, there were no retirements due to ill health (2011/12 - nil).

7.3 Exit Packages agreed during 2012-13

	2012-13			2011-12		
Exit package cost band (including any special payment element)	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band
	Number	Number	Number	Number	Number	Number
Lees than £10,000	4	0	**4**	2	0	**2**
£10,001-£25,000	14	0	**14**	3	0	**3**
£25,001-£50,000	9	0	**9**	29	0	**29**
£50,001-£100,000	13	0	**13**	5	0	**5**
£100,001 - £150,000	1	0	**1**	3	0	**3**
£150,001 - £200,000	4	0	**4**	0	0	**0**
>£200,000	0	0	**0**	0	0	**0**
Total number of exit packages by type (total cost	45	0	**45**	**42**	0	**42**
	£s	**£s**	**£s**	**£s**	**£s**	**£s**
Total resource cost	2,319,615	0	**2,319,615**	1,529,000	0	**1,529,000**

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

7.4 Pension costs

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

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	**36,260**	**187,951**	39,348	183,988
Total Non-NHS Trade Invoices Paid Within Target	**34,741**	**178,974**	37,042	160,450
Percentage of NHS Trade Invoices Paid Within Target	95.81%	95.22%	94.14%	87.21%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**6,257**	**2,497,073**	6,646	2,228,401
Total NHS Trade Invoices Paid Within Target	**5,642**	**2,475,079**	5,425	2,152,767
Percentage of NHS Trade Invoices Paid Within Target	90.17%	99.12%	81.63%	96.61%

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 against the PCT under this legislation in either 2011/12 or 2012/13.

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	0	0	0	0
LIFT: loan interest receivable	0	0	0	0
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	0	0	0	0
Total investment income	0	0	0	0

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	150
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	0	0	0	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	0	0	0	150

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	0	0	0	0
- contingent finance cost	0	0	0	0
Interest on late payment of commercial debt	0	0	0	0
Other interest expense	0	0	0	0
Total interest expense	0	0	0	0
Other finance costs	0	0	0	0
Provisions - unwinding of discount	54		54	110
Total	54	0	54	110

12.1 Property, plant and equipment

2012-13	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:									
At 1 April 2012	**23,176**	**96,598**	**0**	**871**	**1,635**	**31**	**2,664**	**0**	**124,975**
Additions of Assets Under Construction				0					**0**
Additions Purchased	0	13,024	0		0	0	278	0	**13,302**
Additions Donated	0	0	0	0	0	0	0	0	**0**
Additions Government Granted	0	0	0	0	0	0	0	0	**0**
Additions Leased	0	0	0		0	0	0	0	**0**
Reclassifications	0	853	0	(871)	18	0	0	0	**0**
Reclassifications as Held for Sale	(375)	(376)	0	0	0	0	0	0	**(751)**
Disposals other than for sale	0	0	0	0	0	0	0	0	**0**
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	**0**
Impairments/negative indexation	0	0	0	0	0	0	0	0	**0**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	**0**
At 31 March 2013	**22,801**	**110,099**	**0**	**0**	**1,653**	**31**	**2,942**	**0**	**137,526**
Depreciation									
At 1 April 2012	**10**	**17,827**	**0**	**0**	**440**	**11**	**1,934**	**0**	**20,222**
Reclassifications	0	0	0		0	0	0	0	**0**
Reclassifications as Held for Sale	0	(47)	0		0	0	0	0	**(47)**
Disposals other than for sale	0	0	0		0	0	0	0	**0**
Upward revaluation/positive indexation	0	0	0		0	0	0	0	**0**
Impairments	1,042	11,274	0	0	191	31	1,059	0	**13,597**
Reversal of Impairments	0	(6,111)	0	0	(90)	(16)	(511)	0	**(6,728)**
Charged During the Year	0	4,178	0		130	5	460	0	**4,773**
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	**0**
At 31 March 2013	**1,052**	**27,121**	**0**	**0**	**671**	**31**	**2,942**	**0**	**31,817**
Net Book Value at 31 March 2013	**21,749**	**82,978**	**0**	**0**	**982**	**0**	**0**	**0**	**105,709**
Purchased	21,619	81,886	0	0	982	0	0	0	**104,487**
Donated	130	1,092	0	0	0	0	0	0	**1,222**
Government Granted	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2013	**21,749**	**82,978**	**0**	**0**	**982**	**0**	**0**	**0**	**105,709**
Asset financing:									
Owned	21,749	82,978	0	0	982	0	0	0	**105,709**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2013	**21,749**	**82,978**	**0**	**0**	**982**	**0**	**0**	**0**	**105,709**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	**2,011**	**14,830**	**0**	**0**	**0**	**0**	**0**	**0**	**16,841**
Movements	0	0	0	0	0	0	0	0	**0**
At 31 March 2013	**2,011**	**14,830**	**0**	**0**	**0**	**0**	**0**	**0**	**16,841**

Additions to Assets Under Construction in 2012-13

	£000
Land	0
Buildings excl Dwellings	0
Dwellings	0
Plant & Machinery	0
Balance as at YTD	**0**

12.2 Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	**£000**
Cost or valuation:									
At 1 April 2011	**23,740**	**79,284**	**0**	**6,930**	**1,635**	**31**	**2,570**	**0**	**114,190**
Additions - purchased	100	13,492	0	0	0	0	382	0	**13,974**
Additions - donated	0	0	0	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	5,872	0	(6,059)	0	0	187	0	**0**
Reclassified as held for sale	(664)	(2,050)	0	0	0	0	0	0	**(2,714)**
Disposals other than by sale	0	0	0	0	0	0	0	0	**0**
Revaluation & indexation gains	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	(475)	0	**(475)**
Reversals of impairments	0	0	0	0	0	0	0	0	**0**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluatio	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**23,176**	**96,598**	**0**	**871**	**1,635**	**31**	**2,664**	**0**	**124,975**
Depreciation									
At 1 April 2011	**0**	**6,228**	**0**		**304**	**6**	**1,217**	**0**	**7,755**
Reclassifications		0	0		0	0	0	0	**0**
Reclassifications as Held for Sale	0	0	0		0	0	0	0	**0**
Disposals other than for sale	0	(187)	0		0	0	0	0	**(187)**
Upward revaluation/positive indexation	0	0	0		0	0	(273)	0	**(273)**
Impairments	10	7,891	0	0	0	0	422	0	**8,323**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Charged During the Year	0	3,895	0		136	5	568	0	**4,604**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluatio	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**10**	**17,827**	**0**	**0**	**440**	**11**	**1,934**	**0**	**20,222**
Net Book Value at 31 March 2012	**23,166**	**78,771**	**0**	**871**	**1,195**	**20**	**730**	**0**	**104,753**
Purchased	23,036	78,671	0	871	1,195	20	730	0	**104,523**
Donated	130	100	0	0	0	0	0	0	**230**
Government Granted	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**23,166**	**78,771**	**0**	**871**	**1,195**	**20**	**730**	**0**	**104,753**
Asset financing:									
Owned	23,166	78,771	0	871	1,195	20	730	0	**104,753**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**23,166**	**78,771**	**0**	**871**	**1,195**	**20**	**730**	**0**	**104,753**

13.1 Intangible non-current assets

2012-13	Software internally generated £000	Software purchased £000	Licences & trademarks £000	Patents £000	Development expenditure £000	Total £000
At 1 April 2012	**0**	**121**	**0**	**0**	**290**	**411**
Additions - purchased	0	0	0	0	0	**0**
Additions - internally generated	0	0	0	0	0	**0**
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**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation & indexation gains	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	**0**
In-year transfers to/from NHS bodies	0	0	0	0	0	**0**
At 31 March 2013	**0**	**121**	**0**	**0**	**290**	**411**
Amortisation						
At 1 April 2012	**0**	**60**	**0**	**0**	**290**	**350**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation or indexation gains	0	0	0	0	0	**0**
Impairments charged to operating expenses	0	53	0	0	0	**53**
Reversal of impairments charged to operating expenses	0	(41)	0	0	0	**(41)**
Charged during the year	0	49	0	0	0	**49**
In-year transfers to NHS bodies	0	0	0	0	0	**0**
At 31 March 2013	**0**	**121**	**0**	**0**	**290**	**411**
Net Book Value at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**
Net Book Value at 31 March 2013 comprises						
Purchased	0	0	0	0	0	**0**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	**0**
Total at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**

Revaluation reserve balance for intangible non-current assets

	Software internally generated £000's	Software purchased £000's	Licences & trademarks £000's	Patents £000's	Development expenditure £000's	Total £000's
At 1 April 2012	**0**	**0**	**0**	**0**	**0**	**0**
Movements	0	0	0	0	0	**0**
At 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**

13.2 Intangible non-current assets

2011-12	Software internally generated	Software purchased	Licences & trademarks	Patents	Development expenditure	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2011	**0**	**121**	**0**	**0**	**290**	**411**
Additions - purchased	0	0	0	0	0	**0**
Additions - internally generated	0	0	0	0	0	**0**
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	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation & indexation gains	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	**0**
Reversal 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 revaluation	0	0	0	0	0	**0**
At 31 March 2012	**0**	**121**	**0**	**0**	**290**	**411**
Amortisation						
At 1 April 2011	**0**	**28**	**0**	**0**	**290**	**318**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation or indexation gains	0	0	0	0	0	**0**
Impairments charged to operating expenses	0	0	0	0	0	**0**
Reversal of impairments charged to operating expenses	0	0	0	0	0	**0**
Charged during the year	0	32	0	0	0	**32**
In-year transfers to NHS bodies	0	0	0	0	0	**0**
Less cumulative dep written down on revaluation	0	0	0	0	0	**0**
At 31 March 2012	**0**	**60**	**0**	**0**	**290**	**350**
Net Book Value at 31 March 2012	**0**	**61**	**0**	**0**	**0**	**61**
Net Book Value at 31 March 2012 comprises						
Purchased	0	61	0	0	0	**61**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	**0**
Total at 31 March 2012	**0**	**61**	**0**	**0**	**0**	**61**

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
Loss as a result of catastrophe	0		0
Other	0		0
Changes in market price	6,869		6,869
Total charged to Annually Managed Expenditure	**6,869**		**6,869**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Loss or damage resulting from normal operations	0		
Over Specification of Assets	0		
Abandonment of assets in the course of construction	0		
Unforeseen obsolescence	0		
Loss as a result of catastrophe	0		
Other	0		
Changes in market price	0		
Total impairments for PPE charged to reserves	**0**		
Total Impairments of Property, Plant and Equipment	**6,869**	**0**	**6,869**
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
Loss as a result of catastrophe	0		0
Other	0		0
Changes in market price	12		12
Total charged to Annually Managed Expenditure	**12**		**12**
Intangible Assets impairments and reversals charged to the Revaluation Reserve			
Loss or damage resulting from normal operations	0		
Over-specification of assets	0		
Abandonment of assets in the course of construction	0		
Unforeseen obsolescence	0		
Loss as a result of catastrophe	0		
Other	0		
Changes in market price	0		
Total impairments for Intangible Assets charged to Reserves	**0**		
Total Impairments of Intangibles	**12**	**0**	**12**
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
Other	0		0
Total charged to Annually Managed Expenditure	**0**		**0**
Financial Assets impairments and reversals charged to the Revaluation Reserve			
Loss or damage resulting from normal operations	0		
Loss as a result of catastrophe	0		
Other	0		
TOTAL impairments for Financial Assets charged to reserves	**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
Loss as a result of catastrophe	0		0
Other	0		0
Changes in market price	0		0
Total charged to Annually Managed Expenditure	**0**		**0**
Total impairments of non-current assets held for sale	**0**	**0**	**0**
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
Loss as a Result of a Catastrophe	0		0
Other (Free text note required)*	0		0
Changes in Market Price	0		0
Total charged to Annually Managed Expenditure	**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
Loss as a Result of a Catastrophe	0		0
Other (Free text note required)*	0		0
Changes in Market Price	0		0
Total charged to Annually Managed Expenditure	**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		
Over Specification of Assets	0		
Abandonment of Assets in the Course of Construction	0		
Unforeseen Obsolescence	0		
Loss as a Result of a Catastrophe	0		
Other (Free text note required)*	0		
Changes in Market Price	0		
TOTAL impairments for Investment Property charged to Reserves	**0**		
Total Investment Property Impairments	**0**	**0**	**0**
Total Impairments charged to Revaluation Reserve	0		
Total Impairments charged to SoCNE - DEL	0	0	0
Total Impairments charged to SoCNE - AME	6,881		6,881
Overall Total Impairments	**6,881**	**0**	**6,881**
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

	31 March 2013 £000	31 March 2012 £000
At fair value		
Balance at 1 April 2012	**0**	0
Additions Through Subsequent Expenditure	**0**	0
Other Acquisitions	**0**	0
Disposals	**0**	0
Property Reclassified as Held for Sale	**0**	0
Loss from Fair Value Adjustments - Impairments	**0**	0
Gain from Fair Value Adjustments - Reversal of Impairments	**0**	
Gain from Fair Value Adjustments	**0**	0
Transfers (to)/from Other Public Sector Bodies	**0**	
Other Changes	**0**	0
Balance at 31 March 2013	**0**	0
Investment property capital transactions in 2012-13		
Capital expenditure	**0**	0
Capital income	**0**	0
	0	0

16 Commitments

16.1 Capital commitments

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

	31 March 2013 £000	31 March 2012 £000
Property, plant and equipment	**0**	5,868
Intangible assets	**0**	0
Total	**0**	5,868

16.2 Other financial commitments

The trust has entered into non-cancellable contracts (which are not leases or PFI contracts or other service

	31 March 2013 £000	31 March 2012 £000
Not later than one year	**0**	0
Later than one year and not later than five year	**0**	0
Later than five years	**0**	0
Total	**0**	0

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	269	0	4,454	0
Balances with Local Authorities	4,286	0	3,570	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	9,501	0	14,205	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	6,038	0	45,947	0
At 31 March 2013	**20,094**	**0**	**68,176**	**0**
prior period:				
Balances with other Central Government Bodies	6,094	0	4,265	0
Balances with Local Authorities	3,062	0	4,669	0
Balances with NHS Trusts and Foundation Trusts	9,190	0	25,272	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	6,828	0	48,116	0
At 31 March 2012	**25,174**	**0**	**82,322**	**0**

18 Inventories

	Drugs £000	Consumables £000	Energy £000	Work in progress £000	Loan Equipment £000	Other £000	Total £000
Balance at 1 April 2012	**0**	**88**	**0**	**0**	**0**	**0**	**88**
Additions	0	88	0	0	0	0	**88**
Inventories recognised as an expense in the period	0	(88)	0	0	0	0	**(88)**
Write-down of inventories (including losses)	0	0	0	0	0	0	**0**
Reversal of write-down previously taken to SoCNE	0	0	0	0	0	0	**0**
Transfers (to)/from other public sector bodies	0	0	0	0	0	0	**0**
Balance at 31 March 2013	**0**	**88**	**0**	**0**	**0**	**0**	**88**

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	**8,630**	12,977	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**1,139**	2,307	**0**	0
Non-NHS receivables - revenue	**5,350**	2,540	**0**	0
Non-NHS receivables - capital	**344**	0	**0**	0
Non-NHS prepayments and accrued income	**2,200**	6,796	**0**	0
Provision for the impairment of receivables	**(816)**	0	**0**	0
VAT	**927**	278	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	**0**	0	**0**	0
Interest receivables	**0**	0	**0**	0
Finance lease receivables	**0**	0	**0**	0
Operating lease receivables	**0**	0	**0**	0
Other receivables	**2,320**	276	**0**	0
Total	**20,094**	25,174	**0**	0
Total current and non current	**20,094**	25,174		
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	**7,969**	7,750
By three to six months	**2,988**	2,591
By more than six months	**39**	3,034
Total	**10,997**	13,375

19.3 Provision for impairment of receivables

	2012-13 £000	**2011-12 £000**
Balance at 1 April 2012	**0**	(107)
Amount written off during the year	**0**	107
Amount recovered during the year	**0**	0
(Increase)/decrease in receivables impaired	**(816)**	0
Balance at 31 March 2013	**(816)**	0

20 NHS LIFT investments

	Loan £000	Share capital £000	Total £000
Balance at 1 April 2012	**0**	**0**	**0**
Additions	**0**	**0**	**0**
Disposals	**0**	**0**	**0**
Loan repayments	**0**	**0**	**0**
Revaluations	**0**	**0**	**0**
Loans repayable within 12 months	**0**	**0**	**0**
Balance at 31 March 2013	**0**	**0**	**0**
Balance at 1 April 2011	0	0	0
Additions	0	0	0
Disposals	0	0	0
Loan repayments	0	0	0
Revaluations	0	0	0
Loans repayable within 12 months	0	0	0
Balance at 31 March 2012	**0**	**0**	**0**

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	**0**	0
Additions	0	0
Revaluation	0	0
Impairments	0	0
Impairment Reversals	0	0
Transferred to current financial assets	0	0
Disposals	0	0
Transfers (to)/from Other Public Sector Bodies in year	0	0
Total Other Financial Assets - Non Current	**0**	0

21.3 Other Financial Assets - Capital Analysis

	31 March 2013 £000	31 March 2012 £000
Capital Expenditure	**0**	0
Capital Income	**0**	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	**280**	228
Net change in year	**158**	52
Closing balance	**438**	280
Made up of		
Cash with Government Banking Service	**438**	276
Commercial banks	**0**	4
Cash in hand	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**438**	280
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**438**	280
Patients' money held by the PCT, not included above	**0**	0

24 Non-current assets held for sale

	Land	Buildings, excl. dwellings	Dwellings	Asset Under Construction and Payments on Account	Plant and Machinery	Transport and Equipment	Information Technology	Furniture and Fittings	Intangible Assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Balance at 1 April 2012	0	0	0	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	375	329	0	0	0	0	0	0	0	**704**
Less assets sold in the year	(375)	(329)	0	0	0	0	0	0	0	**(704)**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	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	0	0	**0**
Transfers (to)/from other public sector bodies	0	0	0	0	0	0	0	0	0	**0**
Revaluation	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
										0
Balance at 1 April 2011	0	0	0	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	664	2,050	0	0	0	0	0	0	0	**2,714**
Less assets sold in the year	(664)	(2,050)	0	0	0	0	0	0	0	**(2,714)**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	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	0	0	**0**
Balance at 31 March 2012	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2012	0	0	0	0	0	0	0	0	0	**0**

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

At 31 March 2012	0
At 31 March 2013	0

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		
NHS payables - revenue	**7,345**	15,739	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**11,200**	13,798	**0**	0
Family Health Services (FHS) payables	**21,346**	23,498		
Non-NHS payables - revenue	**1,776**	11,728	**0**	0
Non-NHS payables - capital	**2,088**	5,868	**0**	0
Non_NHS accruals and deferred income	**20,843**	8,954	**0**	0
Social security costs	**67**	272		
VAT	**0**	0	**0**	0
Tax	**166**	293		
Payments received on account	**0**	0	**0**	0
Other	**3,345**	2,172	0	0
Total	**68,176**	**82,322**	**0**	0
Total payables (current and non-current)	**68,176**	**82,322**		

26 Other liabilities

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
PFI/LIFT deferred credit	**0**	0	**0**	0
Lease incentives	**0**	0	**0**	0
Other	**0**	0	**0**	0
Total	**0**	**0**	**0**	**0**
Total other liabilities (current and non-current)	**0**	**0**		

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		
Bank overdraft - commercial banks	**0**	0		
PFI liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
LIFT liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**0**	0	**0**	0
Other (describe)	**0**	0	**0**	0
Total	**0**	**0**	**0**	**0**
Total other liabilities (current and non-current)	**0**	**0**		

Borrowings/Loans - Payment of Principal Falling Due in:

	DH	Other	Total
	£000s	£000s	£000s
0 - 1 Years	0	0	**0**
1 - 2 Years	0	0	**0**
2 - 5 Years	0	0	**0**
Over 5 Years	0	0	**0**
TOTAL	**0**	**0**	**0**

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	**0**	0	**0**	0
Deferred income addition	**0**	0	**0**	0
Transfer of deferred income	**0**	0	**0**	0
Current deferred Income at 31 March 2013	**0**	0	**0**	0
Total other liabilities (current and non-current)	**0**	**0**		

30 Finance lease obligations

The PCT has no Finance Lease obligations.

31 Finance lease receivables as lessor

There are no finance lease receivables

32 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	**6,531**	0	4,343	1,586	0	575	0	0	0	27
Arising During the Year	**7,090**	0	71	0	0	6,772	0	0	274	(27)
Utilised During the Year	**(715)**	0	(140)	0	0	(575)	0	0	0	0
Reversed Unused	**(3,566)**	0	(3,566)	0	0	0	0	0	0	0
Unwinding of Discount	**54**	0	54	0	0	0	0	0	0	0
Change in Discount Rate	**59**	0	59	0	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	**9,453**	**0**	**821**	**1,586**	**0**	**6,772**	**0**	**0**	**274**	**0**
Expected Timing of Cash Flows:										
No Later than One Year	**965**	**0**	**105**	**11**	**0**	**575**	**0**	**0**	**274**	**0**
Later than One Year and not later than Five Years	**7,078**	**0**	**303**	**578**	**0**	**6,197**	**0**	**0**	**0**	**0**
Later than Five Years	**1,410**	**0**	**413**	**997**	**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	0
As at 31 March 2012	0

Pensions relating to “other staff” provisions include “back to back” provisions with provider organisations, where the PCT ‘holds’ the provision in respect of relevant staff costs in accordance with standard NHS arrangements. During 2012/13, the PCT paid off the liability for it's back-to-backs to a number of Trusts. Back to back provisions held with NHS trusts within headings 'Pensions relating to staff' and 'Legal claims' amounted to £3,181k in 2011/12. This figure has fallen to £722k in 2012/13.

The provisions were calculated based on the life expectancy of the individuals to whom the provisions relate to. As a result, the uncertainty over this life expectancy leads to uncertainty over how long the provision will remain with the PCT. The PCT receives statements from the other local organisations on a yearly basis that details the amount of the provision that is utilised, the portion of the provision that will be unused, and any revised values for the provision based on their assumptions of how long the provision will remain.

The continuing care provision has increased significantly during 2012/13. The Department of Health has published guidelines to the public in respect of continuing healthcare funding with set deadlines for claims.
This resulted in a significant increase in claims from the public. These claims are still being assessed by management and the level of provision provided has been set in accordance with accounting standards.

33 Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities		
Equal Pay	**0**	0
Other	**0**	0
Amounts Recoverable Against Contingent Liabilities	**0**	0
Net Value of Contingent Liabilities	**0**	0
Contingent Assets		
Contingent Assets *[give details]*	**0**	0
Net Value of Contingent Assets	**0**	0

34 PFI and LIFT - additional information

N/A - The PCT has no PFI or LIFT schemes.

35 Impact of IFRS Treatment - 2012/13

There are no revenue or capital cost implications impacting on the accounts as a result of IFRS treatment.

36 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.

36.1 Financial Assets	**At 'fair value through profit and loss' £000**	**Loans and receivables £000**	**Available for sale £000**	**Total £000**
Embedded derivatives				
Receivables - NHS	0	9,769	0	**9,769**
Receivables - non-NHS	0	10,325	0	**10,325**
Cash at bank and in hand	0	438	0	**438**
Other financial assets	0	0	0	**0**
Total at 31 March 2013	**0**	**20,532**	**0**	**20,532**
Embedded derivatives				
Receivables - NHS	0	15,284	0	15,284
Receivables - non-NHS	0	9,890	0	9,890
Cash at bank and in hand	0	280	0	280
Other financial assets	0	0	0	0
Total at 31 March 2012	0	25,454	0	25,454

36.2 Financial Liabilities	**At 'fair value through profit and loss' £000**	**Other £000**	**Total £000**
Embedded derivatives			
NHS payables	0	18,545	**18,545**
Non-NHS payables	0	49,631	**49,631**
Other borrowings	0	0	**0**
PFI & finance lease obligations	0	0	**0**
Other financial liabilities	0	0	**0**
Total at 31 March 2013	**0**	**68,176**	**68,176**
Embedded derivatives			
NHS payables	0	29,537	29,537
Non-NHS payables	0	52,785	52,785
Other borrowings	0	0	0
PFI & finance lease obligations	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2012	**0**	82,322	82,322

37 Related party transactions

During the year none of the Department of Health Ministers or parties related to any of them, has undertaken any material transactions with the PCT. Claire Quigley (PCT Director of Governance and Transition) was a Governor of Sussex Partnership Foundation Trust, Andrew Foulkes (Medical Director) was a GP Partner with Avisford Medical Group. Details of related party transactions for these individuals are recorded in the table below. During 2012/13 Coastal West Sussex, Crawly and Horsham and Mid Sussex Clinical Commissioning Groups (CCG's) were established in shadow form as sub committees of the Board. The table below records related party transactions with organisations where Governing Body members of shadow CCG's have declared an interest. Where the related party is a General Medical Practice, payments were made under the standard terms and conditions of General Medical Services or Personal Medical Services contracts.

	Payments to Related Party
Claire Quigley, Director of Governance and Transition - Governor of Sussex Partnership Foundation Trust	60,116,475
Charles Everett, Non Executive Director - Trustee of St Michaels Hospice	-
Andrew Foulkes, Medical Director - Partner Avisford Group of Medical Practices	2,199,291
Katie Armstrong, Governing Body Member, Coast West Sussex CCG - Arundel Surgery Medical Practice	1,126,550
Tim Kimber, Governing Body Member, Coast West Sussex CCG - Park Surgery Medical Practice	3,272,728
Eric Wilkinson, Governing Body Member, Coast West Sussex CCG - Southbourne Surgery Medical Practice	1,392,190
Alex MacCallum, Governing Body Member, Coast West Sussex CCG - Riverbank Medical Centre	1,848,340
Alex Rainbow, Governing Body Member, Coast West Sussex CCG - Steyning Health Centre	1,506,966
Howard Bentley, Governing Body Member, Coast West Sussex CCG - The Lyons Practice, Shoreham Health Centre	851,892
Mark Weeks, Governing Body Member, Coast West Sussex CCG - Bersted Green Surgery Medical Practice	1,637,800
Rani Dhillion, Governing Body Member, Coast West Sussex CCG - The Lime Tree Surgery Medical Practice	2,107,891
Stewart Wright, Governing Body Member, Coast West Sussex CCG - Willow Green Surgery Medical Practice	1,333,188
Veronika Cassidy, Governing Body Member, Coast West Sussex CCG - Southbourne SurgeryMedical Practice	1,392,190
David Hopkins, Governing Body Member, Coast West Sussex CCG - Victoria Road Surgey Mediacal Practice	1,434,132
Patrick Feeney, Governing Body Member, Coast West Sussex CCG - Orchard Surgery Medical Practice	1,282,143
Tim Fooks, Governing Body Member, Coast West Sussex CCG - Pulborough Medical Group	3,307,430
Amit Bhargava, Governing Body Member, Crawley CCG - Southgate Medical Group	1,255,308
Laura Hill, Governing Body Member, Crawley CCG - Leacroft Medical Practice	1,626,577
Ketan Kansagra, Governing Body Member, Crawley CCG - Langley Corner Surgery Medical Practice	1,379,292
Jeremy Luke, Governing Body Member, Crawley CCG - Coachmans Medical Centre	1,590,025
Paul Vinson, Governing Body Member, Crawley CCG - Furnace Green Medical Practice	1,350,306
Simon Dean, Governing Body Member, Horsham and Mid Sussex CCG - Park Surgery Medical Practice	3,272,728
Karen Eastman, Governing Body Member, Horsham and Mid Sussex CCG - The Brow Surgery Medical Practice	1,107,405
Ian Holwell, Governing Body Member, Horsham and Mid Sussex CCG - Silverdale Practice	1,418,797
Riz Miarkowski, Governing Body Member, Horsham and Mid Sussex CCG - Park View Health Partnership	900,477
Minesh Patel, Governing Body Member, Horsham and Mid Sussex CCG - Moatfield Surgery	2,053,654

The Department of Health is regarded as a related party. During 2012/13, the 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. The NHS organisations listed below are those where transactions over the year 2012/13 have exceeded £500k:

	£'000
Barts Health NHS Trust	2,143
Birmingham and Solihull	1,135
Brighton and Sussex University Hospitals NHS Trust	413,051
Brighton and Hove City PCT	5,156
Calderdale and Huddersfield NHS Foundation Trust	3,147
Chelsea and Westminster Hospital NHS Foundation Trust	1,311
East Sussex Healthcare NHS Trust	340,477
East Sussex Downs and Weald PCT	1,412
Epsom and St Helier University Hospitals NHS Trust	2,723
Frimley Park Hospital NHS Foundation Trust	1,017
Gloucester Hospitals NHS Foundation Trust	1,282
Guys and St Thomas NHS Foundation Trust	26,490
Imperial College Healthcare NHS Trust	3,216
Kings College Hospital NHS Foundation Trust	11,943
Maidstone and Tunbridge Wells	26,563
Moorfield Eye Hospital NHS Foundation Trust	1,027
North West London Hospitals NHS Trust	690
Portsmouth Hospitals NHS Trust	15,710
Queen Victoria Hospital NHS Foundation Trust	21,152
Royal Free London NHS Foundation Trust	2,626
Royal Surrey Hospital NHS Foundation Trust	13,861
St Georges Healthcare NHS Trust	12,833
Surrey and Borders Partnership NHS Foundation Trust	801
Surrey and Sussex Healthcare NHS Trust	99,044
Sussex Community NHS Trust	137,929
The Royal Marsden NHS Foundation Trust	8,632
The Royal National Orthopaedic Hospital NHS Trust	3,001
University College London NHS Foundation Trust	11,537
University Hospital Southampton NHS Foundation Trust	10,333
West Kent PCT	61,892
Western Sussex Hospitals NHS Trust	309,486

In addition, NHS West Sussex has had a significant number of transactions with other Government Departments and other central and local Government bodies. Most of these transactions have been with West Sussex County Council. Transactions which exceeded £500k were as follows:

	£'000
Horsham District Council	895

38 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	250,000	1
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	0	0
Total losses	250,000	1
Total special payments	0	0
Total losses and special payments	250,000	1

The special payment of £250,000 is in relation to a legal claim which was brought against the PCT in respect of a property scheme which did not go ahead. A settlement has been reached and the PCT agreed to pay £250,000 to close the case. A Settlement Agreement was signed by both parties in March 2013.

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	0	0
Total losses	0	0
Total special payments	0	0
Total losses and special payments	0	0

39 Third party assets

The PCT does not hold any third party assets.

40.1 Mental Health Pooled Fund Memorandum Account

Gross Funding	Cash £'000	Staff £'000	Other £'000	Grant £'000	**Total £'000**		11/12 Total £'000
West Sussex County Council	8,594	0	0	0	**8,594**		8,641
NHS West Sussex	66,608	0	0	0	**66,608**		71,184
Total Funding (a)	75,202	0	0	0	**75,202**	**(a)**	79,825

Expenditure	Cash £'000	Staff £'000	Other £'000	Grant £'000	**Total £'000**		**Cash** 11/12 Total £'000
West Sussex County Council	7,306	0	0	0	**7,306**		5,670
NHS	64,304	173	0	0	**64,477**		65,903
Non-NHS	5,583	0	0	0	**5,583**		5,997
Total Funding (b)	77,193	173	0	0	**77,366**	**(b)**	77,570
Net underspend / (overspend) (a) - (b)	**(2,164)**						2,255

The Mental Health Pool is hosted by NHS West Sussex

40.2 West Sussex Pooled Fund Memorandum Account

Learning Difficulty Partnership Agreement

Gross Funding	Cash £'000	Staff £'000	Other £'000	Grant £'000	**Total £'000**		11/12 Total £'000
West Sussex County Council	54,629	8,353	0	0	**62,982**		61,658
NHS West Sussex	11,977	0	2,483	0	**14,460**		14,900
Total Funding (a)	66,606	8,353	2,483	0	**77,442**	**(a)**	76,558
Expenditure							
Independent Sector	30,820	0	0	0	**30,820**		31,615
Community Support	3,508	0	0	0	**3,508**		3,247
Supported Living	23,235	0	0	0	**23,235**		22,466
Other Commissioned Services	2,399	**0**	0	0	**2,399**		1,474
WSCC In-house Services	3,710	**0**	0	0	**3,710**		10,262
SP Trust	0	**0**	2,483	0	**2,483**		4,200
Section 28a	2,934	8,353	0	0	**11,287**		3,294
	66,606	8,353	2,483	0	**77,442**	**(b)**	76,558
Net underspend / (overspend) (a) - (b)	0	0	0	0	**0**		0

The West Sussex Pooled Fund is hosted by West Sussex County Council

41 Events after the end of the reporting period

NHS West Sussex was abolished as at 31st March 2013 and its resposibilities were split amongst new statutory successor organisations. The bulk of the commissioning responsibilities have been passed to Coastal West Sussex Clinical Commissioning Group (CCG), Horsham and Mid-Sussex CCG and Crawley CCG depending upon the geographical location of the services.

42 Cash Flow Relating to Exceptional Items

There are no cash flows relating to exceptional items

GLOSSARY OF FINANCIAL TERMS

Accruals — An accounting concept. In addition to payments and receipts of cash, adjustment is made for outstanding payments, debts to be collected and stock. This means that the accounts show all of the income and expenditure that related to the financial year.

Assets — An item that has a value in the future. For example, a Receivable (someone who owes money) is an asset, as they will in future pay. A building is an asset, because it houses activity that will provide a future income stream.

Audit — The process of validation of the accuracy, completeness and adequacy of disclosure of financial records.

Capital — Land, buildings, equipment and other long-term assets owned by the Trust, the cost of which exceeds £5,000 and has an expected life of more than one year.

Cash Limit — A limit set by the Department of Health which restricts the amount of cash drawings that the Trust can make in the financial year. There is a combined cash limit for both revenue and capital.

Commissioning — Purchase of healthcare from external service providers (NHS, other public sector, private and voluntary) to meet the needs of the population.

Current Assets — Receivables, stocks, cash or similar, whose value is, or can be converted into, cash within the next twelve months.

Non-Current Assets — Land, buildings, equipment and other long term assets that are expected to have a life of more than one year.

Governance — Governance is the system by which organisations are directed and controlled . It is concerned with how the organisation is run, how it is structured and how it is led. Corporate governance should underpin all that an organisation does. In the NHS, this means it must encompass clinical, financial and organisational aspects.

Gross Operating Costs — This is the total revenue expenditure, including accruals and provisions, incurred in the course of performing all aspects of the Trust's functions during the year.

Intangible Assets — Brand value or some other right (for example, a software licence), which although invisible is likely to derive financial benefit for its owner in the future, and for which you might be willing to pay.

Liabilities — Obligations which the PCT has incurred in the course of business. This includes outstanding payments to suppliers (NHS and non-NHS) as well as obligations arising under longer term arrangements, such as finance leases.

Miscellaneous Income — Income that relates directly to the operating activities of the Trust. This excludes cash voted by Parliament and drawn down by the Trust from the Department of Health, which is credited to the general fund.

Payment by Results — A financial framework in which providers are paid according to the level of activity undertaken. Payment is based on a national tariff.

Practice Based Commissioning — A framework which engages GP practices and other primary care professionals in the redesign of services for the benefit of patients, through the provision of resources, information and support.

Primary Care Trust — Primary care organisations that provide and manage services delivered within the primary and community care sector, as well as commission acute and other services for its population.

Provider	Provision of healthcare from within the Trust to meet the needs of the population.
Resource limit	Expenditure limits are determined for each NHS organisation by the Department of Health for both revenue and capital, which limit the amount that may be expended on revenue purchases, as assessed on an accruals basis (that is, after adjusting for Receivables and payables).
Revenue	Ongoing or recurring running costs or funding for the general provision of services.
Tangible Assets	A sub-classification of non-current assets, which include land, buildings, equipment, and fixtures and fittings.