Department of Health

NHS

Mid Essex Primary Care Trust

2012-13 Annual Report and Accounts

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Mid Essex Primary Care Trust

2012-13 Annual Report

Mid Essex PCT
Annual Report 2012/13

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Foreword from Chair and Chief Executive

Welcome to the Annual Report for 2012/13 for NHS Mid Essex

Mid Essex PCT (known as NHS Mid Essex) is the primary care trust that commissions health services for people living in mid Essex. This report covers the 2012/13 financial year (1 April 2012 to 31 March 2013) – which is the last year of operation of the PCT.

In 2011, we joined forces with NHS North East Essex and NHS West Essex to become a PCT cluster to lead the NHS in north Essex.

In the final year of the PCT, we have continued to work alongside our partners, in particular the emerging Clinical Commissioning Groups (CCGs), to play our part in ensuring the best health outcomes for our patients.

Despite a tough financial climate, NHS Mid Essex achieved the budgeted surplus of **£1m** although this was after utilising £2m of our strategic financial reserve.

In our 2011/12 Annual Report we committed ourselves to the delivery of a Quality Innovation, Productivity & Prevention (QIPP) plan. Together with our health and local authority partners, we have continued to implement this system-wide plan to deliver health care services that keep pace with increasing demand for healthcare and technological change and continue to improve the quality of care despite the tight financial constraints. You can read more about our QIPP achievements in this annual report.

All primary care trusts were disestablished on 31 March 2013 and it is therefore timely to look back and highlight a few of our many achievements over the years including:

- Improvements in the health of community and health services
- Safer services
- Delivery of government targets on waiting times
- Planning strategically and improving the quality of and access to primary care
- Achieving financial balance
- Establishing a successful transition to the new system

On behalf of the whole board we would like to take this opportunity to thank everyone who has contributed over the years to the achievements of the PCT. In particular we must pay tribute to the loyalty and commitment of our staff, also our partners in health, in local government and the community.

Finally we would like to wish the new organisations every success in carrying the NHS forward. There are many successes to build on as well some significant challenges to face.

Dr Pam Donnelly
Chair

Andrew Pike
Chief Executive

Operating and Financial Review

We are required to present an operating and financial review in the context of the Annual Report, which provides the reader with a balanced and comprehensive analysis of the PCT's performance during the year. In accordance with NHS guidelines, this report covers the period from 1 April 2012 to 31 March 2013 and includes an overview of our achievements, details of the PCT's non-financial performance and the financial statements.

About us

NHS Mid Essex is a primary care trust (PCT) for people who live in mid Essex. As your local NHS we are allocated a budget every year for our local population. We use this to plan, develop and commission (buy) healthcare services on your behalf.

Our main functions and responsibilities are to:

- Work with our local population and partners to improve their health and wellbeing.
- Ensure everybody has access to safe, high-quality healthcare services.
- Plan, develop and commission (buy) healthcare services that are appropriate and relevant for the local population in our area so patients have the services they need.
- Manage and coordinate NHS contracts with GPs, dentists, pharmacists, opticians, the ambulance service, specialist services from hospitals and other healthcare providers, community health services, mental health trusts and the voluntary or independent sector.

Mid Essex has a GP-registered population of approximately 379,234 covering the boroughs of Chelmsford, Braintree and District (including Witham and Halstead) Maldon and Dengie and South Woodham Ferrers.

Our place in the NHS

NHS Mid Essex is one of the 13 PCTs in the East of England region. In 2011, along with NHS West and NHS North East Essex, NHS Mid Essex became part of a PCT cluster, NHS North Essex. We are accountable to our local population and to NHS Midlands and East Strategic Health Authority (previously East of England SHA), who monitor and evaluate our performance.

NHS Midlands and East are accountable to the Department of Health, as well as to the local population.

As commissioners, we plan and buy services from other NHS trusts and health care providers such as: Mid Essex Hospital Services NHS Trust and Central Essex Community Services.

We also manage, coordinate and commission services, from GPs, dentists, pharmacists and opticians (who are all independent businesses working under an NHS contract to us).

NHS Mid Essex facts and figures

Location of our headquarters	Swift House, Hedgerows Business Park, Colchester Road Chelmsford, Essex, CM2 5PF
Communities covered	District of Braintree, Chelmsford City and District of Maldon - approximately 520 square miles
Population (GP registered)	379,234
Type of area	Mixed urban and rural, reasonably affluent with pockets of deprivation. Population health above England average but with some health inequalities and differences in life expectancy between some localities.
Budget	£553million
No. of employees	224 (average no. 2012/13)
Clinical Commissioning Groups	Mid Essex Clinical Commissioning Group
No. of GP practices	50
No. of Primary Care Centres	1 North Chelmsford NHS Healthcare Centre Open Monday – Sunday 08.00 – 20.00 a GP led equitable access centre, open seven days a week, 12 hours a day, walk-in appointments)
No. of GP-led health centres	1 As above
No. of community pharmacies	62
No. of opticians' practices	36
No. of dental surgeries	48

Background and changing role of PCT

The creation of NHS North Essex is a form of partnership working that enables us to eliminate duplication, learn from each other and reduce some of the costs associated with the management of three Primary Care Trusts. Each PCT remains a separate statutory body.

Staff are aligned, where possible, to the structures that will take over from April 2013 as a result of national NHS reforms.

Primary Care Trusts will remain accountable until 31 March 2013, when their functions will be taken over by the newly established NHS England, Clinical Commissioning Groups, local authorities, NHS Commissioning Support Unit and NHS Property Services (the NHS Property company). This is the biggest change to how healthcare is delivered

in a generation. GPs and other health professionals will now be working together with experienced NHS managers to decide how commissioning decisions are made.

NHS North Essex has been working with clinicians to help them prepare to take over commissioning of local health services.

From 1 April 2013, the three Clinical Commissioning Groups (CCGs) which will take over in north Essex are:

- West Essex CCG www.westessexccg.nhs.uk
- Mid Essex CCG www.midessexccg.nhs.uk
- North East Essex CCG www.neessexccg.nhs.uk

They underwent a rigorous process to demonstrate readiness to lead commissioning of health services locally - working closely with their local GP member practices and other partners within the NHS, Local Authorities and the community and voluntary sector.

These are part of the changes to the NHS brought about by the Health and Social Care Act 2012. For more details on the Act please see the following link to the Department of Health website: www.dh.gov.uk/health/2012/06/act-explained/

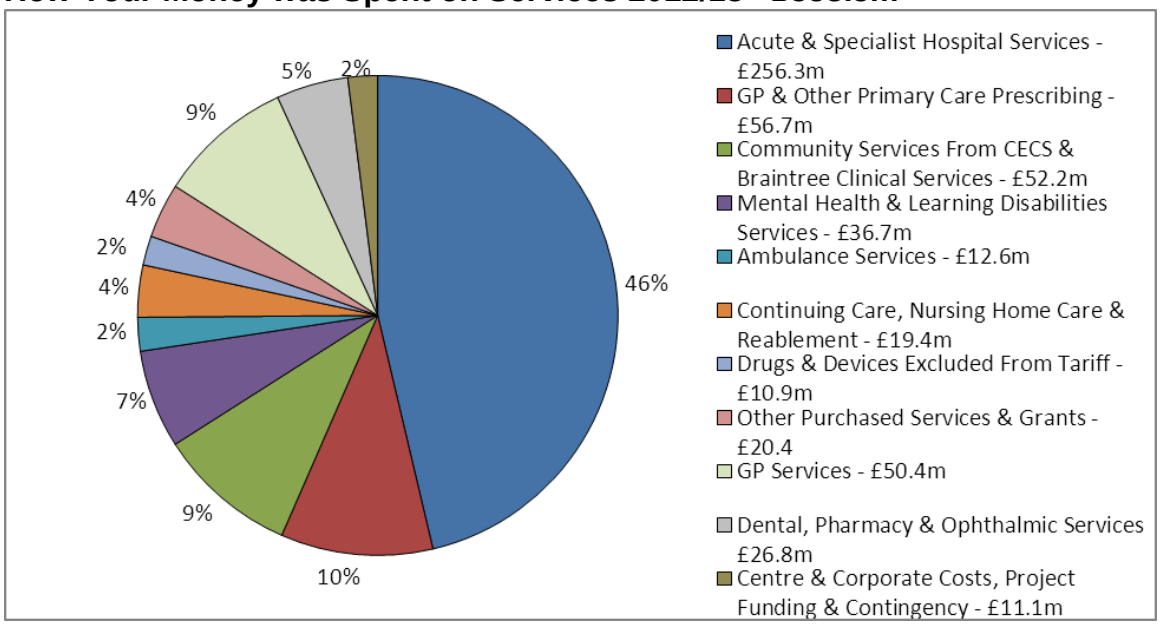
Where we buy your healthcare

The following table gives a summary of where we commissioned services in 2012/13:

Type of healthcare	Where we buy it from on your behalf
Primary care: Your first point of contact for most NHS care.	• Local General Practices • Dentists • Pharmacists • Opticians and • Other provider primary care businesses.
Community services: This includes, district nursing, health visiting, speech and language therapy, podiatry, school nursing.	Central Essex Community Services (CECS), which was formerly the 'provider arm' of the PCT and from 1 April 2011, became a separate Community Interest Company. Service agreements with over 30 voluntary organisations
Hospital services: This includes outpatient clinics, operations and emergency care.	Mid Essex Hospital Services NHS Trust - mainly from Broomfield Hospital. Braintree Clinical Services Limited (at Braintree Community Hospital) Springfield Hospital, Chelmsford Colchester Hospital University NHS Foundation Trust The Princess Alexandra Hospital NHS Trust (Harlow)

Type of healthcare	Where we buy it from on your behalf
	Southend University Hospital NHS Foundation Trust Basildon and Thurrock University Hospitals NHS Foundation Trust Hospitals outside Essex
Mental health services: Includes, for example, psychological therapies, community mental health teams, and learning disability services.	Improving Access to Psychological Therapies (IAPT) – provided by Cambridgeshire and Peterborough NHS Foundation Trust in partnership with Richmond Fellowship. Secondary Care Mental Health services provided by North Essex Partnership University NHS Foundation Trust Learning Disability Assessment and Treatment In-Patient services and Specialist Community LD services provided by Hertfordforshire Partnership NHS Foundation Trust Specialist LD Allied Health Professionals provided by Anglia Community Enterprise
Specialist health services: Includes, for example, treatment for specialist cardiac, renal, children's, neurosciences, specialist cancer services, genetics and many more.	East of England Specialised Commissioning Group commissions these services on our behalf from centres such as: (Great Ormond Street Hospital, Addenbrooke's Hospital, Papworth Hospital, Barts and The London and a wide range of NHS and independent specialised service providers).
Emergency health services and transport.	East of England Ambulance Service NHS Trust Some voluntary organisations

How Your Money was Spent on Services 2012/13 - £553.5m



Our Board

The Board is the accountable body of the PCT and is held to account for the organisation's performance. The Board includes a majority of lay people, known as non-executive directors including the chairman, who ensure that the views of the community are represented, provide independent judgment and ensure good corporate governance and proper husbandry of public funds.

During 2011, the Department of Health made it a requirement for all PCTs to operate as clusters with their neighbouring PCTs, whilst still remaining statutory bodies. NHS North East, NHS Mid and NHS West Essex have been operating with one North Essex Cluster Board covering these PCTs.

Board Members

For the period 1 April 2012 to 31 March 2013 unless otherwise stated follow. Committee membership and governance structural change occurred due to changing of NHS North Essex Cluster directors and the departure of non-executive directors. See Appendix B for committee details.

NHS North Essex – 2012/13 Board Members

Name	Designation	Start Date	End Date
Chris Paveley	Chairman	01/04/2012	31/12/2012
Dr Pamela Donnelly	Non-Executive Director and Chairman	01/04/2012 01/01/2013	31/03/2012 31/03/2013
Dr Qadir Bakhsh	Non-Executive Director	01/04/2012	30/11/2012
Renata Drinkwater	Non-Executive Director	01/04/2012	31/12/2012
Alan Hubbard	Non-Executive Director	01/04/2012	31/03/2013
Stephen King	Non-Executive Director	01/04/2012	31/03/2013
Jerry Wedge	Non-Executive Director and Chair Cluster Audit Committee	01/04/2012	31/03/2013
Tim Young	Non-Executive Director	01/04/2012	30/11/2012
Sheila Bremner	Chief Executive	01/04/2012	30/09/2012
Denise Hagel	Interim Director of Nursing	01/04/2012	30/09/2012
Adrian Marr	Director of Resources	01/04/2012	30/09/2012
Sallie Mills Lewis	Director of Delivery	01/04/2012	30/09/2012
Sarah Jane Relf	Director of Transformation and Governance	01/04/2012	30/09/2012
Dr. Mike Gogarty	Director of Public Health	01/04/2012	30/09/2012
Alison Cowie	Director of Public Health	01/10/2012	31/03/2013
Dr. Rob Gerlis	Chairman, WECCG	01/04/2012	31/03/2013
Dr. Donald McGeachy	Medical Director	01/04/2012	31/03/2013
Dr. Gary Sweeney	Chairman, NEECCG	01/04/2012	31/03/2013
Dr. Lisa Harrod-Rothwell	Chairman, MECCG	01/04/2012	31/03/2013
Luella Dixon	Director of Transition and Workforce	01/10/2012	31/03/2013
Margaret Hathaway	Commercial Director	01/10/2012	31/03/2013

Name	Designation	Start Date	End Date
Andrew Pike	Chief Executive and NCB LAT Director	01/10/2012	31/03/2013
Dawn Scrafield	Deputy CEO/Director of Finance, Performance & Operations	01/10/2012	31/03/2013
Ian Stidston	Director of Commissioning	01/10/2012	31/03/2013
Pol Toner	Director of Nursing	01/10/2012	31/03/2013
Chris Kerrigan	Director of Operations and Delivery	01/01/2013	31/03/2013

Shadow Clinical Commissiong Group Board
For the period 1 April 2012 to 31 March 2013 the mid Essex clinical commissioning group Board operated in shadow form with delegated powers in respect of the resources and responsibilities that formally passed to them on 1 April 2013.

Name	Role
Dr Lisa Harrod Rothwell	Elected GP – Mid Essex CCG Chair (also a PCT cluster board member)
Dr Bryan Spencer	Elected GP and Vice Chair (Clinical) (also a PCT cluster board member)
Dr Caroline Dollery	Elected GP (Governance)
Dr Ahmed Mayet	Elected GP
Carol Anderson	Director of Nursing & Quality
Dan Doherty	Director of Clinical Transformation
David Simmons	Secondary Care Consultant
Keith Andrew	Lay Board Member and non-clincial vice Chair
Alan Hubbard	Lay Board Member (Commercial) (also a PCT Cluster Board NED)
Ann Marie Garrigan	Lay Board Member (PPE Lead)
Dr Donald McGeachy	Elected GP and Interim Accountable Officer (1 April – 31 Aug) (also a PCT cluster board member)
Sushil Jathanna (1 Oct - 31December 2012)	Interim Accountable Officer
James Roach (from 1 March 13)	Accountable Officer
Clare Steward	Director of Strategy and Primary Care, (Interim Accountable Officer (1 Sept – 30 Sept, 1 Jan – 28 Feb.)
Dee Davey	Chief Finance Officer
Suzanne Sinclair	Chief Operating Officer (1 April – 30 Aug)
Donna Derby	Interim Chief Operating Officer (1 Nov – 31 March)
Krishna Ramkhelawon	Public Health Representative (non-voting)
Audrey Bancroft	Social Care Representative (non-voting)

Declarations of Interest 2012/13 NHS North Essex Board Members and Mid Essex CCG Shadow Board

Name	**Business Interests**	**Voluntary Organisations or Charities**	**Contracting for NHS Services**	**Other Interests**
Carol Anderson	Nil	Nil	Nil	Nil
Keith Andrew	Owner Keith Andrew Associates Non-Executive Director/Trustee Chelmer Housing Partnership Ltd	Chairman/ Trustee Farleigh Hospice		Local Consumer Advocate The Consumer Council for Water
Dr Qadir Bakhsh	As Managing Director of EAGLES Consultancy and Managing Editor of Cheetah Books, involved in various projects including health and mental health related work. Some of the clients include • Qalb Mental Health Centre • The Asian Health Agency • Afiya Trust • Waltham Forest Muslim Trust • University of Central Lancashire • University of Warwick • League of British Muslims • Rehbar Trust and Urdu Times (UK)	Chair – Waltham Forest Refugee Advice Centre General Secretary - Waltham Forest Muslim Burial Trust Trustee - Kanka-Gajendra Foundation Executive Committee Member - London East Three Faiths Forum Executive Committee Member – The League of British Muslims	Some of current clients and the organisations involved in (mentioned) are funded by the Dept. of Health, Home Office and their respective LAs and PCTs	Daughter, Dr Nadia Sheikh is an Occupational Health Consultant at Whipps Cross University Hospital, London E17
Audrey Bancroft	Employee of Essex County Council	Nil	Nil	Nil

Name	**Business Interests**	**Voluntary Organisations or Charities**	**Contracting for NHS Services**	**Other Interests**
Dr. Kamal Bishai	Principal in General Practice, Chigwell Medical Centre (West Essex PCT) General Practitioner with Special Interest in Ophthalmology (West Essex PCT) Deputy Clinical Lead west and south west Essex Diabetic Eye Screening Programme (West Essex PCT)	Nil	Nil	Nil
Sheila Bremner **Ended 30/09/2012**	Chief Executive NHS Mid Essex Chief Executive NHS North East Essex Chief Executive NHS West Essex Chief Executive Sponsor for Essex Commissioning Support Unit (VERBAL)	Nil	Nil	Nil
Alison Cowie	Director of Public Health NHS Mid Essex Director of Public Health NHS North East Essex Director of Public Health NHS West Essex	Nil	Nil	Secondment to July 2012 to NHS South West Essex Cluster
Dee Davey	Nil	Trustee of Basildon Women's Aid	Daughter employed by Queen's Hospital Burton on Trent	Sister is a Director in the tax practice at Deloitte
Donna Derby	Nil	Nil	Nil	Nil
Luella Dixon	Director of Transition and Workforce NHS Mid Essex Director of Transition and Workforce NHS North East Essex Director of Transition and	Essex CLAPA – husband treasury	Essex CLAPA – husband treasury	Nil

	Workforce NHS West Essex			
Dan Doherty	Director DNA Physiotherapy Ltd Employed by Central Essex Community Services	Nil	Nil	Lecturer University of Essex Wife works for NHS South West Essex/NELPFT
Dr Caroline Dollery	GP Partner – Danbury Medical Practice	NHS Midlands and East Mental health & LD Lead Chair of Managed Critical Network, EoE Chair of Mental Health/Learning Disability Partnership	Nil	Nil
Pamela Donnelly	Executive Director – Colchester Borough Council	Nil	Nil	Nil
Renata Drinkwater	Director, Capita Symonds Consulting (part of Capita Group PLC) Chief Executive, Expert Patients Programme Community Interest Company Director, Drinkwater Consulting Ltd (currently not trading)	Trustee, Expert Patient's Programme Charity Member, Diabetes UK	Director, Capita Symonds Consulting, Capita Symonds may contract with NHS Chief Executive, Expert Patients Programme Community Interest Company, Expert Patients Programme CIC may contract with the NHS	Nil
Ann Marie Garrigan	Children's Centre Area Manager at Pre-School Learning Alliance, Rochford AVA Collectables (Art Vintage Antiques) (sole trader)	Nil	Nil	Nil
Dr. Rob Gerlis	GP Partner Ross Practice, Keats House, Harlow, Essex	Nil	Nil	Nil
Dr. Mike Gogarty	Director of Public Health, NHS Mid Essex Director of Public Health, NHS	Director of Public Health Essex County Council	Nil	Nil

	North East Essex Director of Public Health, NHS West Essex Director of Public Health – Health and Wellbeing Board (VERBAL)			
Dr. Shane Gordon	North East Essex Clinical Commissioning Group – Chief Executive Officer	North East Essex GP Commissioning Group Ltd – Chief Executive Officer This is a not-for-profit, commissioning only organisation working in partnership with NHS North East Essex since 2006	Salaried GP Bluebell surgery, Highwoods, Colchester	National Co-Lead, Clinical Federation (NHS Alliance) Consultancy (with no on-going interest) to :- • The Improvement Foundation and their clients • NHS Alliance and its clients • Capita • EMAP Publishing • United Business Media • Unilever • Several PCTs and PBC clusters in England • Charitable organisations including Age UK • Pharmaceutical companies in relation to awareness of commissioning including: 1. Glaxo Smith-Kline 2. Pfizer (and subsidiaries) 3. Boeringer-Inglehein 4. Sanofi-Aventis 5. Otsuke 6. Merck, Sharpe & Dhome
Denise Hagel	Interim Director of Nursing, NHS Mid Essex Interim Director of Nursing, NHS North East Essex Interim Director of Nursing, NHS	Nil	Nil	Nil

	West Essex Director Hagel House Ltd			
Dr. Lisa Harrod-Rothwell	Salaried GP at Writtle Surgery Vice Chair and Board LMC member	Nil	Nil	Governor Tyrells Primary School
Margaret Hathaway	Commercial Director NHS Mid Essex Commercial Director NHS North East Essex Commercial Director NHS West Essex	Nil	Director of South East Essex LIFT Ltd Director of Realise Health Ltd	Husband works as an IT project manager in South Essex PCT Cluster
Alan Hubbard	Chair, Essex Probation Trust Lay member (Commercial) Mid Essex Clinical Commissioning Group	Nil	Essex Probation Trust	Nil
Sushil Jathanna	Director in Athena Healthcare PVT Ltd in Mangalore (India)			Wife is a GP in Colchester
Stephen King	None other than indirect via Pension and savings Lay member Governance, West Essex CCG.	Director RNIB Trustee Sightsavers International Trustee IAPB President Daisy Consortium		
Dr. Donald McGeachy	Medical Director, NHS Mid Essex Medical Director, NHS North East Essex Medical Director, NHS West Essex Interim Accountable Officer for Mid Essex Clinical part-time salaried GP and GP with special interest (GPWSI) employed by "The Practice plc." Commissioning Group	Nil	Wife is a GP in Tillingham and holds a contract with NHS Mid Essex	Nil
Adrian Marr **Ended 30/09/2012**	Director of Resources NHS North East Essex	Nil	Public Sector Director for RHL (Liftco)	Nil

	Director of Resources NHS West Essex Director of Resources NHS Mid Essex Executive Lead Director for the d local arm of the NHS Commissio (VERBAL)		School Governor Holbrook High School	
Dr Ahmed Mayet	GP Partner Fern House Surgery Member of Eli Lilly National Primary Care Diabetes Board			Assessor for Essex PAG but intend to take a sabbatical whilst working for the CCG
Sallie Mills Lewis **Ended 30/09/2012**	Director of Delivery NHS North East Essex Director of Delivery NHS West Essex Director of Delivery NHS Mid Essex Acting Managing Director – Essex Commissioning Support Services		Balkerne Garden Trust, Colchester (has contract with North East Essex PCT) Husband and Sallie are shareholders. Sister in law is the director	
Chris Paveley	Jacobite Limited Re-member Ltd Montal Computer Services Ltd Thurrock Thames Gateway Development Corporation	Firstsite, Colchester	Nil	Nil
Andrew Pike	NCB LAT Director NHS Mid Essex NCB LAT Director NHS North East Essex NCB LAT Director NHS West Essex	Member of Extra21 Downs Syndrome Association Charity	Nil	Uncle – Joe Pike is an County Councillor for Essex County Council
Krishna Ramkhelawon	Employed by NHS North East Essex on secondment to Essex County Council as Deputy Director of Public Health	Nil	Nil	NHS North East Essex – Finance and Resource Management
Sarah Jane Relf **Ended 30/09/2012**	Director of Transition and Governance, NHS Mid Essex	Nil	Nil	Nil

	Director of Transition and Governance, NHS North East Essex Director of Transition and Governance, NHS West Essex Interim Director of Organisational and Relationship Development - Essex Commissioning Support Service			
James Roach	Nil	Nil	Nil	Nil
Dawn Scrafield	Deputy CEO/Director of Finance, Performance & Operations NHS Mid Essex Deputy CEO/Director of Finance, Performance & Operations NHS North East Essex Deputy CEO/Director of Finance, Performance & Operations NHS West Essex Deputy	Equal People Theatre Company - Treasurer	Husband is seconded to South Essex Partnership NHS Foundation Trust	GP is Dr Khan, Carnarvon Medical Centre
Dr. Bryan Spencer	Salaried GP and former senior partner at Elizabeth Courtauld Surgery	League of Friends of Halstead Hospital (ex Officio Committee member	Nil	Nil
Clare Steward			Brain Injury Strategy Consultant reviewing CHC funding proposals for NHS Bucks	Parish Councillor, Sheering
Ian Stidson	Director of Commissioning NHS Mid Essex Director of Commissioning NHS North East Essex Director of Commissioning NHS West Essex	Nil	Nil	Nil
Dr. Gary Sweeney	Director for SHEL – non-profit	Member of the North	GPwSI providing	

	making subsidiary of LMC supporting failing practices. Director paid for time	Essex Local Medical Council	Sigmoidoscopy services to NHS	
Pol Toner	Director of Nursing NHS North East Essex Director of Nursing NHS West Essex Director of Nursing NHS Mid Essex	Governor at St John Payne Catholic School Coach at Braintree Rugby Club	Nil	Wife is employed by NHS Mid Essex
Jerry Wedge	Trinity House Lay member North East Essex CCG	Nil	Nil	Nil
Tim Young	Board member, Colne Housing Society Ltd (from June 2012 – Chair from September 2012) Non-Executive Director of Southend University Hospital NHS Foundation Trust (WEF 01/12/2012)	Nil	Nil	Member of Colchester Borough Council Board Member Essex Probation Wife is a member of Colchester Borough Council and Essex County Council School Governor for the Colchester Academy

Directors Details

As far as the directors are aware there is no relevant audit information of which the NHS body's auditors are unaware and he/she has taken all the steps that he/she ought to have taken as a director in order to make himself aware of any relevant audit information and to establish that the NHS body's auditors are aware of that information.

Our principles, values and priorities

Mid Essex Primary Care Trust (PCT), North East Essex PCT and West Essex PCT have been working together as a cluster to lead the NHS in north Essex and ensure the provision of high quality healthcare services to its residents. Our aim is to be a caring, successful and ethical leader of the health system and to build a sustainable and effective system for the future.
Whilst implementing the planned evolutionary change to the system, as envisaged by the Government White Paper, we must nurture and protect pride in our NHS.

The principles and values established in the NHS Constitution will remain at the heart of our commissioning actions now, and form the bedrock in preparing and supporting the commissioners of the future.

We have shared these principles and values with our staff, stakeholders and partners for comment, so that we can be judged by these standards. For more information, visit www.nhs.uk/NHSConstitution

Key issues for NHS Mid Essex during the year

NHS Reform
The Health and Social Care Act (March 2012) makes many major changes to the way the NHS is managed.

The key areas of the Act are:

- Establishes an independent NHS Board to allocate resources and provide commissioning guidance
- Increases GPs' powers to commission services on behalf of their patients (through Clinical Commissioning Groups)
- Strengthens the role of the Care Quality Commission
- Develops Monitor, the body that currently regulates NHS foundation trusts, into an economic regulator to oversee aspects of access and competition in the NHS
- Cuts the number of health bodies to help meet the Government's commitment to cut NHS administration costs by a third, including abolishing Primary Care Trusts and Strategic Health Authorities.

Source: www.parliament.co.uk

This means that, with effect from 1 April 2013, PCTs and Strategic Health Authorities will be abolished and new organisations will be formally established including: CCGs (Clinical Commissioning Groups), CSUs (Commissioning Support Units) and the National Commissioning Board (NCB), which is now known as NHS England.

Additional duties have been placed on local authorities, including joined up commissioning of local NHS services, social care and public health (see below).

Clinical Commissioning Groups in Mid Essex

Mid Essex Clinical Commissioning Group (MECCG) has been operating in shadow form since April 2012 and is due to become a statutory organisation from 1 April 2013. The CCG has 50 member GP practices in its three localities, 48 dental practices, 62 pharmacies and 36 opticians. The CCG's healthcare budget for 2013/14 is £370m.

With a GP registered population of around 380,000 people, mid Essex covers an area of 520 square miles. Mid Essex is a two tier local authority area within the boundary of Essex County Council with Chelmsford City Council and Maldon and Braintree District Councils.

Under the new arrangements MECCG is responsible for the commissioning of health services on behalf of the mid Essex population. The provider landscape in mid Essex is mixed and diverse with NHS providers, social enterprises and private providers delivering care to our population.

The CCG has been authorised with three conditions:

1. CCG must have a clear and credible integrated plan that meets authorisation requirements
2. CCG must have detailed financial plan that delivers financial balance, sets out how it will manage within its management allowance, and is integrated with the commissioning plan
3. Provide evidence that the CCG has appropriate and effective financial reporting, management and governance in order to meet its statutory financial reporting duties and in year financial reporting requirements. In particular, provide evidence that the CCG has appropriate risk-sharing arrangements with other CCGs in place and clearly understood by all parties

The CCG has set its five strategic objectives for 2013/14 which build upon those which it established last year. These are:

- Transformation including integration
- Practice engagement
- Public confidence
- Improving quality and outcomes for all
- Meeting the financial challenge through responsible use of resources.

Contact Mid Essex CCG:
Mid Essex CCG
Swift House, Hedgerows Business Park
Colchester Road
Chelmsford, Essex, CM2 5PF

Tel: 01245 398770
Fax: 01245 398710
Email: me.ccg@nhs.net

NHS Central Eastern Commissioning Support Unit (CSU)

Commissioning Support Units (CSU) will formally be established on 1 April 2013. CSUs will provide capacity and resources to clinical commissioners as an extension of their local team to ensure that commissioning decisions are informed and processes structured. This approach will help achieve economies of scale and allow clinical commissioning groups to focus on direct commissioning of services for their patients.

CSUs are not statutory bodies and therefore have no statutory functions. They are accountable to clinical commissioners.

NHS Central Eastern CSU has a turnover of more than £50m and approximately 750 staff. Between them, its CCG customers serve a population of over 3.5 million people.

NHS Central Eastern CSU was formed by bringing together two separate predecessor bodies Hertfordshire Integrated CSU and Essex CSU – following the appointment of David Stout as the Managing Director of both CSUs in October 2013. It has three Business Units including Essex Commissioning Support which will provide services for CCGs in South Essex.

The CSU is led by:

- David Stout, Managing Director
- Carol Winser, Chief Operating Officer, Essex Business Unit
- Phil Crossley, Interim Chief Operating Officer, Herts, Beds and Luton Business Unit
- Luella Dixon, Director of HR, Organisational Development and Corporate Services
- Richard Rolt, ICT Service Director
- Jason Skinner, Chief Finance Officer
- Mary Currie, Director of Clinical Services

For further information visit: www.centraleasterncsu.nhs.uk

NHS England

NHS England - previously known as the National Commissioning Board (NCB) - will be established formally on 1 April 2013. Its role will be to commission high quality primary care services, support and develop CCGs as well as assessing and assuring performance, direct commissioning (including specialised services), managing and cultivating local partnerships and stakeholder relationships, including representation on Health and Wellbeing Boards.

NHS England will have an overarching role to ensure the NHS delivers better outcomes for patients within its available resources, and uphold the principles and values of the NHS Constitution. It will aim to deliver improved health outcomes as defined by the NHS Outcomes Framework, ensure people's rights under the NHS Constitution are met and that NHS bodies operate within the resource limits. Achieving this will enable patients and the public to have more choice and control over their care and services, clinicians to have greater freedom to innovate to shape services around the needs and choices of patients, and the promotion of equality and the reduction of inequality in access to healthcare.

The overall national running costs budget £527m of NHS England represents a reduction of almost half on previous running costs. Around 75% of the budget will be deployed locally, which reflects that the majority of NHS England's functions will be carried out locally.

NHS England will be accountable to the Department of Health and will have a national support centre in Leeds and a presence in London. There will be 27 Area Teams across England which is divided between four regions and they will all have the same core functions:

- system oversight and configuration
- building partnerships
- Clinical Commissioning Group development and assurance (including allocating resources to CCGs and supporting CCGs in commissioning services on behalf of their patients)
- emergency planning, resilience and response
- quality and safety
- direct responsibility for commissioning the following services:

    - primary care
    - military and prison health services
    - high secure psychiatric services
    - specialised services

The Essex Area Team will be lead by Andrew Pike, the Area Director. Other members of the Executive Director Team include:

- Dawn Scrafield, Director of Finance and Deputy Area Director
- Chris Kerrigan, Director of Operations and Delivery
- Ian Stidston, Director of Commissioning
- Christine Macleod, Medical Director
- Pól Toner, Director of Nursing

The Essex Area Team members will be based at:
Swift House
Hedgerows Business Park
Colchester Road
Springfield
Chelmsford
CM2 5PF

Tel: 01245 398770.
More information is available at www.england.nhs.uk

Public Health moving to Local Authorities

From 1 April 2013, the public health function will formally transfer from PCTs to Local Authorities. This transition has already started with public health teams being co-located with Local Authorities. The public health team in north Essex has moved to Essex County Council.

Public Health England

Public Health England (PHE) is a new organisation which will be established on 1 April 2013 as the authorative national voice and expert service provider for national health. PHE's mission will be to protect and improve the nation's health and wellbeing and to reduce health inequalities. It is an agency of the Department of Health and operationally independent from the department. PHE is led by Duncan Selbie, Chief Executive.

NHS Property Services Ltd

NHS Property Services Ltd will be established on 1 April 2013. Its role is to manage and develop around 3,600 NHS facilities nationally, from GP practices to administrative buildings. For more information visit: www.property.nhs.uk

Health and Wellbeing Boards

A key part of the Government's Health and Social Care Act (2012) will be the establishment of a statutory Health and Wellbeing Board in every upper tier authority.

These Boards will offer the opportunity for system-wide leadership to improve both health outcomes and health and care services. In particular they will have a duty to promote integrated working, and drive improvements in health and wellbeing by promoting joint commissioning and integrated delivery.

Health and Wellbeing Boards will be responsible for:

- Leading on the production of the Joint Strategic Needs Assessment (JSNA) - an assessment of local health and wellbeing needs across healthcare, social care and public health.

- Producing a Joint Health and Wellbeing Strategy in response to the JSNA, which will provide a strategic framework for local commissioning plans.

The Boards will bring together locally elected councillors with the key commissioners, including representatives of clinical commissioning groups, directors of public health, children's services and adult social services and a representative of local Healthwatch (the new patients' representative body).

Essex Health and Wellbeing Board

Plans for the formal establishment of the Essex Health and Wellbeing Board as a committee of Essex County Council on 1 April 2013 continued throughout 2012/13. A shadow board met on six occasions. Membership initially included GPs who were Board members for each of the five Clinical Commissioning Groups covering Essex and the Chief Executives of the north and south Essex PCT clusters. As the NHS continued its transformation to implement the changes from the Health and Social Care Act 2012, representation from the PCTs was changed to the Local Area Director for the NHS Commissioning Board, Andrew Pike.

Throughout the year, the shadow board oversaw the update of the JSNA and the production of a Joint Health and Wellbeing Strategy. Both these documents were then used to support the CCGs in the development of their Commissioning Plans. During the final quarter of the year, the board dedicated significant time to carrying out its statutory duty to comment on the CCGs' Commissioning Plans. These also contained proposals

for the integrated commissioning of health and social care services which formed the health and wellbeing theme of the Community Budget proposal to the government from Essex, Southend and Thurrock. The Board also supported the establishment of Healthwatch Essex and the transfer of public health duties to Essex County Council.

Membership of Essex Shadow Health and Wellbeing Board

Membership	**Name**
Leader of the County Council (Chair)	Cllr Peter Martin
North East Essex CCG	Dr Gary Sweeney
Mid Essex CCG	Dr Lisa Harrod Rothwell James Roach (March 2013 onwards)
West Essex CCG	Dr Kamal Bishai
Brentwood & Basildon CCG	Dr Ann Pretty (April – July 2012) Dr Anil Chopra (September 2012 onwards)
Castle Point & Rochford CCG	Dr Sunil Gupta
Cabinet Member for Adults, Health & Community Wellbeing ECC	Cllr Ann Naylor
Cabinet Member Children's Services ECC	Cllr Ray Gooding
District Council Leader	Cllr Terry Cutmore (Rochford DC)
District Council Leader	Cllr John Galley (Chelmsford City Council)
County Council Chief Executive	Joanna Killian
Acting Director of Adult Social Care ECC	Liz Chidgey (until January 2013)
Director of Children's Services ECC	Dave Hill
Director Public Health ECC	Dr Mike Gogarty
Interim HealthWatch Exec rep	Mike Adams
LInK Exec rep	Tony Hopper
Voluntary sector umbrella rep	Sue Sumner (until November 2012)
District Council Chief Executive	Ian Davidson (Tendring DC)
District Council Chief Executive	Malcolm Morley (Harlow DC)
NHS Commissioning Board Local Area Team Director (initially representing South Essex PCT cluster)	Andrew Pike
North Essex PCT Cluster	Sheila Bremner (until July 2012)

NHS Constitution

The NHS Constitution became law in November 2009. It enshrines the original principle of the NHS when it was founded over 60 years ago – the NHS belongs to the people and the Constitution sets out rights and responsibilities for staff and for patients and the public. For more information, visit www.nhs.uk

NHS Mid Essex

To ensure that NHS Mid Essex is compliant with the NHS Constitution, we have nominated Dr. Lisa Harrod Rothwell as Constitution Champion. We are continuing to promote and have due regard to the NHS Constitution and it is the foundation of our principles and values. Meanwhile, the executive summary for all NHS North Essex Board papers make reference to which aspects of the NHS Constitution are covered by that

paper, which ensures that the NHS Constitution is referred to in our mainstream business.

Looking forward, local clinical commissioners will be responsible for upholding and reinforcing the requirements of the NHS Constitution.

Improving Care

Children's Services
A single care pathway has been developed for the delivery of Children and Young People's Continuing Care across Essex, in partnership with the local authorities (Essex County Council, Thurrock Council and Southend Borough Council). This pathway offers a transparent and consistent approach to commissioning and delivery of provision which ensures equitable and appropriate resource allocation, based on individual need and reflecting value for money.

The services commissioned under this accreditation process will meet the following key objectives:

- To provide a range of quality, patient-focused care programmes to meet patients' needs ensuring an efficient service giving a personalised tailored approach to care, taking account of the patient's dignity, respect, cultural and religious needs
- To develop seamless pathways of care by developing systems and processes so that patients receive continuous joined-up care provision
- To ensure care delivery meets all necessary NHS standards
- To maintain and enhance choice through Plurality of Service Providers
- To encourage innovative ways of working
- To improve value for money through 'added value'
- To move to a position where all Service Providers of services are using Standard NHS Contracts no activity or financial guarantees

Personal Health Budgets
Personal health budgets support the future direction of a modern NHS, which focuses on quality and gives patients more control and choice. It aims to improve the patient experience by delivering care in the most appropriate setting and by the provider of their choice.
In advance of the national roll out of Personal Health Budgets for continuing healthcare in 2014, NHS North Essex, as part of the Department of Health Pilot, has implemented Personal Health Budgets for a small cohort of children and young people who are eligible for continuing care funding.

This initiative offers:

- Greater level of patient choice and control than currently exists
- Improved working relationships between the PCT, Social Care, provider organisations and 3rd sector organisations
- Increased personalisation
- Increased use of patients managing their conditions themselves with a corresponding decrease in unnecessary use of primary and secondary care services
- Decrease in unnecessary use of social and health services

East of England High Impact Pathways
Work on the high impact pathways is underway across all CCG areas.
In line with national, regional and local policy, we need to examine the current utilisation rates of secondary and community health services, with the aim of ensuring that as many children are cared for as close to home as is clinically appropriate. This will deliver better outcomes to the child and family, and may release resources. Significant numbers of children access non-elective services both at hospitals across Essex, when alternatives are available.
This project sets out to achieve a number of outcomes:

- An analysis of A&E utilisation and options for the future
- The development of a cluster-wide approach to paediatric assessment units, including specification of services and tariff
- The development of a specification for acute inpatient care
- A review of current paediatric community nursing services, to ensure that services have the capacity and capability to manage more care at home (linked to the above), provide effective review processes for primary care and facilitate early supported discharge
- The implementation of high impact pathways for common acute conditions in children, including:
    - Workforce redesign
    - training and development
    - communications and engagement
- The high impact pathways are:
    - Bronchiolitis [*pathway complete*]
    - Gastroenteritis [*in progress]*
    - Febrile illness [*in progress*]
    - Respiratory including Asthma [*in progress]*
    - Head Injury [*in progress]*
    - Diabetes [*in progress]*
    - Epilepsy [*in progress]*
    - Constipation/Encopresis [*in progress]*
- A review of current contractual arrangements for phlebotomy is being undertaken in North Essex as a specific piece of work to improve Children & Young People's phlebotomy services.

Families with Complex Needs and Early Offer of Help work with the Local Authority

Background
The Government has recently published draft legislation that follows up proposals set out in the Green Paper, "Support and Aspiration: A new approach to special educational needs and disability" and "The next steps" document signal the Government's intention to require the local authorities to set out a local offer. The purpose of the local offer is to enable parents and young people to see more clearly what services are available in their area and how to access them. The offer will include provision from birth to 25, across education, health and social care.

Essex/Southend
Essex County Council and Southend Borough Council have developed local task and finish groups to enable parents and young people to see more clearly what services are available and how to access them and have also asked multi-agency professionals to collectively work with them to develop this local offer across the county (Essex and Southend).

Both local authorities have very similar timelines for implementation:

Set up Task & Finish Group	March- April 2013
Develop a communication strategy	March-May 2013
Stakeholder workshops	April – June 2013
Develop the draft 'Local Offer' & Present to stakeholders	June – Nov 2013
Consultation	Nov – Jan 2014
Amend	Jan – Feb 2014
Corporate approval process	March-July 2014
Local Offer in place	September 2014

Revised sexual abuse pathways within the Sexual Assault Referral Centre (SARC) and opening up to self referral – Essex wide all CCGs
Agreed revised pathways for C&YP 0 – 5yrs, 5 – 11yrs, over 13 yrs in collaboration with statutory agencies and acute units. In line with the plan for making the service more accessible, the planned service opens to self-referral in April 2013.

Health Visitor Specification and delivery of Maternal Early Sustained Child Home Visiting (MESCH) Essex Wide

The Future Model for Health Visiting Practice
It is proposed health visiting will be delivered at four differing levels led by health visitors but delivered by a range of partners so as to address the range of complex need that is present in today's society.
The first level - **Community** is about building community capacity and health visitors working with local communities to build resources that can support families that are sustainable long term.

The next level - **Universal services for all families**: working with midwives, building strong relationships in pregnancy and early weeks and planning future contacts with families. Responsible for leading the Healthy Child Programme for families with children under the age of 5. **Universal Plus** – this is where **any family** may need additional support some of the time, for example care packages for maternal mental health, parenting support and baby/toddler sleep problems – where the health visitor may provide, delegate or refer. The purpose being to intervene early so as to prevent problems developing or worsening.

Partnership Plus - is a service for **vulnerable families requiring on-going additional support** for a range of special needs, for example families at social disadvantage, families with a child with a disability, teenage mothers, adult mental health problems or substance misuse. Making sure the appropriate health visiting services form part of the high intensity multi agency services for families where there are **safeguarding and child protection concerns**. In Essex we are implementing the Maternal Early Sustained Child Home Visiting Model (MESCH) to address these families' needs.

The final level is **Family Nurse Partnership (FNP)** – this is funded separately and has ring fenced money to support the growth in FNP. In Essex we do not intend to have an additional site for FNP but to utilise the South East Essex FNP site as a hub and to appoint additional FNP nurses who will receive long arm support from the Hub.

Workforce Growth
The NHS Operating Framework for 2011/12 and supporting guidance set clear expectations for workforce and training growth for 2011/12.
It is estimated that some 6,000 additional health visitors will need to be trained over the period to 2015 to allow for retirements and other loss from the workforce and achieve 4,200 extra health visitors.

Maternal Early Sustained Child Home Visiting (MESCH) UK
This is the model of delivery for Essex and is unique to Essex in terms of approach at this point in time. The model provides a structure for health visiting practice for those families identified either ante-natally or within the first three months who meet certain vulnerability criteria. The programme includes 20 visits in the child's first two years, in addition to the Healthy Child programme routine contacts. The home visits enable a therapeutic relationship to develop between the health visitor and the family that is responsive to need and ensures when crises occur they are managed effectively and with significant insight into the family's strengths and resilience as well as their particular vulnerabilities. MESCH is a philosophy of working as opposed to a prescriptive programme of engagement.
Some of the MESCH families will be children with a safeguarding plan or children in need. The family partnership model of engagement underpins MESCH practice and all health visitors in Essex will be familiar with the skills required to work in this way.

Research Application
The model was developed in Sydney Australia, and will be adapted to meet the needs of families in the UK. Funding has been applied for from the Burdett Trust to evaluate the roll out of MESCH in Essex. The research bid has been submitted by Professor Sarah Cowley at Kings College, London, Professor Debra Bick, Crispin Day, Hilton Davies, Jane Barlow and staff from Essex (commissioners and providers).

Children and Adolescent Mental Health Services (CAMHS)
A single gateway has been put into North Essex manned by Tier 2 and 3 CAMHS professionals to screen and triage all CAMHS referrals to ensure they are linked to the right service provision at the point of referral. In 2013/14 MECCG will become the North Essex Cluster lead on CAMHS.

Mental health services in north Essex
In 2012/2013 there has been a focus in adult care on moving from a bed based rehabilitation service to a more community focused modernised service. Recovery principles are key, i.e. the belief that every individual has potential and can be helped to reach that potential. In west Essex bed numbers have reduced from eleven to four, and the community team are working closely with a housing association that is beginning to provide accommodation for people receiving the service. In mid Essex considerable preparation has been undertaken to implement a recovery hub/college and in north east Essex service users are now accessing a care farm which is being positively evaluated. The project is run on a north Essex-wide basis.

Planning has taken place in 2013/2014 to:

a) agree a local mental health strategy to complement the national strategy 'No health without mental health' and the Essex wide dementia strategy
b) agree integrated development plans with Essex County Council
c) carry out considerable work including the establishment of specialist housing groups in each area and the involvement of service users and housing experts in the development of specifications to enable a re-procurement of sheltered housing services. It is anticipated that the new provision will more adequately meet the need.

In child and adolescent care a new Tier Four in patient service for Essex opened in Colchester, at the St Aubyn Centre. This has provided upgraded facilities and a new challenging behaviour service. In addition a new single gateway for access to services has been successfully piloted.

In older adult services, in line with the dementia strategy for Essex, all three PCT areas stabilised and invested in memory assessment services as a key part of the health contribution to treating and caring for people with dementia. The diagnostic gap continues to decrease.

In learning disability services a continuing challenge across north Essex is the achievement of targets of people with learning disability who have had health checks in primary care.

Work has been undertaken in the past year to include mental health in local developments to support CCG priorities around unplanned care and long term conditions to include, for example, the frailty pathway and integrated locality teams.

Improving Access to Psychological Therapies (IAPT) in primary care
The local service already provides an age inclusive service and has no upper age limit. Work was undertaken during 2012/13 to improve access for people with learning disabilities and in 2013/14 a key focus for development will be to develop improved care pathways with local drug and alcohol services and A&E.

Mental health and learning disability services in north Essex

Provider	**Summary of services & comments**
North Essex Partnership NHS Foundation Trust	A range of secondary mental health services including inpatient and community services for adults older adults and children and adolescents
Cambridge & Peterborough NHS Foundation Trust (CPFT) West and Mid Essex provider	Border related and specialist (including CAMH) Eating Disorder services CPFT also provides specialist CAMH Eating Disorder services for North Essex PCTs and IAPT services for Mid Essex PCT
North East London NHS Foundation Trust	Secondary mental health services

(NELFT) West Essex provider	
South Essex Partnership Foundation Trust (SEPT) North Essex provider and West Essex provider	Provision of community forensic services for North Essex and community learning disability services in West Essex
Care UK North Essex provider	Provision of nursing home services to support older people aged 65+ who have been identified as having NHS continuing healthcare needs and require long term nursing home placements.
Together West Essex provider	The provision of supported accommodation continues to support a total of 5 ex-Clayburry patients.
Astracare Connolly House North Essex provider	Nursing home and hospital care mainly for people with dementia
Hertfordshire Partnership NHS Foundation Trust North Essex provider	Assessment and treatment services for people with learning disability
Anglia Community Enterprise Mid and North East provider	Community services for people with learning disability
West Essex MIND Well Being Consortium West Essex provider	IAPT services
Health in Mind North East Essex provider	Rethink and NEPFT providing IAPT services
Tendring mental health support West Essex and North east Essex provider	Independent mental health advocacy services
Mid Essex MIND	Independent mental health advocacy services
Butterfly Lodge Education Centre North East Essex provider	Care farm. Care farming is the therapeutic use of farming practices.
Basildon MIND North Essex provider	Forensic inpatient advocacy
Chelmsford MIND	Eating disorder services
Colchester MIND	Child and Adolescent services
COPE North East Essex provider	Eating disorder services

NB Financial contributions are made through a Section 256 agreement with Essex County Council to assist in the provision of advocacy services, supported housing services, daycare services, employment advisers and service user engagement. A variety of non statutory providers are engaged in providing these services.

NB Tertiary services are provided to individual service users accessing a wide variety of specialist care in London and elsewhere.

Older People: The Mid Essex Approach

The Challenge of Frailty and Dependency

Despite its changing demographic and rapidly increasing elderly population, following public consultation, the CCG agreed that the term 'frailty' was preferred to the previously used 'frail elderly'. This was on the basis that an elderly person may not necessarily be frail and that frail elderly did not cover others who may be frail but not elderly (e.g. children and adults with long term conditions).

The concept of 'frailty' as a syndrome in its own right is fairly new. Frailty can be defined as a combination of factors that reduce an individual's ability to cope with inter-current illness or change in social circumstances. The syndrome may consist of one or more long term conditions, a degree of cognitive impairment and functional performance limitations such as mobility and continence problems, as well as social circumstances such as housing and isolation. Frailty can be assessed and measured on a variety of scales or tools, some of which are evidence based internationally.

Frailty is a risk factor for unplanned hospital admission, longer lengths of stay, poorer outcomes and higher mortality. As an example, the CCG spends in the region of £1.3m on admissions to the acute hospital with a primary diagnosis of urinary tract infections (UTI) and the mortality is 8%. Clearly this is not just due to the UTI itself but as a result of the individual being frail and at high risk.

In addition, as people become more frail they increasingly rely on care and support, either informal or voluntary, or on statutory Social Services support with associated costs.

This is the rationale for developing a pathway and systematic care for people identified as 'frail'.

Developing the pathway and systematic care for people identified as frail

As with any long term condition the first step in the pathway is identification or diagnosis of the condition. The CCG will develop a frailty register in primary care based on other LTC registers on the GP clinical systems. A simple-to- use frailty assessment tool and scale has been identified, which can be used by primary care, community teams, acute and social services to build up the register.

The aim would be for primary care teams to reassess those on the register opportunistically in order to identify deterioration and the cause. Once a certain level of frailty is reached, the individual would be referred into services to more pro-actively manage their care and reduce the risk of unplanned hospital admission and deterioration. Such an approach can also contribute significantly to reduce risks linked to safeguarding issues for all concerned.

The provider of this support service would be commissioned using the 'Lead Provider Model', also known as prime vendor. This model is currently being used as a vehicle for integrated pathway delivery such as for long term conditions. This is an effective model because it aligns incentives across the system both financially and for quality and safety outcomes.

The lead provider is responsible and accountable for the whole integrated pathway of care and, in this model, would be commissioned on the basis of a tariff that includes the costs of care in both acute and community as well as potentially also in part for primary care. In addition, in a truly integrated model it would potentially include the costs of social care and elements of voluntary sector investment.

The CCG plans to commission the pathway applying a 'year of care' tariff for the accountable lead provider based on the degree of frailty of the individual referred into the pathway. The expected outcome would be more proactive and integrated care, with reduced unplanned activity and costs and potentially reduced social care costs.

This approach also shifts resources up front to the lead provider from acute care costs. The model would incentivise the lead provider to invest in community and other services to prevent unplanned hospital admission and manage with the tariff based budget. The risk of costs of unplanned admission up to an agreed level rests with lead provider and not the commissioner.

Programme delivery
A frailty working group has been established and reported to the unplanned care programme board. The working group consists of clinical commissioners, delivery manager, finance and contracting leads as well as representatives of CECS, MEHT and Social Services.

At its first meeting the working group agreed the frailty pathway and the lead provider model of delivery. An outline three year implementation plan was agreed as follows:

In year one the frailty register in primary care will be developed and implemented. Developing the register and identifying individuals at risk due to high frailty scores would support case finding for the integrated care teams (ICT) and potentially lead to increased QIPP savings through the consequent more effective and targeted use of this service.

A database of activity related to this population including community, acute and social care costs would be created. There are tools already available that could be utilised for this. The database would enable the development of the year of care tariff based on the costs associated with a particular degree of frailty.

Outcome based indicators will be developed and agreed that will monitor the quality and performance of the service provider.

In year two, the model will be tested by commissioning the pathway and associated costs in 'shadow' form. This should deliver the cost benefits to the system but with some protection to both parties against some of the risks in implementing the pathway. In year two we will begin a procurement process using the competitive dialogue approach with a view to agreeing a substantive contract for year three.

Year three will be full 'go live', using a year of care tariff with elements of acute care costs stripped out from the acute providers and included in the tariff with a built in element of cost reduction based on the expectation of the lead provider reducing unplanned care.

True integration of commissioning and delivery would mean that the social care element of the costs for a frail individual would be included in the tariff and this element would therefore also be managed by the lead provider.

The joint frailty workshop held on 16 January 2013 established that Essex County Council's priorities for integration are aligned to this model and the three year action plan to deliver this integration was agreed.

It also resulted in agreement between the CCG and Essex County Council to develop a frailty register and jointly commission a service to support persons identified as 'frail' in the community through a truly integrated 'accountable lead provider' or prime vendor model, combining health and social care interventions and basing the year of care tariff on both NHS and social care costs.

Next steps
The working group has agreed the above outline plan and identified a number of sub working teams to move actions forward each with identified tasks. A clinical reference group will be convened to engage with a wider range of clinicians and professionals and public consultation will be on-going as the pathway is developed and implemented. The working group will meet at least on a monthly basis to oversee the delivery of this project and will continue to report to the unplanned care programme board.

Ensuring Quality

We are committed to giving our patients quality healthcare, in the right place and at the right time.

Improving quality, patient safety and experience
The following is just a snapshot of the work that we have been doing in 2012/13 to improve the quality of our patient services, the safety of our patients and their experience of the NHS. More information can be found in our separate PCT board reports, which are available on our website http://www.northessex.nhs.uk

The quality teams across mid Essex provide assurance to the Board that the delivery of safe, excellent quality services are monitored in all providers across mid Essex and that patients have positive and effective experiences. They are responsible for challenging, monitoring and promoting the quality agenda.

The overarching responsibilities within the quality teams are:

1. Organisational accountability for ensuring that the commissioning organisation complies with statutory and mandatory requirements relating to patient quality and safety.
2. Commissioning and procurement support to ensure quality is incorporated into all specifications.
3. Performance monitoring of quality, safety and patient experience in commissioned services contracts, through formal Clinical Quality review meetings, announced and unannounced visits and monitoring of patient experience and feedback.

The quality team is currently organised into three main work streams:

1. **Patient Safety**, which includes:
    - Serious Incident and Never Events - management, investigation and monitoring
    - Distribution and monitoring of implementation of Safety Alert Bulletins
    - Adult and Children Safeguarding (including authorisation of Deprivation of Liberty requests under the Mental Capacity Act)
    - Clinical Audit/Research & Development
    - Working toward the elimination of the following, supported by the national "Safety Thermometer" initiative (which gives a template to check basic levels of care, identify where things are going wrong and take action):
        - Avoidable pressure ulcers
        - Venous thromboembolisms
        - Falls
        - Catheter-acquired urinary tract infections

2. **Patient experience**, which includes:
    - PCT PALS (Patient Advice and Liaison Service) Service (Compliments and Complaints)
    - Eliminating Mixed Sex Accommodation
    - Implementation of the Patient Revolution (Friends & Families Test)

3. **Infection, Protection & Control (IPC)**, which includes:
    - Gaining assurance that providers are compliant with the code of practice for infection prevention and control as part of the Health and Social Care Act 2008
    - Implementation of the IPC Commissioning Framework
    - Development and Leadership of Health and Social Care Economy for IPC
    - Provision of specialist inpatient clinical advice, including custodian of the HPA (Health Protection Agency) HCAI (Healthcare Associate Infections) Care Register
    - Audit and monitoring of suitability of premises to deliver safe services with specific regard to IPC
    - This directorate is also responsible for Nurse Leadership and monitoring standards and practise in the delivery of nursing care within the local health economy.

Patient Safety

Summary Hospital-level Mortality Indicator (SHMI)
The Summary Hospital-level Mortality Indicator (SHMI) is the principal indicator used to measure mortality. The SHMI incorporates all deaths in hospital for all non-specialist acute Trusts. In addition, all patients who die within 30 days after transfer from a non-specialist acute trust to a community or specialist hospital will have their death attributed to the last non-specialist acute provider they were treated by prior to transfer.

The most recent data for our main hospital provider 2012/13 shows:

Mid Essex Hospital Services NHS Trust (MEHT) at 110 (within normal range).

Never events
The PCT receives Serious Incident reports from all commissioned services and closely monitors the investigation and learning from these incidents.

Never Events are a set of events agreed between the NHS and National Patient Safety Agency (NPSA). These are events that are serious and largely preventable, and PCTs have these as part of their contractual agreement with commissioned services.

There has been one Never Event reported to NHS Mid Essex by Mid Essex Hospital Services NHS Trust (Retained Instrument) since April 2012, this has been classified as retained foreign object post surgery. In response to this Never Event Mid Essex Hospitals Trust has invited an external Peer Review of Theatres.

Reducing Harm for Venous Thromboembolism (VTE)

VTE assessment is a national patient safety initiative to reduce avoidable deaths from blood clots that develop in part as a result of patient admission to hospital. If patients are assessed and treated appropriately, then significant morbidity and mortality can be avoided.

VTE risk assessments at Mid Essex Hospital Services NHS Trust (MEHT) have been maintained above the 95% stretch target.

Pressure ulcers

The NHS 'Safety thermometer harm measurement instrument' provides information on all our NHS provided care organisations including acute, mental health, community and district nurse caseloads. All our providers are engaged and actively involved in this process of submitting data.

Reporting of all Grade 3 and 4 pressure ulcers will continue to be through the Serious Incident reporting route in line with Strategic Health Authority (SHA) guidance. All incidents will require a Route Cause Analysis and a decision made on whether the ulcer was avoidable or unavoidable; made against the agreed SHA definition. This will require the scrutiny of the Director of Nursing. All incidents reported as a Serious Incident will be recorded against the originating provider organisation and this information will be held within the Quality and Patient Safety teams.

A Pressure Ulcer Strategy group, that includes membership of tissue viability nurses across our health economy, is reviewing current patient pathways and sharing good practice.

Unfortunately, providers in mid Essex have not been able to achieve the SHA ambition of 'Elimination of unavoidable pressure ulcers'. However, there has been a significant reduction in incidence across mid Essex.

Clinical Audit
The quality and patient safety team continue to support and monitor the process and outcomes of clinical audit across all commissioned services. The PCT endeavours to underpin clinical audit and effectiveness within the umbrella of quality and patient safety to ensure robust processes are in place, for continuously monitoring and improving clinical quality.

We aim to:

- Ensure that audit is an integral part of clinical governance within the Trusts.
- Provide a clear framework to co-ordinate, monitor and report quality improvement.
- Encourage multi-disciplinary audit activity within all professional groups.
- Ensure that problems highlighted by audit lead to actions to improve patient care.
- Involve users and carers in the audit process.
- Ensure that audits are undertaken, where appropriate, as identified by complaints, critical incidents or other problems, and;
- Support effective implementation of evidence based practice throughout the organisation.

Patient experience

Patient experience surveys
There have been a variety of patient experience reports from all our providers, covering aspects of care, dignity, waiting times and communication.

All mid Essex providers have participated in the regional 'Friends and Families Test' initiative where they are asked a simple question: whether they would recommend hospital wards and accident and emergency units to a friend or relative based on their treatment. The most recent score (out of 100) is as follows.

Net Promoter Score	Jan-13
Mid Essex Hospital	83
SHA Average score	71
SHA Upper Quartile score	82

Dignity and respect: delivering same sex accommodation
Delivering same sex accommodation is an important factor in improving patient experience of health care. The new NHS contract makes reference to Single Sex Accommodation and makes provision to withhold payment to Trusts for the treatment costs of any patients affected by decisions to place them in areas not compliant with DH guidance. This is also included in the NHS Constitution as a right.

The NHS Constitution sets out that all patients should always be treated with dignity and respect, in accordance with their human rights. This means, for example, that their right to privacy should be respected. All acute hospitals serving mid Essex have single sex accommodation so patients do not have to share sleeping or bathroom facilities with members of the opposite sex.

Eliminating Mixed Sex Accommodation
The Operating Framework for 2012-2013 states the continued monitoring and delivery of Eliminating Mixed Sex Accommodation.

Recognising breaches of policy
There are some circumstances where mixing can be justified. These are few, and are mainly confined to patients who need highly specialised care, such as that delivered in critical care units. A small number of patients (especially children and young people) will actively choose to share with others of the same age or clinical condition, rather than gender.

NHS Mid Essex continues to work with service providers to ensure that all inpatient facilities commissioned now comply with DH guidance to virtually eliminate all mixed sex accommodation.

There has been no mixed sex breaches in Mid Essex Locality by any Provider in 2012-13.

Reporting breaches of policy
All breaches of sleeping accommodation must be reported nationally through established reporting systems.

Trusts within mid Essex have delivered single sex accommodation since before 1 April 2012.

Infection, Protection & Control (IPC)
The North Essex Infection Prevention and Control Team, covering mid Essex:

- Monitor performance against national and regional targets
- Ensure and demonstrate organisational accountability
- Implement the national framework for IPC commissioning
- Have a specific role in monitoring and following up all Serious Incidents related to Health Care Associated Infections (HCAI), being able to respond with required amount of expert knowledge to situations as they occur (e.g. unexplained increase of HCAI)
- IPC commissioning for the main providers, and the smaller providers
- Have performance monitoring responsibilities for all health care providers to monitor compliance with the code of practice for infection prevention and control
- Have leadership and developmental responsibilities for all health care providers, to ensure compliance with the code of practice for infection prevention and control across the whole economy
- Peruse the root causes for certain cases of HCAI as decreed by national and regional bodies
- Enable independent contractors to implement infection prevention and control standards and then work with colleagues across the organisation to ensure on-going monitoring of those standards
- Monitoring of premises and their appropriateness to be able to carry out specific procedures in a safe environment.

Performance against the targets
It is important to note the very small numbers of cases that are being recorded, compared to previous years, and the year on year improvements that have been achieved. This does not mean however that the determination to continue to reduce HCAI's is diminished in any way.

The national objective for Clostridium *difficile* for 2012/13 was set against the baseline October 2010 to September 2011 as follows:

C. diff as at March 2013

	Cases 2011-12 Total	12-13 Ceiling	Cases 2012-13 Total
Mid Essex PCT	**78**	**61**	**76**
Mid Essex Hospital Services	**20**	**22**	**17**

Ceilings within mid Essex have proven very challenging during 2012/13 although it is important to note there continues to be a reduction in actual cases

The national target for MRSA bacteraemia for 2012/13 was set against the baseline October 2010 to September 2011:

MRSA as at March 2013

	Cases 11-12 Total	12-13 Ceiling	Cases 12-13 Total
Mid Essex PCT	**0**	**2**	**6**
Mid Essex Hospital Services	**0**	**1**	**1**

Ceilings within mid Essex have proven very challenging during 2012/13 there has been a number of Bacteraemia outside the mid Essex health economy. The Infection Prevention Control Team continue to work with lead commissioners to drive the Health Care Acquired Agenda.

Mid Essex CCG Safeguarding Children

Serious Case Reviews (SCR)

The final safeguarding report for 2012-13 is currently being drafted but Mid Essex CCG can report that:

The CCG has finalised and signed off the SCR for "Olivia" the actions for health have been progressed and multi-agency recommendations will be published soon.

SCR "Ryan" actions for health economy in Mid will be completed but run into next reporting year (2013/14).

Training Report For Mid Essex General Practice

The Safeguarding Children Team undertake the monitoring, tracking and providing Safeguarding Children training opportunities for General Practitioners and other clinicians working within General Practice.

All staff should receive Level 1 training as part of induction. Clinicians are required to complete Level 2 (Basic Awareness) currently this via an e-learning course.

Training Delivery

Level 2 training is delivered via e-learning and is administrated by the Team PA/Administrator. This year 54 staff used the PCT e-learning training package to completed level 2 training.

The Designated Nurses for Safeguarding Children and Looked After Children delivered the Level 3 training.

This year (Apr-12-Mar-13) 27 Level 3 training sessions were delivered with a total of 256 staff from General Practice attending.

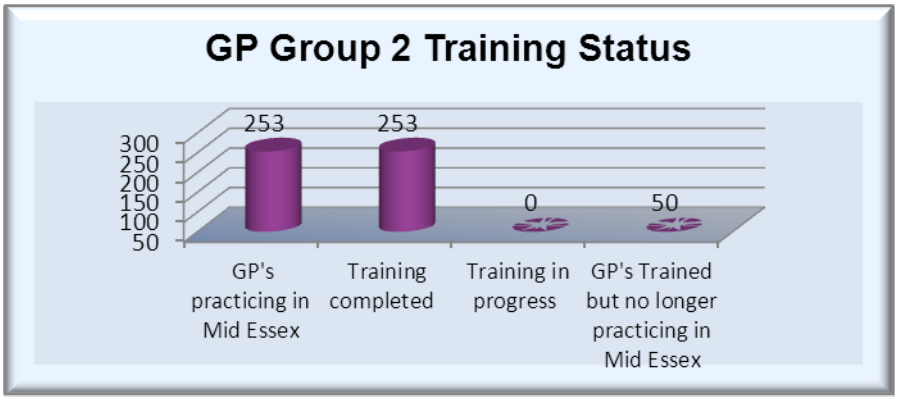
Total Training Sessions	Total Staff Trained	Total Hours Spent Training	Average attendance per session
27	256	79.5	9

	No. of Domestic Abuse Level 3 Training Sessions	No. of Looked After Children Training Sessions	No. of Child Protection Training Sessions	Group 3 CP /LAC Combined Sessions
Number of Sessions Delivered	4	8	12	3
Total Number of staff Trained	25	71	121	39

Current Training Levels General Practitioners

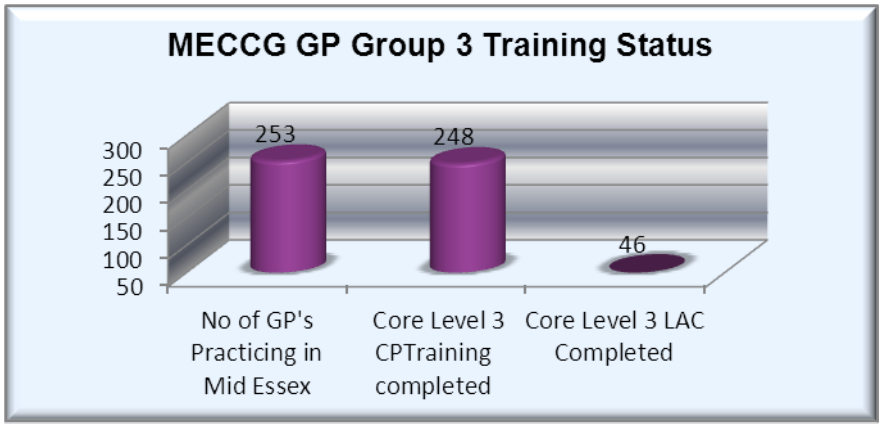
Level 2 Training

By year end, 100% of GPs were trained to Level 2.



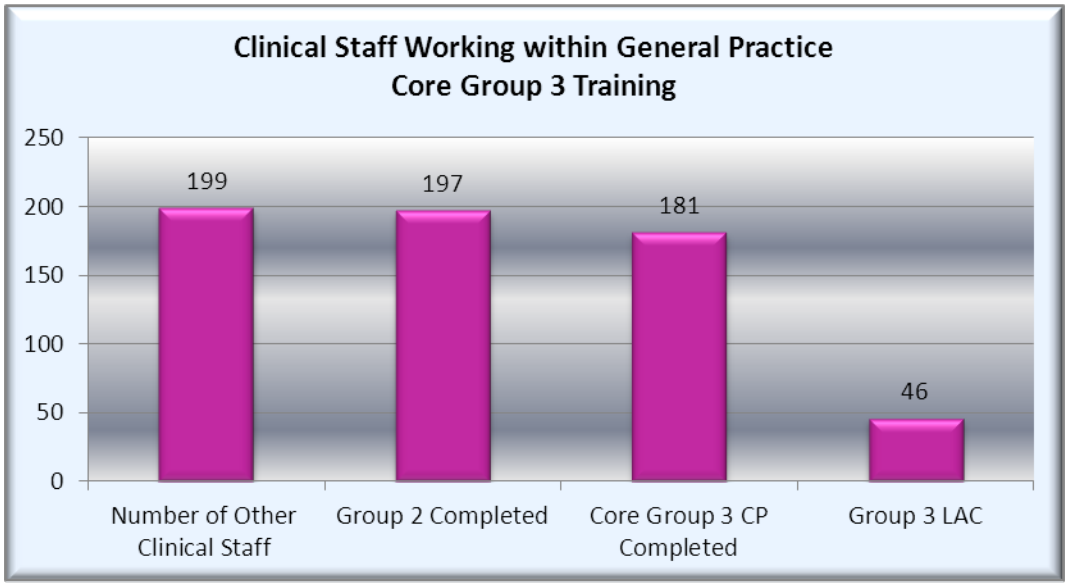
Level 3 Training

By year end 98% of GPs were trained to Level 3.



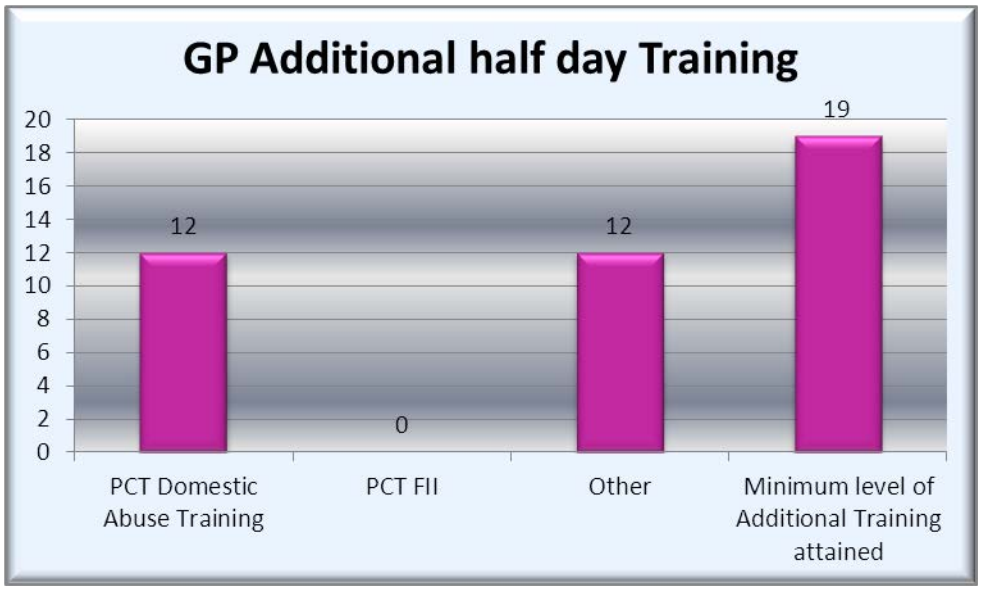
Level 2 & 3 training for Practice Nurses:

By year end 99% of Practice nurses were trained to Level 2.
By year end 91% of Practice nurses were trained to Level 3.



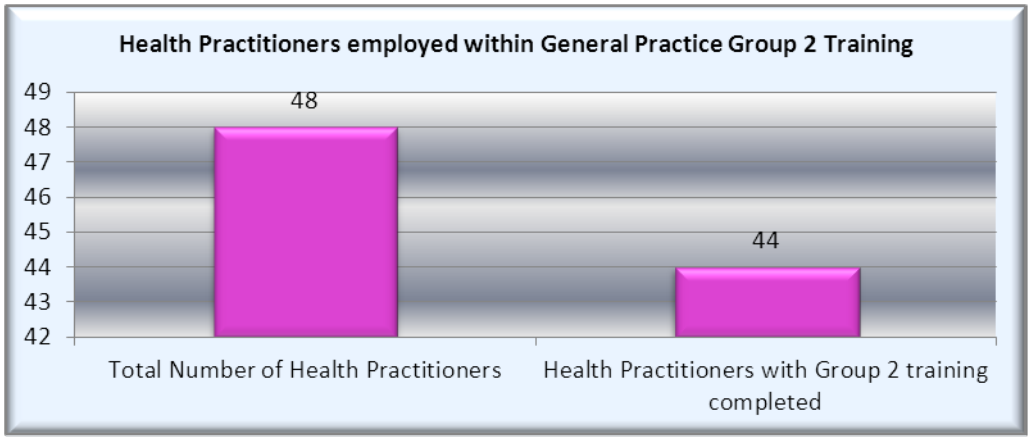
Additional Training

Once Core Group 3 Child Protection and Looked After Children training has been completed GP's are required to undertake an additional half day Safeguarding Children learning



Other Clinical Staff

Some GP Practices employ Health Practitioners these include Health Care Assistants, Phlebotomists, and Pharmacy staff. These types of staff are required to be trained to Group 2 level which should be refreshed on a 3 yearly basis.



External Reviews

Care Quality Commission (CQC). The PCT meets regularly with the CQC to share intelligence about all local providers.

Reports from the CQC to providers are monitored by the PCT. When any concerns are raised by the CQC, the PCT liaises directly with the provider and requests action plans from them. These action plans are robustly monitored and formally reviewed at the Clinical Quality Review Groups.

Compliments, concerns, complaints and queries

Concerns and complaints provide us with valuable information about the experiences of our patients so that we can improve the services that we commission. Compliments help us to find out what we are doing well so that we can share best practice, improving still further local health services.

Under the NHS Complaints Regulations which came into effect on 1 April 2009, patients and the public can make their complaint to NHS North Essex as a commissioner, if they do not wish to complain directly to the provider.

From April 2012 to January 2013, the PCT received a total of 32 complaints from patients or carers (NHS Mid Essex received and investigated 133 formal complaints in 2011/12). In each case, NHS North Essex worked with the complainant and providers to achieve resolution in the majority of cases and to identify service improvements and learning outcomes.

NHS North Essex's Complaints Policy reflects the best practice principles for complaints handling advocated by the Parliamentary & Health Service Ombudsman (Principles for Remedy, Principles of Good Complaint Handling and Principles of Good Administration). In accordance with the Principles for Remedy, we place a strong emphasis upon putting things right and ensuring continuous improvement and learning from complaints.

The PCT Patient Advice & Liaison Service (PALS) provides fast help, information and advice to patients and the public in relation to local health services. The PALS Service handled a total of 944 contacts from April 2012 to January 2013 (in 2011/12, there were 1,470 contacts made with PALS). Service improvements arising from PALS contacts during 2012/13 included securing access to Diabetic Retinopathy Screening services at a more convenient site on the Dengie Peninsula.

Freedom of Information (FoI) Requests

The Freedom of Information Act (2000) gives a general right of access to recorded information held by public authorities, subject to certain conditions and exemptions. NHS Mid Essex has complied with the Treasury guidance on setting charges for FOI requests. NHS Mid Essex received 357 FOI requests during 2012/13 (compared to 353 requests in 2011/12).

Ensuring best value

The NHS budget is under increasing pressure. Demand for healthcare from a growing and ageing population, the availability of new drugs and technologies together with misguided or inappropriate use of essential services such as A&E is leading to a significant financial challenge.

In order to meet the challenges of the coming years, we need to use our NHS funds more imaginatively and effectively. We need to develop different ways of delivering healthcare services, introducing new healthcare providers to provide more choice. We need to move appropriate services into the community, offering patients care closer to where they live.

Ensuring value for public money is an important principle of the PCT and is outlined in the corporate governance framework adopted by the Board. To ensure value for money is achieved, appropriate procurement procedures are in place, including the tendering of goods and services where necessary. The PCT is supported by procurement specialists and non-executive and lay members of the PCT and CCG Boards respectively have significant commercial experience.

Part of the role of the internal audit service that the PCT commissions involves reviewing, appraising and reporting upon value for money within the organisation.

QIPP

QIPP (Quality, Innovation, Productivity and Prevention) is the umbrella term used to describe the approach the NHS is taking at local, regional and national levels to reform its operations and redesign services in light of the above. It is intended to ensure that the economic climate does not change the focus of our direction of travel but puts quality at the heart of the NHS. Its key objectives include:

- Improving quality and productivity
- Engaging and empowering staff

QIPP and the Health and Social Care Act (2012)
The Act outlines the government's commitment to ensuring that QIPP supports the NHS to make efficiency savings, which can be reinvested back into the service to continually improve the quality of care.

PCTs need to ensure the transition to the new commissioning landscape is linked with the delivery of their QIPP plans.

Development of our QIPP Plan

The following are our key QIPP partners:

- Clinical Commissioning Groups comprising 50 GP practices
- Essex Commissioning Support Unit (Essex CSU)
- Mid Essex Hospital Services NHS Trust (MEHT)
- Central Essex Community Services (CECS)
- East of England Ambulance Service NHS Trust
- North Essex Partnership NHS Foundation Trust (NEPFT)
- Essex County Council

Population movements across mid Essex over the next few years, together with financial constraints, mean health care services need to adapt to changing requirements. MECCG has developed a programme of work to redesign health care services over the next three years, in partnership with its providers across the system. This programme is divided into planned care, unplanned care, medicines management, children and maternity services and mental health & learning disabilities, supported by Programme Boards. Redesign work is being undertaken to transform services, with project teams led by clinicians. Transforming pathways will ensure patients receive the appropriate care for their conditions, in the right place, whilst improving the efficiency of the system.

Mid Essex faced a challenging QIPP requirement for 12/13 and achieved 83% of the £20 million planned. The medicines management team has been highly successful, contributing 24% of this target (£4.8 million) and continues to drive efficiency going into the new financial year with a range of initiatives and stretching goals.

Contract efficiencies and discretionary spend cuts have contributed a further 40% (£6.6 million) of the year end forecast.

A range of clinically lead, transformational service redesigns have been developed and implemented throughout the year, to deliver the remaining QIPP savings. Although progress has been slower than originally anticipated in the planned and unplanned care work programmes, the foundations have been laid to deliver the strategy and efficiencies planned for the coming years.

QIPP Projects

Urgent Care

There are a number of initiatives that have been developed during 12/13 to improve the care provision for emergency patients. This will provide an accessible, responsive and integrated service, encouraging prevention and proactive management of patients.

The ambulatory care project has already been implemented, focusing on patients who do not need urgent medical attention.

A high impact team has been established to target care homes in the region. This is a multi-disciplinary team including nurses, therapy and medicines management who are helping to support the residents and care home staff with medicine reviews and therapy. The team has been highly successful across the care homes it has visited.

Frailty

A frailty pathway is being designed to help provide a pro-active and integrated health and social care service. It aims to maximise self-management, mobility and independence and provide appropriate care in the community wherever possible, keeping patients out of hospital. It aims to improve care for frail people, out of hospital.

Long term conditions

A clinically led project team is currently mapping out a pathway to ensure patients with long term conditions can access a range of services to suit their own personal circumstances, maintaining independence and preventing deterioration of their condition. We will be implementing the year of care revised tariff for identified long term conditions during 2013/14.

Planned care

The planned care programme aims to provide appropriate care closer to home and in the community where possible. It has been working to enhance locality services, whilst ensuring clinical excellence, and develop systems and processes to remove duplication and create a more stream-lined health pathway.

A joint project between Mid Essex Improving Access to Psychological Therapies (IAPT) and the local Pulmonary Rehabilitation service is helping patients to manage their symptoms of chronic obstructive airways disease and reduce the number of unplanned emergency admissions to hospital.

Musculo-Skeletal Redesign

A project that stretches across multiple providers designed to promote self-management of musculo-skeletal pathologies within community settings is being developed. When patients do require more specialist advice this project aims to ensure they can access this quickly and easily in community based settings ensuring that only those patients that require hospital based assessment and treatment are referred to acute settings.

Working with our partners and public engagement

Working in partnership for better health

Joint Strategic Needs Assessment

The government white paper *A Commissioning Framework for Health and Wellbeing* followed by the 2010 NHS White Paper: *Equity and Excellence: Liberating the NHS* made it a statutory duty of Primary Care Trusts and top tier local authorities to produce a Joint Strategic Needs Assessment (JSNA) and highlighted the importance of JSNA as a commissioning tool for the future. As outlined in the Health and Social Care Bill, local authorities and GP consortia through the Health and Wellbeing Boards, have an obligation to prepare a JSNA that will inform a Joint Health and Wellbeing Strategy.

However, this is about more than legal duties. It is the opportunity to reduce inequalities in health and wellbeing and improve chances and outcomes for local communities by conducting a comprehensive assessment of health and wellbeing need at a local level that both drives and adds real value to commissioning of services across key strategic partners including health, local government and the third sector. The JSNA should also inform the decision making processes of the new Health and Wellbeing Boards and development of local Health and Wellbeing Strategies. Furthermore, it should also be used as a vehicle to engage patients, clients and users of services, and the general public to understand their needs and opinions and feed these into what services the public sector commissions.

The JSNA in Essex is coordinated through a JSNA Planning Group made up of partner organisations including the County Council, clinical commission groups, Healthwatch and district councils. The group reports to the Business Management Group of the Health and Wellbeing Board. Strategic JSNA products that have been published previously, and will be refreshed each year, include profiles based on our various geographies: countywide and district (x12), CCGs (x5), a Pharmaceutical Needs Assessment and a number of specialist topic reports.

Partners and the public can access all JSNA products along with much of the underlying data on our Data Observatorywww.essexinsight.org.uk

Involving and listening to our patients and public engagement

Our aim is to always keep local people at the centre of our work, listening to them and learning from their experiences.

Engagement for all major initiatives is tracked on the organisation's Engagement Plan. This, together with the outcomes of the engagement report, is regularly monitored by the board ensuring that the feedback received is used to inform and develop services.

A lot of work during this year has been focussed around establishing public engagement groups to meet the needs of the changing landscape of the NHS:

- Recruiting local people and organisations to become members of each CCG. There are three levels of membership.
    - Level 1 - receive information and news updates

- Level 2 - invitations to one off projects such as readers group or specific forum for a project e.g. Maldon Community Hospital
- Level 3 - become more involved and represent patients / public on regular groups such as Patient Reference Group or as Lay members to Board.

- Analysis of a survey into the effectiveness of the Patient Participation Groups at GP practices and subsequently a report has been presented to Practice Managers across North Essex.

- Workshops around the integrated plan and three priority areas:
  - Long Term conditions
  - Older people
  - Urgent care

- Establishing links with Health and Wellbeing Boards and enabling greater partnership working on engagement

- Establishing local Health Forums which are made up of patient, public, voluntary organisations and carers.

Improving the health of our population

We are committed to closing the gap between the most and least disadvantaged in our community, to improve the general mental health and well-being of our population and prevent the causes of ill health and unnecessary illnesses.

The following are just a few of the examples of the work we have done to improve the health of our population.

Commissioning for health improvement

We continue to commission robust and evidence based programmes to enable the population to make positive choices that will result in improved health and wellbeing on a sustained basis. These include:

- **Stop Smoking Services** - stopping smoking remains a key behaviour choice that will ensure better health in the short term and, if sustained, will result in improved long term outcomes by significantly reducing risk of developing cardio vascular disease, respiratory conditions and cancer. Services are commissioned through a range of providers, including GPs and Community Pharmacies, in order to maximise access especially to those communities who are less likely to access services.
- **NHS Health Checks** – Introduced by the government in 2009, the NHS Health Checks programme provides systematic lifestyle screening for eligible patients aged 40 – 74 years once every five years. Cardiovascular risk factors are measured and discussed with patients to meet the overall aim of the programme, which is to prevent the early onset of CVD (cardio vascular disease) through lifestyle change and earlier identification of undiagnosed disease such as hypertension, diabetes and chronic kidney disease.
  The core delivery of the Health Checks programme is through primary care whose engagement in this programme is vital in order to achieve successful outcomes. Maximising uptake of the programme is essential if prevalence of long

term conditions is to be reduced which will result in significant efficiencies across the health and social care system through reduced demand for services

- **Chlamydia screening** – we continue to commission services to raise awareness and encourage testing among young people aged 15-24 as part of both core sexual health service provision and also on an outreach basis working in a range of settings that attract young people including pubs and clubs
- **Youth Health Champions (YHCs):** These are recruited from Essex Secondary schools and attend a four day tailored programme around key areas of public health, including smoking cessation, drugs and alcohol, nutrition, emotional health and wellbeing, physical activity, sexual health and health promotion techniques. Young people engage with these peer health Champions to gain advice on services. The benefits of the programme can be seen in a number of ways. The YHC's act as advocates for positive health behaviour and are often more trusted than non-peer informants, particularly with marginalised young people. There are opportunities to develop innovative methods of health promotion delivery, and the programme encourages young people to take an interest in, and ownership of, their own health. The YHCs can build trust between young people and the services they are promoting.
- **Breastfeeding support** - Breastfeeding is widely acknowledged as being the optimal way to offer infants a healthy start in life. Breast milk provides the optimal nutritional balance for growth and development and also protects against illness. Significant reliable evidence exists which demonstrates that breastfeeding has a major role to play in promoting public health and reducing health inequalities. As a result support services have been commissioned to support women to sustain breastfeeding through community based provision including the use of volunteers offering peer support.
- **Weight management** – we continue to commission an innovative programme of weight management interventions which includes programmes aimed at reducing the risks of obesity in families where a child has been identified as overweight as well as highly specialised and targeted support for adults with serious and enduring weight issues. The service is outcomes based and ensures that programme participants are supported long term to achieve sustained weight loss which has a positive effect on both their physical health and emotional wellbeing.

Reducing health inequalities

- **Essex County Travellers Unit (ECTU) -** The ECTU is an innovative way for partners to work together to address health inequalities that Gypsies and Travellers face and to deliver significant on-going benefits which could not be achieved by partners working in isolation. Early intervention and prevention, especially relating to the health deliverables of the unit, will help to reduce the cost that occurs as a result of poor health outcomes.
- **Football Health 4 Life:** This provides adults with a learning disability the opportunity to participate in football. The aim is to increase players' physical activity, maintain mental wellbeing, promote social inclusion, increase social interaction and provide players with transferrable skills into their everyday lives. Health 4 Life provides training sessions at Clacton, Colchester and Witham. During 2012; 3 players have obtained their Level 1 in Coaching and 1 player has obtained a Referee Level 7

Equality and diversity and sustainability

Ensuring equality for all

Equality is about making sure people are treated fairly and given fair chances. It's not about treating everyone the same way, but recognising that their needs are met in different ways.

The PCT Board was formally committed to the Equality Delivery System; designed to improve the equality and diversity performance of the NHS by embedding it into the mainstream business of NHS commissioners and providers.

Equality and diversity awareness is embedded across our organisation. We ensured all policies, commissioning cases and service developments, have Equality and Diversity as a core guiding principle.

The feedback collected from community engagement events and grading panels held during 2012/13 was used to inform the work and the future work of the PCT cluster and of our local Clinical Commissioning Groups (CCGs).

New duties were placed upon NHS organisations by the Public Sector Equality Duty (PSED) and the Equality Delivery System (EDS) in 2011; a report, evidencing the PCT's compliance with the PSED, is available to view on the PCT cluster website.

We also offered interpreting and translation services (including British Sign Language) to our primary care contractors.

Sustainability and caring for our environment

In 2009 the Sustainable Development Unit (SDU) in the Department of Health published its recommendation for Trust Boards to establish governance structures to support the implementation of carbon reduction and sustainable development agendas through the adoption of a 'Board-approved Sustainable Development Management Plan'.

On 1 February 2011, the SDU published its latest guidance on collaborative working across the health system. Their 'RouteMap' succinctly makes the point that by its nature the NHS must be sustainable: "We must meet the needs of our patients today, while ensuring we have a service fit for tomorrow and beyond."

The Climate Change Act sets a legal requirement for the UK to achieve carbon reductions of 26% by 2020 and 80% by 2050. Work carried out by the SDU for England indicates that the NHS needs to achieve a 10% reduction on 2007 levels by 2015 to meet the legal imperative. The NHS has a carbon footprint of around 18 million tonnes of CO2 per year; this is composed of energy (22%), travel (18%) and procurement (60%). Despite an increase in efficiency, the NHS has increased its carbon footprint by 40% since 1990. This means that meeting the Climate Change Act targets of 26% reduction by 2020 and 80% reduction by 2050 will be a huge challenge; this will require the current level of growth of emissions to not only be curbed, but the trend to be reversed and absolute emissions reduced.

NHS North Essex (SDMP) has developed a comprehensive Sustainable Development Management Plan for the north Essex cluster. The PCT recognises the case for sustainability in healthcare and there is sound evidence that many components of sustainability achieve cost reductions and immediate health gains. Sustainability means ensuring the development of a sustainable system which can reduce inappropriate demand, reduce waste, and incentivise a more effective use of services and products, within a remit of high quality and cost effective commissioning.

Having a robust SDMP helps us fulfill our commitment to conducting all aspects of its activities with due consideration to sustainability whilst providing high quality patient care. We continue to work closely with partners including our Clinical Commissioning Groups, other NHS organisations and Local Authorities, developing a community-wide approach to sustainability and carbon reduction and ensuring it is embedded in the legacy of the organisation.

The SDMP re-emphasises the PCT's pledge to bring a minimum 10% reduction in its carbon emissions by 2015. Critically, the SDMP emphasises the benefits of using the 'Good Corporate Citizen Model' to deliver the improvement in community engagement, employment & skills, travel, transport & access and water consumption which are all under-represented in the original carbon reduction plan.

The PCT contribute to the local economy in terms of procurement, workforce, and community development, in recognition of the health benefits that can be achieved, fulfilling its legislative requirements in relation to climate change mitigation and adaptation. The goal of sustainable development is to meet the needs of today, without compromising the ability of future services.

Display Energy Certificates (DEC)
Display Energy Certificates (DEC) show the actual energy usage of a building. This is defined as the operational rating of the building. Certificates are on display in premises owned or leased by NHS North Essex Cluster (including Mid Essex).

The Good Corporate Citizenship (GCC) assessment model
The GCC was developed in 2006 by the Sustainable Development Commission with the support of the Department of Health. This was then revised in 2009 in cooperation with the NHS Sustainable Development Unit. In January 2013 a revised assessment model was released, which will be the model that CCGs will measure their performance against.

Table 1 below shows the most recent scores from the most recent assessments undertaken by the North Essex PCTs. Each of the PCTs was committed to using the model to identify ways of improving performance and reaching out to the wider community.

The Good Corporate Citizenship Assessment Model is an assessment of our progress on sustainable development. The test is divided into six sections:

- Travel
- Procurement
- Facilities management

- Workforce
- Community engagement
- Buildings

In each section we scored our organisation on a range of questions to see how it is progressing on sustainable development.

Each question has three levels:

- Getting started – scores 0, 1, 2, 3
- Getting there – scores 4, 5, 6
- Excellent – scores 7, 8, 9

Table 1 – Good Corporate Citizenship Assessment Model

Section	**Mid Essex**	**North East Essex**	**West Essex**
Travel	11	30	11
Procurement	4	13	15
Facilities Management	15	19	26
Workforce	31	24	37
Community Engagement	11	15	30
Buildings	22	41	37
Overall Score	16	24	26

The Good Corporate Citizen Model will now feature within the Sustainable Development Management Plan, which in turn links with NHS North Essex strategic objectives. Some work will be required to link with service users to participate in stakeholder workshops as part of the development of the Carbon Management Plan to provide valuable suggestions for carbon reduction initiatives.

Carbon Management Plan
The PCT continues to embrace and embed carbon management into its day-to-day processes as well as ensuring the Clinical Commissioning Groups' key decisions will have due regard to their environmental impact.

Planning For Emergency and Business Continuity

Emergency Planning
NHS North Essex Cluster has been busy working with our local authority, emergency services and NHS providers as we shape the new architecture for emergency planning in North Essex. This involves the development of Local Health Resilience Partnerships and ensuring that we continue to mitigate the risks to public and patients and maintain a functioning health service.

Currently within the Civil Contingencies Act, we have a duty to be prepared for incidents and emergencies and, as a category one responder, must be able to respond to any such incidents in a timely and effective way. We must provide assurances to our community that we are working with partners through the Essex Resilience Forum to assess and address risks by planning adequately.

To this end, we have an Incident Response Plan that is fully compliant with the requirements of NHS Emergency Planning Guidance 2005 and all associated guidance. We have undertaken a significant amount of work and continue to work closely with all our partners including regular testing and exercise to ensure these remain a priority for us all.

Business Continuity Management
NHS North Essex is expected to prepare, maintain and review business continuity plans, the underlying requirement being that the organisation is able to maintain critical services for a period of seven days following an incident interrupting normal services.

Work has been done to maintain the robustness of these plans including reviewing and testing annually against a variety of challenges.

Our staff

Consultation with staff

Consultation took place with staff on the process to manage the transition to new receiver organisations. This process was implemented from October to January 2013. Consultation also took place with staff on their transfer to the new receiver organisations.

As a result of the changes:

473 staff were transferred to receiver organisations during this process.

35 staff from the North Essex Cluster were made redundant

Support to staff
Staff were supported during the year with training and development on CV writing, career development as well as coaching and mentoring. Support was also set up with RENOVO for all staff under notice of redundancy and those made redundant.

Equal Opportunities
The organisation is committed to equal opportunities for all staff. This commitment extends to the employment of disabled people and follows the guidance set out under the Two Ticks symbol.

From our records, only a very small number of staff have disclosed a disability. However, occupational health advice is always acted upon in relation to any disability or long term condition to ensure individuals are supported appropriately within the workplace, in accordance with the Equality in Employment policy.

An equality impact assessment also took place on the impact of implementation of the changes.

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	1	0	1
Administration and estates	**120**	84	36	163	130	33
Nursing, midwifery and health visiting staff	**98**	14	84	69	12	57
Scientific, therapeutic and technical staff	**3**	3	0	4	4	0
Other	**0**	0	0	0	0	0
TOTAL	**224**	**104**	**120**	237	146	91

Off-payroll engagements

For off-payroll engagements at a cost of over £58,200 per annum that were in place as of 31 January 2012

	Shadow CCG	NCB	NHS PS	Total
No. in place on 31 January 2012	3	5	1	9
Of which:				
No. that have since come on to the payroll (31 March 2013)				
No. that have since been re-negotiated/re-engaged to include contractual clauses allowing the PCT to seek assurance as to their tax obligations				
No. that have not been successfully re-negotiated and therefore continue without contractual clauses allowing the PCT to seek assurance as to their tax obligations	3	3	1	7
No. that have come to an end (31 March 2013)		2		2
Total	3	5	1	9

Notes:
Two of the shadow CCG engagements related to elected GPs who were engaged upon a sessional rate. The CCG is considering the contractual relationship in the light of the latest HMRC advice regarding office holders. The 3rd shadow CCG engagement ceased in May 2013. The NCB (CSU) engagements are being reviewed. NHS Property Services will be responsible for making its own contractual engagement arrangements from 1 April 2013.

Staff sickness

	2012-13	2011-12
	Number	Number
Total Days Lost	**1,346**	8,781
Total Staff Years	**278**	1,005
Average working Days Lost	4.84	8.74

The national NHS staff survey

Due to the abolishment of PCTs in March 2013 and the prior transition period during 2012/13, PCTs were not required to take part in the national staff survey for 2012. PCTs were however required to give assurance that they had undertaken local staff engagement.

Under the direction of the Joint Staff Committee, work was undertaken with ACAS to develop an action plan to support staff during the transition. In addition the staff engagement group for the North Essex Cluster was updated regularly regarding the transition and provided a forum for discussion on the transition. The PCT put in place a comprehensive training and development plan to support staff over the year.

Our performance

NHS Mid Essex has worked hard to maintain and where possible, improve performance to meet the needs of its local community and to make further progress in tackling the national and local priorities for healthcare.

Performance in 2012/13

Our performance in 2012/13 is monitored against the requirements of the Annual National Operating Framework and the Regional Strategic Health Authority Commissioning Framework. These include all national and local targets which are used to measure how we are improving health and healthcare year on year for our local population.

In 2012/13, the national priorities continued to focus on improving access to hospital treatment, faster access to cancer services and reducing healthcare associated

infections. A heightened focus was placed on mental health with the requirement to meet national indicators for 'access to psychological therapies' services.

One of the most challenging targets was to continue to ensure that the number of healthcare infections in a hospital was dropping year on year. Mid Essex Hospital Services NHS Trust has made great strides in improving their infection control processes and procedures and continue to improve year on year. Current performance is showing that they are keeping within the ceiling for the number of CDifficile incidents.

MEHT has also made enormous strides to improving performance in Stroke services and meeting both of the stroke national targets, 90% time spent on a stroke unit and Transient Ischaemic Attack (TIA) scan within 24 hrs, as well as improving the A&E performance and the Cancer standards.

The PCT commissioned an IAPT service in 2012/13 following its successful pilot. This is filling a gap in mental health services.

A major part of delivering improved healthcare is to commission services where evidence has proven that it will impact on better health outcomes. Performance has improved in 2012/13 with the increase in the number of people quitting smoking and the number of people having a health check.

The table below shows how we performed in terms of the national priorities for 2012/13 and how our performance compared with 2011/12.

Performance against National Targets

Performance measures	**Target / plan**	**Actual performance** 2012/13	2011/12
Maximum time from referral to treatment			
% People treated with a stay in hospital within 18 weeks of referral by their GP	90%	95.1%	93%
% People treated (non-admitted) within 18 weeks of referral by their GP	95%	98.5%	98%
Reducing healthcare associated infections (PCT)			
Number of *C Difficile* infections	61	73	77
Number of MRSA infections	2	6	0
Reducing healthcare associated infections (MEHT)			
Number of *C Difficile* infections	22	17	20
Number of MRSA infections	1	1	0
Cancer treatment waiting times			
% People attending a first appointment within two weeks of an urgent referral by their GP for suspected	93%	97.0%	95%

cancer			
% People attending a first appointment within two weeks of an urgent referral by their GP for breast symptoms	93%	97.6%	98%
% People receiving treatment within 62 days of an urgent referral by their GP for suspected cancer	85%	84.2%	87%
% People receiving treatment within 31 days of a cancer diagnosis	96%	98.8%	99%
Improving care for strokes			
% People spending 90% of their treatment time on a special stroke unit	80%	86.1%	70%
Patients with a suspected transient ischaemic attack (TIA) seen and treated within 24 hours	60%	66.2%	69%
Reducing blood clots in the vein (VTE)			
% People admitted to hospital who are assessed for risk of VTE	90%	96.5%	95%
Accident & emergency department waiting times			
95% Patients seen in A&E within 4 hours	95%	95.8%	96%
Ambulance response times			
% Calls for life-threatening incidents resulting in a response within 8 minutes	75%	74.0%	75%
% Calls for life-threatening incidents resulting in a response within 19 minutes	95%	93.9%	95%
Improving mental health			
% People who have depression and/or anxiety disorders who receive psychological therapies	9.8%	6.0%	8.9%
% People who complete treatment who are moving to recovery	50.5%	50.8%	47.0%
Choice about where to die			
% Deaths at home, or place of residence (as opposed to in hospital)	To Improve	42.6%	40%
Improving maternity care			
% Women of women who are smoking at time of delivery	<10%	%	%
% Women breastfeeding their babies at 6-8 weeks after birth	To Improve	46.5%	47.6%

Improving support for children and families Increasing number of Health Visitors (HVs)	Target is to increase to 72 HVs by March 2015		45
Reducing smoking Number of people who quit smoking for more than 4 weeks after using NHS Stop Smoking Services	2,850	2,001	2,906
NHS Health Checks			
% People who are eligible being offered a health check	23,613	28,931	14,498
% People who are eligible who received a health check	17,708	15,429	9,313

***This data is provisional for 2012/13**

To find out more
More detailed information on our performance against key targets and indicators is given in the regular performance reports to our public board meetings, which may be found on the PCT's website.

Value for money
A Value for Money (VFM) conclusion is made by BDO LLP, who are NHS Mid Essex's external auditors.

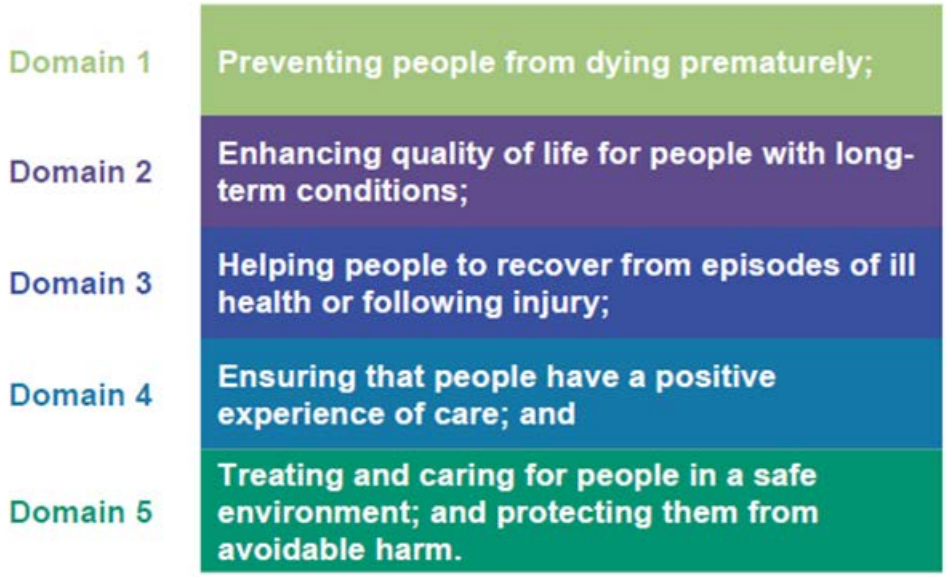
Their conclusion is given in the financial statements section of this report and is based upon an assessment by the auditor as to whether NHS Mid Essex has put in place proper arrangements for securing, economy, efficiency and effectiveness in its use of resources.

Looking ahead
The White Paper, Equity and Excellence: Liberating the NHS set out how the improvement of healthcare outcomes for all will be the primary purpose of the NHS. This means ensuring that the accountabilities running throughout the system are focussed on the outcomes achieved for patients not the processes by which they are achieved.

The NHS Outcomes Framework 2013/14 reflects the vision set out in the White Paper and contains a number of indicators selected to provide a balanced coverage of NHS activity. Its purpose is threefold:

- to provide a national level overview of how well the NHS is performing;
- to provide an accountability mechanism between the Secretary of State for Health and the NHS Commissioning Board for the effective spend of some £95bn of public money; and
- to act as a catalyst for driving up quality throughout the NHS by encouraging a change in culture and behaviour.

The NHS Outcomes Framework is structured around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. They focus on:



Mid Essex CCG's system's key priorities for 2013/14 reflect these domains and NHS Mid Essex has been working with the CCG to support it to develop plans to achieve them.

Everyone Counts: Planning for Patients 2013/14 (published by the NHS Commissioning Board) outlines the incentives and levers that will be used to improve services from April 2013, the first year of the new NHS, where improvement is driven by clinical commissioners.

Information Governance
Information governance ensures necessary safeguards for, and appropriate use of, patient and personal information. We are pleased to report that this year there have been no serious untoward incidents relating to information governance at NHS Mid Essex

Financial Review

During 2012/13 North East Essex PCT, Mid Essex PCT and West Essex PCT continued to work collectively as NHS North Essex, a PCT cluster.

The three PCTs remain as separate statutory bodies. During the year, the PCT cluster began to implement the future structures of the organisations that will be formed from 1st April 2013 when the PCT ceases to exist.

NHS Mid Essex Financial Overview 2012/2013

Financial Duties
NHS Mid Essex achieved its statutory financial duties, achieving its revenue target surplus of £1m and containing capital and cash expenditure within the approved limits. The following table demonstrates the performance against these statutory duties over the past three years.

Financial Duty	All figures in £000	2010/11	2011/12	2012/13
Remain within Revenue Resource Limit	Performance	528,202	534,408	553,460
	Limit	531,969	535,529	554,460
Remain with Capital Resource Limit	Performance	3,098	1,871	2,076
	Limit	3,206	1,918	3,214
Remain within Cash Limit	Performance	529,655	535,997	551,981
	Limit	529,655	538,297	551,981

Capital Expenditure
The PCT had a Capital Resource limit of £3,214k for 2012/13 and spent £2,076k on its Capital Programme:

The main capital schemes were:

Description	£000
Witham Clinic refurbishment (including Dental)	453
Redevelopment of Springfield Clinic	386
Moulsham Lodge refurbishment	357
Maldon Clinic refurbishment	238
South Woodham Clinic refurbishment	173
Colingwood Road – telephone system	165

Other expenditure included minor works, furniture and IT equipment and infrastructure.

Value for Money
Ensuring value for public money is an important principle of the PCT and is outlined in the corporate governance framework adopted by the Board. Valuations have been identified and are in note 12.4 of the accounts. To ensure value for money is achieved,

appropriate procurement procedures are in place, including the tendering of goods and services where necessary. The PCT is supported by procurement specialists and non-executive and lay members of the PCT and CCG Boards respectively have significant commercial experience

During 2012/13 the PCT carried out a review of all areas of expenditure and considered benchmarking data as part of the Financial Recovery Programme. A key priority for the PCT and for the CCG going forward is to ensure that maximum value for money is being achieved through effective commissioning arrangements, as the majority of the PCT's expenditure is spent on commissioning healthcare services. While all healthcare providers, are required to deliver a continuous programme of Quality, Improvement, Productivity and Prevention (QIPP), the PCT and CCG must also demonstrate that it is properly considering the health needs of the local population and commissioning services that address those needs.

During 2012/13 the North Essex PCT cluster has been working with NHS and social care colleagues to identify opportunities for system-wide QIPP and agreeing how we will respond to the challenging financial climate in which the NHS and the wider public sector will operate over the coming years.

The PCT's overall financial management arrangements were also subject to review by the PCT's external auditors, BDO LLP (previously PKF (UK) LLP and referred to herein as BDO), as part of their annual review of the PCT's accounts. The PCT received an unqualified value for money conclusion in 2011/12 and expects to receive a similar opinion in respect of 2012/13.

The PCT's funding per head of population is amongst the lowest in the country and in 2011/12 (the last year for which the information is available) the PCT was funded £24.2m below target funding (i.e. below the amount deemed necessary to fund a uniform level of service, as determined by the Department of Health formula). Mid Essex Hospitals NHS Trust also faces financial pressures due to its comparatively high premises costs. The mid Essex health economy is therefore one of the most challenged in the country.

Mid Essex had a 2012/13 gross QIPP target of £24.7m (£20m net) which was one of the largest in the country. The plans included ambitious targets for demand management. The delivery of these schemes represented a significant financial risk to the PCT. Slippage on delivery led to the PCT formally declaring itself to be in financial recovery mode and seeking alternative solutions to make up for the slippage. The PCT also faced significant financial risk from the claims for the retrospective reimbursement of nursing home costs – the volume of which was exacerbated by the Department of Health setting a deadline for the submission of claims for the period prior to 1 April 2012. Nationally, this resulted in thousands of claims being submitted. The assessment process is complicated and it will be some time before the total financial liability will be known. Mid Essex CCG will inherit any unfunded liabilities in respect of these claims.

NHS reorganisation and the risk of the disaggregation of resources not matching the disaggregation of financial responsibilities represents a further financial risk to be carried into the new arrangements.

Better Payment Practice Code
The Non NHS Trade Creditor Payment Policy of the NHS is to comply with the both the Confederation of British Industry Prompt Payment Code and Government Accounting Rules. The target is for 95% of both the value and number of non-NHS trade creditors to be paid within 30 days of receipt of goods or a valid invoice, whichever is later, unless other payment terms have been agreed.

As a result of this policy the PCT ensured that:
• A clear and consistent policy existed to ensure payment of bills in accordance with contracts and that finance and purchasing teams were aware of this policy;
• Payment terms were agreed at the outset of a contract and were adhered to;
• Suppliers were given clear guidance on payment procedures;
• A system existed for dealing quickly with disputes and complaints;
• Bills were paid within agreed terms.

The performance of the PCT against this target is as follows. The volumes and the value of compliance in 2012/13 is much improved, compared to 2011/12.

	2012-13 Number	**2012-13 £000**	**2011-12 Number**	**2011-12 £000**
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**12,589**	**137,728**	13,001	130,017
Total Non-NHS Trade Invoices Paid Within Target	**11,811**	**132,617**	11,514	122,734
Percentage of NHS Trade Invoices Paid Within Target	93.82%	96.29%	88.56%	94.40%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3,341**	**363,812**	3,516	359,328
Total NHS Trade Invoices Paid Within Target	**2,740**	**355,113**	2,699	348,972
Percentage of NHS Trade Invoices Paid Within Target	82.01%	97.61%	76.76%	97.12%

Audit Arrangements

BDO are our external auditors, appointed by the Audit Commission. 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. The total planned fee for 2012/13 audit was £144k including VAT for the PCT relating to audit services (£227k for audit services and £4k for non audit services in 2011/12).

No other work was carried out by BDO during 2012/13.

Pension Liabilities
The PCT's annual accounts detail the accounting policy adopted regarding the NHS pension scheme liabilities and this can be found in note 7.5 of the accounts.

2013/14 Financial Plans

2013/14 financial planning was undertaken within the shadow successor organisations for the population of Essex. This approach reflects the new NHS landscape and recognised the transferring ownership to future commissioners.

Balanced budgets have been set for 2013/14 across Essex. Given the relatively low funding per head of population in Mid Essex, Mid Essex CCG is seeking to deliver significant efficiency savings through its Quality, Innovation, Productivity and Prevention programme. The CCG's QIPP target is the largest in Essex and one of the highest nationally.

The CCG's challenge to maintain and improve the quality of services it commissions on behalf of the local population whilst delivering significant productivity savings. This challenge is no different from that faced previously by the PCT.

Dawn Scrafield
Director of Finance and Performance
Please see Appendix C at the end of the document for the full set of financial statements for the year ended 31 March 2013.

NHS MID ESSEX ANNUAL GOVERNANCE STATEMENT 2012/13
The Annual Governance Statement sets out the following for the PCT:

- Scope of Responsibility for the Accountable Officer and the sound system of internal control that is in place to support the achievement of the organisation's policies, aims and objectives, whilst safeguarding public funds

- Acknowledgement of the Accountable Officer's responsibilities demonstrating an understanding of propriety and accountable issues Governance framework of the PCT

- Risk assessment process

- Risk and control framework

- Review of the effectiveness of risk management and internal control

- Highlighting of significant issues for this past year

The Annual Governance Statement can be obtained in full in the Annual Accounts (Appendix C).

Statement of the chief executive's responsibilities as the accountable officer of the primary care trust and the Statement of directors' responsibilities in respect of the accounts are also included in the Annual Accounts section of this publication.

The independent auditor's report to the directors of NHS Mid Essex is included in the annual accounts.

Annual Report of the Cluster Audit Committee 2012/13

1. Purpose of Report

The purpose of this report is to demonstrate to the Cluster Board that the Cluster Audit Committee (the Committee) has met its Terms of Reference for 2012/13.

2. Background

The Committee is established and constituted to provide the Cluster Board with an independent and objective review of its financial systems, financial information and compliance with laws, guidance and regulations governing the NHS.
The Committee's Terms of Reference, modeled on NHS guidance, cover the following areas: Governance, Risk Management and Internal Control; Internal Audit; External Audit; Management and Financial Reporting.
The Committee functions as the Audit Committee for the three statutory PCTs: NHS Mid Essex, NHS North East Essex and NHS West Essex. At Clinical Commissioning Group (CCG) level, there is a shadow Audit Committee established within each of the CCG areas which also meet regularly.
The Committee has met 7 times during 2012/13.

3. Integrated Governance, Risk Management and Internal Control

The Committee 'shall review 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 supports the achievement of the organisation's objectives'.

The Committee considered and accepted the 2011/12 Governance Statements for the three PCTs within the cluster. In so doing, it took into account the Head of Internal Audit Opinions which was confirmed by the Annual Governance Reports from the external auditors.
The Cluster Board Assurance Framework to support the strategic objectives has been reviewed at meetings throughout the year so too has the reported red risks.
The Committee reviewed progress on the implementation of cluster governance arrangements throughout the year, including arrangements to support the development of the Clinical Commissioning Groups and the establishment of the Governing Body for the Commissioning Support Unit as a committee of the both South Essex and North Essex Cluster Boards.
The minutes of the committee meetings reporting to the Board such as the Transition Committee, CCG Performance and NCB Performance Committees were reported to the Cluster Audit Committee.
The Committee considered and approved policies such as the Cluster Anti-Fraud and Corruption Policy and updated the Corporate Governance Manuals. It received the developing Constitutions, Standing Orders and Standing Financial Instructions including the intended Scheme of Delegation for each of the CCGs as from 1st April 2013.
It received the Local Security Management Annual Report.

The Committee met privately with both Internal Audit and External Audit on a regular basis as part of the Committee assurance process.

4. Internal Audit

'The Cluster Audit Committee shall ensure that there is an effective Internal Audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Cluster Audit Committee, Chief Executive and NHS North Essex Board.'

The internal audit function is currently provided by the Deloitte which operates at arms length from its clients.

The Committee has viewed the developing audit plans for each of the CCGs.

Internal Audit report progress at each meeting of the Committee. Their findings are presented and discussed. Where recommendations have not been implemented on limited assurance reports, these have been monitored by the Cluster Audit Committee who have progressed the action requirements with the relevant manager lead.

The following audits in the Internal Audit Plan were presented to the Cluster Audit Committee during 2012/13:-

- Order & Receipt of Goods & Creditors
- Financial Ledger
- Income & Debtors
- Financial Reporting & Budgetary Control
- Payroll
- Fixed Assets
- Governance, Risk Management & Assurance Framework (inc CCG's)
- Patient Experience
- Clinical Governance
- Quality, Innovation, Productivity & Prevention
- Transition Management Capacity Planning
- Transition Management Governance
- Transition Management Contract Transfer
- Performance Management (Acute Providers & Transition Management)
- Commissioning Support Services Governance Arrangements

Information Technology

- IT Procurement
- ITIL Service Desk
- Follow up of Recommendations
- Planning, Liaison, Reporting & Meetings

Where necessary, updates are received at each meeting.

5. External Audit

"The Cluster Audit Committee shall review the work and findings of the External Auditors and consider the implications and management's responses to their work."

The 2012/13 Annual Audit plans for NHS Mid Essex, NHS North East Essex and NHS West Essex were reviewed.

The Committee agreed financial governance arrangements for the 2012/13 accounting process for the three PCTs, ensuring that local Audit and Governance Groups were briefed on, and involved in the annual accounts process.

As with Internal Audit, the External Audit function attends each meeting and contributes to discussions and the Committee's understanding of the issues under consideration. The Committee received and accepted External Audit reports, including that on the transition.

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.

6. Counter Fraud

The Cluster Audit Committee approved the workplan and strategy for counter fraud. The Cluster Audit Committee received regular Counter Fraud progress updates at each meeting from the Local Counter Fraud Specialist. Any issues highlighted at meetings as required. The Committee is satisfied that each member PCT has adequate arrangements in place for countering fraud. An update on the progress of existing cases is provided at the Cluster Audit Committee meetings.

7. Management

"The Cluster Audit Committee shall request and review reports and positive assurances from Directors and Managers on the overall arrangements for governance, risk management and internal control."

The Committee has received reports on the Board Assurance Framework governance arrangements, tender waivers and losses and compensation. The Committee agreed a work plan for the year following a self assessment of the audit committee checklist. A review of policy for hospitality as well as revision to Standing Orders and Standing Financial Instructions that were approved by the Board. At each meeting the Committee identified items for reporting to the cluster Board.

8. Financial Reporting

'The Committee shall monitor the integrity of the financial statements of the PCTs and any formal announcements relating to the PCTs' financial performances.

The Committee should ensure that the systems for financial reporting to the Cluster Board, including those of budgetary control are subject to review as to completeness and accuracy of the information provided to the Cluster Board.

The Committee shall review the annual reports and financial statements before submission to the Cluster Board'.

The Cluster Audit Committee is reviewing the Annual Report and Annual Governance Statements and will be seeking delegated authority from the Board to approve the final versions following the dissolution of the PCTs.

The Committee considered both draft and audited financial statements for 2011/12 for the three members PCTs, including compliance with accounting policies and significant adjustments resulting from the audit. The Committee was happy to endorse the statements for approval.

The Committee received progress reports on the development of the new financial ledger.

9. Audit Committee Development

During the early part of the year, the Committee focused on ensuring that all actions from the three PCT Audit Committee meetings were followed up and any issues picked up appropriately.

Ensuring that governance arrangements and local Audit Committees were established by the CCGs and functioning appropriately at a period of significant change within the NHS was a priority for the committee during the year.

In 2012/13 with significant changes to the NHS commissioning system beginning to take shape the committee will focus on ensuring statutory responsibilities for each PCT are met up to March 2013 and that clinical commissioning groups have effective processes in place from April 2013 onwards for audit and governance.

10. Conclusion

On the basis of the above activity, it is the view of the Cluster Audit Committee that the Cluster's system of integrated governance, risk management and internal control is operating effectively.

11. Acknowledgements

The Committee has been supported throughout the year by the Director of Finance and Corporate Services and their staff, the Audit Commission, Local Counter Fraud Service. Various senior PCT managers have attended as appropriate. The Committee wishes to acknowledge its gratitude for their efforts.

12. Recommendation

For the Board to receive and note this report and comments as appropriate.

Jerry Wedge
North Essex Cluster Audit Committee Chair
March 2013

Remuneration report for the period ending 31 March 2013

The tables and related narrative notes for salaries and allowances of senior managers, pension benefits of senior managers and pay multiples included in this report have been audited.

The policy of the remuneration

All senior managers, with the exception of the Chief Executive and Directors, are subject to Agenda for Change terms and conditions. The salary of the Chief Executive and Directors is determined by the Remuneration Committee, with national and local guidance (provided by the Director of Finance and Head of Human Resources) being taken into account in all decisions.

Performance Conditions

The performance of all staff (including the Chief Executive, Directors and Senior Managers) is monitored and assessed through the use of a robust appraisal system. A formal appraisal review is undertaken at least annually. With the exception of the Very

Senior Manager (VSM) Pay scales there are no performance related pay elements contained in any contracts for 2012/13. Where the payment of bonuses to VSMs are proposed, these are scrutinised by the Remuneration Committee and the Strategic Health Authority.

Relevant proportions of remuneration

Agenda for Change contracts do not contain provision for performance related remuneration. There is therefore no proportion of remuneration which is subject to performance conditions. However under the terms of the VSM Pay Scales there is the potential for performance related pay under the terms and conditions of the contract.

Policy on the duration of contracts, notice periods and termination payments

The duration of contracts is determined by the duration of the roles and responsibilities to be undertaken. The contracts of the Chief Executive, Directors and other Senior Managers are permanent unless it applies to a time limited project or funding in which case contracts will be offered as a fixed term contract. The notice period applying to the Chief Executive, Directors and all VSM is 6 months and Senior Managers is 3 months. Any termination payments would be in accordance with relevant contractual, legislative and Inland Revenue requirements.

Senior manager information

Significant Awards

Neither NHS North Essex nor its predecessor organisations have made any significant awards to past Senior Managers during the period ending 31 March 2013.

Salary and Pension Entitlements

Similar to previous years, the information for salaries, benefits in kind and pensions entitlements is required to be detailed in the annual report. This information can be found at Appendix A.

There are no elements of remuneration, other than the benefits in kind detailed in Appendix A, outside of the standard terms and conditions of the contracts of employment of senior managers.

The annual accounts detail the accounting policy adopted regarding the NHS pension scheme liabilities and this can be found in note 1 of the full annual accounts.

As referred to above, the remuneration report and pay multiples can be found in Appendix A.

Glossaries of terms used in this annual report

Glossary of financial terms

Accounting Policies
The Accounting Policies are the accounting rules that the PCT has followed in preparing its accounts. These policies are based on International Financial Reporting Standards and the Treasury's Financial Reporting Manual. The Department of Health's Manual for Accounts and Capital Accounting Manual detail how these rules should apply to PCTs. One of the main policies is that income and expenditure is recognised on an accruals basis, meaning it is recorded in the period in which services are provided even though cash may or may not have been received or paid out.

Current Assets
Assets held for less than one year that can be converted to cash such as stocks of consumables, monies held in the PCT's bank account and the amount of money that is owed to the PCT by individuals or organisation.

Capital Expenditure
Items of expenditure that have a useful life of more than one year and are individually valued at £5,000 or more e.g. land & buildings and large pieces of equipment. It is possible to capitalise smaller items but they have to be over £250 in value and be interdependent.

Cash Limit
The PCT is allocated an amount of cash to match the Revenue and Capital Resource Limits (see below for definition) it has. If the PCT has an element within its Resource or Cash Limit that doesn't require a payment being made e.g. depreciation then the Cash Limit is reduced for those amounts. The PCT has a statutory duty to remain within its Cash Limit.

Capital Resource Limit
The total amount of capital expenditure (see above for definition) that the PCT can commit in the financial year. The PCT has a statutory duty to remain within its Capital Resource Limit.

Depreciation
The annual charge in relation to the utilisation/wearing out of non-current assets. The charge to the non-current assets is spread over the useful life.

Financial Instrument
A contract that gives rise to a financial asset of one entity and a financial liability of another entity e.g. cash and a contractual right to receive cash.

Finance Lease
An arrangement that transfers substantially all the risk and rewards related to ownership of an asset to the PCT although title may not have transferred.

General Fund
The General Fund is similar to a Profit and Loss reserve, the operating cost of the PCT is charged here as well as an opposite entry for the Net Parliamentary Funding (amount of cash drawn down from the Department of Health).

Impairment
A loss on the values of non-current assets compared to the value recorded on the Statement of Financial Position. The impairment (loss) is treated in the same way as depreciation, as a cost in the Statement of Comprehensive Net Expenditure (SCNE), if the change in the value of the asset is permanent.

Intangible Assets
An invisible or 'soft' asset that has been purchased using capital expenditure, has a real current market value and contributes to the (future) operation of the PCT e.g. IT software.

IFRS – International Financial Reporting Standards
The principles-based standards, interpretations and framework which govern the production of the PCT's accounts.

Losses and Special Payments
Costs or payments that Parliament would not have foreseen healthcare funds being spent on, for example fraudulent payments, personal injury payments or payments for legal compensation.

Miscellaneous Income
Income that the PCT receives over and above its revenue resource limit, e.g. room rental and training income.

Net Cash Outflow from Operating Activities
This is the amount of cash actually paid out less miscellaneous income actually received. It differs from the Net Operating Cost which includes non cash items such as depreciation and movements in Debtors and Creditors.

Net Parliamentary Funding
This is the amount of cash drawn down by the PCT from the Department of Health for payments relating to commissioning services and running the PCT.

Non-Current Assets
Tangible assets that have been purchased using Capital Expenditure (see definition above) previously known as Fixed Assets.

Operating Costs
The costs incurred by the PCT on staff, goods and services and other non-capital items. (Gross Operating Costs are the gross cost before taking account of any income.)

Operating Lease
Any lease other than a finance lease.

Programme Expenditure

The costs of the PCT in the purchase of healthcare services and other healthcare related expenditure.

Provisions
A liability for which it is probable the PCT will have to settle, but where the value is not yet confirmed/due but a reliable estimate can be made.

QIPP – Quality, Innovation, Productivity and Prevention
A major savings and value for money cost improvement programme that is being implemented across the NHS in order to manage traditional cost pressures during this period of restraint/reductions in public sector expenditure.

Revaluation Reserve
The cumulative difference between the amount paid for land and buildings and the current valuation. Buildings are revalued on a 'Modern Equivalent Asset Valuation' (MEAV) basis in line with NHS accounting requirements. A modern equivalent asset is a structure similar to an existing structure which could be built using modern materials, techniques and design.

Revenue Resource Limit
The total amount that the PCT can commit in the financial year in respect of revenue items (i.e. operating costs such as purchasing healthcare, salary costs and running costs). The PCT has a statutory duty to remain within its Revenue Resource Limit.

Statement of Cash Flows
The Statement of Cash Flows (SCF) shows the effect of the PCT's operating activities on its cash position.

Statement of Changes in Taxpayer Equity
The Statement of Changes in Taxpayers' Equity highlights financial transactions that may not be reflected in the Statement of Comprehensive Net Expenditure, but which affect the PCT's reserves as shown in the "Financed by" section on the Statement of Financial Position. For example, (reduction)/additions to the General Fund due to the transfer of assets to/from NHS bodies and the Department of Health.

Statement of Comprehensive Net Expenditure
Similar to an income and expenditure statement. This details the costs incurred by and income to the PCT during the year. Under government accounting rules the SCNE shows the net resources used by the PCT in commissioning and providing healthcare rather than the surplus or deficit for the year as shown in the income and expenditure account by NHS trusts. The comprehensive net expenditure is debited to the general fund on the Statement of Taxpayers Equity.

Statement of Financial Position
The Statement of Financial Position provides a view of the PCT's financial position at a specific moment in time – usually the end of the financial year (formerly known as the Balance Sheet). It shows assets (everything the PCT owns that has monetary value), liabilities (money owed to external parties) and taxpayers' equity (public funds invested in the PCT).

Trade and Other Payables
Monies or services that the PCT owes to individuals or organisations (previously known as creditors).

Trade and Other Receivables
Amounts or services owed to the PCT by individuals or organisations (previously known as debtors).

Unrealised Gains and Losses
Gains and losses may be realised or unrealised. Unrealised gains and losses are recognised in the accounts although the financial transaction may not yet have occurred to realise the event e.g. where the value of an asset has increased but the gain will not be realised until the asset is sold or otherwise used.

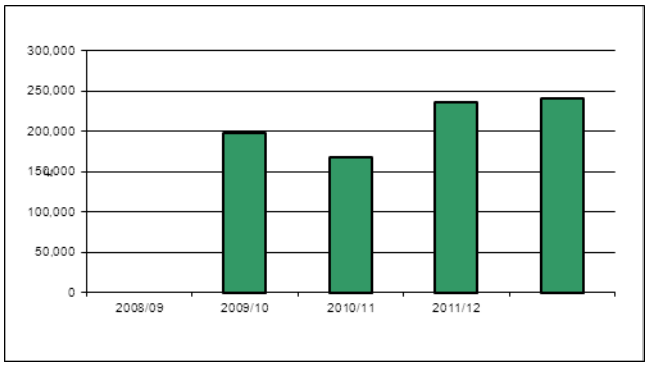
Glossary of non-financial terms

Term	Definition
Care pathway	The route that a patient will take from their first point of contact with an NHS or Social Services member of staff (usually their GP), through referral, to the completion of their treatment.
Choice	Giving patients more choice about how, when and where they access health services.
Civil Contingencies Act 2004	Provides a single framework for UK civil protection against any challenges to society – it focuses on local arrangements and emergency powers.
Clinical Commissioning Group (CCG)	Body led by GPs, senior nurses, public health professionals, social service representatives and lay members responsible for planning and buying healthcare for local communities
Commissioning	The review, planning and purchasing of health and social services.
Community services	Health or social care and services provided outside hospitals. They can be provided in a variety of settings including clinics and in people's homes. Community services include a wide range of services such as district nursing, health visiting services and specialist nursing services.
Commissioning Support Unit (CSU)	Will provide capacity to clinical commissioners as an extension of their local team to ensure that commissioning decisions are informed and processes structured. This approach will help achieve economies of scale and allow clinical commissioning groups to focus on direct commissioning of services for their

	patients.
Diabetic retinopathy	One of the most common causes of blindness in the UK. Retinopathy means damage to the tiny blood vessels (capillaries) that nourish the retina, the tissues in the back of the eye that deal with light.
Enhanced services	i) essential or additional services delivered to a higher specified standard, for example, extended minor surgery ii) services not provided through essential or additional services They are services provided by GPs, over and above the core (essential and additional) services to their patients.
Palliative Care	The total care of patients whose disease is incurable. Control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families.
Primary Care Trust (PCT)	Responsible for the planning and securing of health services and improving the health of the local population.

Sustainability Report

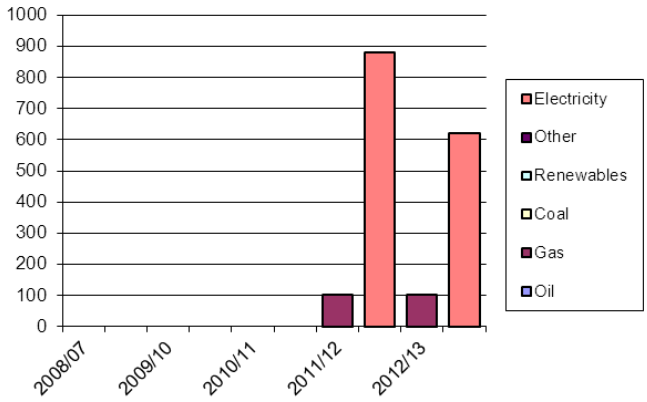
-3%



The NHS aims to reduce its carbon footprint by 10% between 2009 and 2015. Reducing the amount of energy used in our organisation contributes to this goal. There is also a financial benefit which comes from reducing our energy bill. Our energy costs have increased by 3% in 2011/12, the equivalent of 1 hip operations.

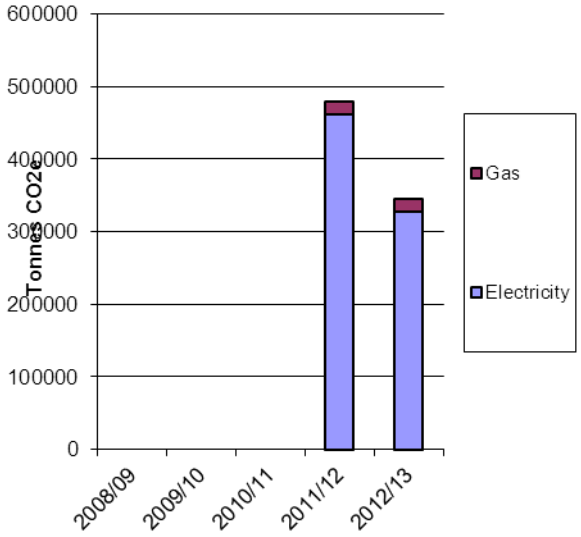
We have not yet quantified our plans to reduce carbon emissions and improve our environmental sustainability

Our total energy consumption has fallen during the year, from 000,982 to 000,724 MWh



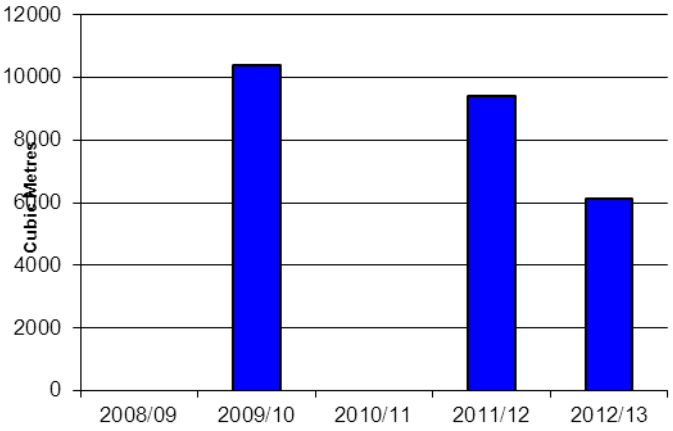
Our relative energy consumption has changed during the year, from 0.11 to 0.08 MWh/square metre.

Renewable energy represents 0.0% of our total energy use. We do not generate any energy. We have not made arrangements to purchase electricity generated from renewable sources



Our measured greenhouse gas emissions have reduced by 134,661 tonnes this year. We do not currently collect data on our annual Scope 3 emissions.

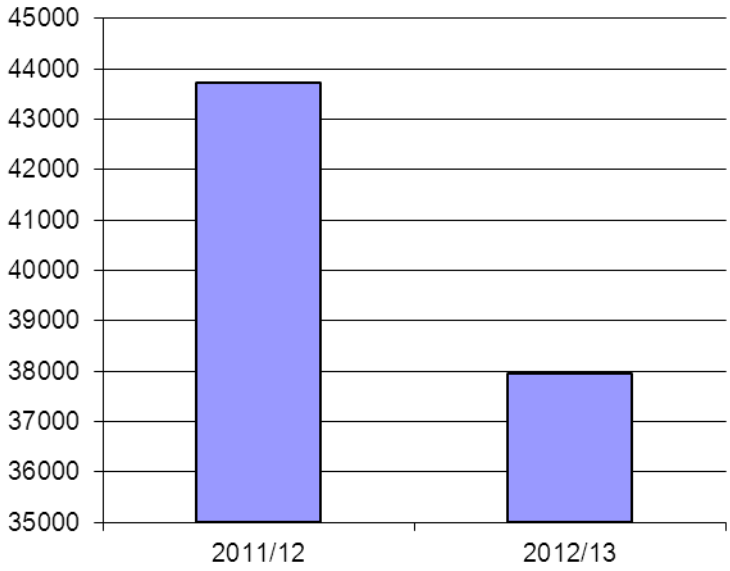
Our water consumption has reduced by 3,297 cubic meters in the recent financial year. In 2011/12 we spent £27,620 on water.



During 2011/12 our gross expenditure on the CRC Energy Efficiency Scheme was £0,000

The CRC Energy Efficiency Scheme is a mandatory scheme aimed at improving energy efficiency and cutting emissions in large public and private sector organisations.

Our expenditure on waste in the last two years was incurred as follows:



Our organisation has an up to date Sustainable Development Management Plan.

Having an up to date Sustainable Development Management plan is a good way to ensure that an NHS organisation fulfills its commitment to conducting all aspects of its activities with due consideration to sustainability, whilst providing high quality patient care. The NHS Carbon Reduction Strategy asks for the boards of all NHS organisations to approve such a plan.

We consider neither the potential need to adapt the organisation's activities nor its buildings and estates as a result of climate change.

Adaptation to climate change will pose a challenge to both service delivery and infrastructure in the future. It is therefore appropriate that we consider it when planning how we will best serve patients in the future.

Sustainability issues are included in our analysis of risks facing our organisation.

NHS organisations have a statutory duty to assess the risks posed by climate change. Risk assessment, including the quantification and prioritisation of risk, is an important part of managing complex organisations.

In addition to our focus on carbon, we are also committed to reducing wider environmental and social impacts associated with the procurement of goods and services. This will be set out within our policies on sustainable procurement.

We plan to start work on calculating the carbon emissions associated goods and services we procure.

Dawn Scrafield is the Board Level Lead for Sustainability.

A Board Level lead for Sustainability ensures that sustainability issues have visibility and ownership at the highest level of the organisation.

Sustainability issues, such as carbon reduction, are not currently included in the job descriptions of all staff.

We have not conducted a staff energy awareness campaign.

A sustainable NHS can only be delivered through the efforts of all staff. Staff awareness campaigns have been shown to deliver cost savings and associated reductions in carbon emissions.

Our organisation does not have a Sustainable Transport Plan.

The NHS places a substantial burden on the transport infrastructure, whether through patient, clinician or other business activity. This generates an impact on air quality and greenhouse gas emissions. It is therefore important that we consider what steps are appropriate to reduce or change travel patterns.

Remuneration Report

Appendix A

Salaries and Allowances (audited)

Name and Title		Note	2012-13 Total Salary & Bonus across the NHS For the Relevant Period (bands of £5,000)	Mid Essex PCT Share of Costs 2012-13 Salary (bands of £5,000)	Other Remun-eration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (Rounded to nearest £00)	2011-12 Salary (bands of £5,000)	Other Remun-eration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (Rounded to nearest £00)
			£,000	£,000	£,000	£,000	£,00	£,000	£,000	£,000	£,00
Sheila Bremner	*EBM Clinical Commissioning Board (CCB) Member - Chief Executive to 30/09/2012	3&4	75 - 80	25 - 30	0 - 5	-	1	55 - 60	-	-	4
Adrian Marr	*EBM - Director of Resources, CCB Member to 30/09/2012	3&5	60 - 65	20 - 25	0 - 5	-	2	40 - 45	-	0 - 5	3
Sallie Mills Lewis	*EBM - Director of Commissioning, CCB Member to 30/09/2012	3&6	55 - 60	20 - 25	0 - 5	-	2	35 - 40	-	0 - 5	2
Sarah Jane Relf	*EBM - Director of Corporate Governance and Organisational Development (redesignated Director of Transition & Governance Jan 2012) to 30/09/2012	3&7	45 - 50	15 - 20	0 - 5	-	1	35 - 40	-	-	2
Dr Donald McGeachy	Medical Director and Mid CCB member	3&8	75 - 80	40 - 45	10 - 15	-	-	25 - 30	-	-	5
Dr Mike Gogarty	Director of Public Health to 30/09/2012	3&9	35 - 40	10 - 15	0 - 5	-	-	15 - 20	-	-	-
Denise Hagel	Interim Director of Nursing to 30/9/2012	3	-	-	20-25	-	-	30 - 35	-	-	-
Andrew Pike	Chief Executive from 1/10/2012	10	70 - 75	-	-	-	-	-	-	-	-
Dawn Scrafield	Director of Finance & Performance from 1/10/2012	10	55 - 60	-	-	-	-	-	-	-	-
Ian Stidson	Director of Primary Care and Partnership Commissioning from 1/10/2012	10	45 - 50	-	-	-	-	-	-	-	-
Pol Toner	Director of Quality and Patient Experience from 1/10/2012	10	45 - 50	-	-	-	-	-	-	-	-
Alison Cowie	Director of Public Health from 1/10/2012	10	40 - 45	-	-	-	-	-	-	-	-
Alan Hubbard	MEPCT NED/Board Member (until Nov 2011), Cluster NED/Board Member (from Dec 2011) and Lay Member CCB	3	5 - 10	0 - 5	0 - 5	-	-	5 - 10	-	-	1
Chris Paveley	Cluster NED & Board Chair from Dec 2011 to 31/12/2012	3	25 - 30	5 - 10	0 - 5	-	3	0 - 5	-	-	2
Jerry Wedge	Cluster NED/Board Member and Chair of Cluster Audit Ctte (from Dec 2011)	3	10 - 15	0 - 5	0 - 5	-	1	0 - 5	-	-	2
Qadir Bakhsh	Non Executive Director from 01/04/2012 to 30/11/2012	3	5 - 10	0 - 5	0 - 5	-	1	0 - 5	-	-	-

Salaries and Allowances (audited)

Name and Title		Note	2012-13 Total Salary & Bonus across the NHS For the Relevant Period (bands of £5,000)	Mid Essex PCT Share of Costs							
				2012-13				2011-12			
				Salary (bands of £5,000)	Other Remun-eration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (Rounded to nearest £00)	Salary (bands of £5,000)	Other Remun-eration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (Rounded to nearest £00)
			£,000	£,000	£,000	£,000	£,00	£,000	£,000	£,000	£,00
Stephen King	Non Executive Director from 01/04/2012 to 31/03/2013	3	5 - 10	0 - 5	0 - 5	-	1	0 - 5	-	-	-
Dr Pam Donnelly	Cluster NED/Board Member (from Dec 2011), Cluster Chair from 01/01/2013	3	10 - 15	0 - 5	0 - 5	-	1	0 - 5	-	-	-
Renata Drinkwater	Non Executive Director (from 01/04/12 to 31/12/12)	3	5 - 10	0 - 5	0 - 5	-	-	0 - 5	-	-	-
Tim Young	Non Executive Director (from 01/04/12 to 30/11/12)	3	5 - 10	0 - 5	-	-	-	0 - 5	-	-	1
Dr Lisa Harrod-Rothwell	Clinical Commissioning Board (CCB) Mid Essex (Chair from 24/10/11) and member of PCT Executive Board	11	90 - 95	90 - 95	-	-	-	60 - 65	-	-	-
Dr Bryan Spencer	GP & Executive Board Member to May 11 then CCB Member (CCB Chair & member of PCT Executive Board May - Oct 11, CCB Vice-Chair and CCB deputy to the Executive Board from Oct 11)	11	80 - 85	80 - 85	-	-	-	65 - 70	-	-	-
Sushil Jathanna	CCB Interim Accountable Officer (October to December 2012)		45 - 50	-	-	-	-	-	-	-	-
James Roach	CCB Accountable Officer from 01/03/13		5 - 10	-	-	-	-	-	-	-	-
Clare Steward	CCB Director of Strategy & Primary Care (Interim Accountable Officer for part of the year)		85 - 90	85 - 90	0 - 5	-	-	-	-	-	-
Carol Anderson	CCB Director of Nursing & Quality (Governance Lead - Primary Care Transformational Delivery Board (TDB) 2011-12)		75 - 80	75 - 80	0 - 5	-	1	5 - 10	55 - 60	-	-
Dee Davey	CCB Chief Finance Officer		80 - 85	80 - 85	0 - 5	-	1	-	-	-	-
Donna Derby	CCB Interim Chief Operating Officer (November 2012 - March 2013)		40 - 45	40 - 45	-	-	-	-	-	-	-
Suzanne Sinclair	Programme Manager - Acute TDB, CCB Chief Operating Officer 1 April to 31 Aug 2012		25 - 30	25 - 30	-	-	-	0 - 5	60 - 65	-	-
Caroline Dollery	CCB GP Board Member (Governance)	11	20 - 25	20 - 25	-	-	-	-	-	-	-
Dr Ahmed Mayet	CCB GP Board Member (Urgent Care)	11	45 - 50	45 - 50	5 - 10	-	-	40 - 45	-	-	-
Dan Doherty	CCB Director of Clinical Transformation		65 - 70	65 - 70	-	-	-	60-65	-	-	-
Keith Andrew	CCB Lay Vice Chair & Lay Member		10 - 15	10 - 15	-	-	-	-	-	-	-

Salaries and Allowances (audited)

Name and Title		Note	2012-13 Total Salary & Bonus across the NHS For the Relevant Period (bands of £5,000)	Mid Essex PCT Share of Costs							
				2012-13				2011-12			
				Salary (bands of £5,000)	Other Remun-eration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (Rounded to nearest £00)	Salary (bands of £5,000)	Other Remun-eration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (Rounded to nearest £00)
			£,000	£,000	£,000	£,000	£,00	£,000	£,000	£,000	£,00
Anne-Marie Garrigan	CCB Lay Member (Quality)		5 - 10	5 - 10	-	-	-	-	-	-	-
David Simmons	CCB Secondary Care Consultant			-	-	-	-	-	-	-	-
Krishna Ramkhelawon	CCB Public Health Lead		50 - 55	50 - 55	0 - 5	-	-	-	-	-	-
Audrey Bancroft	CCB Board Member - Essex County Council			-	-	-	-	-	-	-	-
David Barron	Chairman/Non Executive Director (NED)/Board Member (until Nov 2011)			-	-	-	-	25 - 30	-	-	2
David Bagnall	NED/Board Member/Chair of Audit Committee (until June 2011)			-	-	-	-	0 - 5	-	-	3
Leo Bishop	NED/Board Member (until Nov 2011)			-	-	-	-	5 - 10	-	-	2
Paul Munden	NED/Board Member (until Nov 2011)			-	-	-	-	5 - 10	-	-	2
Cllr Lady Patricia Newton	NED/Board Member (until Nov 2011)			-	-	-	-	5 - 10	-	-	-
Iain Tweedlie	Elected GP member of MECCG and Programme Board Member	11	30 - 35	30 - 35	-	-	-	35 - 40	-	-	-
Dr Paul Davis	Elected GP member of MECCG and Programme Board Member to April 2012	11		-	-	-	-	25 - 30	-	-	-
Dr Jo Merritt	Elected GP member of MECCG and Programme Board Member to March 2012	11		-	-	-	-	25 - 30	-	-	-
Dr Mike North	Elected GP member of MECCG and Programme Board Member to May 2012	11	5 - 10	5 - 10	-	-	-	50 - 55	5 - 10	-	-
Dr Andrew Hildrey	GP & *EBM (until June 2011)	11		-	-	-	-	5 - 10	-	-	-
Sarah Barnes	*EBM and TDB chair (Jan - June 2011)			-	-	-	-	5 - 10	-	-	-
Clare Morris	*EBM - Director of Development to January 2012			-	-	-	-	30 - 35	-	0 - 5	3
Carol Winser	Associate Director of Contract Management			-	-	-	-	45 - 50	30 - 35	-	-
Sian Brand	Programme Lead - Child & Maternity TDB			-	-	-	-	0 - 5	30 - 35	-	-
Nicola Colston	Programme Lead - MH & LD TDB			-	-	-	-	0 - 5	60 - 65	-	-
Melanie Crass	Programme Lead - Primary Care TDB			-	-	-	-	0 - 5	70 - 75	-	-

Salaries and Allowances (audited)

Name and Title		Note	2012-13 Total Salary & Bonus across the NHS For the Relevant Period (bands of £5,000)	Mid Essex PCT Share of Costs 2012-13 Salary (bands of £5,000)	Other Remun-eration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (Rounded to nearest £00)	2011-12 Salary (bands of £5,000)	Other Remun-eration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (Rounded to nearest £00)
			£,000	£,000	£,000	£,000	£,00	£,000	£,000	£,000	£,00
Jane Kinniburgh	Vice Clinical Lead - Community TDB			-	-	-	-	0 - 5	55 - 60	-	-
Alison Manton	AD Delivery and Primary Care TDB			-	-	-	-	0 - 5	60 - 65	-	-
Maggie Pacini	Public Health Lead - Acute TDB			-	-	-	-	0 - 5	75 - 80	-	-
Jane Richards	Programme Lead - Health Improvement TDB			-	-	-	-	0 - 5	60 - 65	-	-

Notes to the Remuneration Report

1 *EBM denotes Executive Board Member.
2 For 2012-13 the decision making forums were the North Essex cluster PCT Board and the Mid Essex CCG Shadow Board. For 2011-12 the decision making forums were the Mid Essex PCT Programme Boards, the Mid Essex PCT Board to Nov 11 and the North Essex cluster PCT Board from Dec 11.
3 Board member costs shared across the North Essex cluster PCTs are shared on a weighted capitation basis (35% Mid Essex PCT, 37% North East Essex PCT and 28% West Essex PCT).
4 Sheila Bremner – Accountable Officer for the North Essex cluster PCTs to September 12 then seconded to the shadow National Commissioning Board (East Anglia).
5 Adrian Marr - Director of Finance for the North Essex cluster PCTs to September 12 then seconded to the shadow National Commissioning Board (East Anglia).
6 Sallie Mills-Lewis Director of Commissioning for the North Essex cluster PCTs to September 12 then seconded to the shadow National Commissioning Board (East Anglia).
7 Sarah Jane-Relf - Director for the North Essex cluster PCTs to September 12 then seconded to the shadow National Commissioning Board (East Anglia).
8 Dr Donald McGeachy was Medical Director for the PCT cluster and was also an elected GP member of Mid Essex CCG and interim Mid Essex Clinical Commissioning Shadow Board Accountable Officer for the period 1 April to 31 Aug.
9 Dr Mike Gogarty is a joint appointment between the north Essex cluster PCTs and Essex County Council. The PCTs cover 50% of his salary costs - which is apportioned over the 3 PCTs on a weighted capitation basis per note 3 above.
10 In accordance with national guidance, the costs of the shadow Local Area Team/new cluster Executive Team from 01/10/2012 were not recharged to the north Essex cluster PCTs.
11 The GP members of Mid Essex Clinical Commissioning Group were not on the payroll of the PCT. Remuneration was either paid directly to the doctor or, in some cases, to their Practice. Remuneration includes payments in respect of employers NI and pension costs. Remuneration for employees of the PCTs excludes employer NI and pension costs. The reported remuneration of the GP members paid on a sessional basis is therefore not directly comparable with the reported remuneration of staff employed by the PCTs.

Pension Benefits (audited)

Name and Title	Real increase in pension at age 60 (bands of £2,500) £'000	Real Increase In pension lump sum at aged 60 (bands of £2,500) £'000	Total accrued pension at age 60 at 31 March 2013 (bands of £5,000) £'000	Lump sum at age 60 related to accrued pension at 31-Mar-13 (bands of £5,000) £'000	Cash Equlvalent Transfer Value at 31-Mar 2013 £'000	Cash Equlvalent Transfer Value at 31-Mar 2012 £'000	Real Increase In cash Equlvalent transfer value £'000	Employer's contribution to stakeholders pension (rounded to nearest £000) £'000
Sheila Bremner	0-2.5	0-2.5	40-45	130-135	718	688	30	0
Donald McGeachy	0-2.5	0-2.5	45-50	135-140	965	925	40	0
Adrian Marr	0-2.5	0-2.5	30-35	100-105	573	557	17	0
Sallie Mills-Lewis	0-2.5	0-2.5	25-30	75-80	451	433	18	0
Sarah Relf	0-2.5	0-2.5	15-20	45-50	249	234	15	0
Carol Anderson	0-2.5	0-2.5	10-15	35-40	185	169	16	0
Dee Davey	(0)-(2.5)	(0)-(2.5)	30-35	95-100	621	609	12	0
Daniel Doherty	0-2.5	0-2.5	10-15	30-35	136	122	14	0
Clare Steward	0-2.5	2.5-5	20-25	60-65	302	277	26	0

Notes

1 As Non-Executive Directors do not receive pensionable remuneration, there are no entries in respect of pensions for members within both of these categories.

2 Part of the salaries of Sheila Bremner, Sallie Mills-Lewis, Adrian Marr, Donald McGeachy and Sarah Relf were recharged to other PCTs. Their full pension benefits are reported in this note as the employing organisation. The 2012-13 pension costs were shared amongst the north Essex cluster PCTs on a weighted capitation basis (35% Mid Essex, 37% North East Essex and 28% West Essex).

3 Mike Gogarty, Andrew Pike, Dawn Scrafield, Pol Toner and Ian Stidson are reported in the accounts of their employing organisation (North East Essex for Mike Gogarty and South East Essex for the remaining Directors.

4 Only GP members directly employed by the PCT are required to be included in this note. Dr Donald McGeachy's pension related to both his former role as a salaried practicing GP employed by the PCT and his senior clinical lead role for the cluster PCTs.

Cash Equivalent Transfer Values

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

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

Real Increase in CETV

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

Pay multiples disclosure

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 salary for the highest paid director has been based on the total cost incurred by the PCT whilst the role was being undertaken.

The banded remuneration of the highest paid director in Mid Essex PCT in the financial year 2012-13 was £25k - £30k (2011-12 £55k-£60k) - which reflects that the 2012-13 directors' costs of the North Essex cluster Executive Team were shared across the North Essex PCT Cluster for the 6 months that they were acting in their cluster executive roles. The highest paid director cost was 0.72 times (2011-12 2.06 times) the median remuneration of the workforce of £38,851 (2011-12 £27,106). The actual banded remuneration of the highest paid Director across the North Essex PCT Cluster was £75k - £80k for the six months in post. In 2012-13 a number of senior roles were appointed for Mid Essex CCG and the costs were borne entirely by Mid Essex PCT - this will have contributed to the increase in the median remuneration compared to 2011-12 when a number of the senior posts were shared across the cluster for the full year.

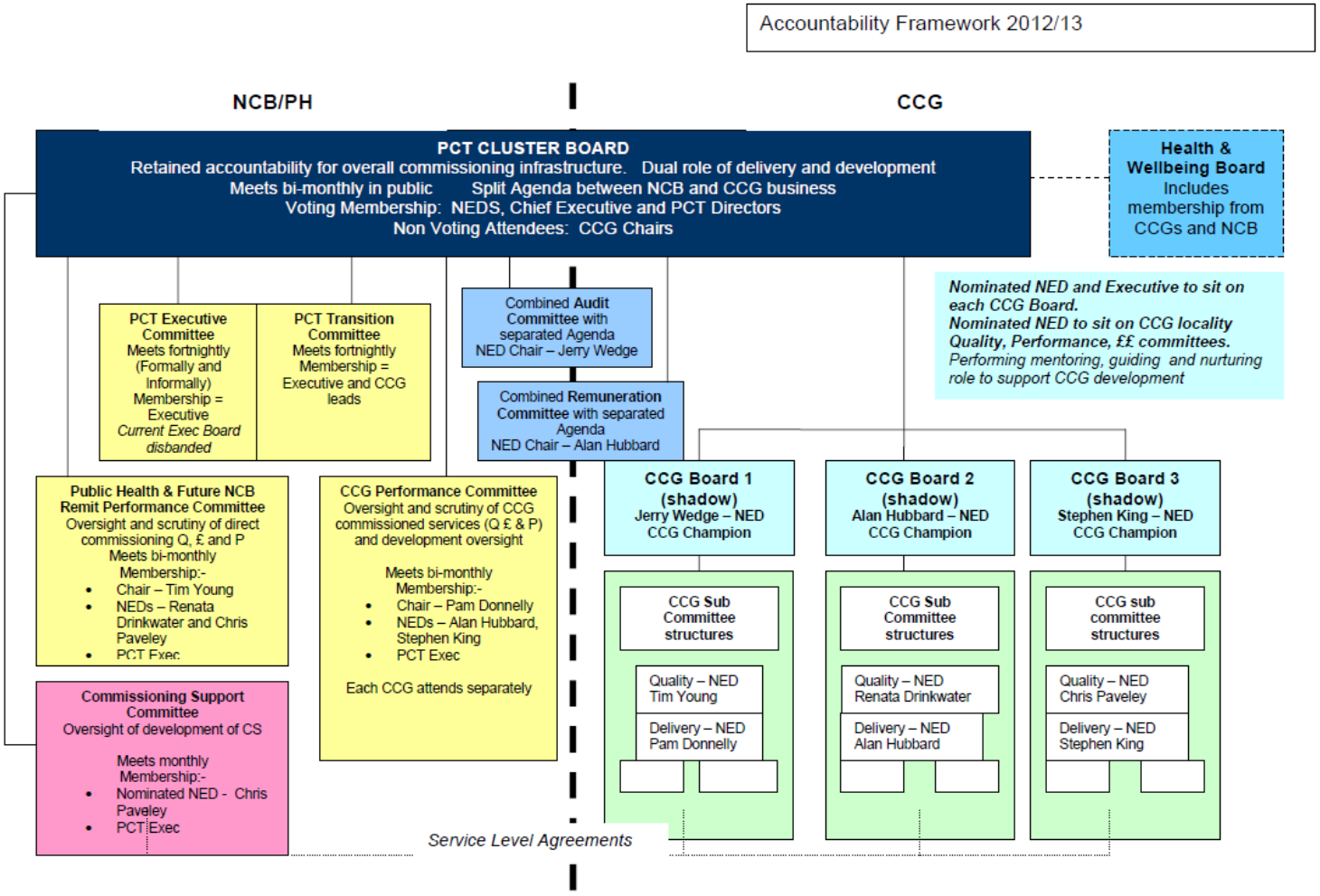
There was no change to the most highly paid Director but during 2012-13 the role was only undertaken for six months. From 1 October the Directors of the South Essex PCT Cluster also assumed the Director roles for the North Essex PCT Cluster but, in accordance with national guidance, the North Essex Cluster PCTs were not recharged for these roles.

In 2012-13 100 (2011-12 30) employees received remuneration in excess of the weighted capitation share of the highest paid Director. Remuneration above the share of the highest paid Director ranged from £28k - £95k (2011-12 £55k - £85k). The increase in the number of employees receiving remuneration in excess of the weighted capitation share of the highest paid Director is due to the Director costs only representing 6 months' costs.

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include employer pension contributions and the cash equivalent transfer value of pensions. Termination and severance payments are excluded from the calculation in accordance with HM Treasury guidance to avoid distorting the ratio.

There were a significant number of redundancies as a result of NHS reorganisation. These largely occurred on 31 March 2013.

APPENDIX B



Version 2.4

Appendix C

Statement of Accounts 2012-13

The 2012-13 Accounts of Mid Essex Primary Care Trust ('NHS Mid Essex' or 'the PCT') are prepared under section 232 (Schedule 15) of the National Health Service Act 2006 in the form which the Secretary of State has, with the approval of the Treasury, directed.

2012-13 is the last year of operation of the PCT.

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The Accounts

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Mid Essex Primary Care Trust

2012-13 Accounts

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www.gov.uk/dh

Mid Essex Primary Care Trust

2012-13 Accounts

Mid Essex PCT
Annual Accounts 2012-13

The 2012-13 Accounts of Mid Essex Primary Care Trust ('NHS Mid Essex' or 'the PCT') are prepared under section 232 (Schedule 15) of the National Health Service Act 2006 in the form which the Secretary of State has, with the approval of the Treasury, directed.

2012-13 is the last year of operation of the PCT.

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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.

Andrew Pike
Designated Signing Officer
4th June 2013

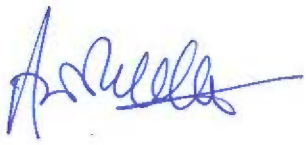
STATEMENT OF RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

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.



4th June 2013

Andrew Pike - Signing Officer

4th June 2013

Dawn Scrafield - Finance Signing Officer

Annual Governance Statement
Organisation Code 5PX

1. Scope of Responsibility

As Accountable Officer and Chief Executive of the NHS North Essex Board[1], I had responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. 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.

Accountability arrangements had been enshrined in the PCT's management structure through a Scheme of Delegation covering both corporate and clinical areas. In addition to the Scheme of Delegation and the Accountability Framework, the Board, Audit Committee and the shadow Clinical Commissioning Group Board with the senior management provided support to enable me to discharge my responsibilities as Accountable Officer.

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

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

The system of internal control set out in this governance statement had been in place in Mid Essex PCT for the year ended 31 March 2013.

2. The Governance Framework of the Organisation

Governance Framework Context

The NHS North Essex Cluster Board was the statutory board for each of the constituent PCTs of NHS Mid Essex, NHS North East Essex and NHS West Essex. It had a single Chair and a single set of Non-Executive and Executive Directors across the Cluster. The Board met on a bi-monthly basis rotating meetings between the three PCT locations. The Standing Orders, Standing Financial Instructions and Scheme of Delegation were the same for each PCT.

In light of the organisational changes arising from the Health and Social Care Act 2012, the Board has ensured a strong focus on the management of this transition whilst continuing to assure itself of the performance of the whole Cluster in delivering its financial and other objectives.

The new organisations, including NHS England, Essex Area Team of NHS England and the new Mid Essex Clinical Commissioning Group (the CCG), operated in shadow form until their formal establishment on the 1st April 2013.

[1] The Board refers to the North Essex Cluster Board which is the statutory board for each of the constituent PCTs in the Cluster of North East Essex PCT, Mid Essex PCT and West Essex PCT with a single Chair and single set of Directors and Non Executive Directors.

The Board approved in March 2012 the dual running of the old and the new governance system to enable all parts of the new system to become established and to test the effectiveness of arrangements that successor/future organisations had put in place. This also gave the performance teams time to test and refine the new reporting regimes. Overall accountability remained with the NHS North Essex Board.

Key components of the transitional governance systems were:-

- an Accountability Framework setting out the principles for the transition governance model and the structural accountability framework with committees reporting to the Board
- a revised Corporate Governance Manual was approved reflecting the change in governance arrangements and confirming the Scheme of Delegation in place
- a CCG accountability framework setting out the committee structure for the shadow CCG Board including conflict of interest arrangements
- a Memorandum of Understanding approved in May 2012, between the Board and each CCG describing the relationship between the CCG and the Board during the transition period until the CCG became a statutory body and the role of the PCT ceased. This included the Assurance Framework for targets and standards.

The NHS North Essex Cluster Chief Executive remained the Accountable Officer during the transition.

3. Board Committee Structure

The Cluster Board met 7 times during 2012-2013 and membership changed on 1 October 2012 following the appointment of the NHS England Area Team Prospective Directors for Essex, who also became the NHS North Essex and NHS South Essex Cluster Director leads. The Chair and 3 of the Non Executive Directors (NEDs) resigned during the year and were not replaced.

Notice of attendance at Board meetings was published on the NHS North Essex website. The Board received regular reports on performance, finance, clinical quality, patient experience, transitional planning and delivery, service commissioning, audit and risk management. These reports gave the Board assurance that they were discharging their responsibilities in managing the key elements of internal control, such as corporate governance, clinical governance and risk management as well as transition.

Until November 2012, the following committees were those that supported the Board in carrying out its function:

- a shadow CCG Board which included a NED from the Board. A supporting committee structure included a CCG Quality, Finance and Performance Committee thus negating the need for the Board to continue with a Quality and Delivery committee
- a CCG Performance Committee to provide oversight and scrutiny of the CCG and which held the CCG to account. This was chaired by a NED with NEDs and PCT executive directors as members
- a public health and future NHS England performance committee, again chaired by a NED and with NED and PCT Executive Directors as members to provide oversight, scrutiny and to hold the public health and commissioning leads of the future NHS England commissioned services to account
- a Commissioning Support Committee which provided oversight of the development of commissioning support and included a NED and PCT Executive Directors as members

- a PCT Executive Committee for all executive matters which were not within the CCG's remit and which only consisted of the PCT executive members
- a PCT Transition Committee with PCT executive and CCG leads
- a combined Remuneration and Terms of Service Committee with a separate agenda for the PCT/CCG locality and with membership attendance from the CCGs. This Committee was chaired by a NED and made up of NEDs
- Cluster Audit Committee which was chaired by a Board NED with separate agenda items for the PCT/CCG locality and with membership attendance from each of the CCGs. During the course of 2012/13 the designated CCG Audit Committee chair attended in preparation for when the CCG Audit Committee was established.

There were changes to the committee structure as approved by the Board in November 2012 as follows:-

- a combined North Essex Cluster Performance Committee was established in place of the previous NCB/Public Health performance Committee and CCG Performance Committee
- a new Essex Transition Board was also formed to replace the North Essex Cluster Transition Committee and the South Essex Cluster Transition Committee. This reported to both the South and the North Essex Cluster Boards
- a new North Essex Cluster Finance and Performance Committee was established which met up to and including January and which was then dissolved
- a Commissioning Support Unit (CSU) Committee was established as the governing body for the CSU
- the Executive Committee was replaced with a Corporate Management Team meeting which was not a committee of the Board.

The Audit Committee met 7 times during 2012-2013, was properly constituted and addressed key internal control issues by monitoring the work of internal and external audit functions, counter fraud and financial management. Minutes and reports from these meetings were received by the Board. The Audit Committee was a joint Audit Committee for the Cluster reviewing both cluster wide and separate PCT agenda items. The terms of reference included reviewing the annual financial statements before submission to the Board. Delegated authority for the Audit Committee to approve the Annual Report and Annual Accounts had been obtained from the Board and these will be reviewed and signed off by a joint Audit Committee for the North and South Essex PCT Clusters in June 2013.

4. Board Performance and Assessment of its Own Effectiveness

The Board's assessment of its performance has been informed by the Annual Accountability Review letter from the SHA in 2012/2013 on the outcome of the 2011/12 Annual Accountability Review. In addition to confirming the outcome of performance for 2011/12, it confirmed the following as key issues to focus on in 2012/13:-

NHS North Essex	Concern	Improvements required
HCAI (Healthcare Associated Infections)	The PCT Cluster, Colchester Hospital University Foundation Trust (CHUFT) and Princess Alexandra Hospital (PAH) breached their ceilings for C.*difficile* in 2011/12.	Improvements are necessary such that monthly C. *difficile* performance for the commissioner and both providers is below ceiling. This should be sustained for a minimum of three consecutive months to demonstrate real improvements have been embedded.
18 weeks performance	The PCT and all three providers have reported periods of underperformance against both admitted and non-admitted standards in 2011/12, at both aggregated and specialty level.	Performance across the Cluster is to be improved such that all required 18 week metrics are met on a monthly basis. Referral to Treatment performance should be delivered consistently on a specialty level basis from Quarter 2.
A&E	PAH failed to deliver the A&E standard for the full year and recovery of performance has been slow. Mid Essex Hospitals Trust (MEHT) also failed to deliver the standard in Q1 2011/12. Ambulance handover times at MEHT have also been an issue during 2011/12 with long waits regularly reported during the winter period.	Performance at all providers to be above 95% cumulatively on a consistent basis with evidence of sustainability during periods of peak demand. A reduction in ambulance handover times at MEHT during 2012/13 including during the winter period.

5. Highlights of Board Committee reports, notably by the Audit Committee

5.1 Board Committee reports

Board Committee reports were provided in Part I of the meeting, which was open to the public and were published on the website with Part 2 of the meeting reserved for matters that were confidential to members of the Board.

During the year the Board continued to monitor the financial position of the PCT, the PCT's performance against key performance indicators, key risks facing the organisation and progress against the transition plan, including the preparation of a Handover Document for the North Essex cluster to the NHS England Area Team, the CCG and Essex County Council. This handover document was finalised in March 2013 and is complemented by the Quality handover document and the Public Health handover document. The Board approved a schedule of properties and assets that were to be transferred.

5.2 Audit Committee highlights

The Audit Committee carried out its functions in accordance with its Terms of Reference. Specifically, the Committee:

- discussed external audit reviews on e.g. demand management and the Payment by Results assurance programme;
- followed up on internal audit recommendations and approved the internal audit programme;
- reviewed specific policies such as the Hospital and Interest Policy;
- discussed the Local Counter Fraud Reports;
- reviewed the assurance frameworks for the cluster and the CCG for the strategic objectives;
- regularly received the risk register reports;
- sought assurance in relation to the transition programme and handover arrangements; and
- received the development of the Schemes of Delegation for the new CCG in readiness for the 1st April 2013.

6. Account of Corporate Governance

The Board had a Corporate Governance Manual which was accessible to all staff.

The Board had a system for the Declaration of Interests and there have been no reported departures of its compliance with the Corporate Governance Code.

Statutory and Board lead roles had been in place as follows:-

- **Chair of the North Essex Cluster Board**
  Chris Paveley (to end December 2012)

- **Vice Chair of the North Essex Cluster Board**
  Stephen King

- **Interim Chair of the North Essex Cluster Board**
  Pam Donnelly (from January 2013)

- **Accountable Officer**
  Sheila Bremner – Chief Executive Officer – (up to October 2012) thereafter Andrew Pike

- **Accounting Officer**
  Adrian Marr – Director of Resources (up to October 2012) thereafter Dawn Scrafield – Director of Finance, Performance and Operations/Deputy Chief Executive Officer

- **Cluster Audit Committee Chair**
  Jerry Wedge - Non Executive Director

- **Public Health Board Lead**
  Dr. Mike Gogarty - Director of Public Health (up to October 2012) thereafter Alison Cowie

- **Caldicott Guardian**
  Donald McGeachy, Medical Director

- **Senior Information Responsible Officer**
  Sarah Jane Relf, Director of Transition and Governance (up to October 2012), thereafter Margaret Hathaway – Director of Commercial Services to the South Essex PCT cluster.

- **NHS Constitution Champion**
  Pam Donnelly – Non Executive Director (and Interim Chair from January 2013)

- **Director of Infection Prevention and Control**
  Denise Hagel, Interim Director of Nursing (up to October 2012) and thereafter Pol Toner – Director of Nursing

- **Security Management Board Lead**
  Adrian Marr – Director of Resources (up to October 2012) and thereafter Dawn Scrafield – Director of Finance, Performance and Operations and Operations/Deputy Chief Executive Officer.

- **Non-Executive Director for Promotion of Security Management Measures**
  Chris Paveley – Chairman (up to 31st December 2012) and thereafter Pamela Donnelly, Interim Chair.

- **Equality and Diversity Lead**
  Sarah Jane Relf – Director of Transition and Governance (up to October 2012) and thereafter Dawn Scrafield – Director of Finance, Performance and Operations/Deputy Chief Executive.

- **Equality and Diversity Champion**
  Qadir Bakhsh – Non-Executive Director (up to end November 2012) then no formally designated Cluster Board champion. Clare Steward – Director of Strategy and Primary Care was the designated champion for the Mid Essex CCG Shadow Board.

- **Dignity Champion**
  Sarah Jane Relf – Director of Transition and Governance (up to October 2012) and thereafter Pol Toner – Director of Nursing.

- **Non-Executive Contact - Whistle Blowing**
  Alan Hubbard – Non-Executive

- **Deprivation of Liberty (DoLs)**
  Shoena Siewesten – Assistant Director of Safeguarding Adults – West Essex CCG
  Donald McGeachy – Medical Director – back up to the above
  Carol Anderson – Director of Nursing – Mid Essex CCG – back up to the above.

7. Handover to New Organisations - Transition Board

During 2012/13 the PCT Cluster established a Transition Board to oversee the transition arrangements of implications of the White Paper. From October 2012 the Transition Board covered the whole of Essex and was chaired by the South Essex Chairman.

Final DH guidance was received regarding transition in October 2012 and at this point the Transition Board established a close down plan that reflected the requirements of the DH. The close down plan was established drawing upon the previous transition plans that had been developed and monitored in the earlier part of the financial year. The Transition Board was a formal subcommittee of each of the Cluster Boards and met monthly to oversee the delivery of the close down plan.

In addition to the close down plan the Transition Board ensured that appropriate processes were in place for finalising the Legacy document and the Quality handover document. The subcommittee of the Board that scrutinised these documents was the Quality and Governance Committee.

The Transition Board monitored the risks associated with the transition and these were reported to each of the PCT Cluster Board meetings during the year, with a final report being presented to the last Board meeting in March 2013.

The Audit Committee approved a series of reports, including the financial transition arrangements for the accounts and the transfer of outstanding audit weaknesses and recommendations. The plan for the financial accounts was based on the letter setting out roles for financial closedown of PCTs (Gateway ref 18561) and arrangements were assessed as green. The financial services teams of the Central Eastern Commissioning Support Unit have been utilised to close down the accounts as the majority of the staff relating to financial services have transferred from the PCTs into the CSU.

The Audit Sub Committee of the DH has been established to meet on the 3rd June 2013 to sign off the accounts and discharge the statutory responsibilities of the PCT, checking for any irregularities and ensuring that all reporting is legally compliant.

8. Risk Assessment

The PCT used a framework for carrying out risk assessments within the organisation. Guidance included policy, procedures and tools which set out how to undertake risk assessment and the control measures that could be introduced to manage those risks.

Responsibility for identification of risks and completion of risk assessments rested with all staff thereby encouraging ownership and action.

The Assurance Framework identified the strategic risks, risk rating and the risk owner. Strategic Objectives for 2012/13 were agreed by the PCT in March 2012, from which the Assurance Framework was developed.

A Corporate Risk Register was in place to help ensure that risks to the achievement of organisational objectives were identified and to allow for the identification of any gaps or weaknesses in the system of internal control. The risks were rated and had an assigned owner responsible for the management of that risk.

Up to October 2012, all risks were reported to the Executive Committee (thereafter the Corporate Management Team) each quarter with red risks being reviewed and reported to the Executive Committee monthly and to the Board bi-monthly. The Audit Committee received a red risk report at each meeting.

9. Risk Profile

Close Down Plan

In October 2012 the PCT received checklist guidance from the Department of Health on the Handover and Close Down programme to manage the abolition of the SHA and PCT by the 31st March 2013. A close down plan was developed across Essex and this was approved by the Board in November 2012.

The close down plan was monitored by the Transition Board. The last meeting was held on the 7th March 2013 and the areas rated as red in their progress were:

- IT Infrastructure
- IT Systems/ Informatics
- CCG Organisational Development
- Public Health – in respect of the allocations concerns

The remaining cluster red risks at the end of the year were recorded as:-

- Delivery of quality of service
- Either people and/or functions do not safely transition thereby affecting staff and/or continuity of service provision.

The high risks for the CCG are:-

- Potential non achievement of Quality Innovation Productivity and Prevention (QIPP) target
- Over performance on contracts for acute and other key budget areas such as continuing healthcare and specialist commissioning
- HCAI breaches
- Delivery of continuing health care function
- Achievement of financial balance
- Ambulance turnaround times

10. The Risk and Control Framework

The North Essex Cluster's risk and control framework described the structure and accountabilities for risk management and it defined the method used for quantifying, reporting and monitoring risk. It enabled the systematic identification, assessment, treatment and monitoring of risks. It minimised the possibility of recurrence of risks and their associated consequences. Risk

management was incorporated into the cluster's strategic aims and objectives and was embedded in the culture. Risks were entered onto the risk register, an assessed risk rating was provided using a standardised risk assessment matrix and each risk had a risk owner. The Corporate Management Team determined the red risks that were to be highlighted to the Board.

The PCT had responsibility for reporting and ensuring appropriate investigation of and monitoring of any Serious Incidents (SIs) that were reported by its primary (including independent contractor), acute, community (including children's) mental health services and learning disabilities providers. There was a robust process in place for this which encompasses the East of England SI Policy.

10.1 Prevention of risks

Examples of how the PCT prevents risks include:

- the Code of Conduct for Managers affirms the responsibilities and accountabilities of the role of Managers
- through guidance published by the National Quality Board all PCTs were charged with producing a Cluster Legacy document. The Board approved a suite of handover documents including a general, quality and public health document to capture and safeguard the organisational knowledge and corporate memory for the PCT's successor organisations
- through contracts which clearly state the responsibilities of contracted personnel with regard to risk limitation, identification and reporting. Managers ensured contractors were aware of local instructions and procedures concerning risk reporting and encourage an open and proactive approach.

10.2 Deterrent to Risks Arising (e.g. fraud deterrents)

The Board had procedures in place that reduced the likelihood of fraud occurring. These included Standing Orders, Standing Financial Instructions, documented procedures and a system of internal control and risk assessment. In addition the Board promoted a risk and fraud awareness culture in the Cluster.

NHS Protect had established Local Counter Fraud Specialists (LCFS) for NHS Organisations. Both proactive and reactive work is carried out by the PCT's LCFS in accordance with the NHS Counter Fraud and Corruption Manual.

10.3 Management of Both Manifest and Potential risks.

The ways in which management of both manifest and potential risks take place were:-

- risk reports were provided to the CCG Board, Executive Committee (to October 2012) and thereafter to the Corporate Management Team, Board and Cluster Audit Committee and CCG risks were reported to the CCG's Audit Committee.
- a grip was maintained on performance, including quality, safety, delivery of QIPP and financial control while the changes for the new system took place. A Transition Plan provided a road map of the identified key work streams and deliverables.
- a Transition Committee approved an Information Governance Transition Action Plan which provided a framework to identify key risks and mitigating actions to manage these risks during the transition.

- good practice gained from risk resolution and incident management was disseminated through team and management briefings. The CCG's clinical quality team analysed incidents and risks in order to identify improvements and best practice using Root Cause Analysis.

- the Clinical Quality Review Group monitored contracts.

- the Assurance Framework helped to ensure that the Cluster was focusing on and tackling its strategic responsibilities by identifying the risks associated with the achievement of the PCT's strategic objectives. The CCG developed its own Assurance Framework during the year and on which reports were made to the CCG Board. The controls and assurances were detailed and mitigating actions to tackle risk were listed, along with the risk rating and risk owners and reported using the Board Assurance Framework.

- the principal systems and processes that were in place to ensure that certain key operational and risk activity areas had sufficient clinical perspective and control and the Director of Nursing had significant input to these functions. These included complaints, incident management, risk assessment, serious incident management and independent contractor performance investigations.

Other Risk Management Controls:-

- NHS Pension Scheme arrangements: as an employer with staff entitled to membership of the NHS Pension Scheme, control measures were in place to ensure all employer obligations contained within the Scheme regulations are complied with. This included ensuring that deductions from salary, employer's contributions and payments into the Scheme were in accordance with the Scheme rules, and that member Pension Scheme records were accurately updated in accordance with the timescales detailed in the Regulations.

- NHS Mid Essex was the host lead for the cluster for emergency planning in Essex. The NHS England Area Team is now the lead for emergency planning in Essex through a Memorandum of Understanding. The Area Team approved both the Incident Response and Incident Coordination Centre Plan. Regular reviews will be undertaken by the Operations and Delivery Directorate of the Area Team, training ensures a continual state of readiness to respond to any major incidents. The Essex Area Team has submitted its final assessment of readiness following an informal assessment by the regional NCB / SHA team.

- absolute commitment was given by the Board for Equality and Diversity in respect of the services that were commissioned for the population of our local area and for our own staff. The Executive Board level lead for Equality and Diversity was the Director of Finance, Performance and Operations and there was a Non Executive Director who championed equality and diversity.

The Equality Delivery System review led by the Equality and Diversity Group enabled future priorities and actions to be identified and informed the four Equality Objectives which were formally approved, together with an implementation plan, by the Board in March 2012.

- Information Governance: at the end of March 2013 the North Essex Cluster submitted a self-assessment of the Department of Health Connecting for Health's Information Governance Toolkit. The Cluster overall score was 50%.

11. Review of the Effectiveness of Risk Management and Internal Control

My review of effectiveness is informed by external auditors, internal audit, clinical audit, the Executive Team and other staff who have responsibility for the development and maintenance of the internal control framework.

11.1 Internal Audit

The Head of Internal Audit Opinion has provided Significant Assurance 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 reported on the processes by which the Board obtains assurance on the effective management of significant risks relevant to the organisation's principal objectives. They have confirmed that an Assurance Framework has been developed aligned with organisational objectives and have provided Adequate Assurance that the Assurance Framework is sufficient to meet the requirements of the 2012-13 Annual Governance Statement and provide a reasonable assurance that there is an adequate and effective system of internal control to manage the significant risks identified by the PCT.

The Internal Audits reviewed Financial Process Key Controls; Debtors, Order and Receipt of Goods and Creditors; Payroll; Governance; Risk Management and Assurance Framework; Patient Experience; Clinical Governance; Quality, Innovation, Productivity and Prevention (QIPP); Transition Management Capacity Planning; Transition Management Governance; Transition Management Contract Transfer; Performance Management; Commissioning Support Services Governance Arrangements; Information Technology Procurement and Recommendation Follow-up.

Adequate Assurance was given for all audits except for the following two audits which were given Limited Assurance:

- **Payroll Audit** – seven priority 2 recommendations which related predominantly to the processing of new starters, leavers and changes of circumstances.
- **Information Technology Procurement** – one priority 1, three priority 2 and one priority 3 recommendations were raised. The priority 1 recommendation was that the PCT Cluster should restrict the ability of staff to install hardware and software linked to the Network – this should only be carried out by suitable authorised members of the IM&T team.

"During the year good progress has been made in reviewing and following up outstanding audit recommendations and a significant number of recommendations from previous years have now been confirmed as completed. This focus on the implementation of recommendations needs to continue to ensure the Audit Committee is receiving adequate assurance that control weaknesses are being addressed. Independent verification of successful implementation was undertaken as part of the Internal Audit follow up work." The PCT has also formally handed over outstanding recommendations to the successor organisations in order to strengthen the assurance available to these new organisations.

12. Summary of Lapses of Data Security Including Any that Were Reported to the Information Commissioner

NHS Mid Essex - Information Governance

Information governance ensures necessary safeguards for, and appropriate use of, patient and personal information. We are pleased to report that in 2012/13 there were no serious untoward incidents relating to information governance at the PCT.

Signature:  **4 June 2013**

Designated Signing Officer: Andrew Pike

INDEPENDENT AUDITOR'S REPORT TO THE ACCOUNTABLE OFFICER FOR MID ESSEX PRIMARY CARE TRUST

Financial statements

We have audited the financial statements of Mid Essex 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 Mid Essex 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.

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 Mid Essex 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 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:

- 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.

Conclusion on the PCT'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 pace 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. 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 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:

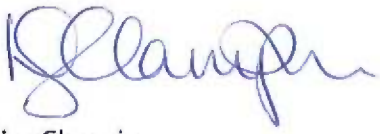
- our review of the Annual Governance Statement;
- the work of other relevant regulatory bodies or inspectorates, to the extent that the results of this work impact on our responsibilities at the Primary Care Trust; and
- our locally determined risk-based work on the transition to successor bodies and delivery of savings 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 Mid Essex 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.



Lisa Clampin

for and on behalf of BDO LLP

Ipswich, UK

6 June 2013

STATEMENT OF COMPREHENSIVE NET EXPENDITURE
For the Year Ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Administration costs and programme expenditure			
Gross employee benefits	7.1	**14,696**	11,715
Other costs	5.1	**616,725**	599,821
Income	4	**(78,983)**	(78,204)
Net operating costs before interest		**552,438**	533,332
Investment income		**0**	0
Other (gains) / losses		**0**	0
Finance costs	9	**1,022**	1,076
Net operating costs for the financial year		**553,460**	534,408
Of which:			
Administration costs			
Gross employee benefits	7.1	**7,823**	7,893
Other costs	5.1	**6,021**	6,006
Income	4	**(2,225)**	(2,090)
Net administration costs before interest		**11,619**	11,809
Finance costs	9	**0**	17
Net administration costs for the financial year		**11,619**	11,826
Programme expenditure			
Gross employee benefits	7.1	**6,873**	3,822
Other costs	5.1	**610,704**	593,815
Income	4	**(76,758)**	(76,114)
Net programme expenditure before interest		**540,819**	521,523
Finance costs	9	**1,022**	1,059
Net programme expenditure for the financial year		**541,841**	522,582

Other comprehensive net expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**0**	52
Net (gain) / loss on revaluation of property, plant & equipment	**(18)**	0
Net (gain) / loss on other reserves	**0**	(206)
Net (gain) / loss on Assets Held for Sale	**(48)**	
Reclassification Adjustments		
Reclassification adjustment on disposal of available for sale financial assets	**0**	0
Total comprehensive net expenditure for the year*	**553,394**	534,254

*This is the sum of the rows above plus net operating costs for the financial year.
The notes on pages 5 to 53 form part of this account.

STATEMENT OF FINANCIAL POSITION
As at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	10	**38,693**	38,521
Intangible assets	11	**71**	141
Trade and other receivables		**0**	0
Total non-current assets		**38,764**	38,662
Current assets:			
Inventories	15	**60**	0
Trade and other receivables	16	**6,785**	7,394
Cash and cash equivalents	17	**673**	2
Total current assets		**7,518**	7,396
Non-current assets held for sale	18	**160**	0
Total assets		**46,442**	46,058
Current liabilities			
Trade and other payables	19	**(38,242)**	(34,717)
Other liabilities		**0**	0
Provisions	22	**(1,937)**	(3,729)
Borrowings	21	**(376)**	(333)
Other financial liabilities		**0**	0
Total current liabilities		**(40,555)**	(38,779)
Total non-current assets less net current liabilities		**5,887**	7,279
Non-current liabilities			
Trade and other payables	19	0	0
Provisions	22	(2,427)	(2,030)
Borrowings	21	(16,241)	(16,617)
Other financial liabilities		0	0
Total non-current liabilities		**(18,668)**	(18,647)
Total Assets Employed:		**(12,781)**	(11,368)
Financed by taxpayers' equity:			
General fund		(16,268)	(14,789)
Revaluation reserve		3,487	3,421
Other reserves		0	0
Total taxpayers' equity:		**(12,781)**	(11,368)

The notes on pages 5 to 53 form part of this account.

The financial statements on pages 1 to 4 were approved by the Essex Subgroup of the Department of Health Audit and Risk Committee on 3 June and signed on its behalf by

Signing Officer:  4th 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	**(14,789)**	**3,421**	**0**	**(11,368)**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(553,460)	0	0	**(553,460)**
Net gain on revaluation of property, plant, equipment	0	18	0	**18**
Net gain on revaluation of assets held for sale	0	48	0	**48**
Impairments and reversals	0	0	0	**0**
Movements in other reserves	0	0	0	**0**
Total recognised income and expense for 2012-13	**(553,460)**	**66**	**0**	**(553,394)**
Net Parliamentary funding	551,981			**551,981**
Balance at 31 March 2013	**(16,268)**	**3,487**	**0**	**(12,781)**

Balance at 1 April 2011	(16,378)	3,473	(206)	(13,111)
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(534,408)	0	0	(534,408)
Net gain / (loss) on revaluation of property, plant and equipment	0	0	0	0
Net gain / (loss) on assets held for sale	0	0	0	0
Impairments and reversals	0	(52)	0	(52)
Movements in other reserves	0	0	206	206
Transfers between reserves	0	0	0	0
Release of reserves to Statement of Comprehensive Net Expenditure	0	0	0	0
Total recognised income and expense for 2011-12	(534,408)	(52)	206	(534,254)
Net Parliamentary funding	535,997			535,997
Balance at 31 March 2012	(14,789)	3,421	0	(11,368)

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	**(552,438)**	(533,332)
Depreciation and amortisation	**1,786**	1,727
Impairments and reversals	**94**	(449)
Interest paid	**(953)**	(972)
(Increase) / decrease in Inventories	**(60)**	180
(Increase) / decrease in Trade and Other Receivables	**609**	1,232
(Increase) / decrease in Other Current Assets	**0**	0
Increase / (decrease) in Trade and Other Payables	**3,875**	(858)
(Increase) / decrease in Other Current Liabilities	**0**	0
Provisions utilised	**(2,270)**	(1,902)
Increase / (decrease) in Provisions	**806**	1,474
Net cash inflow / (outflow) from operating activities	**(548,551)**	(532,900)
Cash flows from investing activities		
Interest Received	**0**	0
Payments for Property, Plant and Equipment	**(2,426)**	(2,721)
Payments for Intangible Assets	**0**	(24)
Rental revenue	**0**	0
Net cash inflow / (outflow) from Investing activities	**(2,426)**	(2,745)
Net cash inflow / (outflow) before financing	**(550,977)**	(535,645)
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI	**(333)**	(358)
Net Parliamentary Funding	**551,981**	535,997
Net cash inflow / (outflow) from financing activities	**551,648**	535,639
Net increase / (decrease) in cash and cash equivalents	**671**	(6)
Cash and cash equivalents at beginning of the period	**2**	8
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies	**0**	0
Cash and cash equivalents at year end	**673**	2

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.

Under the provisions of The Health and Social Care Act 2012 (Commencement No.4.Transitional, Savings and Transitory Provisions) Order 2013, Mid Essex PCT was dissolved on 1st April 2013. The PCT's functions, assets and liabilities transferred to other public sector entities as outlined in Note 29. 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 as 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 liabilites and no disclosures have been made under IFRS 5 Non - current Assets Held for Sale and Discontinued Operation in the current year.

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 PCT is not a corporate trustee of donated charitable funds. Donated charitable funds in the mid Essex area are managed by Mid Essex Hospital Services NHS Trust on behalf of the PCT.

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.

Critical accounting judgements and key sources of estimation uncertainty

In the application of the PCT's accounting policies, management are 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.

1. Accounting policies (continued)

Critical judgements in applying accounting policies

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

- Department of Health guidance on accounting for Private Finance Initiative (PFI) assets has been adopted for the Braintree Community Hospital which was completed during 2009/10;
- Management have considered the changes proposed by the Government in the Health and Social Care Act and, as services will continue to be provided by another public sector entity, have concluded that it is appropriate for the accounts to be prepared on a going concern basis. In addition, management has considered the implications of the Act and does not believe that it will have a material impact on the carrying value of assets and liabilities as the functions of the PCT will be transferred to the various successor bodies. As a result, the accounts are prepared on a going concern basis.

Key sources of estimation uncertainty

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

- where possible the value of end of year transactions have been agreed with NHS counter-parties on an estimated basis;
- where information is not available, the PCT has made estimates of the value of liabilities in respect of activity in the final weeks of the financial year and, if appropriate the value of work in progress, at major acute hospital providers and specialised services at 31 March 2013;
- assets were valued by the District Valuer (DV) as at April 2009 and have subsequently been indexed in accordance with DV's recommendation. The indexation factor applied to buildings in 2012-2013 was broadly 1%, for land nil. In addition to this, the DV carried out a full year revaluation for Halstead House to open market valuation, in readiness for disposal;
- the Braintree Community Hospital PFI scheme was valued by the DV at March 2010 prices and has been indexed to March 2013 prices in line with his recommendations;
- where significant capital works have been undertaken on an asset since 2009, these assets have been individually revalued by the DV;
- asset life assumptions are based upon standard assumptions for each category of non-current asset, except where the non-current asset relates to minor or building works on a leased building. In such cases, the shorter of the lease life or the standard asset life is used;
- during 2012-13 the PCT impaired its IT assets in preparation for the disaggregation of assets upon the demise of the PCT;
- provisions have been reviewed in 2012 - 13 and an effort was made to clear all of the back to back provision with NHS Trusts in preparation for reorganisation;
- the PCT has a new year end provision of £3.1m to cover expected liabilities in respect of retrospective claims for the reimbursement of nursing home costs (also known as "continuing healthcare" provision). These claims have not yet been fully processed but their likelihood of success has been estimated based on the information received to date and the main areas of notable estimation uncertainty within the calculated provision made in respect of these claims are:

1. Accounting policies (continued)

- Accuracy of assesment of the likelihood of claims to go on to be ultimately successful.
- Accuracy of the number of days likely to be awarded in the case of claims which go on to be successful, compared to the number of days originally claimed.
- Accuracy of the average estimated day rate likely to be payable in respect of those cases which go on to be ultimately successful.

The PCT is also reporting contingent liability of £6.1m in respect of claims for which no provision has been made, which includes those for which insufficient information has been received to make an assessment of likelihood of ultimate success. This estimate is subject to the same main areas of estimation uncertainty as for the provision.

No provisions have been reversed unused during 2012-13 unless advised by the expected recipient/internal review that they are no longer required.

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

HM 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 HM 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 cost at least £5,000; or
- collectively, a number of items cost at least £5,000 and individually cost 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.

Staff time and external support costs which are essential in order to long time asset into use are also capitalised.

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.

1. Accounting policies (continued)

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.

1.6 Intangible assets

Recognition

The PCT's intangible assets comprise of purchased software. Intangible assets are carried at depreciated historic cost as this is not considered to be materially different from fair value.

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.

1. Accounting policies (continued)

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME) from 2011-12. This is necessary to comply with HM 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 HM 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 HM 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 HM Treasury approval.

1.8 Donated assets

Following the accounting policy change outlined in the HM Treasury's Financial Reporting Manual (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 Government grants

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

1.10 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.

1. Accounting policies (continued)

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 22.

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, 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.

1.14 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. Accounting policies (continued)

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 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.

1.17 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

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.

1. Accounting policies (continued)

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.

1.18 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.

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.

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.

1. Accounting policies (continued)

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.

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.

1.20 Private Finance Initiative (PFI)

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

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

a) Services received

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

b) PFI assets, liabilities, and finance costs

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

1. Accounting policies (continued)

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

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

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

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

c) Lifecycle replacement

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

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

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

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

The HM 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
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

In 2012-13 the operating segments denote the distinction between the resources and responsibilities delegated to the Shadow Board of the Clinical Commissioning Group and the resources reserved to the PCT Cluster Board.

2012-13

	Commissioning Healthcare Costs & Running Costs Delgated to the CCG £000	**Other Commiss-ioning & Running Costs £000**	**Total £000**
Gross Expenditure before interest	466,825	164,596	631,421
External Income	(68,263)	(10,720)	(78,983)
Net Expenditure before interest	398,562	153,876	552,438
Finance Costs	1,022		1,022
Net Operating Costs	399,584	153,876	553,460

CCG expenditure includes £158.7m to Mid Essex Hospital Services NHS Trust (MEHT).
CCG income includes the recharge of service costs to NHS North East Essex (£33m) and NHS West Essex (£24.5m) for the services which the PCT commissions on their behalf.
£6.6m of Other Commissioning & Running Cost income relates to dental charge income and £3.8m to prescription charges.

2011-12

2011-12 operating segments denoted the main commissioning categories of the PCT at that time. PCT headquarters, corporate and commissioning costs (mainly staff costs) were not apportioned over the commissioned services categories.

	Acute & Specialist £000	MH & LD (1) £000	Primary Care £000	Other Commiss-ioning £000	Commiss-ioning PCT £000	Total £000
Gross Expenditure before interest	251,154	93,844	150,354	97,332	16,206	608,890
External Income	(2,640)	(57,612)	(7,277)	(2,638)	(5,391)	(75,558)
Net Expenditure before interest	248,514	36,232	143,077	94,694	10,815	533,332
Finance Costs	0	0	0	1,076	0	1,076
Other Losses	0	0	0	0	0	0
Investment Income	0	0	0	0	0	0
Net Operating Costs	248,514	36,232	143,077	95,770	10,815	534,408

(1) Mental Health & Learning Disabilities
Acute and Specialist expenditure includes £155.2m to Mid Essex Hospital Services NHS Trust (MEHT).

3. Financial performance targets

3.1 Revenue Resource Limit (Operational Financial Balance)

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

	2012-13 £000	2011-12 £000
Total Net Operating Cost for the Financial Year	**553,460**	534,408
Revenue Resource Limit	**554,460**	535,529
Under / (over) spend against Revenue Resource Limit (RRL)	1,000	1,121

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	**3,214**	1,918
Charge to Capital Resource Limit	**2,076**	1,871
(Over) / underspend against CRL	**1,138**	47

3.3 Under / (over) spend against Cash Limit

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

	2012-13 £000	2011-12 £000
Total charge to Cash Limit	**551,981**	535,997
Cash Limit	**551,981**	538,297
Under / (over) spend against Cash Limit	**0**	2,300

3.4 Reconciliation of cash drawings to Parliamentary funding (current year)

	2012-13 £000
Total cash received from Department of Health (Gross)	481,573
Less: Trade income from Department of Health	(619)
Less / (Plus): movement in Department of Health working balances	0
Sub total: net advances	**480,954**
Plus: cost of Dentistry Schemes (central charge to cash limits)	14,359
Plus: drugs reimbursement (central charge to cash limits)	56,668
Parliamentary funding credited to General Fund	**551,981**

4. Miscellaneous revenue

	Comments	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Fees and Charges		**48**	48	0	16
Dental Charge income from Contractor-Led GDS & PDS		**6,570**	0	6,570	5,983
Prescription Charge income		**3,307**	0	3,307	3,132
Strategic Health Authorities	a	**487**	29	458	708
NHS Trusts		**62**	0	62	99
NHS Foundation Trusts	b	**475**	0	475	276
Primary Care Trusts - Other	c	**2,787**	1,090	1,697	1,155
Primary Care Trusts - Lead Commissioning		**61,277**	0	61,277	63,072
NDPBs and Others (CGA)		**68**	0	68	0
Department of Health - Other	d	**619**	0	619	665
Local Authorities		**187**	0	187	146
Patient Transport Services		**0**	0	0	0
Charitable and Other Contributions to Expenditure		**33**	0	33	55
Rental revenue from operating leases		**1,005**	0	1,005	1,134
Other revenue		**2,058**	1,058	1,000	1,763
Total miscellaneous revenue		**78,983**	**2,225**	**76,758**	78,204

Comments

a. In 2011-12 the PCT received one-off funding of £200k for Cancer Network project funding and £43k relating to other commissioning contracts.
b. 2012-13 includes the impact of £100k of aggregated creditor Foundation Trust reversals - which under national Agreement of Balance requirements must be treated as income.
c. In 2012-13 the PCT accounted for the costs of the Collingwood Road administrative offices, the costs of which were shared across the north Essex cluster PCTs (£300k income) and received £600k from S.E. Essex PCT in respect of leading on a prison health services contract.
d. In 2012-13 the PCT received £604k income from the Department of Health in respect of a Mental Health hospice. The previous year the funding was received as revenue resource limit.

5. Operating costs

5.1 Analysis of operating costs:

	Comments	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
Goods and services from other PCTs					
Healthcare	a	**55,213**	0	55,213	51,914
Non-Healthcare		**1,393**	1,350	43	1,240
Total		**56,606**	**1,350**	**55,256**	53,154
Goods and services from other NHS bodies other than FTs					
Goods and services from NHS Trusts		**185,232**	0	185,232	182,757
Goods and services (other, excl Trusts, FT and PCT)		**3**	2	1	93
Total		**185,235**	**2**	**185,233**	182,850
Goods and services from Foundation Trusts		**113,966**	125	113,841	115,461
Purchase of healthcare from non-NHS bodies	b	**93,091**	0	93,091	83,072
Non-GMS Services from GPs		**545**	0	545	528
Contractor Led GDS & PDS (excluding employee benefits)		**20,738**	0	20,738	20,559
Chair, Non-executive Directors & PEC remuneration		**60**	60	0	55
Executive committee members costs	c	**76**	76	0	539
Consultancy services	d	**339**	297	42	71
Prescribing costs		**56,441**	0	56,441	56,943
G/PMS, APMS and PCTMS (excluding employee benefits)	e	**48,141**	0	48,141	46,475
Pharmaceutical services		**3,337**	0	3,337	3,244
New Pharmacy Contract	f	**12,707**	0	12,707	12,534
General ophthalmic services		**3,223**	0	3,223	3,188
Supplies and services - Clinical		**5,970**	170	5,800	5,840
Supplies and services - General		**84**	38	46	59
Establishment		**678**	584	94	614
Transport		**7**	7	0	15
Premises	g	**4,087**	1,596	2,491	3,673
Impairments & reversals of property, plant and equipment	h	**84**	0	84	(449)
Depreciation		**1,726**	341	1,385	1,670
Amortisation		**60**	0	60	57
Impairment & reversals intangible non-current assets		**10**	0	10	0
Audit fees		**144**	144	0	227
Other auditors remuneration		**0**	0	0	4
Clinical negligence costs		**26**	26	0	65
Education and training		**104**	19	85	134
Grants for capital purposes		**125**	0	125	106
Grants for revenue purposes	i	**7,658**	0	7,658	8,279
Other	j	**1,457**	1,186	271	854
Total operating costs charged to Statement of Comprehensive Net Expenditure		**616,725**	**6,021**	**610,704**	599,821
Employee benefits (excluding capitalised costs)					
Employee benefits associated with PCTMS		**32**	0	32	43
PCT Officer Board Members		**350**	0	350	470
Other employee benefits		**14,314**	7,801	6,513	11,202
Total employee benefits charged to SOCNE		**14,696**	**7,801**	**6,895**	11,715
Total operating costs		**631,421**	**13,822**	**617,599**	611,536
Analysis of grants reported in total operating costs					
For capital purposes					
Grants to fund Capital Projects - GMS		**87**	0	87	0
Grants to Fund Capital Projects - Dental		**38**	0	38	106
Grants to Fund Capital Projects - Other		**0**	0	0	0
Total Capital Grants		**125**	**0**	**125**	106
Grants to fund revenue expenditure					
To Local Authorities		**6,809**	0	6,809	7,354
To Other		**849**	0	849	925
Total revenue grants		**7,658**	**0**	**7,658**	8,279
Total grants		**7,783**	**0**	**7,783**	8,385

5.1 Analysis of operating costs (continued):

Comments

a. 2012-13 includes £6.8m increase in Specialist Commissioning.
b. 2012-13 includes £2.9m increased expenditure with local private acute providers, £1m increase in Mental Health private provider expenditure (hosted service for the north cluster), £2.1m increase in the prison healthcare contract and increased continuing healthcare costs.
c. Although operating in shadow form, the Clinical Commissioning Group were not part of the formal Executive Committee and therefore expenditure is included within other employee benefits.
d. Consultancy costs included support for establishing the Commissioning Support Unit and support for the PCT's Financial Recovery Plan.
e. Quality Outcomes Framework costs increased significantly, including some underprovision of 2011-12 costs.
f. Increased expenditure includes the full year effect of the new pharmacy reimbursement arrangements - with some offsetting reduction in prescribing expenditure.
g. In 2012-13 the PCT accounted for the costs of the corporate admin. building at Collingwood Road. Costs were shared across the north Essex cluster (reported as income in note 4).
h. In 2012-13 IT assets were impaired in preparation for disaggregation of assets to successor organisations. The impairment reversal in respect of Braintree Community Hospital was lower in 2012-13 than the previous year.
i. Social Care ring-fenced funding which is paid to Essex County Council as a Section 256 Grant was £646k less in 2012-13 than the previous year.
j. 2012-13 includes the cost of creating the provision for reimbursement to families if retrospective continuing healthcare claims are successful.

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**11,597**	11,081	516
Weighted population (number in units)*	**320,171**	320,171	320,171
Running costs per head of population (£ per head)	**36.22**	**34.61**	**1.61**
PCT Running Costs 2011-12			
Running costs (£000s)	11,818	10,977	841
Weighted population (number in units)	320,171	320,171	320,171
Running costs per head of population (£ per head)	36.91	34.28	2.63

* 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	48,199	46,518
Prescribing costs	56,441	56,943
Contractor led GDS & PDS	20,738	20,559
General ophthalmic services	3,223	3,188
Pharmaceutical services	3,337	3,244
New Pharmacy Contract	12,707	12,534
Non-GMS Services from GPs	218	196
Other	0	0
Total Primary Healthcare purchased	**144,863**	143,182
Purchase of Secondary Healthcare		
Learning difficulties	4,130	4,432
Mental Illness	31,542	30,614
Maternity	13,330	15,283
General and acute	261,194	246,400
Accident and emergency	7,442	6,521
Community Health Services	68,120	61,987
Other contractual	12,729	9,822
Total Secondary Healthcare Purchased	**398,487**	375,059
Grant Funding		
Grants for capital purposes	125	106
Grants for revenue purposes	7,658	8,279
Total Healthcare Purchased by PCT	**551,133**	526,626
Healthcare from NHS FTs included above	112,803	114,715

6. Operating leases

The PCT leases 15 buildings for clinical use (mainly as community clinics) and 2 administrative buildings. The leases are for a variety of years and are on typical market terms.

6.1 PCT as lessee

	Land £000	Buildings £000	Other £000	2012-13 Total £000	2011-12 £000
Payments recognised as an expense					
Minimum lease payments				**277**	306
Contingent rents				**678**	666
Sub-lease payments				**0**	0
Total				**955**	972
Payable:					
No later than one year	**144**	**575**	**148**	**867**	912
Between one and five years	**534**	**2,135**	**74**	**2,743**	2,910
After five years	**920**	**3,679**	**0**	**4,599**	5,500
Total	**1,598**	**6,389**	**222**	**8,209**	9,322
Total future sublease payments expected to be received				505	502

Under the terms of the national GP contract, the PCT is required to cover GP premises costs (either leases or notional rents for GP owned premises). Under IAS 17: Leases and IFRIC 4: Determining whether an arrangement contains a lease, the PCT has determined payments to GPs should be recognised as operating leases but there is no defined term in the arrangements entered into and it is not possible to analyse the arrangements over financial years. The financial value included in the Statement of Comprehensive Net Expenditure for 2012-13 is £3,133k (£3,048k in 2011-12).

6.2 PCT as lessor

	2012-13 £000	2011-12 £000
Recognised as income		
Rental revenue	**1,005**	1,134
Contingent rents	**0**	0
Total	**1005**	1,134
Receivable:		
No later than one year	**1,005**	1,134
Between one and five years	**0**	1,134
After five years	**0**	0
Total	**1,005**	2,268

Central Essex Community Services (CECS), the Communit Interest Company which provides the majority of our community based services has leases to occupy defined areas of the various PCT clnical premises on an annual renewable basis.

The Braintree Community Hospital is occupied by the service providers under Licence.

7. Employee benefits and staff numbers

7.1 Employee benefits

2012-13				Permanently employed			Other		
	Total £000	Admin £000	Pro-gramme £000	Total £000	Admin £000	Pro-gramme £000	Total £000	Admin £000	Pro-gramme £000
Employee Benefits - Gross Expenditure									
Salaries and wages	**12,690**	6,167	6,523	**5,717**	4,281	1,436	**6,973**	1,886	5,087
Social security costs	**558**	408	150	**558**	408	150	**0**	0	0
Employer Contributions to NHS BSA - Pensions Division	**819**	619	200	**819**	619	200	**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	**629**	629	0	**629**	629	0	**0**	0	0
Total employee benefits	**14,696**	**7,823**	**6,873**	**7,723**	**5,937**	**1,786**	**6,973**	**1,886**	**5,087**
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	**14,696**	**7,823**	**6,873**	**7,723**	**5,937**	**1,786**	**6,973**	**1,886**	**5,087**
Employee costs capitalised	**0**	0	0	**0**	0	0	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**14,696**	**7,823**	**6,873**	**7,723**	**5,937**	**1,786**	**6,973**	**1,886**	**5,087**
Recognised as:									
Commissioning employee benefits	**14,696**			**7,723**			**6,973**		
Provider employee benefits	**0**			**0**			**0**		
Gross Employee Benefits excluding capitalised costs	**14,696**			**7,723**			**6,973**		

Where staff worked across the north Essex cluster of PCTs and were recharged, the recharges were netted off the reported expenditure. The costs of the cluster Directors were shared across the 3 cluster PCTs on a weighted population basis (35% to Mid Essex PCT). Other staff costs were shared on a project specific basis.

On 1 October the PCT/north Essex cluster Accountable Officer, Director of Finance, Director of Delivery and Director of Corporate Governance & Organisational Development became responsible for setting up the Local Area Team of NHS England for East Anglia. The executive team of the south Essex cluster took over responsibility for the north Essex cluster on 1 October in addition to continuing with their south Essex responsibilities. Under the nationally directed transition arrangements, the north Essex cluster continued to meet the costs of the original north Essex cluster executive team and did not incur a recharge from the south Essex cluster.

Employee Benefits incurred in respect of functions hosted on behalf of all the Essex PCTs are recharged to PCTs on a full cost recovery basis. The income is not apportioned over the various categories of expenditure.

7. Employee benefits and staff numbers (continued)

Employee benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee benefits gross expenditure 2011-12			
Salaries and wages	10,308	5,525	4,783
Social security costs	578	578	0
Employer Contributions to NHS BSA - Pensions Division	812	812	0
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	80	37	43
Total - Net employee benefits including capitalised costs	11,778	6,952	4,826
Employee costs capitalised	63	0	63
Net employee benefits excluding capitalised costs	11,715	6,952	4,763

7.2 Staff numbers

	2012-13 Total Number	2012-13 Permanently employed Number	2012-13 Other Number	2011-12 Total Number	2011-12 Permanently employed Number	2011-12 Other Number
Average staff numbers						
Medical and dental	**3**	3	0	1	0	1
Administration and estates	**120**	84	36	163	130	33
Nursing, midwifery and health visiting staff	**98**	14	84	69	12	57
Scientific, therapeutic and technical staff	**3**	3	0	4	4	0
Other	**0**	0	0	0	0	0
TOTAL	**224**	**104**	**120**	237	146	91
Of the above - staff engaged on capital projects	**0**	0	0	1	0	1

7.3 Staff sickness absence and ill health retirements

	2012-13 Number	2011-12 Number
Total Days Lost	**1,346**	8,781
Total Staff Years	**278**	1,005
Average working Days Lost	4.84	8.74

	2012-13 Number	2011-12 Number
Number of persons retired early on ill health grounds	**0**	2
	£000s	£000s
Total additional pensions liabilities accrued in the year	**0**	112

7.4 Exit packages agreed during 2012-13

Exit package cost band (including any special payment element)	2012-13			2011-12		
	*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	0	0	0	0	3	3
£10,001-£25,000	1	0	1	0	1	1
£25,001-£50,000	2	0	2	0	0	0
£50,001-£100,000	2	0	2	0	0	0
£100,001 - £150,000	1	0	1	0	0	0
£150,001 - £200,000	2	0	2	0	0	0
>£200,000	1	0	1	0	0	0
Total number of exit packages by type	9	0	9	0	4	4
	£	£	£	£	£	£
Total resource cost	1,047,854	0	**1,047,854**	0	34,000	34,000

*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 under the terms & conditions of Agenda for Change. 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.

As a result of national restructuring in the NHS, there were a number of redundancies that occurred across the Essex commissioning system during 2012/13. The disclosures reported above relate specifically to the PCT's employees, however the cost of redundancies across Essex have been shared across Essex commissioners using a capitation or service split. The rationale for this shared cost was to reflect that the recruitment into the new NHS structures prioritised Essex PCTs employees in the first instance, therefore the consequential cost of any redundancies were agreed to be shared in the same area.

7.4 Exit Packages agreed during 2012-13 (Continued)

The following is a summary of the redundancies as a result of the national restructure across Essex.

	2012-13		
Exit package cost band (including any special payment element)	***Number of compulsory redundancies Number**	***Number of other departures agreed Number**	**Total number of exit packages by cost band Number**
Less than £10,000	**9**	**0**	**9**
£10,001-£25,000	**19**	**0**	**19**
£25,001-£50,000	**12**	**0**	**12**
£50,001-£100,000	**17**	**0**	**17**
£100,001 - £150,000	**4**	**0**	**4**
£150,001 - £200,000	**3**	**0**	**3**
>£200,000	**2**	**0**	**2**
Total number of exit packages by type	**66**	**0**	**66**
	£000	**£000**	**£000**
Total resource cost	3,706	0	**3,706**

	£000
Cost to Mid Essex PCT	**567**

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.

7.5 Pension costs (continued)

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.

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.

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".

7.5 Pension costs (continued)

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 Cosumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

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

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

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

8. Better Payment Practice Code

8.1 Measure of compliance

	2012-13 Number	**2012-13 £000**	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**12,589**	**137,728**	13,001	130,017
Total Non-NHS Trade Invoices Paid Within Target	**11,811**	**132,617**	11,514	122,734
Percentage of NHS Trade Invoices Paid Within Target	93.82%	96.29%	88.56%	94.40%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3,341**	**363,812**	3,516	359,328
Total NHS Trade Invoices Paid Within Target	**2,740**	**355,113**	2,699	348,972
Percentage of NHS Trade Invoices Paid Within Target	82.01%	97.61%	76.76%	97.12%

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

The PCT did not incur any interest in respect of the late payment of commercial debts in either 2012-13 or 2011-12.

9. 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	**953**	0	953	972
- 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	**953**	0	953	972
Other finance costs	**0**	0	0	0
Provisions - unwinding of discount	**69**		69	104
Total	**1,022**	**0**	**1,022**	1,076

10 Property, plant and equipment

10.1 Property, plant and equipment 2012-13

2012-13	Land	Buildings excluding dwellings	Assets under construction and payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:							
At 1 April 2012	**6,578**	**30,141**	**0**	**968**	**5,605**	**384**	**43,676**
Additions of assets under construction			638				**638**
Additions purchased	0	1,106		0	322	10	**1,438**
Reclassifications as held for sale	(36)	(76)	0	0	0	0	**(112)**
Disposals other than for sale	0	0	0	0	0	0	**0**
Upward revaluation/positive indexation	0	18	0	0	0	0	**18**
Impairments/negative indexation	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	**0**
At 31 March 2013	**6,542**	**31,189**	**638**	**968**	**5,927**	**394**	**45,658**
Depreciation							
At 1 April 2012	**0**	**471**	**0**	**631**	**3,841**	**212**	**5,155**
Reclassifications		0		0	0	0	**0**
Reclassifications as held for sale	0	0		0	0	0	**0**
Disposals other than for sale	0	0		0	0	0	**0**
Upward revaluation/positive indexation	0	0		0	0	0	**0**
Impairments	0	0	0	0	280	0	**280**
Reversal of impairments	0	(196)	0	0	0	0	**(196)**
Charged during the year	0	861		123	702	40	**1,726**
At 31 March 2013	**0**	**1,136**	**0**	**754**	**4,823**	**252**	**6,965**
Net Book Value at 31 March 2013	**6,542**	**30,053**	**638**	**214**	**1,104**	**142**	**38,693**
Purchased	6,542	29,206	638	214	1,104	142	**37,846**
Donated	0	847	0	0	0	0	**847**
Total at 31 March 2013	**6,542**	**30,053**	**638**	**214**	**1,104**	**142**	**38,693**

10.1 Property, plant and equipment 2012-13 (continued)

	Land	Buildings excluding dwellings	Assets under construction and payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Asset financing:							
Owned	6,542	11,970	638	214	1,104	142	**20,610**
Held on finance lease	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	18,083	0	0	0	0	**18,083**
PFI residual: interests	0	0	0	0	0	0	**0**
Total at 31 March 2013	**6,542**	**30,053**	**638**	**214**	**1,104**	**142**	**38,693**

Revaluation reserve balance for Property, plant & equipment

	Land	Buildings	Assets under construction & payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	**1,375**	**2,036**	**0**	**8**	**0**	**2**	**3,421**
Movements (specify)	0	66	0	0	0	0	**66**
At 31 March 2013	**1,375**	**2,102**	**0**	**8**	**0**	**2**	**3,487**

Additions to assets under construction in 2012-13

	£000
Land	0
Buildings excl dwellings	638
Dwellings	0
Plant & machinery	0
Balance as at YTD	**638**

10.2 Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	Assets under construction and payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:							
At 1 April 2011	6,578	28,585	495	957	4,990	276	41,881
Additions - purchased	0	1,018	0	11	615	108	1,752
Additions - donated	0	95	0	0	0	0	95
Reclassifications	0	495	(495)	0	0	0	0
Impairments	0	(52)	0	0	0	0	(52)
At 31 March 2012	6,578	30,141	0	968	5,605	384	43,676
Depreciation							
At 1 April 2011	0	0		496	3,251	187	3,934
Impairments	0	32	0	0	0	0	32
Reversal of impairments	0	(481)	0	0	0	0	(481)
Charged during the year	0	920		135	590	25	1,670
At 31 March 2012	0	471	0	631	3,841	212	5,155
Net book value at 31 March 2012	6,578	29,670	0	337	1,764	172	38,521
Purchased	6,578	28,828	0	337	1,764	172	37,679
Donated	0	842	0	0	0	0	842
At 31 March 2012	6,578	29,670	0	337	1,764	172	38,521
Asset financing:							
Owned	6,578	11,390	0	337	1,764	172	20,241
On-SOFP PFI contracts	0	18,280	0	0	0	0	18,280
At 31 March 2012	6,578	29,670	0	337	1,764	172	38,521

10.3 Asset values

The PCT's land and buildings were revalued to a 'Modern Equivalent Asset Valuation' (MEAV) at 1 April 2009 (31 March 2010 for the Braintree Community Hospital PFI). The valuations were carried out by the District Valuer for land and owned buildings and by professional valuers for the PFI.

The District Valuer has provided a desktop valuation of all the land and buldings (including the Braintree Community Hospital PFI) on the Statement of Financial Position to reflect a MEAV value as at 31 March 2012 and 31 March 2013.

The PCT has one property held for sale as at 31.3.13. Halstead House is currently held at Open Market Value (OMV), following a valuation estimate, at the end of the year, from the District Valuer.

10.4 Economic lives of property, plant & equipment

	Min Life Years	Max Life Years
Property, plant and equipment		
Buildings excl. dwellings	1	89
Plant & machinery	1	6
Information technology	1	3
Furniture & fittings	1	5
Intangible assets		
Software	1	2

No existing assets (aside from note below) have had a material change to their life in the period but there have been some small changes to some buildings components as a result of the MEAV valuation as at 31 March 2013.

A review of PCT IM&T assets was carried out in year, such that those with a positive NBV as at 31.3.2013 but with an originally assigned life in excess of 3 years were reworked on the basis of a standard 3 year life. This impairment created a 12-13 expenditure charge of £290k.

11. Intangible non-current assets

11.1 Intangible non-current assets 2012-13

	2012-13 Software £000	2011-12 Software £000
At 1 April	**359**	335
Additions - purchased	0	0
Impairments	0	24
At 31 March	**359**	359
Amortisation		
At 1 April	**218**	161
Impairments charged to operating expenses	10	0
Charged during the year	60	57
In-year transfers to NHS bodies	0	0
At 31 March	**288**	218
Net book value at 31 March	**71**	141
Net book value at 31 March comprises		
Purchased	71	141
Donated	0	0
Total at 31 March	**71**	**141**

Software assets are not revalued.

12. Impairments and reversals

Property, plant and equipment impairments and reversals taken to SoCNE	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000
Unforeseen obsolescence	0		0
Loss as a result of catastrophe	0		0
Other	280		280
Changes in market price	(196)		(196)
Total impairments of Property, plant and equipment	**84**	**0**	**84**
Intangible assets impairments and reversals charged to SoCNE			
Unforeseen obsolescence	0		0
Loss as a result of catastrophe	0		0
Other	10		10
Changes in market price	0		0
Total impairments of Intangibles	**10**	**0**	**10**
Total impairments charged to Revaluation Reserve	0		
Total impairments charged to SoCNE - DEL	0	0	0
Total impairments charged to SoCNE - AME	94		94
Overall total impairments	**94**	**0**	**94**
Of which:			
Impairment on revaluation to "modern equivalent asset" basis	**0**	0	0
Donated and Government 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

Impairments in year, as follows;
Negative impairment of £196k being an increase in the value of Braintree Community Hospital, which is credited to expenditure in reversal of an impairment loss taken in previous years.
£290k IM&T impairment of IM&T assets to bring accounting treatment in line with other organisations in preparation for reorganisation.

*DEL - DH Departmental Expenditure Limits
*AME - Annually Managed Expenditure

13. Commitments

13.1 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	**20**	0
Intangible assets	**0**	0
Total	**20**	0

14. 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	3,411	0	4,703	0
Balances with Local Authorities	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	508	0	9,738	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	3,174	0	24,404	0
At 31 March 2013	**7,093**	**0**	**38,845**	**0**
prior period:				
Balances with other Central Government Bodies	3,659	0	3,858	0
Balances with Local Authorities	113	0	0	0
Balances with NHS Trusts and Foundation Trusts	431	0	5,955	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	3,191	0	24,904	0
At 31 March 2012	7,394	0	34,717	**0**

NHS Trust payables at 31 March 2013 included £5.1m for Mid Essex Hospitals Services Trust due to late agreement of the final billing.

15. Inventories

	2012-13 Drugs £000	2011-12 Total £000
Balance at 1 April	**0**	180
Additions	329	0
Inventories recognised as an expense in the period	(269)	0
Write-down of inventories (including losses)	0	0
Transfers (to)/from other bodies	0	(180)
Balance at 31 March	**60**	0

The 2011-12 opening inventory (consumables and loan equipment) transferred to the Community Services provider.

16. Trade and other receivables

16.1 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	**718**	821	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**2,893**	2,930	**0**	0
Non-NHS receivables - revenue	**999**	1,185	**0**	0
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**1,874**	2,126	**0**	0
Provision for the impairment of receivables	**(7)**	(7)	**0**	0
VAT	**308**	339	**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	**0**	0	**0**	0
Total	**6,785**	7,394	**0**	0
Total current and non current	**6,785**	7,394		
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.

16.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	**183**	214
By three to six months	**336**	75
By more than six months	**62**	18
Total	**581**	307

16.3 Provision for impairment of receivables

	2012-13 £000	**2011-12 £000**
Balance at 1 April 2012	**(7)**	(202)
Amount written off during the year	**0**	195
Amount recovered during the year	**0**	0
(Increase)/decrease in receivables impaired	**0**	0
Balance at 31 March 2013	**(7)**	(7)

17. Cash and cash equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**2**	8
Net change in year	**671**	(6)
Closing balance	**673**	2
Made up of		
Cash with Government Banking Service	**673**	2
Commercial banks	**0**	0
Cash in hand	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**673**	2
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**673**	2
Patients' money held by the PCT, not included above	**0**	0

18. Non-current assets held for sale

	Land	Buildings, excl. dwellings	Plant and Machinery	Information Technology	Total
	£000	£000	£000	£000	£000
Balance at 1 April 2012	0	0	0	0	0
Plus assets classified as held for sale in the year	36	76	0	0	112
Less assets sold in the year	0	0	0	0	0
Transfers (to)/from other public sector bodies	0	0	0	0	0
Revaluation	0	48	0	0	48
Balance at 31 March 2013	**36**	**124**	**0**	**0**	160
Liabilities associated with assets held for sale at 31 March 2013	**0**	**0**	**0**	**0**	0
Balance at 1 April 2011	0	0	0	0	0
Plus assets classified as held for sale in the year	0	0	0	0	0
Less assets sold in the year	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
Balance at 31 March 2012	0	0	0	0	0
Liabilities associated with assets held for sale at 31 March 2012	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

Asset held for sale as at 31.3.2013 is Halstead House, a small building adjacent to Halstead Hospital. The property was declared as surplus to PCT requirements in year, and valued in accordance with DV's open market assessment - a valuation increase of £48k.

19. Trade and other payables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
NHS payables - revenue	**3,677**	6,347	**0**	0
NHS accruals and deferred income	**10,161**	3,466	**0**	0
Family Health Services (FHS) payables	**12,258**	13,023		
Non-NHS payables - revenue	**892**	188	**0**	0
Non-NHS payables - capital	**227**	577	**0**	0
Non-NHS accruals and deferred income	**9,715**	11,097	**0**	0
Social security costs	**93**	0		
VAT	**0**	0	**0**	0
Tax	**392**	0		
Payments received on account	**0**	0	**0**	0
Other	**827**	19	0	0
Total	**38,242**	34,717	**0**	0
Total payables (current and non-current)	**38,242**	34,717		

NHS accruals at 31 March 2013 included £5.1m for Mid Essex Hospitals Services Trust due to late agreement of the final billing.
Non-NHS payables - revenue includes £450k winter pressure grant funding which was not invoiced by the County Council until March.
Other payables revenue includes the payroll creditor for the £529k year end supplementary pay run in relation to cluster reorganisation severance payments and the £156k cluster redundancy creditor.

20. Other liabilities

The PCT did not have 'Other liabilities' in either 2012-13 or 2011-12.

21. Borrowings

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
PFI liabilities:				
Main liability	**376**	333	**16,241**	16,617
Lifecycle replacement received in advance	**0**	0	**0**	0
Other	**0**	0	**0**	0
Total	**376**	333	**16,241**	16,617
Total other liabilities (current and non-current)	**16,617**	16,950		

Borrowings / loans - Payment of principal falling due in:

	DH £000s	**Other £000s**	**Total £000s**
0 - 1 Years	0	376	**376**
1 - 2 Years	0	332	**332**
2 - 5 Years	0	1,255	**1,255**
Over 5 Years	0	14,654	**14,654**
TOTAL	**0**	**16,617**	**16,617**

22. Provisions

	Total £000s	Pensions to former Directors £000s	Pensions relating to other staff £000s	Legal claims £000s	Restructuring £000s	Continuing Care £000s	Other £000s	Redundancy £000s
Balance at 1 April 2012	**5,759**	9	1,574	167	530	80	3,281	118
Arising during the year	**2,980**	0	0	0	0	2,980	0	0
Utilised during the year	**(2,270)**	0	(527)	(18)	(340)	0	(1,267)	(118)
Reversed unused	**(2,174)**	(9)	(436)	(10)	(84)	0	(1,635)	0
Unwinding of discount	**69**	0	28	39	0	0	2	0
Change in discount rate	**0**	0	0	0	0	0	0	0
Transferred (to) / from other Public Sector bodies	**0**	0	0	0	0	0	0	0
Balance at 31 March 2013	**4,364**	**0**	**639**	**178**	**106**	**3,060**	**381**	**0**
Expected timing of cash flows:								
No later than one year	**1,937**	**0**	**56**	**20**	**106**	**1,500**	**255**	**0**
Later than one year and not later than five years	**1,849**	**0**	**166**	**23**	**0**	**1,560**	**100**	**0**
Later than five years	**578**	**0**	**417**	**135**	**0**	**0**	**26**	**0**

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

As at 31 March 2013	74
As at 31 March 2012	0

22. Provisions (continued)

Uncertainly exists over the value, and in some cases timing, of all of the potential liabilities.

No reimbursement from third parties is expected to offset any of the potential costs provided for.

Pensions relating to other staff

This provision largely relates to ill health early retirement liabilities.

Legal claims

This provision transferred to the predecessor bodies of the PCT from the former North Essex Health Authority and represents back to back provisions with NHS Trusts. Where possible a full and final settlement was reached with individual Trusts in 2012-13. Where settlement was not agreed, the NHS Trusts have confirmed the amounts as at 31 March 2013 but, due to the nature of the outstanding claims, uncertainty exists over the timing and value of these claims.

Continuing Healthcare

This provision relates to claims received in 2012-13 from individuals and their families/estates claiming for reimbursement of continuing healthcare costs. In some cases these claims go back a number of years. Further information has been requested from the claimants in order to assess their validity. Based upon the information currently held, the PCT has carried out a crude assessment of the claims recieved and made a provision based upon an informal view of likely eligibility. In due course a formal review process will be carried out on all applications.

Other

£132k of 'Other Provisions' is in respect of Industrial Tribunal cases which are in progress. A further £103k relates to provisions for building dilapidations and the balance relates to a variety of liabilities including matters being dealt with by the NHS Litigation Authority.

23. Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities		
Equal pay	**0**	0
*Other	**(6,096)**	(131)
Amounts recoverable against contingent liabilities	**122**	121
Net value of contingent liabilities	**(5,974)**	(10)
Contingent assets		
Contingent assets	**0**	0
Net value of contingent assets	**0**	0

*£6m of the estimated contingent liability relates to claims received for the retrospective reimbursement of continuing healthcare costs (for which a £3m provision has also been created). The PCT received a large number of claims in 2012-13 and over 400 of these have yet to be formally assessed. Due to the volume and complexity of claims it will be some time before the potential liability can be assessed. The contingent liability disclosed is in relation to claims for which no provision has been made.

£122k of the estimated contingent liability relates to a Deed of Guarantee to support the annual lease to the practice for Earls Colne Surgery premises for a period of 20 years from 6 May 2004. The rent is reviewed every three years. If the Deed of Guarantee is invoked, the PCT expects the costs to be recovered from GMS funding.

The remaining £2k is in respect of potential costs arising from 'Liabilities to Third Party' claims.

24. PFI - additional information

24.1 Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI

	31 March 2013 £000	31 March 2012 £000
Total charge to operating expenses in year - OFF SOFP PFI	**0**	0
Service element of on SOFP PFI charged to operating expenses in year	**364**	351
Total	**364**	**351**
Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI		
No later than one year	**373**	360
Later than one year, no later than five years	**1,587**	1,530
Later than five years	**12,111**	12,376
Total	**14,071**	14,266

24.2 Imputed "finance lease" obligations for ON SOFP PFI contracts due

Analysed by when PFI payments are due		
No later than one year	**1,309**	1,286
Later than one Year, no later than five years	**5,109**	5,146
Later than five years	**25,441**	26,712
Subtotal	**31,859**	33,144
Less: Interest element	**(15,242)**	(16,194)
Total	**16,617**	16,950

25. Impact of IFRS treatment

	20012-13 £000	2011-12 £000
Revenue costs of IFRS: arrangements reported on SoFP under IFRIC12 (e.g LIFT / PFI)		
Depreciation charges	404	403
Interest expense	1,127	1,096
Impairment charge - AME	(174)	(456)
Impairment charge - DEL	0	0
Other expenditure	529	489
Revenue receivable from subleasing	0	0
Total IFRS expenditure (IFRIC12)	**1,886**	1,532
Revenue consequences of LIFT/PFI schemes under UK GAAP / ESA95 (net of any sublease income)	(1,989)	(1,932)
Net IFRS change (IFRIC12)	**(103)**	(400)
Capital consequences of IFRS : LIFT/PFI and other items under IFRIC12		
Capital expenditure	0	96
UK GAAP capital expenditure (Reversionary Interest)	0	96

IFRS expenditure is all accounted for as "programme" expenditure.

26. 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

The majority of the PCT's income comes from funds voted by Parliament therefore it 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.

26.1 Financial assets

	At 'fair value through profit and loss' £000	Loans and receivables £000	Available for sale £000	Total £000
Embedded derivatives	0			**0**
Receivables - NHS		3,611		**3,611**
Receivables - non-NHS		1,307		**1,307**
Cash at bank and in hand		673		**673**
Other financial assets	0	0	0	**0**
Total at 31 March 2013	**0**	**5,591**	**0**	**5,591**
Embedded derivatives	0			0
Receivables - NHS		3,751		3,751
Receivables - non-NHS		1,524		1,524
Cash at bank and in hand		2		2
Other financial assets	0	0	0	0
Total at 31 March 2012	0	5,277	0	5,277

26.2 Financial liabilities

	At 'fair value through profit and loss' £000	Other £000	Total £000
Embedded derivatives	0		**0**
NHS payables		13,366	**13,366**
Non-NHS payables		28,023	**28,023**
Other borrowings		0	**0**
PFI & finance lease obligations		16,617	**16,617**
Other financial liabilities	0	0	**0**
Total at 31 March 2013	**0**	**58,006**	**58,006**
Embedded derivatives	0		0
NHS payables		9,813	9,813
Non-NHS payables		27,234	27,234
Other borrowings		0	0
PFI & finance lease obligations		16,950	16,950
Other financial liabilities	0	0	0
Total at 31 March 2012	**0**	53,997	53,997

27. Related party transactions

Mid Essex Primary Care Trust is a body corporate established by order of the Secretary of State for Health.

For 2012-13 the decision making forums of the PCT were the PCT Cluster Board, the Cluster Executive Committee and the shadow CCG Board.

Members of the decision making forums are required to complete a formal 'Declarations of Interest' statement each year, relating to both themselves and the relevant interests of close family members. This enables the PCT to ensure that the accounts disclose transactions with related parties declared in those annual statements.

27.1 2012-13 Related party transactions

The Department of Health is regarded as a related party. During the years 2012-13 and 2011-12 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:

Mid Essex Hospital Services NHS Trust
Colchester Hospital University NHS Foundation Trust
Barts & the London NHS Trust
Cambridge University Hospital NHS Foundation Trust
Basildon & Thurrock University Hospital NHS Foundation Trust
North Essex Partnership University NHS Foundation Trust
Cambridgeshire & Peterborough NHS Foundation Trust
East of England Ambulance Service
North East Essex PCT
West Essex PCT
South East Essex PCT
South West Essex PCT
Other East of England and London Acute and Primary Care Trusts
The NHS Litigation Authority
Midlands and East of England Strategic Health Authority

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 Essex County Council, Braintree District Council, Chelmsford City Council (formerly Chelmsford Borough Council) and Maldon District Council.

Voluntary and charitable donations to the PCT are managed on behalf of the PCT by the North Essex Charitable Funds Committee which is hosted by Mid Essex Hospital Services NHS Trust, having transferred from North East Essex PCT during the year. Separate statutory Charitable Funds accounts are published by Mid Essex Hospital Services NHS Trust and are available from the Trust upon request.

27.1 2012-13 Related Party Transactions (continued)

Members of the PCT Cluster Board and the Shadow Board of the Clinical Commissioning Group were required to complete a formal 'Declarations of Interest' statement, relating to both thenselves and the relevant interests of close family members.

During the year the following members of the PCT Cluster Board and the Shadow Board of the Clinical Commissioning Group had significant transactions with the PCT in respect of their practice and private accounts. These transactions were in accordance with the usual arrangements with practices for the provision of services.

	Payments to £000	Receipts from £000	Amounts owed to £000	Amounts due from £000
Cluster PCT Board				
Essex County Council - Mike Gogarty	9,227	187	297	176
Hagelhouse Ltd - Denis Hagel	135	0	8	0
NHS Alliance - Shane Gordon	1	0	0	719
North East Essex PCT - Cluster Executive Team	385	34,564	3,515	737
South East Essex PCT - Cluster Executive Team (2nd half of the year)	48,938	902	0	1,393
South West Essex PCT - Cluster Executive Team (2nd half of the year)	159	456	20	77
West Essex PCT - Cluster Executive Team	7,209	25,604	85	751
	66,054	**61,713**	**3,925**	**3,853**

The value of the transactions reported in the above tables exclude the costs of the shared Executive posts. In line with NHS accounting arrangements, the costs of the shared Executive posts were netted off the employing PCT's reported expenditure and accounted for as direct expenditure by the recipient PCTs.

During the year the following elected GP members of the Clinical Commissioning Group had significant transactions with the PCT in respect of their practice costs. These transactions were in accordance with the usual arrangements with practices for the provision of services.

	Payments to £000	Receipts from £000	Amounts owed to £000	Amounts due from £000
Boreham EA Ltd - Les Brann	43	0	0	0
Dickens Place Surgery - Amit Singha	565	0	37	0
Danbury Medical Centre - Caroline Dollery	1,480	0	87	0
Elizabeth Courtauld Surgery - Bryan Spencer	1,624	0	138	0
Fern House Surgery - Ahmed Mayet	1,713	0	114	0
John Guy & Partners - Les Brann	1,684	0	79	0
Little Waltham Surgery - Iain Tweedlie	2,271	0	96	0
The Practice, South Woodham Ferrers - Donald McGeachy	698	0	28	0
Tillingham Surgery - Donald McGeachy's wife	500	0	19	0
Writtle Surgery - Lisa Harrod-Rothwell	911	0	54	0
	11,489	0	**652**	0

27.1 2012-13 Related Party Transactions (continued)

Amounts owed at 31st March relate to Quality (QOF) Achievement due. These values are higher than in 2011/12 because practices had received a cash advance in March 2012 against anticipated achievement. Advances were not made in March 2013.

During the year the following members of the Mid Essex Clinical Commissioning Shadow Board had interests with the organisations listed below and which conducted significant transactions with the PCT.

	Payments to £000	Receipts from £000	Amounts owed to £000	Amounts due from £000
Addenbrooke's Hospital - David Simmons	2,967	0	46	0
Assura Chelmsford LLP - Les Brann	220	4	16	0
Central Essex Community Services CIC - Dan Doherty	40,540	2,585	1,259	719
Chelmer Housing Partnership Ltd - Keith Andrew	81	0	0	0
Deloitte & Touche Public Sector Internal Audit Ltd - Dee Davey	53	0	1	0
East of England Ambulance Service NHS Trust - Paula Wilkinson	15,277	0	333	0
Essex Cares - Caroline Dollery	185	0	0	0
Essex County Council - Krishna Ramkhelawon & Audrey Bancroft	9,227	187	297	176
Essex GP Commissioning LLP - Caroline Dollery	29	0	0	0
Farleigh Hospice - Keith Andrew	1,887	0	17	0
League of Friends of Halstead Hospital - Bryan Spencer	1	0	0	0
Mid Essex Mind (formerly Maldon Mind) - Caroline Dollery	43	0	0	0
North & South Essex local Medical Committee - Lisa Harrod-Rothwell & Ahmed Mayet	1	0	0	0
University of Essex - Dan Doherty	6	0	0	0
	70,517	**2,776**	**1,969**	**895**

As indicated above, a number of assets have transferred to NHS Property Services on 1st April 2013. These were considered operational at the year end, and so have not been

27.2 2011-12 Related Party Transactions

Members of the PCT Board, Executive Board and the Transformational Development Boards were required to complete a formal 'Declarations of Interest' statement, relating to both themselves and the relevant interests of close family members. The following related party information was required to be disclosed as a result of those declarations:

	Payments to £000	Receipts from £000	Amounts owed to £000	Amounts due from £000
Directors				
Central Essex Community Services CIC - Sarah Barnes	38,263	2,493	289	366
Essex County Council - Dr Mike Gogarty	9,873	392	122	13
Hagelhouse Ltd - Denis Hagel	53	0	41	0
Kier Eastern - Carol Winser	44	0	0	0
Kier Facilities Services Ltd - Carol Winser	484	0	2	0
NHS Alliance - Dr Shane Gordon	1	0	0	0
North East Essex PCT - Cluster Executive Team	735	36,394	2,262	1,799
West Essex PCT - Cluster Executive Team	9,675	28,315	14	66
	59,128	**67,594**	**2,730**	**2,244**

	Payments to £000	Receipts from £000	Amounts owed to £000	Amounts due from £000
NEDs				
Braintree District Council - Lady Patricia Newton	165	0	0	0
Braintree MENCAP - Leo Bishop	8	0	0	0
Capita Symonds Ltd - Renata Drinkwater	6	0	0	0
Colchester Borough Council - Pam Donnelly	0	0	0	0
As indicated above, a number of assets have transferred tc	1	927	52	0
Essex Cares - Leo Bishop	182	0	0	0
Farleigh Hospice - Lady Patricia Newton	1,882	120	0	0
Halstead Day Centre - Lady Patricia Newton	32	0	0	0
Open Road - David Barron	30	0	0	0
Tabor Centre - Lady Patricia Newton	11	0	0	0
Whipps Cross University Hospital - Qadir Bakhsh	167	0	37	0
	2,484	**1,047**	**89**	**0**

The value of the transactions reported in the above tables exclude the costs of the shared Executive posts. In line with NHS accouting arrangements, the costs of the shared Executive posts were netted off the employing PCT's reported expenditure and accounted for as direct expenditure by the recipient PCTs.

During the year the following members of the PCT Board, Executive Board and voting members of the Transformational Development Boards had significant transactions with the PCT in respect of their practice costs. These transactions were in accordance with the usual arrangements with practices for the provision of services.

27.2 2011-12 Related Party Transactions (continued)

	Payments to £000	Receipts from £000	Amounts owed to £000	Amounts due from £000
AF Clough Dental Care Ltd - Tony Clough	1,754	0	26	37
Castle Hedingham Surgery - Dr Paul Davis	306	0	7	0
Danbury Medical Centre - Dr Caroline Dollery	1,592	0	16	0
Elizabeth Courtauld Surgery - Dr Bryan Spencer	1,830	0	37	0
Fern House Surgery - Dr Ahmed Mayet	1,790	0	40	0
John Guy & Partners - Dr Les Brann & Dr John Guy	1,746	0	51	0
Little Waltham Surgery -Dr Iain Tweedlie	2,290	0	40	0
Maylandsea Medical Centre - Dr Mike North	333	0	11	0
Mount Chambers Surgery - Dr Jo Merrit	1,418	0	26	0
The Practice, South Woodham Ferrrers - Dr Donald McGeachy	733	0	11	0
The Pump House Surgery - Dr Paul Spowage	1,010	0	23	0
Tillingham Surgery - Dr Donald McGeachy's wife	483	0	13	0
Writtle Surgery - Dr Mike Bailey	915	0	22	0
	16,200	0	**323**	**37**

During the year the following transactions were recorded with organisations declared as an interest of the members or close family of the PCT Board, Executive Board and voting members of the Transformational Development Boards. These transactions were in accordance with usual business arrangements.

	Payments to £000	Receipts from £000	Amounts owed to £000	Amounts due from £000
As indicated above, a number of assets have transferred to NHS Property Services on 1st April 2013. These w				
Assura Chelmsford LLP - Dr Mike Bailey and Dr Les Brann	730	0	0	0
Boreham EA Ltd Trading as Boreham Pharmacy - Dr John Guy	38	0	0	0
Chelmsford Council for Voluntary Service - Lorraine Jarvis	53	0	0	0
East of England Ambulance Service NHS Trust - Dr Mike Bailey	11,464	0	272	10
EQUIP - Dr John Guy	54	26	0	0
Essex Dementia Care - April Lawlor	5	0	0	0
League of Friends of Halstead Hospital - Dr Bryan Spencer	1	0	0	0
Maldon District Council - Lew Schnurr	27	6	0	0
Mid Essex Hospital Services Trust - Dr Mike Bailey and Dr Jo Merritt	159,523	7	2,306	92
Mid Essex Mind (formerly Maldon Miind) - Dr Caroline Dollery	55	0	0	0
North & South Essex local Medical Committee - Dr Lisa Harrod-Rothwell & Dr Ahmed Mayet	1	0	0	0
North East London NHS Foundation Trust - Nicola Colston	341	0	88	0
North Essex Partnership Foundation Trust - Mary Davies	75,935	160	817	210
South West Essex PCT - Dan Doherty, Dr John Guy & Jane Richards	61	526	14	665
Ramsay Health Care - Kevin Kiff	4,994	0	1,222	6
St Helena Hospice - Mary Davies	65	0	3	0
St John Ambulance County HQ - Dr Mike Bailey	2	0	0	0
Two Counties Community Care Ltd. - Paul Baker	104	0	0	0
University of Essex - Nicola Colston	0	0	0	0
	253,453	**725**	**4,722**	**983**

28. Losses and special payments

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

	Total Value of Cases £s	Total Number of Cases
Losses - PCT management costs	185	1
Special payments - PCT management costs	15,800	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	185	1
Total special payments	15,800	3
Total losses and special payments	15,985	4

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	195	10
Special payments - PCT management costs	20	2
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	195	10
Total special payments	20	2
Total losses and special payments	215	12

29. Events after the end of the reporting period

On 1 April 2013 the PCT ceased operation. The successor organisations which have inherited the assets, liabilities and ongoing responsibilities of the PCT, along with the net balances, are:

	£000
Mid Essex Clinical Commissioning Group	(2,854)
Department of Health	(31,612)
NHS England	1,000
NHS Property Services	20,303
NHS Trusts and Foundation Trusts	364
Essex County Council	5
HM Prison Service	13
	(12,781)

At the time of producing the accounts the guidance advised that all short term balances should be recognised against the Department of Health and only long term assets and liabilities should transfer to the future bodies.

The functions that were previously carried out by Mid Essex PCT will be transferred across to the following organisations:

Future	
Mid Essex Clinical Commissioning Group	Acute care, mental health, community services, GP prescribing
NHS England	Primary care, specialised services, offender health
Central Eastern Commissioning Support Unit	Business support and management services
NHS Property Services	Ownership and management of all premises
Essex County Council	Public health services

During 2013/14 a further exercise will be undertaken to ensure that the appropriate accounting treatment of the closing balances will be mapped across into the new organisations and this work will be audited by the National Audit Office in the autumn of 2013.

As indicated above, a number of assets have transferred to NHS Property Services on 1st April 2013. These were considered operational at the year end, and so have not been impaired in the PCT's books. It is for the successor body to consider whether, in 2013-2014, it is necessary to review these for impairment.

The financial statements on pages 1 to 4 were authorised for issue by the Essex Sub-Group of the Department of Health Audit and Risk Committee on behalf of the Department of Health on 3 June 2013 following the demise of the PCT.