Department of Health

NHS

South West Essex Primary Care Trust

2012-13 Annual Report and Accounts

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South West Essex Primary Care Trust

2012-13 Annual Report

NHS South East Essex
and NHS South West Essex

South West Essex PCT

Annual Report 2012/13

Contents

Foreword from Chair and Chief Executive

Welcome to the Annual Report for 2012/13 for NHS South West Essex

South West Essex PCT (known as NHS South West Essex) is the primary care trust that commissions health services for people living in south west Essex. This report covers the 2012/13 financial year (1 April 2012 to 31 March 2013).

In 2011, we joined forces with NHS South East Essex to become a PCT cluster to lead the NHS in south 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 South West Essex finished the financial year with a surplus of £0.7m.

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 deliver 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 the annual report.

All Primary Care Trusts were dis-established 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 of waiting times
- Planning strategically and attracting more GPs to the area
- Improving the quality of and access to primary care
- Improved premises for 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.

Katherine Kirk
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 our dis-establishment on 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 South West Essex is a primary care trust (PCT) for people who live in South West Essex. As your local NHS we were 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 were 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.

South West has a GP-registered population of approximately 428,700, covering the geographical areas of Basildon, Billericay, Brentwood, Thurrock and Wickford.

The local population of South West Essex has proportionately more children and middle aged adults and fewer young adults, than the national average. However, the composition of the local population does vary between areas, with Thurrock having proportionately more children and younger people and Brentwood more older people.

Over the next twenty years the population of south west Essex is expected to continue to grow, in part due to the inclusion of Thurrock and Basildon in the Thames Gateway development area. At the same time, the local population will age, with the 85-plus age group (those with the greatest care needs) experiencing proportionately the greatest growth.

Essex County Council provides certain strategic services such as social services, highways and education to the boroughs of Basildon and Brentwood and the towns of Billericay and Wickford. Meanwhile, Thurrock, as a unitary authority, is responsible for providing all local government services and is independent of Essex County Council. Therefore, South West Essex PCT is charged with working in partnership with both of these 'top tier' authorities, to ensure that inequalities in health and social care provision are avoided.

Our place in the NHS
NHS South West Essex was one of the 13 PCTs in the East of England region, and in 2011 became part of a PCT cluster (alongside NHS South East Essex) covering south Essex.

Our accountabilities were to our local population and to NHS Midlands and East Strategic Health Authority (previously East of England SHA), who monitored and evaluated our performance.

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

As commissioners, we planned and bought services from other NHS trusts and health care providers such as: Basildon and Thurrock University Hospitals NHS Foundation Trust, North East London NHS Foundation Trust, SEPT (South Essex Partnership University NHS Foundation Trust) and other specialist healthcare providers.

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

NHS South West Essex facts and figures

Location of our headquarters	Phoenix Court, Christopher Martin Road, Basildon, SS14 3HG.
Communities covered	NHS South West Essex is within the Thames Gateway area close to London and stretches into rural Essex. The area has two 'top tier' local authorities (a county council and a unitary authority) along with two borough councils: • Essex County Council - Basildon Borough Council - Brentwood Borough Council • Thurrock Council
Population (GP registered)	We serve a GP registered population of around 428,700.
Type of area	South west Essex is similar to the England average, with the exception of having greater numbers of children aged 14 and below; a higher distribution of women in their 30s and 40s; and fewer in their 20s.
Budget	£683m
No. of employees	221.54 WTE (Whole Time Equivalents)
No. of Clinical Commissioning Groups in south west Essex	Two: • Basildon and Brentwood • Thurrock
No. of GP practices	79
No. of GP-led health centres (equitable access centre, open seven days a week, 12 hours a day, walk-in appointments)	One: Thurrock Health Centre, 55-57 High Street, Grays, Essex, RM17 6NJ
No. of Minor Injuries Units	One: Orsett Minor Injuries Unit, Rowley Road, Orsett, Grays, Essex, RM16 3EU

No. of community hospitals - we manage these health facilities and commission services (usually from other healthcare providers) to run from them	Mayflower Community Hospital (Billericay) Brentwood Community Hospital Thurrock Community Hospital (Grays)
No. of community pharmacies	82 plus one internet pharmacy
No. of opticians practices (including mobile)	57
No. of dental surgeries	48
Main provider of acute hospital services	Basildon and Thurrock University Hospitals NHS Foundation Trust
Community services name and head office	North East London NHS Foundation Trust (NELFT), Wigham House, Barking, IG11 8PJ
Mental health and learning disabilities Provider	South Essex Partnership University NHS Foundation Trust (SEPT)
Main private hospitals providing NHS services	BMI Hospital (formerly Phoenix), Nuffield Healthcare, Ramsey, Spire Healthcare

Background and changing role of PCT

In May 2011, NHS South West Essex began working closely together with NHS South East Essex (our neighbouring Primary Care Trust) in a 'cluster' arrangement under a single executive team. This 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 two primary care trusts. Each PCT remains a separate statutory body.

In September 2011, South East Essex PCT and South West Essex PCT started working with one team of staff under the banner of NHS South Essex and staff were aligned, where possible, to the new structures that will take over from April 2013, as a result of national NHS reforms (see transition section).

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 • Out of Hours Providers • Dentists • Pharmacists • Opticians • Other provider primary care businesses.
Community services: This includes, district nursing, health visiting, speech and language therapy, podiatry, school nursing.	• North East London NHS Foundation Trust • Partnership arrangements with voluntary organisations.
Hospital services: This includes outpatient clinics, operations and emergency care.	• Basildon and Thurrock University Hospitals NHS Foundation Trust, • Mid Essex Hospital Services NHS Trust • Barking, Havering & Redbridge NHS Trust

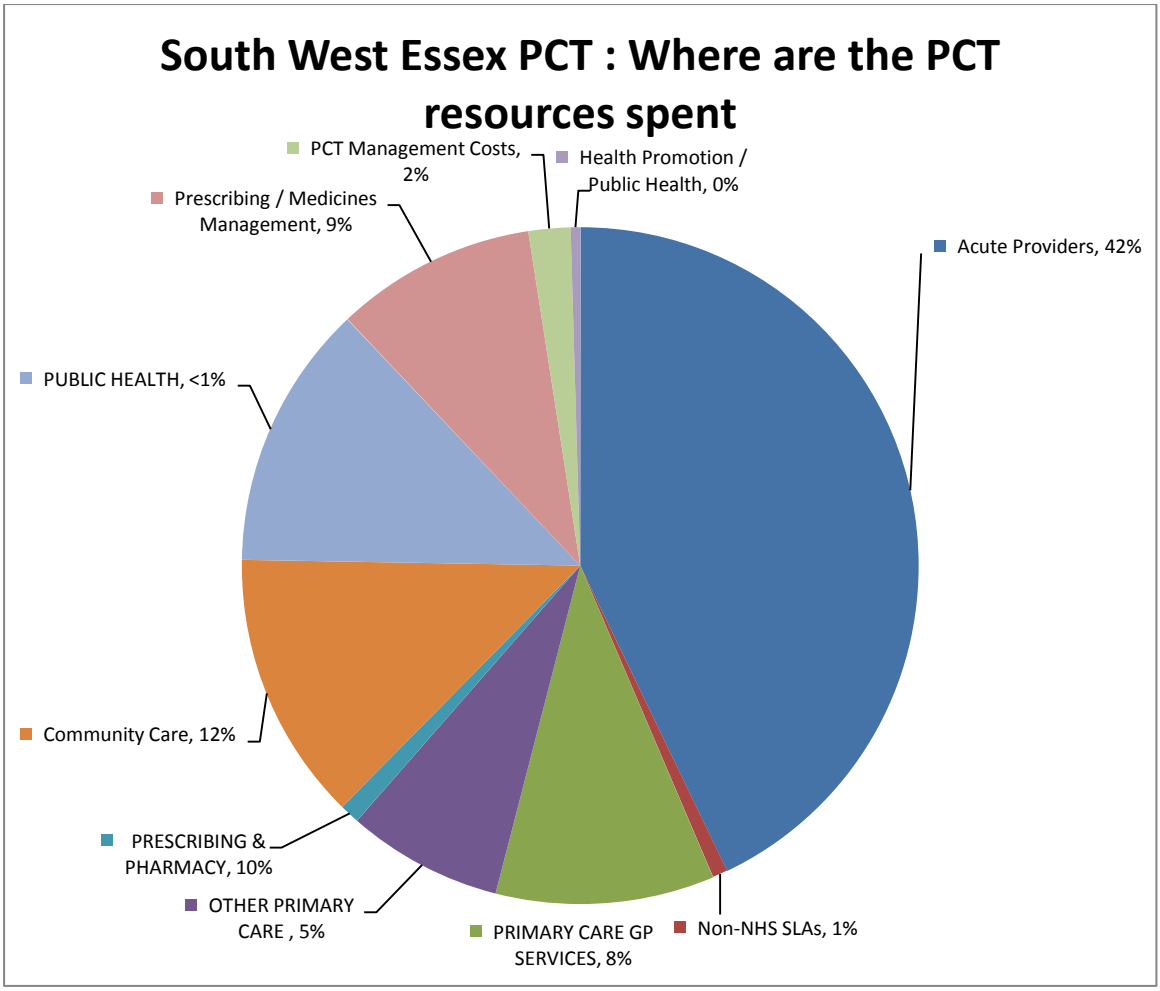
	• Southend University Hospital NHS Foundation Trust • Barts & The London NHS Trust • Independent sector providers including Nuffield Health and Spire Healthcare.
Mental health services: This includes psychological therapies, community mental health teams, learning disability services.	• SEPT (South Essex Partnership University NHS Foundation Trust) • Partnership arrangements with voluntary organisations.
Specialist health services: This includes, for example, treatment for specialist cardiac, renal, children's, neurosciences, cancer, genetics and many more.	The East of England Specialised Commissioning Group* commissions these services on our behalf from specialist centres such as: • Basildon and Thurrock University Hospitals NHS Foundation Trust • Great Ormond Street Hospital NHS Trust • The Royal Marsden NHS Foundation Trust • Barts & The London NHS Trust
Emergency health services and transport.	• East of England Ambulance Service NHS Trust • Thames Ambulance Service

* The other PCT within our cluster, South East Essex PCT, hosts the East of England Specialised Commissioning Group which is accountable to all 13 PCTs in the East of England. It covers a population of over five million people.

How your money was spent

In 2012/13, NHS South West Essex achieved its financial responsibilities and delivered financial balance at the year end. The total budget for 2012/13 was £683million and at year-end we carried forward a small surplus of £0.7 million. Achieving this position was challenging and we managed a number of pressures on our budgets.

Regrettably, we did spend above our plan in the most unpredictable and demanding areas, such as acute activity and in continuing care. The PCT met all of its statutory financial duties in 2012/13. CCGs and all successor bodies will face though financial challenges over the next few years. For full details of annual accounts, see Appendix B.



Our Board
South East Essex PCT and South West Essex PCT

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 2011/12, the Department of Health made it a requirement for all PCTs to operate as clusters with their neighbouring PCTs, whilst still remaining statutory bodies. With effect from 1 December 2011, South East Essex PCT and South West Essex PCT have been operating with one South Essex Cluster Board covering these PCTs.

Board Members
(for the period 1 April 2012 to 30 March 2013 unless otherwise stated)
Please note the declarations of interest are as at March 2013 unless the Board member was not in office at that time (as indicated by the appointment end dates). In the latter cases, the declarations of interest are the latest declarations received during the period of their Board membership.

Mrs Katherine Kirk Chairman Committees: Finance, Quality and Governance, Remuneration Declarations of interest: Nil.
Dr Andrea Atherton Director of Public Health Committees: Finance, Quality and Governance Declarations of interest: My husband, Dr Paul Husselbee, is a GP in Leigh on Sea and a GP partner of Dr B Houston; He is also Accountable Officer of Southend CCG, Director of Fortis Healthcare and Director of Atrium Clinic.
Mrs Glynis Cheers Non Executive Director Committees: Quality and Governance, Remuneration Declarations of interest: Business Therapy consultancy. Referrals occur from NHS consultants, doctors, GPs and other professionals for therapy (not from S Essex). No pecuniary transactions with NHS.
Dr Anil Chopra Medical Director, South West Essex (South Essex from 1 July 2012) Committees: Quality and Governance Declarations of interest: Kingswood Medical Centre – Partner in GMS practice.
Mr Tony Cox Non Executive Director Committees: Audit, Quality and Governance Declarations of interest: Director - Tony Cox Consultancy Ltd, appointed as Lay Member of Board of Basildon and Brentwood CCG w.e.f. 1 October 2012.
Mrs Margaret Hathaway Commercial Director Committees: Quality and Governance Declarations of interest: Director of South East Essex Lift Ltd. Husband works as IT project manager in PCT.
Mrs Gillian Hind Non Executive Director Committees: Audit Declarations of interest: I chair the Adoption and Fostering Panels at London Borough of Newham. I am the lay member (PPE) for Castle Point and Rochford CCG.
Mr Tony Le Masurier Non Executive Director (to 30 November 2012) Committees: Audit, Finance, Quality and Governance Declarations of interest: Chair of Trustees / Director at Southend Darby and Joan Organisation Ltd; School Governor at Darlinghurst School, Leigh on Sea; Magistrate – South Essex Bench, spouse is part time worker at Age Concern Southend.
Mr Rob Peters Non Executive Director and Audit Committee Chair Committees: Audit, Finance Declarations of interest: Lay member (Governance), Castle Point and Rochford CCG.

Mr Andrew Pike Chief Executive Committees: Finance, Quality and Governance Declarations of interest: My uncle Joe Pike is a County Councillor for Essex County Council.
Ms Dawn Scrafield Director of Finance & Performance Committees: Finance, Quality and Governance Declarations of interest: Treasurer, Equal People. My husband David Griffiths is seconded to SEPT.
Mr Roger Sinden Non Executive Director Committees: Quality and Governance Declarations of interest: Consultant to providers of residential/nursing care and organisational support; regularly work for Runwood Homes as main client; volunteer for Dengie Project Trust (Mid Essex); wife is Chief Officer of Dengie Project Trust (Mid Essex); Dengie Project Trust receives funding from Essex County Council/North Essex Cluster in relation to some services.
Mr Ian Stidston Director of Primary Care and Partnership Commissioning Committees: Finance, Quality and Governance Declarations of interest: Nil.
Mr Pól Toner Director of Quality and Patient Experience Committees: Quality and Governance Declarations of interest: Wife works for NHS Mid Essex; governor at St John Payne Catholic School; Coach at Braintree Rugby Club.

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 and values

South East Essex Primary Care Trust (PCT) and South West Essex PCT have been working together as a cluster to lead the NHS in south 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.

As we implement 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 remain at the heart of our commissioning actions now, and form the bedrock in preparing and supporting the commissioners of the future.

1. Principles that guide us as a caring successful commissioner - We aim to improve the quality of patient services, the safety of patients and their experience of the NHS. To achieve this requires wide involvement of the public, patients, partners and staff in planning and commissioning services.

2. Principles that guide us as a caring and responsible employer - It is the commitment, professionalism and dedication of our staff which really makes a difference to achieving our key organisational objective of high quality care for all.

3. Principles that guide us as a supportive and enabling leader of the NHS in south Essex - Our aim is, with partners, to improve the health of the population we serve. As the local leader of the NHS, we will continue to work with our partners to overcome organisational boundaries and ensure seamless patient care is delivered across the system.

4. Principles that guide us in making decisions on behalf of the public we serve -
We will abide by the Nolan Principles of Public Life: selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

In addition, we will:

- Hold partner decision-makers to account
- Abide by the Equality Act
- Make best use of scarce resources
- Use quality information
- Communicate clearly
- Prioritise appropriately

5. Principles that guide us as a responsible, financially accountable organisation -
Both PCTs have separate statutory duties to maintain spending within budget limits. Therefore we are faced with a number of ethical considerations when allocating scarce NHS resources.

6. Principles that guide as a supportive and enabling leader of change -
The changes in government policy require PCTs to plan for the future commissioning arrangements when successor organisations take over the responsibilities that PCTs currently undertake.

We would want to ensure that the future provision of healthcare will be further improved. We aim to do this by developing and supporting the emerging Clinical Commissioning Groups, NHS England (previously called NHS Commissioning Board NCB)), local authorities and other successor bodies.

Key issues for NHS South East Essex during the year

Transition - 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 that it:

- 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 were abolished and new organisations were formally established including: CCGs (Clinical Commissioning Groups), CSUs (Commissioning Support Units) and NHS England (formally called the National Commissioning Board (NCB)).

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 South West Essex
From 1 April 2013, CCGs took over many of the duties of the PCTs and became responsible for commissioning most healthcare – planning, buying and monitoring services to meet the needs of their local communities.

During 2012/13, CCGs have been working towards authorisation to allow them to become statutory organisations on 1 April 2013. The authorisation process involved rigorous reviews of the CCG's governance systems, procedures and policies. This assessment process involved a review of the evidence submitted by CCGs and in depth assessment visits.

Basildon and Brentwood CCG
Basildon and Brentwood (B&B) CCG consists of all GP practices in the Basildon and Brentwood Council areas, and the governing body includes 10 GP board members. It covers a population of approximately 264,300.

B&B CCG has been authorised with 57 conditions and some legal directions. As part of these conditions, the CCG will continue to work closely with the NHS Commissioning Board to commission services from Basildon Hospital and tackle some of the system wide changes facing the local health economy.

Basildon and Brentwood CCG is based at: Phoenix Court, Christopher Martin Road, Basildon SS14 3HG, tel: 01268 245765, email: bb.ccg@nhs.net

For more information visit: www.basildonandbrentwoodccg.nhs.uk

Thurrock CCG
Thurrock CCG covers a population of 161,000 residents of the Unitary Authority of Thurrock; the CCG is co-terminus with the council and this allows affective joint working across health and social care for the residents.

All 34 practices are members of the CCG, and the governing body includes 12 GP board members.

Thurrock CCG has been authorised with 37 conditions and some legal directions. As part of these conditions, the CCG will continue to work closely with the NHS Commissioning Board to commission services from Basildon Hospital and tackle some of the system wide changes facing the local health economy.

Thurrock CCG is based at: Civic Offices, 2nd Floor, New Road, Grays, RM17 6SL
tel: 01375 365810

For more information visit: www.thurrockccg.nhs.uk

Commissioning Support Unit (CSU)
Commissioning Support Units (CSU) were formally established on 1 April 2013. CSUs 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.

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 2012. 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) was established formally from 1 April 2013. It is a national organisation whose 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 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, a presence in London and there will be 27 area teams across England which are divided between 4 Regions and 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 of the following services:
  - primary care;
  - military and prison health services;
  - high secure psychiatric services; and
  - specialised services.

The Essex Area Team is led 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

More information is available at www.england.nhs.uk

NHS Property Services Ltd

NHS Property Services Ltd was 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

Public Health England

Public Health England (PHE) is a new organisation which was 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.

Public Health moving to Local Authorities

From 1 April 2013, the public health function will formally transfer from PCTs to Local Authorities. This transition had already started with South West Essex public health

teams being co-located with Local Authorities – Essex County Council and Thurrock Council.

Health and Wellbeing Boards
A key part of the Government's Health and Social Care Act (2012) is 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.

From 1 April 2013, Health and Wellbeing Boards are 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 key commissioners, including representatives of CCGs, 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 (HWB) 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 CCGs 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 (now called NHS England), Andrew Pike.

Throughout the year, the shadow board oversaw the update of the Joint Strategic Needs Assessment 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.

Thurrock Health and Well Being Board
Thurrock Health and Well-Being Board (HWB) has been in place in shadow form since April 2011. Thurrock CCG has been a key part of the Board since its inception.

Over the past year (2012/13) the Board has worked on a number of areas. This includes the following:

HWB Arrangements - Preparing for April 2013

- Holding a number of independently facilitated development sessions focused on cementing Board relationships and developing priorities;
- The development of Thurrock's Health and Well-Being Strategy 2013/16;
- Development and agreement of JSNA products;
- Development of the Board's governance arrangements - including reviewing Terms of Reference and Structure;
- Development of communication and engagement arrangements; and
- Development of Board sub-structure - HWB Executive and Joint Commissioning Group

Key issues discussed and taken forward

- Poor take-up of Learning Disability Health Assessments
- Carers' Strategy - sign-off
- South Essex Mental Health Strategy - consultation
- Violence Against Women and Girls Strategy - sign-off
- Joint Commissioning Intentions
- Quality of Care at Basildon and Thurrock University Hospitals FT

Next Steps

Understandably, the Board has spent a high proportion of its time focusing on ensuring robust arrangements are in place; that relationships are developed; and that HWB priorities for Thurrock are developed. This has been important for ensuring the Board has a good foundation to work from as of April 2013.

From April 2013, the balance will shift with the Board focusing on delivering the agreed Strategy and identifying and discussing key issues as they emerge.

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

To ensure that NHS South Essex is compliant with the NHS Constitution, we nominated our Non-Executive Director and Chairman, Katherine Kirk, 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 South Essex Board papers made reference to which aspects of the NHS Constitution are covered by that paper, which ensured that the NHS Constitution was referred to in our mainstream business.

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

Examples of the NHS Constitution operating in South Essex include:

- All local providers are achieving overall 18 week referral to treatment times targets.
- A choice of providers continued to be offered across south Essex.

- Targets relating to ensuring that patients are not asked to share sleeping or bathroom facilities with members of the opposite sex, except on the rare occasions where you need very specialised or urgent care are being achieved locally.
- The PCT continues to meet statutory deadlines to respond to complaints and this is supported by the PCT's Patient Advice and Liaison Service.

Improving Care

Mental Health Services

The South West Essex PCT Mental Health Team have made various improvements to patient care by implementing the following key projects in South West Essex:

Dementia Intensive Support Team

The Dementia Intensive Support Team (DIST) was initially piloted in summer 2011 in South West and has now been fully rolled out in South East Essex. The aim of the service is to improve patient care by:

- assessing patients in their home environment and referring to the appropriate service (e.g. mental health, memory service, Social Services, Alzheimer's Society, district nursing)
- identifying and managing risk factors that would lead patients going into hospital or attending A&E
- providing support up to 6 weeks - until an appropriate package care is in place
- supporting the carers and the patient with dementia
- taking direct referrals from the Ambulance Service and GPs
- disseminating specialist knowledge and advice to hospital teams when requested (i.e. risk assessment) for patient with dementia that are due for discharge
- providing information and advice to social services

Community Dementia Nurses

The purpose of this pilot was to reduce the level of prescription of antipsychotic medication for people with dementia, reduce admissions and re admissions to the acute hospital from care homes. This was achieved by investing in three dementia mental health nurses who were allocated to care homes within each locality. These workers were able to deliver on-going training to all care home staff and were line managed by the current older peoples' community and mental health teams. Building skills and support to care home staff is vital if we are to improve the quality of care provided to people with Dementia and their carers. The evaluation of the pilot was successful and has therefore now been fully funded for 2013/14.

Mountnessing Court

Dementia is a severe and devastating disorder which impacts not only on the individuals with dementia, but also on the family members who care for them. It is not a disease in itself but the term used for a collection of symptoms including changes in memory, reasoning and communication skills with a gradual loss of ability to carry out daily activities. These symptoms are caused by structural and chemical changes in the brain such as those which occur in Alzheimer's disease. In addition, individuals may experience behavioral and psychological symptoms at any stage in their illness. The wellbeing of people with dementia is affected by environmental, psychological

and biological factors and people can easily become disoriented in strange surroundings such as hospital or when being cared for by different people.

In 2012/13 we began piloting a 22 bedded dementia unit at Mountnessing Court, Billericay which enables patients with dementia to be managed in a dementia friendly environment who would otherwise require admission to acute hospitals for relatively minor physical treatments e.g. fluid resuscitation/ oral antibiotic treatments. The aim of the pilot is to help Dementia patients to return back to their premorbid (pre admission) functional levels or as close as possible. This innovative service is being delivered using a multi-disciplinary approach with clinical leadership from consultant psychiatrist, geriatrician, physical health nurses, mental health nurses, physiotherapy, OT and carers support from the voluntary organisations. The evaluation of the pilot will be completed in the summer 2013'.

Children's Services

Continuing Health Care (CHC) – Any Qualified Provider process

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 which is based on individual need which reflects value for money.

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

- Provide a range of quality, patient focused, care programmes to meet patients' needs ensuring an efficient service which gives a personalised tailored approach to care, taking account of the patient's dignity, respect, cultural and religious needs;
- Develop seamless pathways of care by developing systems and processes so that patients receive continuous joined-up care provision
- Ensure care delivery meets all necessary NHS standards.
- Maintain and enhance choice through Plurality of Service Providers.
- Encourage innovative ways of working.
- Improve value for money through 'added value'.
- Move to a position where all service providers of services are using standard NHS contracts no activity or financial guarantees.

Work on the high impact pathways

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 will address a number of issues:

- 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 incl Asthma
    - Head Injury
    - Diabetes
    - Epilepsy
    - Constipation/Encopresis
- A review of current contractual arrangements for phlebotomy

Early Offer of Help and Complex Families work with Local Authorities
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.

Thurrock: A joint agency approach is being developed to early offer of help with all entry into services through one access point. Health commissioners have been working with Thurrock Council to procure the new services and align appropriate health staff to the model of delivery

Sickle Cell Disease Local Specialist Service South Essex
Background - Sickle cell is the most common serious genetic disorder in England and as such it must be viewed as a mainstream issue for the NHS. The growing number of paediatric patients – many of whom come from disadvantaged communities in urban centres - require services at specialist level, local hospital level and community level to provide a better quality of life for both the child and their family.

The project will review and re-design a Sickle Cell Pathway to deliver 0 – 19 Service aiming to: reduce acute hospital attendance for children and young people for general advice and support to align to best practice standards; and reduce tertiary centre activity.

Revised sexual abuse pathways within the SARC and opening up to self referral –
Revised pathways have been agreed for children and young people aged 0 to 5 years, 5 – 11years, and over 13 years, in collaboration with statutory agencies and acute units. In line with the plan for making the service more accessible, the service as planned opens to self referral in April 2013.

Health Visitor Specification and delivery of Maternal Early Sustained Child Home Visiting (ESCH)

The Future Model for Health Visiting Practice

It is proposed that 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 needs 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 five.

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 is 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 model of delivery 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 (developed in Sydney, Australia) 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).

CAMHS (Child and Adolescent Mental Health Services)
A single gateway has been put into North Essex and South Essex separately 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.

CAMHS - Tier 3 specialist services and Tier 4 in patient services
During 2012/13 CAMHS work focused on ensuring that:

- Children and families were offered services in locations close to home and in ways that children and young people wanted, ensuring high quality care
- Services were integrated - personalised, age-appropriate, joined-up, and built around children and young people's needs
- Effective transitions to adult services - ensuring children and young people and their families/carers were effectively prepared and had the information they needed
- Services were based on the best available evidence, using individual, and service-level measures of effective outcomes
- Teaching, training, liaison and consultation with staff in universal services were embedded in the delivery of specialist services
- Essex CAMHS provided close collaborative working during the transition period 2012/13 in respect of Tier 4 in patient services commissioned by Midlands and East of England Specialised Commissioning Group. This included the management of referrals, case management, contract management and funding agreements to March 2013.

CAMHS Gateway
In response to feedback regarding the inconsistency and complexity of previous referral systems health and social care commissioners together with providers agreed to ensure that by working in an integrated way, access to CAMH services were easily available via a single gateway approach

The CAMHS Gateway Pilot offered a single point of access for CAMHS referrals in the localities of Castle Point and Rochford, Basildon and Brentwood. A screening process ensured that referrals were directed to the most appropriate services to meet the emotional and mental health needs of all children and young people in this area of South Essex.

The gateway has been successful in integrating the Tiers 2 and 3 CAMH Services forming closer working relationships and a better understanding of the criteria between services. The gateway also provided an opportunity to utilise the extensive knowledge of a range of services from the voluntary and independent sectors, including national charities and locally commissioned providers.

Following evaluation of the pilot it was clearly evident that improved access across all tiers of CAMHS ensured better service quality, early intervention, reduced inequalities, and ultimately improved outcomes for children young people and their families.

The aim for 2013/14 will be to build on the recommendations of the pilot by modifying and refining elements of the gateway pathway and improving the quality of information.

CAMHS Learning Disabilities Service (CAMHS/LD)
A service for children with learning disabilities (LD) covers the age range of 5-11 years and is commissioned from SEPT, following on from a Department of Health funded pilot.

The CAMHS LD team provides a community based service, which supports children who have severe to profound learning disabilities, with additional mental health problems, and emotional and behavioural issues.

The funding available has only enabled the team to focus on children between the ages of 5-11 years who are in special education for severe to profound learning disabilities and complex needs. Even with this restricted age range demand for the service during 2011/12 resulted in increased waiting times.

During 2012/13 the South Essex Cluster PCTs provided additional resources for this service, and the additional financial investment to date has resulted in reducing the numbers on the waiting list for a first appointment by 41%, compared to the position in January 2012.

The average length of wait for first appointments for CAMHS LD clients is currently ten weeks, which again is a reduction of 25% compared to the position in January 2012.

Older People's Services

During 2012/13, through the emerging CCGs, the PCT has worked closely with a number of stakeholders including Basildon and Thurrock Hospital, North East London NHS Foundation Trust, Essex County Council and Thurrock Council, to implement a number of innovative service changes to improve the quality of care for older people.

To support patients and carers manage exacerbations of their condition in their normal place of residence, the PCT has developed and implemented the Single Point of Response in Essex and the Rapid Response and Assessment Service in Thurrock. Both services aim to provide a joint health and social assessment and then direct patients to appropriate services that enable them to be managed in their home or care home. This service has prevented many unnecessary hospital admissions. The CCGs will look to expand the operating hours and function of these services in the future.

Working closely with Basildon Hospital and North East London NHS Foundation Trust, in September 2012, the PCT commissioned a new community geriatrician service. This service aimed to bring expert clinical opinions that would usually only be available in a hospital setting into the community. This has been particularly effective in a number of care homes where new care plans have been agreed for the management of patients with a complex range of conditions.

Working with general practices, community and mental health providers and social services, the PCT has rolled out regular multi disciplinary team meetings (MDTs) to help case manage patients at risk of acute exacerbation of conditions. These meetings aim to bring together the collective knowledge of services and patients that is known by each organisation to agree a joint plan/strategy for improving the quality of care we can offer to patients. This has enabled patients to quickly access health,

social and voluntary services that they may previously would have not accessed in a coordinated way.

These service developments form part of the overarching unplanned care programme that has been developed and implemented by the two CCGs that form the PCT. This work will continue to be implemented and enhanced during 2013/14.

Ensuring Quality

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

Achievements during 2012/13 included:

- Developed services locally to better support manage and plan for care of frail patients with multiple co morbidities, by employing community geriatrics.

- Enhanced advance planning for care of patients through a Multi-Disciplinary Team (MDT) approach (primary, community, specialist health care and social care) - establishing true working integration between health and social care.

- Improved crisis management, by developing admission avoidance services, intermediate care services and long term condition support.

- Enhanced support for patients with Dementia, with the Dementia intensive support team and dementia liaison services

- Improved access to services and timely input to support care in the community, through the continuation of the single point of referral (SPOR) service.

- Improved support and community services for care homes, by introducing a care home support team

- Developed alternative pathways to improve care quality, improve outcomes and to promote efficient use of resources

Improving quality, patient safety and experience
The following is just a snapshot of the work we have undertaken in 2012/13, to improve the quality and safety of our patient services and improve their experience of the NHS.

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry
The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry was published on 6 February 2013. There is a requirement for all those connected to the provision, commissioning and regulation of health services, to act on the recommendations.

Key findings
The Inquiry found that appalling suffering at Mid-Staffordshire hospital was primarily caused by a “serious failure” on the part of the Trust Board, which failed to listen to patients and staff and “failed to tackle an insidious negative culture, involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities.”

There were 290 recommendations from the report and the PCT began the review of the recommendations to consider local requirements; this work is being continued by the successor bodies.

As is widely understood (following the publication of the Francis Report), Basildon and Thurrock university Hospitals NHS Foundation Trust, is among a small number of Trusts across the country who will be subject to a Department of Health led investigation into its mortality rates.

The full scope of this is yet to be understood, although the following has recently been shared:

- Investigation is to be led by Bruce Keogh.
- The investigations will be the most comprehensive the NHS has ever undertaken, but they will be supportive investigations for the Trust.
- There will be a data collection exercise (from all sources) around week commencing 11 March 2013.
- With the first of the investigations starting week of 15 April 2013 – it is expected that Basildon and Thurrock University Hospitals NHS Foundation Trust will be the first investigation.
- The last of the investigations will be week commencing, 7 June 2013.

Patient Safety Thermometer

The PCT, supported by the National Patient Safety Thermometer Initiative, is working with all providers to collect data on pressure ulcers; Venous Thromboembolism (VTE); Falls and Catheter Acquired Urinary Tract Infections (CAUTI).

Data has been submitted for all providers since March 2012; this information is retrieved from the National Safety Thermometer database, each month, to provide a monthly point prevalence study on the 4 harms measured

The patient safety thermometer data collection was a ‘Commissioning for Quality’ Innovation, in provider contracts for 2012/2013 and this has been taken forward for 2013/2014.

The latest results for the Patient Safety Thermometer can be found via the following website link - www.hscic.gov.uk/thermometer

The PCT has also been very active in the implementation of the Strategic Health Authority (SHA) ambition, for the elimination of avoidable Grade 3 and 4 pressure ulcers

Peer Review

The PCT participated in an SHA Pressure Ulcer Prevention Health Economy Peer Review, for the South Essex Cluster, during 2012/13.

The review was conducted across the South Essex PCT cluster provider and commissioning organisations and involved presentations and site visits to Basildon and Thurrock University Hospitals NHS Foundation Trust and to South Essex Partnership University NHS Foundation Trust. Information and presentations were also received from North East London NHS Foundation Trust and Southend University Hospital NHS Foundation Trust.

Recommendations:
The recommendations noted that there is an overall commitment to delivering the ambition across the cluster. To assure grip and pace, the cluster needed to ensure there is:

- A clear strategic focus; with organisational pressure ulcer prevention strategies linked to strategic objectives
- Development of Board awareness, regarding the importance of the ambition
- Further education of CCGs and GPs, to assist them in understanding the complexity of the challenge and to make clear their role in achieving the ambition
- An up to date action plan with a clear lead; deliverables and responsibilities
- Effective data reporting, information and audit
- Good practice (and what works) being shared across the cluster, to drive improvement
- The shared understanding that the reduction in pressure ulcers is a driver to quality improvement.

These recommendations will be taken forward by the CCGs with the local providers.

Patient Revolution
As part of the NHS reforms, one of the defining features of the consultation was the intention to place' patient revolution' at the heart of its work programme. It was considered that there are too many questions and surveys are too infrequent; and fundamentally, organisations fail to act on the information to make change happen.

Therefore the "net promoter" question has become one of 5 ambitions the SHA wished to deliver, over the 2011/12.

The patient revolution or 'Friends and Family Test' (FFT) question, was a part of the wider work to improve the patient experience and it would take the format of a tin opener question for provider organisations, to ask 10% of their footfall, the following question:

"How likely is it that you would recommend this service to friends and family?"

(Extremely; Likely; Unsure; Unlikely; Not at all; or don't know).

This data set would then be broken down to detractors, passives and promoters and a calculation gave a score out of 100.

This would then identify key areas, wards and departments where patient experiences can be measured. Initially this was rolled out to the acute providers (Basildon and Thurrock University Hospital NHS Foundation Trust and Southend Hospital NHS Foundation Trust). Going forward, it will be implemented within the other providers including, SEPT mental health and NELFT and SEPT community services.

The cluster PCT has also been proactive in challenging the providers when the numbers of detractors increases, e.g. unplanned care pathway. These results continue to be monitored at the Clinical Quality Review Group (CQRG), for each organisation.

The results for the FFT question is shown as a 'Net Promoter' score, which is the number of promoters minus the detractors; the 'summary range' for the results is from -100 to +100.

The March Board reported the position for Basildon and Thurrock University Hospital NHS Foundation Trust (BTUH) was 72.7

Standard Hospital Mortality Indicators (SHMI)
This indicator monitors mortality at trust level across the NHS in England, using standard and transparent methodology. The indicator has been produced and published quarterly, since October 2011.

The indicator enables a focus on particular areas where benchmarking shows there may be areas of concern. It also supports initiatives for review of processes and data, and the development of improvement plans. This can be viewed via the website link: http://www.qie.eoe.nhs.uk/mortalitys.aspx

The latest BTUH mortality indicator score (published in January 2013) is 114. Trusts aim for a SHMI result of 100 or less, based on the calculation used. Therefore Basildon and Brentwood CCG is working closely with the Trust, to monitor the indicator and reduce the indicator score. BTUH, as stated earlier, will be subject to external review for its mortality rates.

The PCTs stressed within their policy and through contracting processes, that 'near misses' relating to these incidents must also be reported. If an organisation was in doubt, whether an incident constitutes an SI (Serious Incident), it should be reported and may later be retracted (if appropriate). This ensured timely and robust reporting and also showed that the PCTs had a clear understanding of events happening in commissioned services.

The timescales for reporting on SIs is clearly laid down in the current, Serious Incidents Requiring Investigation Policy, which forms part of the contract with acute, community and mental health services.

NHS England will be issuing new guidance on the serious incident process which will inform future management and monitoring.

Never Events
The core list of Never Events was published on 24 February 2011. The Never Events policy framework has been reviewed and updated, in order to address areas of uncertainty and provide greater clarity about Never Events and the recommended response to them; following feedback from stakeholders. It offers a useful reference for Boards, clinicians, other staff and patients.

The cluster PCT had a responsibility to publicly report Never Events, as part of their annual quality reporting arrangements. This entailed identifying the frequency and type of events that have occurred in commissioned services, and provided a summary of the types of actions that providers have implemented; following root cause analysis or significant event audit.

There have been six Never Events reported across the commissioned services, in the PCT Cluster for 2012/2013. These involved the misplacing of a nasogastric tube, surgical events including ophthalmology and the insertion of a lens, maternity events involving the use of surgical packs and an event involving a surgical incision.

These events were subject to full investigation and actions put in place to prevent re-occurrence. The PCT Quality and Safety team worked closely with the organisations involved to ensure that all checking processes are in place and regularly monitored. A review of the use of the World Health Organisation (WHO) Checklist for surgery was undertaken to confirm that the checklist is used within the commissioned services and the PCT sought assurance of the audit processes in place.

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 patients in areas not compliant with DH guidance. This is also included in the NHS Constitution as a right.

The NHS Constitution states that patients should always be treated with dignity and respect in accordance with their human rights. This means that their right to privacy should be respected.

Infection, Prevention and Control (IPC)

The PCT Cluster's Commissioning Infection Prevention and Control Team:

- Monitors performance against national and regional targets
- Ensures and demonstrates organisational accountability
- Implements the national framework for IPC commissioning
- Has a specific role in monitoring and following up all Serious Incidents related to Health Care Associated Infections (HCAIs) 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
- Has performance monitoring responsibilities for all health care providers to monitor compliance with the code of practice for infection prevention and control
- Has 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.
- Peruses the root causes for certain cases of HCAI as decreed by national and regional bodies
- Enables 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.
- Monitor premises and their appropriateness to be able to carry out specific procedures in a safe environment

Performance against the targets for Infection Control
It is important to note the very small numbers of cases that are being recorded, compared to previous years, and the year on year progress is shown in the table below:

Clostridium difficile infections information 2010-13

South West Essex	2010-2011	2011-2012	2012-2013
PCT Ceiling	150	120	86
PCT Actual	128	74	77

BTUH Ceiling	72	45	32
BTUH Actual	53	28	29

MRSA Information 2010 – 2013

South West Essex	2010-2011	2011-2012	2012-2013
PCT Ceiling	10	10	6
PCT Actual	7	6	10
BTUH Ceiling	4	3	2
BTUH Actual	3	4	5

The PCT Infection Control Team meet regularly with the Trusts Infection Control Team's regarding the breaches and the way forward to support zero tolerance for MRSA blood stream infections and a reduction in C.diff figures.

The Trust Trusts has used the Post Infection Review tool for the latest bacteramias to ensure effective management of infection incidents.

Legionella at Basildon and Thurrock University Hospital NHS Foundation Trust
One of the key quality and safety issues for BTUH has been the incidents of legionella. Therefore the detailed history of the incidents and actions taken has been given to the CCG to ensure ongoing monitoring.

Monitoring of Legionella in other providers
The CCG Quality and Patient Safety team is ensuring that robust monitoring processes for legionella are in place for all providers.

Environmental audit of Independent Contractor Premises
The Commissioning Infection Prevention and Control team is responsible for auditing all Independent contractors and PCT owned premises on an annual basis; to develop and improve the environment and IPC practice. Areas of infection risk are identified and measured against national and local standards/directives. Once audits are carried out a report is written and an action plan sent to each independent contractor which we ask to be sent back within 3 – 6 months. All action plans also include; all practitioners should be bare below the elbow and review of segregation of waste.

In addition this role facilitates the ability to assess the appropriateness of premises for various procedures that may be requested to be undertaken in primary care where they had previously been carried out in secondary care.

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Key Challenges:
Key challenges continue to be:

- Maintenance of the commissioning processes
- Working with all partners to ensure safe practices in primary care
- Responding to unexplained Period of Increased Incidence in HCAIs
- Ensure clear understanding and interpretation of data, to ensure the correct decision are made
- Managing other organisations expectations
- Responding to the SIs for Legionella, and ensuring continued robust systems to monitor and assure safety
- Driving forward whole economy programmes to reduce HCAI
- Maintain delivery of the HCAI QIPP plan and associated IPC workplan

Research
The PCT was aware of and supported the level of research being undertaken in commissioned services. The PCT also had a role in supporting primary care clinicians in undertaking research and the following are some of the studies that are being undertaken:

ASCEND: This was a study for people with Diabetes, looking at the effects of aspirin and omega-3 fatty acids in diabetes to help prevent Cardiovascular events. 10,000 recruits who do NOT have known vascular disease. Recruitment finished in 2011. There was a good uptake from both South West and South East Essex GPs.

3Cs: Cough Complications Cohort study. The aim was to find out how we can use antibiotics better and develop non-antibiotic strategies for treating respiratory infections. There is little clinical evidence to help predict which patients presenting with a cough and suspected lower respiratory tract infection are at high risk of an adverse outcome, particularly pneumonia. The primary objective is to determine which clinical and patient characteristics best predict a subsequent diagnosis of pneumonia requiring admission to hospital. There was a fantastic response in our area, with two of our practices, one in South East (Scott Park) and one in South West (Mount Avenue, Brentwood) being very high in the recruitment tables.

TARGET: This was as for 3Cs but for children up to age 16. Again a fantastic response, especially from Scott Park and Mount Avenue.

DARE: Study of People with Type I or II Diabetes, having bloods taken to be kept on database for future research. A community-wide collaboration between patients and professionals to provide a research resource to enable further study into the causes and complications of Diabetes, combining clinical, laboratory and genetic information to improve our understanding of I & II Diabetes and their associated complications. This study has recruited extremely well with approx. 5 practices waiting to start.

TASMIN. A randomised controlled trial of self-management of blood pressure. Aged 35+ with uncontrolled hypertension for people with stroke and/or other high risk conditions. This study was taken up by approximately 5 practices across South East/West.

PIVOT. This entailed asking patients in doctor's waiting room to complete an online questionnaire with an overall aim of optimising the diagnosis of symptomatic cancer. – At what level of risk does the population believe rapid investigation for possible

cancer is warranted? This study was taken only offered to South West and 2/3 practices were signed up

MYQUEST. This study was to help European nurses develop a tool for nurses to use in their patient interactions on order to optimise diabetes, to provide an opportunity for people to assess and review their diabetes self-care and take an active role in identifying barriers and solutions. The study also aimed to increase

iQUIT. This study was to establish the feasibility of conducting a randomised controlled trial of a web-based program to provide tailored smoking cessation advice in primary care. This study had a good response from practices across both South East and South West

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 were monitored by the PCT. When any concerns were raised by the CQC, the PCT liaised directly with the provider and requested action plans from them. These action plans are robustly monitored and formally reviewed at the Clinical Quality Review Groups. The CCGs will continue this close working with the CQC to support the improvement in quality and patient safety

Care Quality Commission reviews of services

Basildon and Thurrock University Hospitals NHS Foundation Trust
Unannounced CQC visit – 21/22/23 January 2013

An unannounced visit by the CQC took place on Monday 21 – Wednesday 23 January 2013. This visit was following the expiry of the Warning Notices that had been issued to the Trust against outcomes 16 and 4 in November 2012.

The Trust received the draft report from the CQC

A number of Essential Standard Outcomes were inspected:

- Outcome 1 - Respecting and involving people who use services
- Outcome 4 - Care and welfare of people who use services
  Current Warning Notice in place against this outcome
- Outcome 5 - Meeting nutritional needs
- Outcome 7 - Safeguarding people who use services from abuse
- Outcome 8 - Cleanliness and infection control
- Outcome 9 - Management of medicines
- Outcome 10 – Safe Environment
- Outcome 13 - Staffing
- Outcome 14 - Supporting workers

- Outcome 16 - Assessing and monitoring the quality of service provision

- Outcome 17 – Complaints

The CQC report was published on 27 February 2013.

A Warning Notice against Outcome 16 - Assessing and monitoring the quality of service provision was received, with a completion date of 13th August 2013.

Two minor concerns are against:
- Outcome 4 – Care and welfare of people who use the service
- Outcome 8 – infection prevention and control

A moderate concern on outcome 10 – Safe Environment (about the management of Legionella) remains. This outcome did not form part of the visit in January as the CQC await the outcome of the view of the Legionella Steering Group to help inform their decision making.

Findings from CCG visits
The CCG has undertaken a number of visits to the Trust in recent months. These have predominantly been in the paediatric unit and on 8 January 2013 a team visited a number of representative areas across the Trust.

Vertias Review – Serious Incidents
The Trust has commissioned an external review of all serious incidents since April 2011. The purpose is to review all incidents to look for trends and themes, and the review all action plans to provide assurance of the level of evidence of embedment of all actions across the Trust.

The Trust has commissioned a number of other external reviews in the following services:
- Paediatrics
- Pharmaceutical management
- A+E IST
- Quality assurance
- Cultural survey
- Skill mix

Monitoring of Action Plans
A process to monitor progress of all action plans within the Trust has been established to enable adequate assurance of improvements for patient safety and quality to the commissioning CCG.

South Essex Partnership University NHS Foundation Trust
CQC review of Thurrock Community Hospital:

The unannounced visit was carried out on 4 March 2013, to ensure that Thurrock Hospital had taken action to meet the following essential standards:
- Respecting and involving people who use services
- Care and welfare of people who use services
- Supporting workers
- Records

The CQC has reported that the Trust met each of these outcomes.

Safeguarding Adults
Safeguarding adults is fundamental to the work of the NHS; it is essential to ensure that organisations are compliant with local and national policy and the services commissioned are governed by clear policies, processes and that providers cooperate with partnership arrangements to protect and promote the welfare of vulnerable adults as set out in the No Secrets guidance.

Inspection / Audit:
The Care Quality Commission (CQC) is the independent regulator of health and care services, irrespective of whether they are provided by a private, public or voluntary organisation. One aspect of the regulatory process is to undertake periodic inspections of adult social care and health providers at which point the CQC assesses compliance with safeguarding guidance and the Social Care Act 2008 (Regulated Activities) Regulations 2010, and the Care Quality Commission (Registration) Regulations 2009 particularly using Outcome 7 (Safeguarding people who use services from abuse) of their guidance.

Although CQC is responsible for regulating providers and informing the public about the quality and safety of services, other parts of the system also play an important role in making sure that people receive good care. Local authorities, primary care trusts and clinical commissioning groups should make sure that the services they commission provide good quality care.

Mental Capacity Act (MCA) / Deprivation of Liberty (DoLs)
The Deprivation of Liberty Safeguards Supervisory Body function moves to local authority in April 2013. This is set in law and at that point the responsibility for past and future applications lies with them.

The PCT Board received reports on Safeguarding Adults to ensure compliance against current requirements.

Safeguarding Children
Statutory guidance: Working Together to Safeguard Children (DFE 2010) provides definition and clarity about the infrastructure and governance needed to deliver safeguarding responsibilities as required by section 11 of the Children Act (2004) which places a duty on key persons and bodies to make arrangements to ensure that in discharging their functions, they have regard to the need to safeguard and promote the welfare of children**.**

Everyone shares responsibility for safeguarding and promoting the welfare of children. In order to achieve positive outcomes for children, all those with responsibility for assessment and provision of services must work together to an agreed plan of action. In relation to this the general principles for all health services are that:

- The safety and the health of a child are intertwined aspects of their wellbeing.
- There is board level focus on the needs of children
- Safeguarding children is an integral part of governance systems.

At the time of writing this the document Working Together is under consultation and a revised version will be in place by April 2013. However, the fundamental principles of safeguarding and promoting the welfare of children will remain the same.

Safeguarding children reports were presented to the PCT Board by the Designated Nurse about serious case reviews, safeguarding recommendation status and Local Safeguarding Children Board requirements. These reports provided assurance on the current safeguarding status and ensured that all matters of non-compliance and risk were raised and escalated up to the Board as necessary

Alignment arrangements of designate professionals employment
The PCT ensured that there were professionals in post covering all relevant children's safeguarding statutory functions.

Role	South West	South East
Designate Nurse Safeguarding	In post	In post
Designate Nurse Looked After Children	In post	In post
Named Nurse for Safeguarding (0.5)	In post	In post
Designate Doctor Child Protection	In post	In Post
gnate Doctor Looked After Children	In post	In post
Named GP	In post	In post
Designate Doctor Child Death	In post	In post

Report re: Gateway ref 18350: Saville Allegation
Letters have been sent on to all main provider organisations and, at the request of the SCCN (Safeguarding Children Clinical Network) to Primary Care, to request that they advise CCGs on what internal reviews they have undertaken in light of the Jimmy Savile allegations.

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.

Between April 2012 and March 2013, we received 20 complaints and 11 compliments about our commissioning decisions and corporate functions. All of these complaints were responded to at the local resolution stage within the timescale and in the manner agreed with the complainant.

The PCT's Complaints and Concerns 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's complaints handling was commended by the Health Service Ombudsman during 2012/13.

Under the NHS Complaints Regulations which came into effect on 1 April 2009, patients and the public can make their complaint to NHS South East Essex as a commissioner, if they do not wish to complain directly to the provider. During 2012/13, the PCT received 151 complaints about commissioner services from patients or carers who wished to exercise this right. In each case, NHS South East Essex worked with the complainant and the provider to achieve resolution in the majority of cases and to identify service improvements and learning outcomes.

The Patient Advice and 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 3696 contacts during 2012/13.

Service improvements and a commissioning decision arising from PALS and Complaints contacts during 2012/13 included:

- Highlighting a gap in provision of psychosexual counselling for South East Essex residents (as the result of a complaint). The sexual health commissioners are exploring potential solutions such as extending the remit of the Anthony Wisdom Centre in Brentwood to encompass South East Essex residents.
- An NHS dental practice purchased and installed an induction loop for the benefit of its hearing impaired patients, following a PALS contact. This had wider implications as it coincided with the community dental service (CDS) procurement. The requirement for bidders to install hearing loops in their premises has now been included in the service specification.

Freedom of Information 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 South Essex has complied with the Treasury guidance on setting charges for FOI requests. NHS South Essex received 301 FOI requests during 2012/13.

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.

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 partners:

Health
- East of England Ambulance Service NHS Trust
- Clinical Commissioning Groups
- South East Essex PCT (NHS South East Essex)
- South Essex Partnership University NHS Foundation Trust (SEPT)
- Basildon and Thurrock University Hospitals NHS Foundation Trust (BTUH)
- North East London NHS Foundation Trust (NELFT)

Social care
- Thurrock Council
- Essex County Council

Taking into account the current and future needs of the population and the financial constraints, the system has identified a number of opportunities for service redesign that we believe offer scope to deliver better care and outcomes for less direct investment.

In order to take our plans forward, we have established work programmes across the health and social care system including: planned care; unplanned care; mental health and children. This approach continues to ensure that redesign is fully supported by the public sector organisations in South West Essex that have the greatest part to play in this agenda.

The role of our GP commissioning leads in QIPP scheme delivery has been one of the critical success factors as we move to new forms of commissioning.

QIPP projects

Care of the Elderly
As part of the care of the elderly review the following services have been rolled out the SPOR – a single point of referral, the Dementia Intensive Support Team (DIST), the Community Geriatrician with community and practice level multi-disciplinary teams (MDTs) and also the use of community step up beds. This is to ensure that elderly residents receive the care they require closer to home and also avoid inappropriate A&E attendance and reduce hospital admissions.

Children's QIPP projects

There are a number of children's QIPP projects across South Essex. These include two paediatric projects (Basildon and Thurrock University Hospitals NHS Foundation Trust and Southend University Hospital NHS Foundation Trust), and Children's Continuing Care.

The two paediatric projects are focused on the development of a model of care that incorporates a Paediatric Assessment Unit and triage systems across the health economy to support admission avoidance and keep children in the community as far as possible. This model will be developed across South Essex incorporating SUHFT and BTUH, South East and South West Essex community providers (South Essex Partnership University NHS Foundation Trust and North East London NHS Foundation Trust) primary care services. Discussions have taken place with the hospital trusts and community providers and CCGs.

Achievements in 2012/13 includes the agreement of a reduced tariff with BTUH for under 5s phlebotomy service instead of being charged a full outpatient tariff.

The Continuing Care project has focused in 2012/13 on:

- Establishing a consistent single model of Procurement for Children's Continuing Care for Essex
- Establishing a fair and sustainable pricing tool for a range of Children's continuing care services which are funded by the NHS North and South Essex Clusters and the Local Authority (Essex County Council).
- Improving the quality of care provided to service users and to streamline cluster wide contracting and quality policy, process and procedures in relation to children and young people's continuing care.

Working with our partners and public engagement

Working in partnership for better health

Joint Strategic Needs Assessment
Section 116 of the Local Government and Public Involvement in Health Act (2007) introduced the statutory requirement for a JSNA to be produced by each upper tier local authority and primary care trust. The JSNA is an important tool for informing the commissioning of future services for the population. It is used in the development of strategic plans such as the Joint Health and Wellbeing Strategy and by local Health and Wellbeing Boards to inform decision making.

Given the rapidly changing public sector environment, the JSNA offers an excellent mechanism to facilitate collaborative working between local authorities, CCGs, the third sector and other stakeholders who contribute to improving the health of the population. The primary use of the JSNA should be to inform action taken to reduce health inequalities and disadvantage at the local level. This means local people should be given a voice in the JSNA process. Their views and opinions matter and should be used to inform the findings of the JSNA and any subsequent commissioning priorities that arise.

Thurrock JSNA
NHS South West Essex Public Health team led a JSNA process in Thurrock which has also been overseen by a partnership steering group with published products. The JSNA products include a detailed overview of health and wellbeing in Thurrock and a specific product for Thurrock CCG, including an analysis of the usage of clinical services, and the value for money they provide. The JSNA products have helped to

inform the Thurrock CCG integrated plan and the priorities in the Thurrock Health and Wellbeing Strategy. The JSNA has featured regularly on the agenda of the Shadow Health and Wellbeing Board. A Thurrock JSNA refresh is underway to incorporate the newly released 2011 census data and more recent data in other areas of health and social care.

Essex JSNA
The JSNA in Essex is coordinated through a JSNA Planning Group made up of partner organisations including Essex County Council, CCGs, Healthwatch and district councils. This group reports to the Business Management Group of the Health and Well Being Board. Strategic JSNA products that have been published previously and will be refreshed each year include profiles based on the various geographies: countywide, district, CCGs, a Pharmaceutical Needs Assessment and a number of specialist topic reports. Partners and the public are able to access all JSNA products along with much of the underlying data online at: www.essexinsight.org.uk

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.

Despite modest improvement, substantial health inequalities persist across South West Essex. Male residents in the most advantaged areas of Basildon are living around ten years longer than peers in the most disadvantaged areas; the corresponding figure for female residents is 7.3 years. For Thurrock and Brentwood these figures are 8.3 years and 9.4 years respectively for men and 3.6 years and 6.4 years respectively for women.

Smoking, hazardous drinking, obesity, and low levels of physical activity are all lifestyle-related factors that can increase the risk of ill health and premature death. In South West Essex 22% of adults smoke, 15% drink at hazardous levels, 21% are obese and 21% have low levels of physical activity (East of England Lifestyle Survey 2008).

To address this and other inequalities NHS South Essex has commissioned a wide range of services to help people improve their health, to prevent causes of ill-health and detect disease. Below are some examples of work completed in 2012/13 to achieve our commitment to better health.

Improving the health of South West Essex population
NHS South West Essex continues to support the national work that is being done around helping our residents to eat well, move more and live longer via the Change4Life campaign. Health trainers and a Health4Life programme are key interventions in helping people in South West Essex achieve their own individual goals.

During 2012/13 a number of health improvement activities took place which were delivered by our community provider, Vitality, including: childhood obesity programmes, health checks, stop-smoking services.

Children's weight management services
The public health team commissions a Change4Life team to provide support and training to community health providers and other key professionals working with children to enable them to offer support and interventions to reduce childhood obesity. The MEND programme incorporating healthy eating education and physical activity and the National Childhood Measurement Programme (NCMP) are delivered by this team. Programmes incorporating weight management and physical activity for adults are delivered by our community provider Vitality Health and Wellbeing service. During 2012/13 the team have been working with the provider to redesign this service. A new integrated service is being provided from 1 April 2014.

NHS Health Checks
Everyone is at risk of a long term condition such as heart disease, stroke, diabetes, or kidney disease, particularly if you are over 40 years of age. You can reduce this risk by having a health check to find out what your current risk is and what you have to do to reduce the risk and take charge of your health. Health checks in South West Essex are available from the GPs and our provider Vitality. In addition a Health Bus has been used to deliver an outreach health check programme in a variety of community settings including industrial estates and supermarket car parks, to access those populations less likely to attend their GP practice for a health check.

Stop smoking service
Around 22% of the population in south west Essex smoke. NHS South Essex has commissioned a variety of ways to help individuals stop smoking including our community service Vitality – delivered by NELFT. Brief interventions, advice and signposting are also available from GPs and community pharmacies.

A service is commissioned from Vitality that delivers one to one support, group support, and drop-ins for smokers wishing to quit, including specialist services for pregnant women encompassing home visits and post-delivery support.

Sexual health and wellbeing
Providing access to information and sexual health services is key to promoting sexual health well-being. On-line resources, a chlamydia screening programme as well as contraceptive and sexual health services are available to support our population. A new integrated sexual health service is being proposed for the summer of 2013.

Alcohol screening and interventions
A new alcohol liaison service that provides screening and interventions is being commissioned for twelve months in BTUH. The service will run until January 2014. This allows service links between health and local authorities to understand the hospital trends within communities.

Public health and the drug and alcohol teams continue to support and develop tier level two and tier level three services across Thurrock unitary authority and Essex County Council.

Preventing the causes of ill health

Screening programmes
The aim of screening programmes is to detect early disease in otherwise healthy people. In South West Essex we have a number of screening programmes for adults, these cover cancer and other conditions. We also have a number of screening

programmes aimed at pregnant women and newborn babies. NHS South Essex has also been working with colleagues elsewhere in the East of England in planning for an abdominal aortic aneurysm screening service. This programme will target men from the age of 65 years who are at increased risk of serious complications from this type of aneurysm.

Cancer and retinopathy screening
In south west Essex there are individual cancer screening programmes for breast, bowel, and cervical cancer.

The South West and West Essex NHS Diabetic Eye Screening Programme is the eye screening service for people with diabetes. The aim of diabetic eye screening is to identify and treat early signs of diabetic eye disease and prevent the subsequent loss of vision or visual impairment.

Immunisation
Immunisation is a method of protecting individuals against disease; the universal childhood programme is aimed at immunising children against many serious childhood illnesses. There are also targeted programmes aimed at individuals at increased risk of conditions such as Hepatitis B and Tuberculosis.

In response to an increasing number of cases of whooping cough (pertussis), a national campaign was launched to offer the vaccine to pregnant women between 28 and 38 weeks gestation, to offer babies protection against whooping cough in the first few months of life before they receive their own vaccines.

HPV vaccination
The HPV vaccine was introduced in September 2008 to immunise teenage girls against HPV, this will reduce the likelihood of them developing cervical cancer in later life. It is administered to teenage girls at school with a course of three vaccinations. The programme is being delivered to those in year 8, age 12-13. There are also opportunities in the community for those who have missed their immunisation.

Winter planning
The PCT was active in preparing for winter, as it poses a challenge for some vulnerable residents due to increased levels of influenza and other respiratory illnesses. The cold temperatures have an adverse effect on people with underlying cardiovascular and respiratory illness and there is an increased incidence of diarrheal disease. In addition to these conditions affecting the health and well-being of the population, they also place increased demand on health services. Strategies to prevent adverse effects included the influenza vaccination programme, targeted at people over the age of 65, those under the age of 65 with chronic medical conditions and pregnant women.

Public Engagement

Involving and listening to our patients
Our aim has always been to keep local people at the centre of our work, listening to them and learning from their experiences. Of key importance this year has been the work we have undertaken with our CCGs, supporting them in setting up and recruiting to their Commissioning Reference Groups (CRGs), and in the establishment of their mechanisms to achieve meaningful for patient and public engagement in their work.

Our patient and public engagement has been monitored by the PCT cluster's Quality and Governance Committee, ensuring that the feedback received is used to inform and develop services.

Patient representatives
A procurement process for the remaining seven PCTMS GP practices in South West Essex was undertaken in 2012. Two patient representatives and the project manager for Thurrock LINk were involved in the evaluation of the bids, to ensure that e patient's perspective was reflected.

A patient representative from South West Essex has also been involved in the procurement process for dental sedation services across South Essex. This ensured that the project group had a good understanding of the issues faced by patients whose level of anxiety means that they require sedation in order to have dental treatment.

LINk representatives from both South East Essex and South West Essex have been members of the project group for NHS111. They have been fully involved in the project meetings and also in the evaluation of the bids. They are both members of the communications and engagement working group, and their input has helped to ensure that communication and engagement activities have been appropriate and relevant.

LINk (Local Involvement Network)
We have continued to have a strong working relationship with the LINk locality groups for South West Essex,and Thurrock, with a representative from NHS South Essex regularly attending their public meetings. The chairs of both these LINk locality groups have speaking rights at the PCT Cluster board meetings. We have always supported LINk in their work, and have been working with them as they transition into Healthwatch. From 1 April 2013, there are three local Healthwatch organisations in Essex: Healthwatch Essex, Healthwatch Southend and Healthwatch Thurrock, reflecting the three top tier local authority boundaries.

Patient and public involvement in Clinical Commissioning Groups (CCGs)
Over the course of the year, each CCG has developed its own Commissioning Reference Group (CRG). Membership of these groups includes representatives from Patient Participation Groups (PPGs), LINk/Healthwatch, local community groups, and carers. Other representatives can be invited to attend meetings for discussions on specific topics on an ad hoc basis. The CRGs have discussed the CCGs' commissioning intentions, and individual commissioning cases are brought to the CRGs to ensure that patient feedback informs the development of the commissioning case. This was particularly relevant when the proposal to relocate the diabetes service hub for South West Essex was discussed by the CRG, when it was agreed that the service provision would be further reviewed later in 2013, with representatives from the CRG and the local diabetes group to be involved in the review.

A workshop was jointly organised with North Essex PCT Cluster in May 2012, to support CCGs with their work towards authorisation for domain two 'Meaningful engagement with patients, carers and communities'. Speakers included the patient engagement team at the Department of Health, the PPI lead for clinical commissioning from the NHS Midlands and East, a GP from Southend CCG and an expert on the Directed Enhanced Service for Patient Reference Groups from Primary Care Commissioning. Delegates from across Essex included clinicians, patient

representatives, members of LINk/Healthwatch, representatives from the voluntary sector, GP patient participation groups, practice managers and local authority staff.

As well as focusing on the requirements of domain two, the agenda included presentations on equality and diversity, delivering the Patient Reference Group DES, the 'Smart Guide to Engagement' booklets, and learning from the experience of involving patients and public in GP commissioning.

Patient Participation Groups (PPGs)
CCGs have been encouraging their constituent GP practices to have a patient participation group, so that a patient representative from the PPG can be a member of the Commissioning Reference Group, thereby ensuring that the views of the patients of that practice can be reflected in the CCG's work.

There has been a disappointing take-up of the Directed Enhanced Service (DES) agreement for Patient Reference Groups (PRGs) that was introduced by the Department of Health in April 2011, and only a few GP practices were successful in meeting the full requirements of the DES for 2011/12. Support and advice for achieving the DES was included in the PPI workshop held in May 2012.

Overview and Scrutiny Committee
We have a good working relationship with both the Essex and Thurrock Overview and Scrutiny Committees, and give regular briefings, updates and presentations to members.

South West Essex PPG Network
We have continued to support this network, arranging regular meetings with speakers on relevant topics. The network has now effectively split into two, with members of this network from the Thurrock area joining the Thurrock CCG Commissioning Reference Group, and members from the Basildon, Brentwood, Billericay and Wickford localities working with Basildon and Brentwood CCG.

Electronic media
To reach our younger generation, we continue to use electronic channels such as Facebook, Twitter and YouTube. All of these raise the profile of our work, encouraging young people to be more involved. Browsealoud is installed on our website so that people who are visually impaired, or who have difficulty with the written word, can listen to the words.

Joint Mental Health Strategy Consultation
The South Essex Joint Mental Health Strategy has been developed through dialogue with a wide cross section of people (including service users and carers, stakeholders, health and social care professionals and voluntary/community groups) during engagement exercises undertaken in 2012. A formal consultation commenced on 15 February 2013, and runs until 3 May 2013, to enable the Joint Mental Health Board to seek the views of as many people as possible across South Essex about the proposals to improve and re-design mental health services over the next few years.

Proposed relocation of Acorns GP Surgery, Grays
An engagement exercise was undertaken with the patients and staff of Acorns Surgery about the proposed relocation of this surgery to the first floor of the Thurrock walk-in centre. As a result of the feedback received from the patients and staff, it was agreed that further engagement work was needed, and that this would be undertaken once the new service provider was in place (1 April 2013).

Informal engagement

Informal engagement activities were undertaken throughout the year, which included arranging a visit to the specialist dementia unit at Mountnessing Court in Billericay for LINk and Health Overview and Scrutiny Committee members.

Equality and diversity

Ensuring equality for all:
Working towards an NHS that is personal, fair and diverse

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 is formally committed to the NHS Equality Delivery System (EDS), and has been kept updated on this work. Progress is monitored by the PCT's Equality & Diversity Working Group, which is chaired by a non-executive Director. Membership of this working group includes representatives from the four CCGs in South Essex. The work of this group is reviewed by the PCT's Quality and Governance Committee.

In recognition that the CCGs would be taking forward the equality and diversity work initiated by the PCT for EDS, we have worked with CCGs so that they each have an EDS action plan and an Equality and Diversity Strategy, for formal adoption by their Board. The CCGs have also been provided with reports giving the feedback, gradings, outcomes and recommendations for their area from the work and EDS community events previously undertaken by South West Essex PCT, which will help to inform their work going forward.

The PCT has continued to ensure that Equality Impact Assessments (EIAs) are undertaken on policies, projects and commissioning proposals (both for the PCT and CCGs).

In addition to the work being carried out by the CCGs, an important piece of work has been initiated with partner organisations, to establish a 'Winterbourne' group to lead on the joint south Essex implementation of the requirements of the DH Report: *Transforming Care: a national response to Winterbourne View Hospital (Dec 2012).* The Winterbourne group is a sub-committee of, and will report to, the South Essex Learning Disability Steering Group.

We have continued to offer interpreting and translation services (including British Sign Language) to our primary care contractors. During 2012-13 our PALS (Patient Advice and Liaison Service) arranged 78 GP and dental practice consultations, funded by the PCT. Funding for these services has been identified by the Essex Local Area Team of NHS England (formerly called NHS Commissioning Board), to ensure that this important provision continues.

Sustainability and caring for our environment

Background
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'.

In February 2011, The SDU published its latest guidance on collaborative working across the health system. Their 'Route Map' 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 compared to 1990 levels 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 20 million tonnes CO_2 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 over 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. While carbon emission levels appear to have stopped rising, the trend now needs to be reversed and absolute emissions reduced.

NHS South Essex Cluster's response
NHS South Essex Cluster's Board approved and adopted a Sustainable Development Management Plan in July 2012. NHS South Essex Cluster 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 Sustainable Development Management Plan helps us fulfil our commitment to conducting all aspects of its activities with due consideration to sustainability whilst providing high quality patient care. NHS South Essex Cluster continues 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 NHS South Essex Cluster's pledge to bring a minimum 10% reduction in its carbon emissions by 2015. Critically, the SDMP emphasises the benefits of using the NHS Sustainable Development Unit's 'Good Corporate Citizen Model' to deliver the improvement in community engagement, employment and skills, travel, transport & access and water consumption which are all underrepresented in the original carbon reduction plan.

NHS South Essex Cluster contributes to the local economy in terms of procurement, workforce, and community development, recognising the health benefits that can be achieved and 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.

Carbon Reduction Commitment Energy Efficiency Scheme (CRC)
NHS South Essex Cluster is registered as an information declarer for the CRC as its constituent parts each used less than 6,000 megawatt-hours (MWh) of electricity through their meters during 2008 (6,000 MWh emits approximately 3,333 tonnes of CO2). Therefore, all that is required at this point is a simple information disclosure.

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 all premises owned or leased by NHS South Essex Cluster.

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. The model was then revised in 2009 in cooperation with the NHS Sustainable Development Unit. It has been revised again with a new GCC model being released in late 2012.

NHS South Essex Cluster was formed through the merger of NHS South East Essex PCT and NHS South West Essex PCT. Both PCTs have signed up to the GCC scheme and have committed to use the model to further identify ways to improve performance, and to reach out to the wider community. This is the first year that their combined performance as NHS South Essex Cluster has been assessed and the first year of the new model. Therefore we are unable to compare year-on-year performance. However it is clear that we are continuing to make progress in our carbon saving objectives.

The Good Corporate Citizen Model features within the Sustainable Development Management Plan, which in turn links with NHS South Essex Cluster's strategic objectives. Work has been going on throughout the year to link with service users to participate in stakeholder workshops as part of the development of the Carbon Management Plan and this has provided valuable suggestions regarding carbon reduction initiatives.

Carbon management planning
NHS South Essex Cluster has been working with the Carbon Trust since June 2012 to further carbon management planning and to establish a baseline of CO_2 emissions across the Cluster in order to realise substantial carbon and cost savings. The SDMP and the results of this work with the Carbon Trust form part of NHS South Essex Cluster's legacy for the Clinical Commissioning Groups to develop and meet the target to reduce its CO_2 emissions by 10% by 2015 in absolute terms from the baseline year of 2009.

NHS South Essex Cluster continues to embrace and embed carbon management into its day-to-day processes as well as ensuring Clinical Commissioning Groups' key decisions will have due regard to their environmental impact.

See attached as Appendix B the Cluster's Good Corporate Citizen Report 2013.

See attached as Appendix C the Cluster's Sustainability Report.

Planning for emergencies and business continuity management

Emergency planning

NHS South Essex has been busy working with our local authority, emergency services and NHS providers as we shape the new architecture for emergency planning in south 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 South 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

South Essex Cluster

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 staff transferred to the following receiver organisations on 1 April 2013:

	NHS South East Essex	NHS South West Essex
NHS England	44	17
CCGs	53	36
CSU	83	56
Local Authorities (Public Health)	32	13
Public Health England	1	2
NHS Property Services	38	11

35 staff (across the cluster) were also made redundant as a result of the changes (17 staff – NHS South East Essex, 18 staff – NHS South West Essex).

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.

In addition, the organisation is accredited under the Mindful Employer Charter, which supports the employment of people with mental health problems.

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. The PCT Cluster has an Equal Opportunities policy in place. An equality impact assessment also took place on the impact of implementation of the changes.

Staff numbers (as at March 2013)
There were 276.91 Whole Time Equivalents (WTE) employed by NHS South East Essex and 221.54 WTE employed by NHS South West Essex.

For NHS South East Essex this figure includes East of England Specialised Commissioning Group staff who were hosted by NHS South East Essex.

For both PCTs, these figures include PCTMS (PCT Managed Services) staff (who were transferred to GP provider organisations during 2012/13).

Staff sickness
An average of 8.85 working days per year (NHS South East Essex) and an average of 8.9 working days per year (NHS South West Essex) were lost due to staff sickness.

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. During the summer a mini staff survey was undertaken to determine whether the actions put in place had an impact. 85% of staff had received an appraisal. The PCT put in place a comprehensive training and development plan to support staff over the year.

Our performance

NHS South 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.

QIPP

As previously discussed, QIPP is the acronym used in the NHS to describe the approach to successfully deliver national and local service and quality objectives within the anticipated future funding constraints. QIPP is made up of four interlinked elements: Quality, Innovation, Productivity and Prevention. Together they will enable the NHS to deliver on its vision for change and improvement, whilst maintaining the quality and range of services people want and need.

Taking into account the current and future needs of the population and the financial constraints, the system identified a number of opportunities for service redesign that offered scope to deliver better care and outcomes for less direct investment, for delivery through 2012/13.

In terms of monitoring progress against QIPP for 2012/13, on a monthly basis as part of preparing the monthly financial performance report, the PCT prepares a forecast in delivery of QIPP schemes. The 2012/13 position as at YTD month 10 is as follows:

Overall delivery in the South Essex Cluster achieved a delivery yield of 51% (£13.2m) and with the use of underachievement reserves and contingency of £18.5m the cluster is reporting 100% delivery to ambition. This includes all schemes to month 10 except prescribing and acute with actual data up to month 8. The following provides information on scheme achievements over 2012/13.

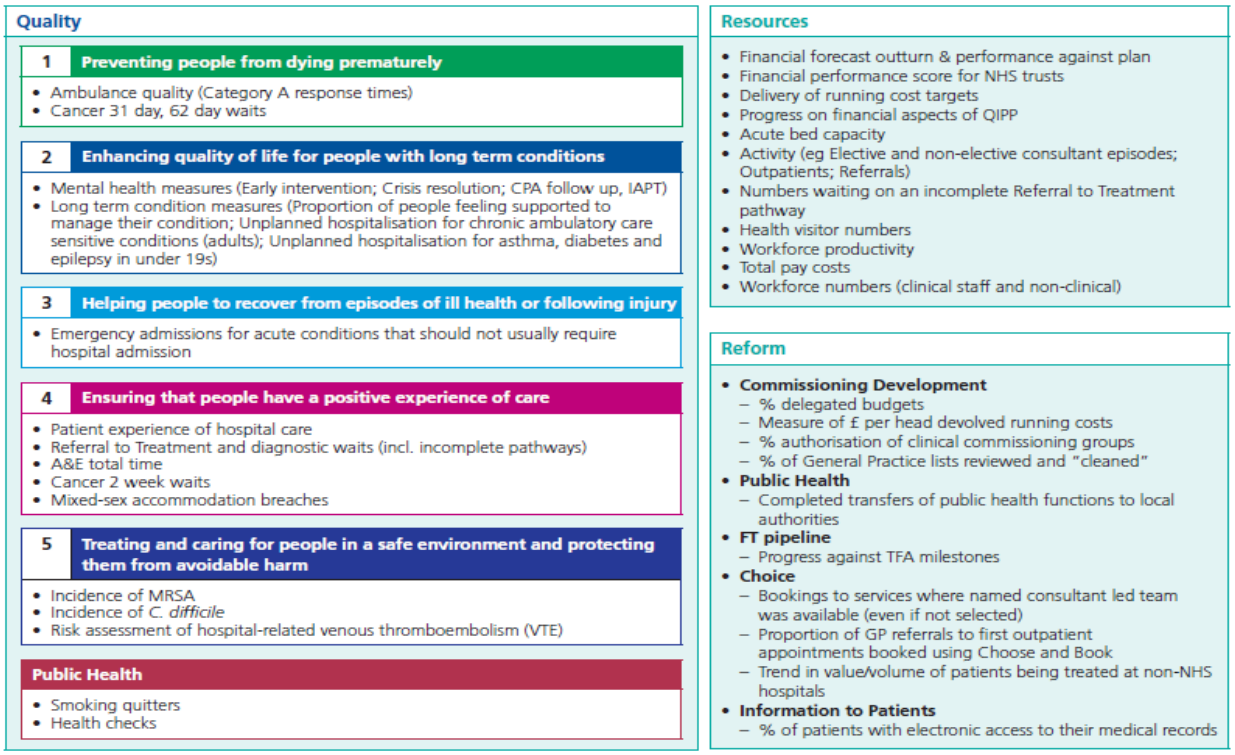
NHS South West Essex achieved a delivery yield of 45%. This has been achieved through the implementation of a number of work programmes, including better control of prescribing. The medicines management workstream has been working with GPs to understand drug costs and ways to use resources more cost effectively. All CCGs have delivered YTD actual savings above plan. Focused practice visits continue to take place to enhance and drive savings delivery into 2013/14.

The planned care workstream has not achieved planned savings target this is mostly due to the delay in the implementation of planned any qualified provider (AQP) schemes moving activity from the hospital into the community this was mostly driven by new DH AQP process introduced in the year. The CCGs in the area have also developed referral management schemes utilising peer review, a retrospective and prospective referral gateway system. The CCGs are expecting savings delivery to improve in 2013/14 as the AQP schemes are implemented and the new referral management processes are embedded and utilised by GPs.

The NHS South West Essex unplanned care workstream schemes were implemented later than planned in the year, this has led to the expected QIPP savings not being achieved. The reason for the delay in implementation has been due to the transition and also slow engagement of CCGs in the area. It is expected that as CCG engagement has increased the full benefit of the schemes implemented will be achieved in 2013/14.

Performance against national targets

The NHS Operating Framework for 2012/13 sets out the indicators and milestones noted below, which all health trusts must have regard to when planning healthcare services. They are used to assess how SHAs and PCTs are delivering during the year of transition.



Our performance 2012/13

In 2012/13 NHS South Essex has been able to demonstrate strong progress and achievements in these areas, although there were also some targets that posed significant challenges and where further work is needed to achieve the expected levels of performance.

The local progress that we are making benefits in many ways from the contributions of our partners, including NHS provider trusts and local authorities. We are continuing to build on the strong partnership working that has been achieved.

Key areas for further improvement

- Although performance has improved in cancer and stroke waiting times, there remain key elements that require further improvement and actions plans have been developed with our providers. These include a review of the cancer care pathway and increased number of stroke nurses at Southend University Hospital NHS Foundation Trust.

- Breastfeeding prevalence rates at 6-8 weeks remain significantly below the national average and public health are working with acute, community and voluntary providers to increase the number of women continuing to breastfeed after 6-8 weeks.

Supporting quality measures
This section details the service performance for 2012/13, based on the suite of 'supporting' quality measures specified in the National Operating Framework 2012/13:
(Please note these are the latest figures available as at 31 May 2013).

Description of Measure	Target/Plan 2012/13	Performance 2012/13
Percentage of deaths at home (including Care Homes)	42.4%	@ Sept SE 50.3% SW data not available
Cancer Waits - % of patients seen within two weeks of an urgent GP referral for suspected cancer	93%	YT Jan SE 94.6% SW 94.6%
Cancer Waits -% of patients seen within two weeks of an urgent referral for breast symptoms where cancer is not initially suspected	93%	YT Jan SE 92.3% SW 95.8%
Cancer Waits - % of patients receiving first definitive treatment within one month of cancer diagnosis	96%	YT Jan SE 97.9% SW 98.7%
Cancer Waits - 31 day standard for subsequent cancer treatments – Surgery	94%	YT Jan SE 95.8% SW98.8 %
Cancer Waits - 31 day standard for subsequent cancer treatments - anti cancer drug regimens (Chemo)	98%	YT Jan SE 99.8% SW99.3 %
Cancer Waits - 31 day standard for subsequent cancer treatments – radiotherapy	94%	YT Jan SE 98.1% SW 97.3%
Cancer Waits - % of patients receiving first definitive treatment for cancer within 62-days of an urgent GP referral for suspected cancer	85%	YT Jan SE 89.2% SW81.4 %
Cancer Waits - % of patients receiving first definitive treatment for cancer within 62-days of referral from NHS Cancer Screening Service	90%	YT Jan SE 98.0% SW 94.8%
Cancer Waits - % of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status	~	YT Jan SE 96.7% SW87.9 %
Stroke: Percentage of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit	80%	YT Dec SE 91.1 % SW86.8 %
Stroke: Percentage of Transient Ischemic Attack (TIA) cases with a higher risk of stroke assessed/treated within 24 hours	60%	YT Dec SE 68.8% SW64.9 %
Access to NHS Dentistry - Number of patients receiving NHS primary dental services (within a 24 month period)	SE 209030 (62%) SW 229139 (59%)	@ Oct 12 SE 186,644 (54%) SW 227,168 (56%)
Access to maternity services - % of women seen (within 12 weeks) for an assessment of needs	90%	@ Q3 SE 84.2 % SW 66.8%
Mental health: Early intervention in psychosis - The number of new cases of psychosis served by early intervention teams	SE 41 SW 51 S 92	@ Q2 SE 22 SW 22
Mental health: Number of Home Treatment episodes carried by Crisis Resolution/Home Treatment teams	SE 548 SW 675 S 1223	@ Q2 SE 331 SW 283

Mental health: Care programme approach (CPA)	90%	@ Q2 SE 94.2% SW96.3 %
Mental health - IAPT: Proportion of people that enter treatment against the level of need in the population	SE 12.8% SW 12.6%	@ Q3 SE 2.1% SW 1.9%
Mental health - IAPT: Proportion of patients completing treatment moving to recovery (caseness at start)	56.7%	@ Q3 SE 62.6% SW63.0 %
Number of clients of NHS Stop Smoking Services who report that they are not smoking four weeks after setting a quit date	SE 3,006 SW 3,337	YT 10/03/13 SE 2397 SW 2649
Breastfeeding at 6-8 weeks - (Prevalence of breastfeeding 6-8 weeks after birth)	SE 38.4% SW 37.0% S 34.5%	YT Q3 SE 37.17% SW 36.56%
Breastfeeding at 6-8 weeks - (Coverage)	95%	YT Q3 SE 98.82% SW87.79 %
Breast Screening - Percentage of women aged 47-49 and 71-73 invited for breast screening	TBA	data not available
Bowel screening - Percentage of adult population aged 70-75 invited for bowel cancer screening	TBA	@ Q1 SE 49.0% SW 50.2%
Cervical Screening test results - Women to receive results of cervical screening tests within two weeks	98%	@ Q2 SE 79.22% SW 79.80%
Percentage of eligible people offered Diabetic Retinopathy Screening for the early detection (and treatment if needed):	95%	@ Q3 SE 106.5% SW 103.2%
Referral to treatment waits: The median time waited for Admitted patients whose clocks stopped during the period	11.1	@ Jan 13 SE 12.04 SW 10.10
Referral to treatment waits: The median time waited for Non-Admitted patients whose clocks stopped during the period	6.6	@ Jan 13 SE 4.75 SW 5.26
Referral to treatment waits: The median time waited for patients on Incomplete Pathways at the end of the period	7.2	@ Jan 13 SE 6.49 SW 6.78
Coverage of NHS Health Checks - Offered (Against Local Trajectory)	SE 25,600 SW 23,210	YT Q3 SE 13.53% SW14.39 %
Coverage of NHS Health Checks Received (Against Local Trajectory)	SE 15372 SW 15086	YT Q3 SE 6.96% SW 5.57%
Emergency Admissions for long term conditions	<91.14	data not available

Value for money assessment 2012/13

As part of the national changes, the Department of Health abolished the Use of Resources assessment for 2010/11 onwards and replaced it with a Value for Money (VFM) conclusion to be made by the Ernst Young who are NHS South West 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 how far NHS South West Essex has put in place proper arrangements for securing, economy, efficiency and effectiveness in its use of resources and financial resilience.

Looking ahead

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.

Planning for the future
As new organisations take over the responsibilities of NHS South Essex from 1 April 2013 (see Transition section for details), the PCT has been working with these emerging organisations during 2012/13 to ensure a smooth transition and legacy handover.

Information Governance
Information governance ensures necessary safeguards for, and appropriate use of, patient and personal information. We reported three serious untoward incidents relating to information governance at NHS South West Essex.

Despite all the work we do, there were incidents involving data loss and confidentiality breaches. The breaches, which have been reported to NHS Midlands and East as serious untoward incidents during 2012/13, are listed below.

Date of incident (month)	Nature of incident	Nature of data involved	Number of people potentially affected	Notification steps
Dec 12	GP letter went to patient address	Performance	1	GP practice, PCT Quality and Patient Safety Team informed.
Feb 13	Laptop stolen from Nurse due to break-in	Patient Assessments	17	SHA and ICO informed Investigation on-going
Feb 13	Mis-use of Clinical System	Patient records	TBC	SHA and ICO informed On-going investigation

Summary of other personal data related incidents in 2012/13

Category	Nature of incident	Total
I	Loss of inadequately protected electronic equipment, devices or paper documents from	

	secured NHS premises.	
II	Loss of inadequately protected electronic equipment, devises or paper documents from outside secured NHS premises.	1
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents.	
IV	Unauthorised disclosure	2
V	Other	

Financial Overview 2012/2013

South West Essex PCT

Financial duties
NHS South West Essex achieved its statutory financial duties recording a surplus of £0.7m by the end of the financial year. This met the target surplus set for NHS South West Essex by East of England Strategic Health Authority of £0.7m. 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	681,106	665,516	683,528
	Limit	681,154	665,768	684,212
Remain with Capital Resource Limit	Performance	(7,942)	1,960	684
	Limit	(9,653)	1,094	1,653
Remain within Cash Limit	Performance	682,505	657,038	685,988
	Limit	682,505	662,101	685,988

Capital expenditure
The PCT had a capital resource limit of £1,653k for 2012/13 and spent £686k on its capital programme:

The capital expenditure was on the following developments

Description	£000
GP IT Investments	360
Telephony system	86
Minor building improvement works	240

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. To ensure value for money is achieved, appropriate procurement procedures are in place, including the tendering of goods and services where necessary. This includes a separate procurement group, with non-executive and executive director membership. 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.

A key priority for the PCT and CCGs looking 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 QIPP, the PCT also must demonstrate that it is properly considering the health needs of the local population and commissioning those services that address those needs.

During 2012/13 the PCT cluster has been working with our NHS and social care colleagues across South Essex in developing system-wide Quality, Improvement, Productivity and Prevention plans setting out how the 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, Ernst Young (previously the Audit Commission), as part of their annual review of the PCT's accounts. The PCT received an unqualified value for money opinion in 2011/12 and expect to receive a similar opinion in respect of 2012/13.

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 of paying bills in accordance with contracts existed and that finance and purchasing divisions 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:

	2012-13 Number	2012-13 £000
Non-NHS Payables		
Total Non-NHS Trade Invoices Paid in the Year	**14,953**	**53,346**
Total Non-NHS Trade Invoices Paid Within Target	**12,302**	**44,555**
Percentage of NHS Trade Invoices Paid Within Target	82.27%	83.52%
NHS Payables		
Total NHS Trade Invoices Paid in the Year	**4,263**	**523,408**
Total NHS Trade Invoices Paid Within Target	**3,335**	**515,708**
Percentage of NHS Trade Invoices Paid Within Target	78.23%	98.53%

Audit arrangements
Ernst Young are our external auditors, appointed by the Audit Commission. The total planned fee for 2012/13 audit was £101,350 compared to £168,916 in 2011/12.

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 on page 22 of the accounts.

2013/14 financial plans
The 2013/14 the financial planning was undertaken within the shadow 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 and we are seeking to deliver significant efficiency savings through our Quality, Innovation, Productivity and Prevention programme, which is variable in size across each of the CCG and area team within Essex.

Our challenge remains to maintain and improve the quality of services we commission on behalf of the local population whilst delivering significant productivity savings. This challenge will be no different in the future NHS configuration.

Dawn Scrafield
Director of Finance and Performance

Please see Appendix B for the full set of financial statements for the year ended 31 March 2013.

South West Essex PCT Annual Governance Statement 2012/13

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievements of the PCT's policies, aims and objectives, whilst safeguarding the public funds and the PCT's assets for which I am personally responsible, in accordance with the responsibilities assigned to me by the Accountable Officer Memorandum. I am also responsible for ensuring that the PCT is administered prudently and economically and that resources are applied efficiently and effectively, with due regard for standards of propriety, transparency and accountability to the public.

In order to meet my responsibilities as Accountable Officer, I have processes in place to ensure good working arrangements with partner organisations and the Strategic Health Authority which include:

- Strategic Health Authority Chief Executive meetings;
- PCT Chief Executive meetings;
- Regular monitoring meetings with the Midlands and East of England Strategic Health Authority;
- Local Strategic Partnership meetings;
- Essex and Southend Local Involvement Network meetings;
- Essex Overview and Scrutiny Committee and Southend Community Services Scrutiny Committee meetings;
- Health Networks, e.g., Cancer and Diabetes Networks;
- Local Safeguarding Children Boards;

- Local Adult Safeguarding Boards; and
- Health and Wellbeing Boards.

Based on the work undertaken in 2012/2013, internal audit has given significant assurance that there is a sound system of internal control which is designed to meet the organisation's objectives, and that controls are being consistently applied in all the areas reviewed. The above statement provides an unqualified opinion and this is an improvement on last year where although significant assurance was provided, some weakness in the design and inconsistent application of controls put the achievement of particular objectives at risk.

The governance framework of the organisation

South East Essex PCT and South West Essex PCT are in a clustering arrangement with each other and have a single Cluster Board. An Audit Committee, Finance Committee and Quality and Governance Committee were established as joint sub-committees of the Cluster Board[1]. Under these cluster governance arrangements both PCT Boards retain their full range of statutory accountabilities and there is a clear agreement, via the Corporate Governance Manual adopted by both Boards, which functions are being exercised through the cluster arrangements and which are being retained at PCT Board level.

The Board meets on a bi-monthly basis and as of 31 March 2012 its voting members comprised the Chairman, six Executive Directors, including the Chief Executive, and six Non-Executive Directors (excluding the Chair). In the light of the organisational changes arising from the Health and Social Care Act 2012, the Board has ensured that a strong focus has been maintained on the management of this transition whilst continuing to assure itself of the performance of the whole organisation in delivering its financial and other objectives.

The Board undertakes an annual review of its effectiveness and has determined that it fulfils its role effectively either all or most of the time and that there has been good attendance at meetings. The Board has promoted the NHS Codes of Conduct and Accountability via its 'Principles and Values for the South Essex Cluster' which were adopted on 30 November 2011 and assessed itself as being compliant with these Codes as part of its annual review of effectiveness. This assessment also identified that the Board is compliant with the relevant principles of the Corporate Governance Code in relation to providing effective leadership, having an appropriate balance of skills, experience, independence and knowledge to enable Board members to discharge their duties and responsibilities effectively, presenting a balanced and understandable assessment of the PCT's position in its financial and other reporting, and ensuring that Executive remuneration is set appropriately.

To support the Board in carrying out its duties effectively, sub-committees reporting to the Board are formally established. The remit and terms of reference of these sub-committees have been reviewed during the year to ensure robust governance and assurance. Each sub-committee submits its minutes regularly to the Board and produces an annual report of its activities and any key findings.

The main sub-committees providing assurance to the Board are:

[1] All references to 'the Board' from this point onwards should be taken as referring to the South Essex Cluster Board.

Audit Committee – this Committee has delegated authority from the Board to review and approve the Annual Accounts and Annual Report and provides assurance to the Board on the organisation's Quality and Governance, Risk Management and Internal Control, Internal and External Audit; Counter Fraud and Financial Reporting arrangements. In addition to these areas, the Audit Committee has also focused on the transition governance arrangements of the PCT, the East of England Specialised Commissioning Group and Clinical Commissioning Groups and their associated risks. The average attendance of members at Audit Committee meetings during the 2012/13 year was 95%.

The Audit Committee approves an annual work programme for the PCT's Local Counter Fraud Service. Regular reports against this programme are received at Audit Committee meetings, which are attended by the Local Counter Fraud Specialist, with particular scrutiny being given to the implementation of required actions. The Audit Committee also takes proactive measures by identifying potential risk areas and, where necessary, calling on management to bring forward corrective actions.

As part of its review of the PCT's transition governance arrangements, the Audit Committee agreed the financial transition arrangements for the preparation and approval of the 2012/13 accounts and the transfer of outstanding audit 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 of the Greater Eastern Commissioning Support Unit have been utilised to close down the accounts as the majority of PCT financial services staff have transferred into the CSU.

A sub-committee of the Department of Health's Audit Committee has been established to meet on 3 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.

Quality and Governance Committee – this Committee provides assurance to the Board on the systems and processes by which the PCT leads, directs and controls its functions in order to achieve organisational objectives, safety and quality of services. The Quality and Governance Committee also reviews the arrangements in place for the discharge of the PCT's statutory functions in relation to Employment practice, Equality and Diversity, Safeguarding, Health and Safety, Information Governance, patient consultation and involvement, and Complaints handling to ensure that there are no irregularities and that the PCT is legally compliant.

The average attendance of members at Quality and Governance Committee meetings during the 2012/13 year was 75%.

Finance Committee – this Committee provides assurance to the Board that financial issues are being appropriately managed and escalated where necessary, as well as overseeing the development, co-ordination and implementation of estates matters and reviewing the performance of the main services commissioned by the PCT. The average attendance of members at Finance Committee meetings during the 2012/13 year was 66%.

Transition Board - during 2012/13 the PCT cluster established a Transition Board to oversee the transition arrangements arising from the Health and Social Care Act 2012. The Transition Board was a formal committee of the Board and met monthly to oversee the delivery of the close down plan. From October 2012 the Transition Board covered the whole of Essex and was chaired by the South Essex Chairman.

In line with Department of Health guidance, the Transition Board established a close down plan drawing upon the earlier transition plans that had been developed and monitored previously.

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 committee that scrutinised these documents was the Quality and Governance Committee.

The Transition Board monitored the risks associated with the transition and these were reported at every Board meeting, with a final report being presented to the last Board meeting in March 2013.

Risk assessment

The Board has overall accountability for ensuring that the PCT has an effective programme for managing all types of risk and delegated the responsibility for ensuring that key strategic risks are identified and evaluated and that adequate responses are in place and monitored by the Board.

The Audit Committee has responsibility for reviewing the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the PCT's activities that supports the achievement of the PCT's objectives. The Audit Committee is chaired by a Non-Executive Director and, as a sub-committee of the Board, regularly submits its minutes to the Board and produces an annual report of its activities.

The Quality and Governance Committee assists the PCT in the identification and management of operational risks. Operational risks are monitored on a quarterly basis by the Quality and Governance Committee and reported to the Board via the Corporate Risk Register. The Quality and Governance Committee is chaired by a Non-Executive Director and, as a sub-committee of the Board, regularly submits its minutes to the Board and produces an annual report of its activities.

The PCT has adopted the Australia / New Zealand risk management model. This provides a generic model for identifying, prioritising and dealing with risk in any situation – whether at a local or corporate level. The PCT's risk assessment process ensures a consistent approach is taken to the evaluation and monitoring of risk in terms of the assessment of likelihood and consequence.

The most significant risks to the organisation are identified through discussions at the Board, Quality and Governance Committee and Audit Committee meetings and are reviewed by the Board at its meetings in public on a quarterly basis. Each of these risks has an associated action plan to address any gaps in control or assurance and these are also monitored by the Board.

The top risks to the PCT have remained largely consistent throughout the 2012-13 year and have comprised:

- The ability and capacity of the PCT and new organisations to implement the various requirements of the Health and Social Care Act, in particular to respond to different and slipping timescales of receiver organisations.
- Assurance regarding the quality of PCT Providers.
- The PCT's capacity to manage, and the financial impact of, retrospective continuing healthcare claims.

- Winter pressures and their impact upon waiting time targets
- Uncertainty regarding the economic climate and future resources available to the PCT and NHS.
- A lack of collaborative working between CCGs resulting in unnecessary duplication and unintended consequences across the health economy.

During the year there were 3 reported lapses of data security. The first of these incidents related to an incorrectly addressed letter, the second to the theft of a laptop which contained patient identifiable data, and the third to inappropriate access to patient records. An action plan has been developed to address the control weaknesses that led to the first of these incidents and its implementation is currently being monitored. The latter two incidents were still under investigation at the time of this report.

The risk and control framework

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 and the impact should they be realised; and
- Manage these risks efficiently, effectively and economically.
- Identify key statutory duties and associated transition management.

The system of internal control has been in place in South West Essex PCT for the year ended 31 March 2013 and up to the date of approval of the annual report and accounts.

The PCT has in place a risk management strategy that is reviewed annually and distributed to all staff and key partners.

The Director of Quality, Patient Experience & Nursing has delegated responsibility for managing the strategic development of clinical risk management and clinical governance.

The Director of Finance & Performance has delegated responsibility for managing the strategic development and implementation of financial risk management.

The Associate Director of Corporate Services & Communications had delegated responsibility for managing the strategic development and implementation of organisational risk management and corporate governance.

All Directors and managers are responsible for ensuring that appropriate and effective risk management processes are in place within their designated areas and scope of responsibility.

The risk management process is co-ordinated by the Head of Governance, Risk & Customer Services for non-clinical risks. Lessons are learnt through incidents, complaints and issues raised through the Patient Advice & Liaison Service (PALS), internal audit recommendations, performance management and individual peer reviews, benchmarking information from the National Patient Safety Agency (NPSA),

NCB Special Health Authority, national inquiries and reviews. These lessons are shared with appropriate staff groups, via monthly staff briefings, Staff Involvement Group meetings, team meetings and through the organisation's internal newsletter and Local Security Management newsletters.

Risk prevention and deterrence is also undertaken via pro-active security and counter fraud risk reviews, pro-active risk assessments, the dissemination of guidance on the requirements of the PCT's Standing Orders and Standing Financial Instructions, monitoring compliance against key PCT policies such as Information Governance, and regular staff awareness raising.

The above mechanisms are also used to deter risks

The Assurance Framework is based on the top local priorities (principal objectives) for 2012/13 identified in the PCT's Integrated Plan. The Assurance Framework identifies the effectiveness of the key controls to manage the risks against achievement of these priorities and the assurance provided for those controls.

The Corporate Risk Register details the operational risks, the controls and assurance in place, any actions to be taken to reduce the level of risk and is reviewed quarterly by the Quality and Governance Committee and the Board.

The PCT has defined the amount of risk that it is prepared to accept, tolerate or be exposed to at any one point in time – its risk appetite – against a range of risk categories. The agreed risk appetite is recorded for each risk on the Board Assurance Framework and Corporate Risk Register in order to enable the Board to identify those risks where more work needs to be done to bring the risk ratings to a level it is prepared to tolerate.

The partnership mechanisms described previously are used to explore potential risks which may impact upon other organisations and public stakeholders. Additionally there are a number of cross organisation forums which support the process for identifying partnership risks.

The PCT has provided statutory and mandatory training for all staff groups and sessions on risk management, health and safety, safeguarding, equality and diversity and information governance. Articles on risk management and health and safety regularly feature in internal bulletins and newsletters.

The PCT has a policy on the reporting and investigation of adverse incidents. Face-to-face training and written guidance has been provided to PCT staff in order to support the implementation of the policy.

Review of the effectiveness of risk management and internal control

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the PCT who have responsibility for the development and maintenance of the internal control framework. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and Quality and Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Significant issues

Through the Board Assurance Framework, gaps in control and assurance have been identified during the course of the year in relation to the organisation's ability and capacity to implement the various elements of the Health and Social Care Act, managing financial uncertainty, achievement of financial balance, the organisation's capacity to manage all its contracts, managing the scale and pace of QIPP changes, Clinical Commissioning Group engagement , improvement of patient experience within agreed timescales and safeguarding training for independent contractors and their staff. However none of these were significant and work has either been undertaken, or is still on going, to develop controls for all of these areas. The Board and Audit Committee monitor the development and implementation of these action plans.

Although it is not directly accountable for the performance of the organisations from which it commissions NHS services, the PCT closely monitors the quality of such services as part of its contract management arrangements. Accordingly the PCT has worked alongside external regulators such as the Care Quality Commission and the Health and Safety Executive to ensure that the various safety and quality concerns identified at Basildon & Thurrock University Hospital NHS Trust are being addressed in a timely and robust fashion. The most significant of these concerns have been in relation to the quality of paediatric services, the control of legionella risks and potentially high mortality rates. A number of action plans have been developed to address these issues and these plans are subject to ongoing scrutiny to ensure that they reflect the needs of the inspection, report or survey, that the action plan is progressing satisfactorily, that implemented actions can be demonstrated as complete with evidence of embedment, and that final actions and timelines for completion have been agreed.

During 2012/13, the Internal Auditors reviewed a number of areas of PCT business. Overall ratings of Amber/Red were given in respect of findings from reviews of the PCT's
Clinical Commissioning Group development, Payroll Services, and Information Governance arrangements. Action plans to implement the recommendations from these audits are in place and any outstanding recommendations will be brought to the attention of the PCT's successor organisations. Internal audit have also undertaken a number of other reviews as part of their risk-based audit plan, none of which have identified any significant concerns in relation to the PCT's systems of internal control in place.

Accountable Officer: Andrew Pike

Organisation: South East Essex PCT

Signature: *Andrew Pike*

Date: 3 June 2013

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

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

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

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

Signed.....*Andrew Pike* .....Designated Signing Officer

Name: Andrew Pike (Essex Area Director)

Date.....3 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.

…3 June 2013.....Date...*Andrew Pike* .....Signing Officer

…3 June 2013.....Date .....*Dawn Scrafield*.....Finance Signing Officer

INDEPENDENT AUDITORS' REPORT TO THE ACCOUNTABLE OFFICER FOR SOUTH WEST ESSEX PRIMARY CARE TRUST

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

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

- the table of salaries and allowances of senior managers and related narrative notes on page 73;
- the table of pension benefits of senior managers and related narrative notes on page 76; and
- the table of pay multiples and related narrative notes on page 77.

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

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

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

Scope of the audit of the financial statements

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

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

- the overall presentation of the financial statements.

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

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

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

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

Opinion on other matters

In our opinion:

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

Matters on which we report by exception

We report to you if:

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

- we issue a report in the public interest under section 8 of the Audit Commission Act 1998

We have nothing to report in these respects

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

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

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

- our review of the Governance Statement; and

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

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

Certificate

We certify that we have completed the audit of the accounts of South West Essex in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Debbie Hanson
for and on behalf of Ernst & Young LLP
400 Capability Green, Luton LU1 3LU
6 June 2013

Glossaries of terms used in this annual report

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.
Clinical Commissioning Group (CCG)	Formally established on 1 April 2013, Clinical Commissioning Groups (CCGs) are statutory bodies responsible for commissioning most healthcare – planning, buying and monitoring services to meet the needs of their local communities.
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.
Commissioning	The review, planning and purchasing of health and social services.
Community services	Health or social care and services provided outside of hospital. 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)	Commissioning Support Units 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.
Enhanced services	Enhanced services are: 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.
Equality Delivery System (EDS)	The EDS has been designed nationally as an optional tool launched 2011 to support NHS commissioners and providers to deliver better outcomes for patients and communities and better working environments for staff, which are personal, fair and diverse. The EDS is all about making positive differences to healthy living and working lives.
Equality Impact Assessment	An equality impact assessment involves assessing the

(EIA)	likely or actual effects of policies or services on people in respect of disability, gender and racial equality. It helps us to make sure the needs of people are taken into account when we develop and implement a new policy or service or when we make a change to a current policy or service.
NHS111	NHS 111 is a new service that's being introduced to make it easier for you to access local NHS healthcare services. People can call 111 when they need medical help fast but it's not a 999 emergency. NHS 111 is available 24 hours a day, 365 days a year. Calls are free from landlines and mobile phones.
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)	Primary Care Trusts are responsible for the planning and securing of health services and improving the health of the local population.

Glossary of financial terms

Term	**Definition**
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.
Budget	A **Budget** usually refers to a list of all planned and expected future expenses and revenues. A budget is set at the beginning of the financial year.
Capital Expenditure	**Capital Expenditure** is money spent on buying non-current assets (fixed assets) or to add to the value of an existing fixed asset with a useful life that extends beyond a year.
Capital Resource Limit	The **Capital Resource Limit** (CRL) is the amount allocated each year to the PCT for capital expenditure. The PCT must not spend more than the CRL on capital items.

Cash Limit	The **Cash Limit** (CL) is a limit set by the Government on the amount of cash which a PCT may spend during a given financial year. The PCT must ensure that the net amount of cash flowing out of the PCT over the financial accounting period is not more than the CL.
Revenue Resource Limit	The **Revenue Resource Limit** (RRL) is the total amount that the PCT may spend on the services that it commissions. This limit is set for the PCT at the start of the financial year by the Department of Health and may change on a monthly basis depending on changes to allocations to the PCT from the Strategic Health Authority for either commissioning or provider functions. Each PCT has a statutory duty not to spend more than its RRL. The RRL takes into account all accrued income and expenditure irrespective of whether income has been received or bills paid.
Depreciation	**Depreciation** refers to the fact that assets with finite lives lose value over time. Depreciation involves allocating the cost of the fixed asset (less any residual value) over its useful life to the **Statement of Comprehensive Net Expenditure (SCNE)**. This will cause an expense to be recognised on the SCNE while the net value of the asset will decrease on the Statement of Financial Position.
Impairments	**Impairments** are the losses in the values of non-current assets compared to those values recorded on the Statement of Financial Position. A PCT is required to undertake routinely revaluation reviews of its fixed assets or undertake an impairment review when there is a decline in an asset's value. 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 [formerly Intangible Fixed Assets]	**Intangible Assets** are invisible or 'soft' assets of an organisation that, nevertheless, have a real current market value and contribute to the (future) operation/income generation of the organisation and may include software licences, trademarks and research development expenditure.
International Financial Reporting Standards	**International Financial Reporting Standards (IFRS)** are the international accounting standards that the Department of Health require PCTs to follow when they prepare their accounts. 2009-10 was the first year in which PCTs were required to prepare IFRS compliant accounts, having previously used UK reporting standards.

Losses and Special Payments	**Losses and Special Payments** are payments that Parliament would not have foreseen healthcare funds being spent on, for example fraudulent payments, personal injury payments or payments for legal compensation.
NHS Payables (formerly known as NHS Creditors)	An **NHS Payable** is an amount owed to an NHS organisation for services rendered or goods supplied to the PCT or to patients of the PCT.
Statement of Comprehensive Net Expenditure (formerly known as Operating Cost Statement)	The **Statement of Comprehensive Net Expenditure** (SCNE) records the costs incurred by the PCT during the year, net of miscellaneous income (which is income other than the PCT's main funding from the Department of Health which is credited to the general fund on the Statement of Financial Position and not treated as income on the SCNE). It includes non cash expenses such as depreciation. 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.
Over Spend	**Over Spend** occurs when more money is spent than was allowed within the cash limit, revenue resource limit or capital limit, or that was planned in the budget.
Pooled budget	A **Pooled Budget** is a joint arrangement with other bodies, such as local authorities and other PCT's, to pool funds for a specific purpose. Each body has to account for its own contribution to the pool within their accounts. Contributions would generally include the resources normally used for the identified services, together with partnership and other grants specific to the services. The host partner will manage the financial affairs of the pooled fund. The pooled budget manager is responsible for managing the pooled fund on behalf of the host authority, and for providing information to enable the partners to monitor the effectiveness of the pooled fund arrangements.
Procurement	**Procurement** is the acquisition of goods and/or services, generally through a contract, at the best possible total cost, in the right quantity and quality, at the right time and in the right place for the direct benefit of the PCT and its patients.

Property, plant & equipment (formerly Tangible Fixed Assets)	**Property, plant and equipment** are assets that individually (or with integrally linked other items) cost more than £5,000 and are held for longer than one year and include: land, buildings, transport equipment, IT and furniture and fittings.
Provisions	A **Provision** is a liability arising from a past event where it is probable the PCT will have to settle and a reliable estimate can be made of the amount to be paid.
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 Taxpayers' Equity (formerly Statement of Recognised Gains and Losses)	The purpose of the **Statement of Changes in Taxpayers' Equity** is to highlight 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 in the General Fund due to the transfer of assets to/from NHS bodies and the Department of Health".
Statement of Financial Position (formerly Balance Sheet)	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. 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).
Tendering	**Tendering** is the process by which one can seek prices and terms for a particular service/project to be carried out under a contract.
Trade and other Payables (Non-NHS) (formerly known as Non-NHS Creditors)	**Trade and other Payables Creditors** are non-NHS organisations owed money by the PCT for goods and services provided to the PCT, e.g. for utilities, equipment, etc.
Trade and other receivables (formerly Debtors)	**Trade and other receivables** represent money owed to the PCT at the Statement of Financial Position date for services rendered or goods supplied by the PCT to the receiver.
Under Spend	**Under Spend** occurs when less money is spent than was allowed within the cash limit or that was planned in the budget.

Remuneration report for the year end 31 March 2013 – Appendix A

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 2011/12. 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 South West 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 in this report from pages 70 to 74.

There are no elements of remuneration, other than the benefits in kind detailed from pages 70 to 74, 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.

The remuneration report and pay multiples can be found below:

South West Essex PCT
Salaries and Allowances

			2012-13				2011-2012			
Name and Title			**Salary (bands of £5,000)**	**Other Remuneration (bands of £5000)**	**Bonus Payments (bands of £5000)**	**Benefits in kind (Rounded to nearest £00)**	**Salary (bands of £5,000)**	**Other Remuneration (bands of £5000)**	**Bonus Payments (bands of £5000)**	**Benefits in kind (Rounded to nearest £00)**
		Note	**£,000**	**£,000**	**£,000**	**£'00**	**£,000**	**£,000**	**£,000**	**£'00**
Chair and Non Executive Directors										
Derek Morrison	Chair (until 30/11/2011)	1					25-30	-	-	-
Katherine Kirk	Chair (from 01/12/2011)	3	15-20	-	-	-	5-10	-	-	-
Jonathan Cope	Non Executive Director (until 30/11/2011)	1					5-10	-	-	-
Anthony Cox	Non Executive Director	3	0-5	-	-	-	5-10	-	-	-
Glynis Cheers	Non Executive Director	3	0-5	-	-	-	5-10	-	-	-
Mel Porter	Non Executive Director	3	15-20	-	-	-	5-10	0-5	-	-
Desmond Shillingford	Non Executive Director (until 30/11/2011))	1					5-10	-	-	-
Tony Le-Masurier	Non Executive Director (from 01/12/2011)	3	0-5	-	-	-	0-5	-	-	-
Gill Hind	Non Executive Director (from 01/12/2011)	3	5-10	-	-	-	0-5	-	-	-
Rob Peters (Audit Committee Chair)	Non Executive Director (from 01/12/2011)	3	10-15	-	-	-	0-5	-	-	-

Roger Sinden	Non Executive Director (from 01/12/2011)	3	0-5	-	-	-	0-5	-	-	-
								-	-	-
Board Officer Members										
Andrew Pike	Chief Executive	2	50-55	-	-	-	75-80		0-5	
Barbara Stuttle CBE	Deputy Chief Executive / Director of Quality, Clinical Development and Innovation. (until 31/05/2011)	1					15-20	-	-	-
Dr Andrea Atherton	Director of Public Health (from 19/07/2010 until 8/05/2011)	3	25-30	-	-	-	5-10	-	-	-
Dr Anil Chopra	Medical Director, South West Essex (from 26/05/2011)	4	35-40	-	-	-	35-40	-	-	-
Dawn Scrafield	Director of Finance & Performance (from 26/05/2011) Acting Director of Finance, South West Essex to 25/05/2011	2	35-40	-	-	-	65-70	-	0-5	
Jonathan Marron	Director of Strategy and Planning (until 03/05/2011)	1					5-10	-	-	-
Tom Abell	Director of Commissioning (Operations) (from 26/05/2011 to 01/04/2012)	3	0-5	-	-	-	55-60	-	-	-
Ian Stidson	Director of Primary Care and Partnership Commissioning (from 26/05/2011) Interim Director of Primary and Community Care to 25/05/2011	2	30-35	-	-	-	45-50	-	-	-
Luella Dixon	Human Resources Project Director (from	3,5	40-45	0-5	-	1	55-60	-	-	-

	1/09/2010)									
Pol Toner	Director of Quality and Patient Experience (from 04/07/2011)	2	30-35	-	-	-	35-40	-	-	-
Margaret Hathaway	Commercial Director (from 26/05/11 to 01/05/2013)	3	45-50	-	-	-	35-40	-	-	-
Alison Cowie	Director of Public Health, (from 01.10..2012 to 31/03/2013)	3	20-25	0-5	-	1	-	-	-	-
					-	-	-	-	-	-
Nimal Raj	CCG Lead Thurrock		75-80	-	-	-	-	-	-	-
Tonia Parsons	CCG Lead Basildon & Brentwood		80-85	-	-	-	-	-	-	-

Note1: Some Non Exective and board directors information has been included as a coparator to previous years reports . They ceased their Non Executive Duties and board duties on the the previous financial year 2011/12.

Note 2 : The Members of the cluster Board who have been apportioned across all 5 PCTs are(South West Essex -35% ,South East Essex,-35%,West Essex-10%., Mid Essex-10%, North East Essex-10%)
Andrew Pike (£149,822) , DawnScrafield (£110,428), Ian Stidson (£90,071), Pol Turner (£99,078)

Note 3 : The Members of the Cluster Board who have been apportioned across SWE PCT and SEE PCT at 50% each are Tom Abell (£1,484), Luella Dixon(£89,628) Margaret Hathaway(£92,727), Katherine Kirk(£39,405),Tony Le-Masurier(£5,254),Gill Hind(£12,435), Rob Peters(£20,725) , Glynis cheers (£7,881), Anthony Cox (£7,881) , Roger Sinden (£7,881) and Alison Cowie whose apportionment is based on 25% SEE PCT, 25% SWE PCT and 50% weighted capitation apportionment against North Essex Cluster (£89,628). Dr Andrea Athertons (£114,950), aportionment was based on a 25% SWE PCT and a 75% SEE PCT.
Mel Porter (£26,000) apportionment based on 75% SWE PCT and 25% SEE PCT

Note 4 Dr Anil Chopra is apportioned 100% to SWE PCT

Note 5 : Luella Dixon have been seconded from West Essex ,the charge has been reflected in both SWE and SEE remuneration

Where any individual does not hold office for the full financial year, the dates are noted in the report and only remuneration relating to the period that

an executive position was held are included in this report.

Other remuneration (where shown) relate to payments for other positions held within the PCT at the same time, but which are separate to the positions noted in this report.

Benefits in kind (where shown) relate to the provision of motor vehicles.

Pension Benefits

Name and Title	Note	Real increase in pension at age 60 (bands of £2,500)	Real Increase In pension lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2013 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31-Mar-13 (bands of £5,000)	Cash Equlvalent Transfer Value at 31-Mar 2013	Cash Equlvalent Transfer Value at 31-Mar 2012	Real Increase In cash Equlvalent transfer value	Employer's contribution to stakeholders pesion (rounded to nearest £00)
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'00
POL TONER	1	0-2.5	0-2.5	15-20	45-50	238	221	17	-
DAWN SCRAFIELD	1	0-2.5	0-2.5	20-25	65-70	265	249	16	-
ANDREW PIKE	1	0-2.5	0-2.5	50-55	150-155	944	932	12	-
IAN STIDSTON	1	0-2.5	0-2.5	20-25	70-75	427	413	15	-
ANDREA ATHERTON	1	0-2.5	0-2.5	30-35	95-100	602	591	11	-
ALISON COWIE	2	0-2.5	0-2.5	20-25	60-65	284	275	9	-
LUELLA DIXON	2	0-2.5	0-2.5	20-25	70-75	411	400	10	-
MARGARET HATHAWAY	1	0-2.5	2.5-5	10-15	40-45	222	192	30	-
TONIA PARSONS		0-2.5	2.5-5	15-20	45-50	323	284	39	-

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

Staff with more than one position within the NHS (note 1)
Some staff work for both South West Essex PCT and South East Essex PCT, as part of clustering arrangements. These staff are either on the payroll of South West Essex or South East Essex PCT and their full pension entitlements have been included in the remuneration report of both organisations. Readers should be aware of this in order to avoid any 'double-count' of these entitlements.

Staff with more than one position within the NHS (note 2)
Luella Dixon and Alison Cowie are both on secondment from West Essex PCT. Their pay is recorded in the Annual reports of all 5 PCTs within the Essex cluster. Readers should be aware of this in order to avoid any 'double-count' of these entitlements.

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.

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 banded remuneration of the highest paid director in The South West Essex PCT in the financial year 2012-13, at mid point , was £130,000-135,000 (2011-12, £80,000-85,000). This was 3.57 times (2011-12, 5.43 times)
the median remuneration of the workforce, which was £37,359 (2011-12, £15,199).

In 2012-13, 2 (2011-12, 2) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £6,000 to £144,810 (2011-12 £1,470-£116,805)
Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions

The change in the highest paid Director and ratio is a result in the allocation of the directors time allocated from two pct to 5 PCT (30% of the directors time allocated to North Essex Cluster). This has resulted in a different highest paid director for 12/13
The highest paid director does not have any pay scale as this is the set payments for the grade of staff.

TERMS OF REFERENCE OF NHS SOUTH ESSEX REMUNERATION COMMITTEE
A JOINT COMMITTEE OF SOUTH EAST ESSEX PCT AND SOUTH WEST ESSEX PCT

1. CONSTITUTION

South East Essex Primary Care Trust and South West Essex Primary Care Trust (the PCTs), acting through their statutory Boards, have agreed to establish a joint Committee in accordance with paragraph 5.1.2 (ii) of their Standing Orders known as the Joint Remuneration and Terms of Service Committee. The Committee has no executive powers other than those specifically delegated in these Terms of Reference and the PCTs' Scheme of Delegation.

2. ROLE OF THE COMMITTEE

The committee has delegated authority to establish and review local terms and conditions applicable to Directors. This is in accordance with the Pay Framework for Very Senior Managers in Strategic & Special health Authorities, Primary Care Trusts and Ambulance Trusts, July 2006.

The committee must also operate in accordance with the Codes of Conduct and Accountability EL(94)40, in particular Section B on the functions and composition of Remuneration Committees, and the Code of Conduct and Code of Accountability in the NHS July 2004.

The Committee will operate taking account of advice and guidance from NHS Midlands and the East of England.

3. ACCOUNTABILITY

The committee shall report to the Joint Cluster Board. For this purpose the 'Board' will exclude Executive Directors when considering matters affecting them and, additionally the Chief Executive, when decisions relate to that position.

4. PRIORITIES

The committee will:

a) Determine the contracts of employment, remuneration and other benefits, including severance packages, of the Chief Executive, Executive Directors and other "Very Senior Managers" in the light of the overall performance of the Trust and the individual achievement of key objectives.[2]

b) Determine the remuneration for individual PCT Executive Committee Members and for specific project work/roles undertaken by independent clinicians, so as to ensure that the

[2] In considering remuneration levels for the Chief Executive, Executive Directors and other "Very Senior Managers", the following should be referred to:

- NHS statutory regulations
- Market Forces
- Specific characteristics of the Trust
- Relativities between posts in the Trust
- Auditors' requirements

individual is fairly rewarded for their individual contribution to the PCT while having proper regard to the PCT's circumstances and performance, and to the requirements of fair and open tendering or recruitment policies.

c) Receive from the Chairman details of the outcome of appraisal and performance of the Chief Executive and consider recommendations on performance related pay.

d) Receive from the Chief Executive details of the outcome of appraisal and performance of Executive Directors and other "Very Senior Managers" and consider recommendations on performance related pay.

e) Determine proposed termination and ex gratia payments for non VSM staff, ensuring the proper calculation of payments and compliance with relevant national guidance

f) Review major management changes and monitor their impact and implementation.

g) Approve any shadow Remuneration Committee arrangements within CCGs.

5. DECISION MAKING

The committee has delegated authority to make decisions in respect of points a) to e) above. The committee will report all decisions to the Board, via submission of the minutes of its meetings, subject to the exclusions referred to in Section 3.

6. MONITORING AND REPORTING

The Committee will submit its minutes to the Board at its Part II meeting, except for any matters directly affecting Executive Directors which will be reported at the Part III meeting.

In order to discharge its duties effectively, the Remuneration Committee will require the following information:

- Regular transition updates

Administrative support will be provided by the HR team.

7. MEMBERSHIP

Chair:
The Chair will be a Non Executive Director nominated by the Joint Board Chairman.

Core members:

- Joint Board Chairman
- Three Non-Executive Directors, one of whom will be the Chair of the Committee
- At least one of the above members will be a member of the Audit Committee

In attendance:

- Chief Executive (for agenda items not concerning the Chief Executive)
- Senior Human Resources representative

- Other PCT Non-Executive Directors will have an open invitation to attend any meeting
- CCG representatives by invitation

8. QUORUM

A quorum will be 3 Non-Executive Directors (one of which may be the Joint Board Chairman).

9. MEETING FREQUENCY

The committee will meet at least once annually. The Chair may convene additional meetings as and when required, and members will normally be given at least 7 day's notice, but if necessary meetings may be called at shorter notice.

10. REVIEW OF TERMS OF REFERENCE

To be reviewed annually.
To be agreed by the Committee and ratified by the Joint Cluster Board.

11. REVIEW OF EFFECTIVENESS

The committee will develop a workplan that prioritises and monitors the delivery of objectives. This workplan will be monitored regularly and will be formally reviewed on an annual basis.

The committee will also review its performance on an annual basis.

Appendices attached:

Financial Statements
(Appendix B)

Good corporate citizen report
(Appendix C)

Sustainability Report
(Appendix D)

Department of Health

NHS

South West Essex Primary Care Trust

2012-13 Accounts

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www.gov.uk/dh

South West Essex Primary Care Trust

2012-13 Accounts

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

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

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

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

Signed.....  .....Designated Signing Officer

Name: 4/6/13 A. Pike

Date.....

STATEMENT OF RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

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

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

- make judgements and estimates which are reasonable and prudent;

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

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

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

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

By order of the Permanent Secretary.

4/6/13 Date ..... Signing Officer

4/6/13 Date ..... Finance Signing Officer

SOUTH WEST ESSEX PCT ANNUAL GOVERNANCE STATEMENT 2012/13

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievements of the PCT's policies, aims and objectives, whilst safeguarding the public funds and the PCT's assets for which I am personally responsible, in accordance with the responsibilities assigned to me by the Accountable Officer Memorandum. I am also responsible for ensuring that the PCT is administered prudently and economically and that resources are applied efficiently and effectively, with due regard for standards of propriety, transparency and accountability to the public.

In order to meet my responsibilities as Accountable Officer, I have processes in place to ensure good working arrangements with partner organisations and the Strategic Health Authority which include:

- Strategic Health Authority Chief Executive meetings;
- PCT Chief Executive meetings;
- Regular monitoring meetings with the Midlands and East of England Strategic Health Authority;
- Local Strategic Partnership meetings;
- Essex and Southend Local Involvement Network meetings;
- Essex Overview and Scrutiny Committee and Southend Community Services Scrutiny Committee meetings;
- Health Networks, e.g., Cancer and Diabetes Networks;
- Local Safeguarding Children Boards;
- Local Adult Safeguarding Boards; and
- Health and Wellbeing Boards.

Based on the work undertaken in 2012/2013, internal audit has given significant assurance that there is a sound system of internal control which is designed to meet the organisation's objectives, and that controls are being consistently applied in all the areas reviewed. The above statement provides an unqualified opinion and this is an improvement on last year where although significant assurance was provided, some weakness in the design and inconsistent application of controls put the achievement of particular objectives at risk.

The governance framework of the organisation

South East Essex PCT and South West Essex PCT are in a clustering arrangement with each other and have a single Cluster Board. An Audit Committee, Finance Committee and Quality and Governance Committee were established as joint sub-committees of the Cluster Board[1]. Under these cluster governance arrangements both PCT Boards retain their full range of statutory accountabilities and there is a clear agreement, via the Corporate Governance Manual adopted by both Boards, which functions are being exercised through the cluster arrangements and which are being retained at PCT Board level.

[1] All references to 'the Board' from this point onwards should be taken as referring to the South Essex Cluster Board.

The Board meets on a bi-monthly basis and as of 31 March 2012 its voting members comprised the Chairman, six Executive Directors, including the Chief Executive, and six Non-Executive Directors (excluding the Chair). In the light of the organisational changes arising from the Health and Social Care Act 2012, the Board has ensured that a strong focus has been maintained on the management of this transition whilst continuing to assure itself of the performance of the whole organisation in delivering its financial and other objectives.

The Board undertakes an annual review of its effectiveness and has determined that it fulfils its role effectively either all or most of the time and that there has been good attendance at meetings. The Board has promoted the NHS Codes of Conduct and Accountability via its 'Principles and Values for the South Essex Cluster' which were adopted on 30 November 2011 and assessed itself as being compliant with these Codes as part of its annual review of effectiveness. This assessment also identified that the Board is compliant with the relevant principles of the Corporate Governance Code in relation to providing effective leadership, having an appropriate balance of skills, experience, independence and knowledge to enable Board members to discharge their duties and responsibilities effectively, presenting a balanced and understandable assessment of the PCT's position in its financial and other reporting, and ensuring that Executive remuneration is set appropriately.

To support the Board in carrying out its duties effectively, sub-committees reporting to the Board are formally established. The remit and terms of reference of these sub-committees have been reviewed during the year to ensure robust governance and assurance. Each sub-committee submits its minutes regularly to the Board and produces an annual report of its activities and any key findings.

The main sub-committees providing assurance to the Board are:

Audit Committee – this Committee has delegated authority from the Board to review and approve the Annual Accounts and Annual Report and provides assurance to the Board on the organisation's Quality and Governance, Risk Management and Internal Control, Internal and External Audit; Counter Fraud and Financial Reporting arrangements. In addition to these areas, the Audit Committee has also focused on the transition governance arrangements of the PCT, the East of England Specialised Commissioning Group and Clinical Commissioning Groups and their associated risks. The average attendance of members at Audit Committee meetings during the 2012/13 year was 95%.

The Audit Committee approves an annual work programme for the PCT's Local Counter Fraud Service. Regular reports against this programme are received at Audit Committee meetings, which are attended by the Local Counter Fraud Specialist, with particular scrutiny being given to the implementation of required actions. The Audit Committee also takes proactive measures by identifying potential risk areas and, where necessary, calling on management to bring forward corrective actions.

As part of its review of the PCT's transition governance arrangements, the Audit Committee agreed the financial transition arrangements for the preparation and approval of the 2012/13 accounts and the transfer of outstanding audit 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 of the Greater Eastern Commissioning Support Unit have been utilised to close

down the accounts as the majority of PCT financial services staff have transferred into the CSU.

A sub-committee of the Department of Health's Audit Committee has been established to meet on 3 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.

Quality and Governance Committee – this Committee provides assurance to the Board on the systems and processes by which the PCT leads, directs and controls its functions in order to achieve organisational objectives, safety and quality of services. The Quality and Governance Committee also reviews the arrangements in place for the discharge of the PCT's statutory functions in relation to Employment practice, Equality and Diversity, Safeguarding, Health and Safety, Information Governance, patient consultation and involvement, and Complaints handling to ensure that there are no irregularities and that the PCT is legally compliant.

The average attendance of members at Quality and Governance Committee meetings during the 2012/13 year was 75%.

Finance Committee – this Committee provides assurance to the Board that financial issues are being appropriately managed and escalated where necessary, as well as overseeing the development, co-ordination and implementation of estates matters and reviewing the performance of the main services commissioned by the PCT. The average attendance of members at Finance Committee meetings during the 2012/13 year was 66%.

Transition Board - during 2012/13 the PCT cluster established a Transition Board to oversee the transition arrangements arising from the Health and Social Care Act 2012. The Transition Board was a formal committee of the Board and met monthly to oversee the delivery of the close down plan. From October 2012 the Transition Board covered the whole of Essex and was chaired by the South Essex Chairman.

In line with Department of Health guidance, the Transition Board established a close down plan drawing upon the earlier transition plans that had been developed and monitored previously.

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 committee that scrutinised these documents was the Quality and Governance Committee.

The Transition Board monitored the risks associated with the transition and these were reported at every Board meeting, with a final report being presented to the last Board meeting in March 2013.

Risk assessment

The Board has overall accountability for ensuring that the PCT has an effective programme for managing all types of risk and delegated the responsibility for ensuring that key strategic risks are identified and evaluated and that adequate responses are in place and monitored by the Board.

The Audit Committee has responsibility for reviewing the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the PCT's activities that supports the achievement of the PCT's objectives. The Audit Committee is chaired by a Non-Executive Director and, as a sub-committee of the Board, regularly submits its minutes to the Board and produces an annual report of its activities.

The Quality and Governance Committee assists the PCT in the identification and management of operational risks. Operational risks are monitored on a quarterly basis by the Quality and Governance Committee and reported to the Board via the Corporate Risk Register. The Quality and Governance Committee is chaired by a Non-Executive Director and, as a sub-committee of the Board, regularly submits its minutes to the Board and produces an annual report of its activities.

The PCT has adopted the Australia / New Zealand risk management model. This provides a generic model for identifying, prioritising and dealing with risk in any situation – whether at a local or corporate level. The PCT's risk assessment process ensures a consistent approach is taken to the evaluation and monitoring of risk in terms of the assessment of likelihood and consequence.

The most significant risks to the organisation are identified through discussions at the Board, Quality and Governance Committee and Audit Committee meetings and are reviewed by the Board at its meetings in public on a quarterly basis. Each of these risks has an associated action plan to address any gaps in control or assurance and these are also monitored by the Board.

The top risks to the PCT have remained largely consistent throughout the 2012-13 year and have comprised:

- The ability and capacity of the PCT and new organisations to implement the various requirements of the Health and Social Care Act, in particular to respond to different and slipping timescales of receiver organisations.
- Assurance regarding the quality of PCT Providers.
- The PCT's capacity to manage, and the financial impact of, retrospective continuing healthcare claims.
- Winter pressures and their impact upon waiting time targets
- Uncertainty regarding the economic climate and future resources available to the PCT and NHS.
- A lack of collaborative working between CCGs resulting in unnecessary duplication and unintended consequences across the health economy.

During the year there were 3 reported lapses of data security. The first of these incidents related to an incorrectly addressed letter, the second to the theft of a laptop which contained patient identifiable data, and the third to inappropriate access to patient records. An action plan has been developed to address the control weaknesses that led to the first of these incidents and its implementation is currently being monitored. The latter two incidents were still under investigation at the time of this report.

The risk and control framework

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 and the impact should they be realised; and
- Manage these risks efficiently, effectively and economically.
- Identify key statutory duties and associated transition management.

The system of internal control has been in place in South West Essex PCT for the year ended 31 March 2013 and up to the date of approval of the annual report and accounts.

The PCT has in place a risk management strategy that is reviewed annually and distributed to all staff and key partners.

The Director of Quality, Patient Experience & Nursing has delegated responsibility for managing the strategic development of clinical risk management and clinical governance.

The Director of Finance & Performance has delegated responsibility for managing the strategic development and implementation of financial risk management.

The Associate Director of Corporate Services & Communications had delegated responsibility for managing the strategic development and implementation of organisational risk management and corporate governance.

All Directors and managers are responsible for ensuring that appropriate and effective risk management processes are in place within their designated areas and scope of responsibility.

The risk management process is co-ordinated by the Head of Governance, Risk & Customer Services for non-clinical risks. Lessons are learnt through incidents, complaints and issues raised through the Patient Advice & Liaison Service (PALS), internal audit recommendations, performance management and individual peer reviews, benchmarking information from the National Patient Safety Agency (NPSA), NCB Special Health Authority, national inquiries and reviews. These lessons are shared with appropriate staff groups, via monthly staff briefings, Staff Involvement Group meetings, team meetings and through the organisation's internal newsletter and Local Security Management newsletters.

Risk prevention and deterrence is also undertaken via pro-active security and counter fraud risk reviews, pro-active risk assessments, the dissemination of guidance on the requirements of the PCT's Standing Orders and Standing Financial Instructions, monitoring compliance against key PCT policies such as Information Governance, and regular staff awareness raising.

The above mechanisms are also used to deter risks

The Assurance Framework is based on the top local priorities (principal objectives) for 2012/13 identified in the PCT's Integrated Plan. The Assurance Framework identifies the

effectiveness of the key controls to manage the risks against achievement of these priorities and the assurance provided for those controls.

The Corporate Risk Register details the operational risks, the controls and assurance in place, any actions to be taken to reduce the level of risk and is reviewed quarterly by the Quality and Governance Committee and the Board.

The PCT has defined the amount of risk that it is prepared to accept, tolerate or be exposed to at any one point in time – it's risk appetite – against a range of risk categories. The agreed risk appetite is recorded for each risk on the Board Assurance Framework and Corporate Risk Register in order to enable the Board to identify those risks where more work needs to be done to bring the risk ratings to a level it is prepared to tolerate.

The partnership mechanisms described previously are used to explore potential risks which may impact upon other organisations and public stakeholders. Additionally there are a number of cross organisation forums which support the process for identifying partnership risks.

The PCT provides statutory and mandatory training for all staff groups and sessions on risk management, health and safety, safeguarding, equality and diversity and information governance. Articles on risk management and health and safety regularly feature in internal bulletins and newsletters.

The PCT has a policy on the reporting and investigation of adverse incidents. Face-to-face training and written guidance has been provided to PCT staff in order to support the implementation of the policy.

Review of the effectiveness of risk management and internal control

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the PCT who have responsibility for the development and maintenance of the internal control framework. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and Quality and Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Significant issues

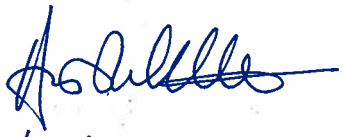
Through the Board Assurance Framework, gaps in control and assurance have been identified during the course of the year in relation to the organisation's ability and capacity to implement the various elements of the Health and Social Care Act, managing financial uncertainty, achievement of financial balance, the organisation's capacity to manage all its contracts, managing the scale and pace of QIPP changes, Clinical Commissioning Group engagement , improvement of patient experience within agreed timescales and safeguarding training for independent contractors and their staff. However none of these were significant and work has either been undertaken, or is still on going, to develop controls for all of these areas. The Board and Audit Committee monitor the development and implementation of these action plans.

Although it is not directly accountable for the performance of the organisations from which it commissions NHS services, the PCT closely monitors the quality of such services as part of its contract management arrangements. Accordingly the PCT has worked alongside external regulators such as the Care Quality Commission and the Health and Safety Executive to ensure that the various safety and quality concerns identified at Basildon & Thurrock University Hospital NHS Trust are being addressed in a timely and robust fashion. The most significant of these concerns have been in relation to the quality of paediatric services, the control of legionella risks and potentially high mortality rates. A number of action plans have been developed to address these issues and these plans are subject to ongoing scrutiny to ensure that they reflect the needs of the inspection, report or survey, that the action plan is progressing satisfactorily, that implemented actions can be demonstrated as complete with evidence of embedment, and that final actions and timelines for completion have been agreed.

During 2012/13, the Internal Auditors reviewed a number of areas of PCT business. Overall ratings of Amber/Red were given in respect of findings from reviews of the PCT's Clinical Commissioning Group development, Payroll Services, and Information Governance arrangements. Action plans to implement the recommendations from these audits are in place and any outstanding recommendations will be brought to the attention of the PCT's successor organisations. Internal audit have also undertaken a number of other reviews as part of their risk-based audit plan, none of which have identified any significant concerns in relation to the PCT's systems of internal control in place.

Accountable Officer: Andrew Pike

Organisation: South West Essex PCT

Signature: 

Date: 4/6/13

INDEPENDENT AUDITORS' REPORT TO THE ACCOUNTABLE OFFICER FOR SOUTH WEST ESSEX PRIMARY CARE TRUST

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

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

- the table of salaries and allowances of senior managers and related narrative notes on page 70;
- the table of pension benefits of senior managers and related narrative notes on page 73; and
- the table of pay multiples and related narrative notes on page 74.

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

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

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

Scope of the audit of the financial statements

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

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

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

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

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

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

Opinion on other matters

In our opinion:

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

Matters on which we report by exception

We report to you if:

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

We have nothing to report in these respects

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

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

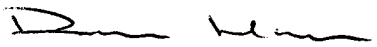
We have undertaken our audit in accordance with the Code of Audit Practice, having regard to the guidance issued by the Audit Commission in November 2012. We have considered the results of the following:

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

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

Certificate

We certify that we have completed the audit of the accounts of South West Essex in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.



Debbie Hanson
for and on behalf of Ernst & Young LLP
400 Capability Green, Luton LU1 3LU
6 June 2013

Statement of Comprehensive Net Expenditure for year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure			
Gross employee benefits	7.1	**13,435**	15,896
Other costs	5.1	**685,748**	667,228
Income	4	**(18,238)**	(19,566)
Net operating costs before interest		**680,945**	663,558
Investment income	9	**0**	0
Other losses	10	**617**	0
Finance costs	11	**1,966**	1,958
Net operating costs for the financial year		**683,528**	665,516
Transfers by absorption - (gains)		**0**	
Transfers by absorption - losses		**0**	
Net (gain)/loss on transfers by absorption		**0**	
Net Operating Costs for the Financial Year including absorption transfers		**683,528**	**665,516**
Of which:			
Administration Costs			
Gross employee benefits	7.1	**9,021**	8,651
Other costs	5.1	**7,875**	6,651
Income	4	**(2,549)**	(578)
Net administration costs before interest		**14,347**	**14,724**
Investment income	9	**0**	0
Other losses	10	**95**	0
Finance costs	11	**0**	35
Net administration costs for the financial year		**14,442**	**14,759**
Programme Expenditure			
Gross employee benefits	7.1	**4,414**	7,245
Other costs	5.1	**677,873**	660,577
Income	4	**(15,689)**	(18,988)
Net programme expenditure before interest		**666,598**	**648,834**
Investment income	9	**0**	0
Other losses	10	**522**	0
Finance costs	11	**1,966**	1,923
Net programme expenditure for the financial year		**669,086**	**650,757**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**831**	322
Net (gain) on revaluation of property, plant & equipment	**(1,481)**	(216)
Net (gain) on revaluation of intangibles	**0**	0
Net (gain) on revaluation of financial assets	**0**	0
Net (gain)/loss on other reserves	**0**	0
Net (gain)/loss on available for sale financial assets	**0**	0
Net (gain) /loss on Assets Held for Sale	**0**	
Release of Reserves to Statement of Comprehensive Net Expenditure	**0**	
Net actuarial (gain)/loss on pension schemes	**0**	0
Reclassification Adjustments		
Reclassification adjustment on disposal of available for sale financial assets	**0**	0
Total comprehensive net expenditure for the year*	**682,878**	**665,622**

*This is the sum of the rows above plus net operating costs for the financial year after absorption accounting adjustments.
The notes on pages 5 to 43 form part of this account.

Statement of Financial Position at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	12	**46,958**	47,660
Intangible assets	13	**221**	486
investment property	15	**0**	0
Other financial assets	21	**0**	0
Trade and other receivables	19	**0**	0
Total non-current assets		**47,179**	48,146
Current assets:			
Inventories	18	**0**	0
Trade and other receivables	19	**2,486**	3,398
Other financial assets	21	**0**	0
Other current assets	22	**0**	0
Cash and cash equivalents	23	**18,444**	61
Total current assets		**20,930**	3,459
Non-current assets held for sale	24	**0**	0
Total current assets		**20,930**	3,459
Total assets		**68,109**	51,605
Current liabilities			
Trade and other payables	25	**(48,985)**	(38,131)
Other liabilities	26	**0**	0
Provisions	32	**(2,333)**	(2,307)
Borrowings	27	**(474)**	(446)
Other financial liabilities	28	**0**	0
Total current liabilities		**(51,792)**	(40,884)
Non-current assets plus/less net current assets/liabilities		**16,317**	10,721
Non-current liabilities			
Trade and other payables	25	0	0
Other Liabilities	26	0	0
Provisions	32	(6,633)	(3,672)
Borrowings	27	(26,970)	(27,445)
Other financial liabilities	28	0	0
Total non-current liabilities		**(33,603)**	(31,117)
Total Assets Employed:		**(17,286)**	(20,396)
Financed by taxpayers' equity:			
General fund		(27,894)	(30,740)
Revaluation reserve		10,608	10,344
Other reserves		0	0
Total taxpayers' equity:		**(17,286)**	(20,396)

The notes on pages 1 to 4 form part of this account.

The financial statements on pages 1 to 4 were approved by the Audit Committee on the 3rd June 2013 and signed on its behalf by

Chief Executive:

Date: 4/6/13

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	**(30,740)**	**10,344**	**0**	**(20,396)**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(683,528)	0	0	**(683,528)**
Net gain on revaluation of property, plant, equipment	0	1,481	0	**1,481**
Net gain on revaluation of intangible assets	0	0	0	**0**
Net gain on revaluation of financial assets	0	0	0	**0**
Net gain on revaluation of assets held for sale	0	0	0	**0**
Impairments and reversals	0	(831)	0	**(831)**
Movements in other reserves	0	0	0	**0**
Transfers between reserves	386	(386)	0	**0**
Release of Reserves to SOCNE	0	0	0	**0**
Reclassification Adjustments				
Transfers between Revaluation Reserve & General Fund in respect of assets transferred under absorption	0	0	0	**0**
Net actuarial gain/(loss) on pensions	0	0	0	**0**
Total recognised income and expense for 2012-13	**(683,142)**	**264**	**0**	**(682,878)**
Net Parliamentary funding	685,988			**685,988**
Balance at 31 March 2013	**(27,894)**	**10,608**	**0**	**(17,286)**

Balance at 1 April 2011	**(24,326)**	**12,516**	**0**	**(11,810)**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(665,516)	0	0	(665,516)
Net gain on Revaluation of Property, Plant and Equipment	0	216	0	216
Net gain / (loss) on Revaluation of Intangible Assets	0	0	0	0
Net gain / (loss) on Revaluation of Financial Assets	0	0	0	0
Net gain / (loss) on Assets Held for Sale	0	0	0	0
Impairments and Reversals	0	(324)	0	(324)
Movements in other reserves	0	0	0	0
Transfers between reserves	2,064	(2,064)	0	0
Release of Reserves to Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification Adjustments				
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0	0
On disposal of available for sale financial assets	0	0	0	0
Net actuarial gain/(loss) on pensions	0	0	0	0
Total recognised income and expense for 2011-12	(663,452)	(2,172)	0	(665,624)
Net Parliamentary funding	657,038			657,038
Balance at 31 March 2012	**(30,740)**	**10,344**	**0**	**(20,396)**

Statement of cash flows for the year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities			
Net Operating Cost Before Interest		**(680,945)**	(663,558)
Depreciation and Amortisation		**2,201**	2,390
Impairments and Reversals		**(515)**	166
Other Gains / (Losses) on foreign exchange		**0**	0
Donated Assets received credited to revenue but non-cash		**0**	0
Government Granted Assets received credited to revenue but non-cash		**0**	0
Interest Paid		**(1,929)**	(1,897)
Release of PFI/deferred credit		**0**	0
(Increase)/decrease in Inventories		**0**	0
Decrease in Trade and Other Receivables		**912**	6,802
(Increase)/decrease in Other Current Assets		**0**	0
Increase/(decrease) in Trade and Other Payables		**11,417**	(867)
Decrease in Other Current Liabilities		**0**	59
Provisions Utilised		**(1,843)**	(1,632)
Increase in Provisions		**4,793**	3,273
Net Cash Outflow from Operating Activities		**(665,909)**	**(655,264)**
Cash flows from investing activities			
Interest Received		**0**	0
(Payments) for Property, Plant and Equipment		**(1,245)**	(1,439)
(Payments) for Intangible Assets		**(4)**	0
(Payments) for Other Financial Assets		**0**	0
(Payments) for Financial Assets (LIFT)		**0**	0
Proceeds of disposal of assets held for sale (PPE)		**0**	0
Proceeds of disposal of assets held for sale (Intangible)		**0**	0
Proceeds from Disposal of Other Financial Assets		**0**	0
Proceeds from the disposal of Financial Assets (LIFT)		**0**	0
Loans Made in Respect of LIFT		**0**	0
Loans Repaid in Respect of LIFT		**0**	0
Rental Revenue		**0**	0
Net Cash Outflow from Investing Activities		**(1,249)**	**(1,439)**
Net cash outflow before financing		**(667,158)**	**(656,703)**
Cash flows from financing activities			
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**(446)**	(420)
Net Parliamentary Funding		**685,988**	657,038
Capital Receipts Surrendered		**0**	0
Capital grants and other capital receipts		**0**	0
Cash Transferred (to)/from Other NHS Bodies (free text note required)		**0**	0
Net Cash Inflow/(Outflow) from Financing Activities		**685,542**	**656,618**
Net increase/(decrease) in cash and cash equivalents		**18,384**	**(85)**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**61**	**146**
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies		**(1)**	0
Cash and Cash Equivalents (and Bank Overdraft) at year end		**18,444**	**61**

1. Accounting policies

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

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

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

1.1 Accounting Conventions

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

Transforming Community Services (TCS) transactions

Under the TCS initiative, services historically provided by PCTs have transferred to other providers - notably NHS Trusts and NHS Foundation Trusts. Such transfers fall to be accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCNE, and is disclosed separately from operating costs.

Acquisitions and Discontinued Operations

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

Critical accounting judgements and key sources of estimation uncertainty

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

Critical judgements in applying accounting policies

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

- Retrospective Continuing Healthcare Claims, where a provision has been made on the basis of the number of claims received in year.

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

- Prescribing creditor, where the timelag in charges is 9.53 weeks, the charges are a combination of ppa reporting having a time lag of two months which generates the main proportion of the balance and the time lag of the cash advance payments for prescribed drugs. The accrual is based on the estimated remaining liability that will be payable in 2013/14. (£13,919k)

1. Accounting policies (continued)

Key sources of estimation uncertainty (continued)

- Continuing Care Provision

Continuing healthcare claims provision - During 2012/13 a significant number of claims were received for retrospective Continuing Healthcare services from members of the public and agents acting on their behalf. The volume of claims is such that it will take a considerable period of time to complete the processing of these claims, reflecting the work involved to retrospectively assess each claims eligibility. In order to complete the accounts a thorough process has been undertaken to draw together the information that was available for each of the claims and make provision where there is sufficient information. The number of such claims received across the 2 PCTs in the South Essex cluster was 897.

A provision has been made based on claims where there is sufficient information available to enable a reasonable estimate of the PCTs obligation. The value of this provision is £6,803k and has been calculated on the basis of the value of the claims submitted multiplied by the success rate of previous claims and the % of days claimed that have been paid for claims settled during 2012/13. The key sources of estimation uncertainty within the calculated provision are therefore the assumed success rate and % of days claimed that are paid.

There are a number of individual claims where there is insufficient information available to enable the PCT to make a reasonable estimate of its likely liability and this brings about some uncertainty in the provision estimate. Until all the claims have been formally assessed and concluded on it is not possible to be certain that individual claims are not eligible. If those claims that have currently been assessed and classified as unlikely to succeed and therefore not provided for were to be successful the value of the additional liability could be up to £658k. This estimation uncertainty is based on the value of the individual claims made, the estimated likely success rate and % of claimed days paid. There are 580 claims across the 2 PCTs in the South Essex cluster that have not been provided for as adequate information has not been provided to support the claim. These cannot be valued but it should be recognised that should any further information become available for these cases, this may result in a future liability that has not been provided for within the accounts.

1.2 Revenue and Funding

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

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

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

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

1.3 Pooled budgets

The PCT does not have any pooled budgets.

1.4 Taxation

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

1.5 Administration and Programme Costs

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

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

1.6 Property, Plant & Equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

1. Accounting policies (continued)

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

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

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

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

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

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

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

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

1.7 Intangible Assets

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

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

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

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

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

1. Accounting policies (continued)

1.8 Depreciation, amortisation and impairments

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

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

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

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

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

1.09 Government grants

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

1. Accounting policies (continued)

1.10 Cash and cash equivalents

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

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

1.11 Losses and Special Payments

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

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

1.12 Clinical Negligence Costs

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

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

1.13 Employee benefits

Short-term employee benefits

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

Retirement benefit costs

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

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

1.14 Research and Development

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

1.15 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.

1.16 Grant making

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

1. Accounting policies (continued)

1.17 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.

1.18 Leases

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

The PCT as lessee

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

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

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

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

The PCT as lessor

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

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

1.19 Provisions

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

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

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

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

1. Accounting policies (continued)

1.20 Financial Instruments

Financial assets

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

Financial assets are initially recognised at fair value.

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

Financial assets at fair value through profit and loss

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

Held to maturity investments

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

Available for sale financial assets

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

Loans and receivables

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

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

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

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

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

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

1. Accounting policies (continued)

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

Financial liabilities are initially recognised at fair value.

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

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

Other financial liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.21 Private Finance Initiative (PFI) and NHS LIFT transactions

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

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

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

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

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.

The PCT does not have any LIFT assets.

1. Accounting policies (continued)

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

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

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

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

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

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

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

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

1.23 Events after the reporting period

Under the provisions of The Health and Social Care Act 2012 (Commencement No 4 Transitional, Savings and Transitory provisions) Order 2013, South West 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 42 Events after the Reporting Period. Where reconfigurations of this nature take place within the public sector, Government accounting requires that the activities concerned are to be considered as continuing operations, and so the closing entity prepares accounts on a "going concern" basis.
The SOFP has therefore been drawn up at 31 March 2013 on the same basis as in previous years, reporting balances on the same basis as would a continuing entity. In particular, there has been no general revaluation of assets or liabilities, and no disclosures have been made under IFRS 5 Non-current Assets Held for Sale and Discontinued Operation.

There has been revaluations and impairments recognised in the period, £827k of impairments and £1,481k of revaluations charged to revaluation reserve and £861k of impairments and £1,422k revaluations charged to SOCNE, and such transactions are considered routine.

2 Operating segments

During 2012/13 PCT has been reporting in shadow form the Clinical Commissioning Group expenditure. This is not the full extent of commissioning resource as this was phased across to CCG segment reporting during the year.

The residual commissioning arrangements of the PCT have been reported as the remaining segment. Across these three segments there are clearly defined governance arrangements, being to commission healthcare services for the residents of South West Essex.

	Basildon & Brentwood CCG		**Thurrock CCG**		**Residual PCT Commissioning**		**Total**	
	2012-13 £000	2011-12 £000	**2012-13 £000**	2011-12 £000	**2012-13 £000**	2011-12 £000	**2012-13 £000**	2011-12 £000
Expenditure	**302,573**		**178,096**		**202,859**	665,516	**683,528**	665,516
Surplus/(Deficit)								
Segment surplus/(deficit)	**(10,830)**		**(4,438)**		**15,952**	252	**684**	252
Common costs	**0**		**0**		**0**	0	**0**	0
Surplus/(deficit) before interest	**291,743**		**173,658**		**218,811**	**665,768**	**684,212**	665,768
Net Assets:								
Segment net assets					**(17,286)**	(20,396)	**(17,286)**	(20,396)

Prior Year figure have not been disclosed, as 2012-13 was the first year that we reported the Clinical Commissioning group expenditure in shadow form.

All the expenditure was to external suppliers excluding the staff costs of £13,453k (2011-12 £15,896k)

Expenditure with Basildon and Thurrock University Hospital Foundation Trust amounts to over 10% of total expenditure at £106,703k for Basildon & Brentwood CCG and £74,150k for Thurrock CCG.

3. Financial Performance Targets

3.1 Revenue Resource Limit

	2012-13 £000	2011-12 £000
The PCTs' performance for the year ended 2012-13 is as follows:		
Total Net Operating Cost for the Financial Year		665,516
Net operating cost plus (gain)/loss on transfers by absorption	**683,528**	
Adjusted for prior period adjustments in respect of errors	**0**	0
Revenue Resource Limit	**684,212**	665,768
Underspend Against Revenue Resource Limit (RRL)	684	252

3.2 Capital Resource Limit

	2012-13 £000	2011-12 £000
The PCT is required to keep within its Capital Resource Limit.		
Capital Resource Limit	**1,653**	1,960
Charge to Capital Resource Limit	**69**	1,094
Underspend Against CRL	**1,584**	**866**

3.3 Provider full cost recovery duty

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

3.4 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**685,988**	657,038
Cash Limit	**685,988**	662,101
Underspend Against Cash Limit	**0**	**5,063**

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

	2012-13 £000	2011-12 £000
Total cash received from DH (Gross)	**600,781**	568,759
Less: Trade Income from DH	**0**	0
Less/(Plus): movement in DH working balances	**0**	0
Sub total: net advances	**600,781**	**568,759**
(Less)/plus: transfers (to)/from other resource account bodies (free text note required)	**0**	0
Plus: cost of Dentistry Schemes (central charge to cash limits)	**16,145**	16,083
Plus: drugs reimbursement (central charge to cash limits)	**69,062**	72,196
Parliamentary funding credited to General Fund	**685,988**	**657,038**

4 Miscellaneous Revenue

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Fees and Charges	**12**	0	12	15
Dental Charge income from Contractor-Led GDS & PDS	**5,249**	0	5,249	4,860
Dental Charge income from Trust-Led GDS & PDS	**0**	0	0	0
Prescription Charge income	**3,281**	0	3,281	3,138
Strategic Health Authorities	**693**	6	687	648
NHS Trusts	**0**	0	0	8
NHS Foundation Trusts	**1,230**	939	291	3,380
Primary Care Trusts Contributions to DATs	**0**	0	0	0
Primary Care Trusts - Other	**397**	9	388	1,339
Primary Care Trusts - Lead Commissioning	**0**	0	0	0
English RAB Special Health Authorities	**0**	0	0	0
NDPBs and Others (CGA)	**0**	0	0	0
Department of Health - SMPTB	**0**	0	0	0
Department of Health - Other	**0**	0	0	0
Recoveries in respect of employee benefits	**1,052**	1,024	28	0
Local Authorities	**598**	179	419	479
Patient Transport Services	**0**	0	0	0
Education, Training and Research	**0**	0	0	0
Non-NHS: Private Patients	**0**	0	0	0
Non-NHS: Overseas Patients (Non-Reciprocal)	**0**	0	0	0
NHS Injury Costs Recovery	**0**	0	0	0
Other Non-NHS Patient Care Services	**0**	0	0	1
Charitable and Other Contributions to Expenditure	**0**	0	0	0
Receipt of donated assets	**0**	0	0	0
Receipt of Government granted assets	**0**	0	0	0
Rental revenue from finance leases	**0**	0	0	0
Rental revenue from operating leases	**5,539**	329	5,210	5,506
Other revenue	**187**	63	124	192
Total miscellaneous revenue	**18,238**	**2,549**	**15,689**	**19,566**

5. Operating Costs

5.1 Analysis of operating costs:

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
Goods and Services from Other PCTs				
Healthcare	**74,967**		74,967	71,686
Non-Healthcare	**653**	392	261	1,181
Total	**75,620**	**392**	**75,228**	**72,867**
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	**69,446**	6	69,440	67,030
Goods and services (other, excl Trusts, FT and PCT))	**20**	3	17	80
Total	**69,466**	**9**	**69,457**	**67,110**
Goods and Services from Foundation Trusts	**320,894**	1,213	319,681	314,279
Purchase of Healthcare from Non-NHS bodies	**42,572**		42,572	38,007
Social Care from Independent Providers	**253**		253	0
Expenditure on Drugs Action Teams	**1,025**		1,025	802
Non-GMS Services from GPs	**999**	628	371	1,616
Contractor Led GDS & PDS (excluding employee benefits)	**22,323**		22,323	20,907
Salaried Trust-Led PDS & PCT DS (excluding employee benefits)	**0**		0	0
Chair, Non-executive Directors & PEC remuneration	**7**	7	0	38
Executive committee members costs	**34**	34	0	73
Consultancy Services	**2,017**	1,329	688	1,147
Prescribing Costs	**60,773**		60,773	64,441
G/PMS, APMS and PCTMS (excluding employee benefits)	**48,271**	0	48,271	46,068
Pharmaceutical Services	**0**		0	0
Local Pharmaceutical Services Pilots	**0**		0	0
New Pharmacy Contract	**15,127**		15,127	14,383
General Ophthalmic Services	**4,142**		4,142	4,181
Supplies and Services - Clinical	**4,932**	1	4,931	2,992
Supplies and Services - General	**749**	328	421	1,126
Establishment	**1,055**	630	425	1,191
Transport	**54**	0	54	72
Premises	**7,040**	1,747	5,293	7,439
Impairments & Reversals of Property, plant and equipment	**(561)**	140	(701)	166
Impairments and Reversals of non-current assets held for sale	**0**	0	0	0
Depreciation	**1,826**	223	1,603	2,094
Amortisation	**375**	58	317	296
Impairment & Reversals Intangible non-current assets	**46**	0	46	0
Impairment and Reversals of Financial Assets	**0**	0	0	0
Impairment of Receivables	**16**	0	16	28
Inventory write offs	**0**	0	0	0
Research and Development Expenditure	**0**	0	0	0
Audit Fees	**134**	134	0	212
Other Auditors Remuneration	**0**	0	0	0
Clinical Negligence Costs	**0**	0	0	0
Education and Training	**174**	165	9	69
Grants for capital purposes	**188**	0	188	60
Grants for revenue purposes	**0**	0	0	0
Impairments and reversals for investment properties	**0**	0	0	0
Other	**6,197**	837	5,360	5,564
Total Operating costs charged to Statement of Comprehensive Net Expenditure	**685,748**	**7,875**	**677,873**	**667,228**
Employee Benefits (excluding capitalised costs)				
Employee Benefits associated with PCTMS	**2,590**	0	2,590	3,686
Trust led PDS and PCT DS	**0**	0	0	0
PCT Officer Board Members	**431**	431	0	291
Other Employee Benefits	**10,414**	8,590	1,824	11,919
Total Employee Benefits charged to SOCNE	**13,435**	**9,021**	**4,414**	**15,896**
Total Operating Costs	**699,183**	**16,896**	**682,287**	**683,124**
Analysis of grants reported in total operating costs				
For capital purposes				
Grants to fund Capital Projects - GMS	**188**	0	188	60
Grants to Local Authorities to Fund Capital Projects	**0**	0	0	0
Grants to Private Sector to Fund Capital Projects	**0**	0	0	0
Grants to Fund Capital Projects - Dental	**0**	0	0	0
Grants to Fund Capital Projects - Other	**0**	0	0	0
Total Capital Grants	**188**	**0**	**188**	**60**
Grants to fund revenue expenditure				
To Local Authorities	**0**	0	0	0
To Private Sector	**0**	0	0	0
To Other	**0**	0	0	0
Total Revenue Grants	**0**	**0**	**0**	**0**
Total Grants	**188**	**0**	**188**	**60**

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**14,442**	13,982	460
Weighted population (number in units)*	**405,756**	405,756	405,756
Running costs per head of population (£ per head)	**£ 35.59**	**£ 34.46**	**£ 1.13**
PCT Running Costs 2011-12			
Running costs (£000s)	**14,759**	13,895	864
Weighted population (number in units)	**405,756**	405,756	405,756
Running costs per head of population (£ per head)	**£ 36.37**	**£ 34.24**	**£ 2.13**

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

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

5.2 Analysis of operating expenditure by expenditure classification	2012-13 £000	2011-12 £000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	50,861	46,068
Prescribing costs	60,759	64,441
Contractor led GDS & PDS	22,323	20,907
Trust led GDS & PDS	36	43
General Ophthalmic Services	4,142	4,181
Department of Health Initiative Funding	0	0
Pharmaceutical services	0	0
Local Pharmaceutical Services Pilots	0	0
New Pharmacy Contract	15,127	14,383
Non-GMS Services from GPs	904	563
Other	7,744	7,744
Total Primary Healthcare purchased	**161,896**	158,330
Purchase of Secondary Healthcare		
Learning Difficulties	3,981	4,013
Mental Illness	52,602	53,456
Maternity	20,159	21,962
General and Acute	299,761	282,135
Accident and emergency	12,974	12,906
Community Health Services	73,741	74,501
Other Contractual	36,190	33,204
Total Secondary Healthcare Purchased	**499,408**	482,177
Grant Funding		
Grants for capital purposes	188	60
Grants for revenue purposes	0	0
Total Healthcare Purchased by PCT	**661,492**	**640,567**
PCT self-provided secondary healthcare included above	0	0
Social Care from Independent Providers	253	0
Healthcare from NHS FTs included above	320,223	310,907

6. Operating Leases

The PCT leases a range of office accommodation for administration staff, and a number of health centres and clinics to facilitate the provision by itself, or other health care contractors of primary and community care services.

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				**1,939**	2,018
Contingent rents				**0**	0
Sub-lease payments				**367**	0
Total				**2,306**	**2,018**
Payable:					
No later than one year	**0**	**1,462**	**21**	**1,483**	1,826
Between one and five years	**0**	**4,402**	**9**	**4,411**	4,282
After five years	**0**	**6,286**	**0**	**6,286**	5,208
Total	**0**	**12,150**	**30**	**12,180**	**11,316**

Total future sublease payments expected to be received	0	56

The PCT has no renewal options beyond the term of the lease and has no purchase options contained in any of its leases.

6.2 PCT as lessor

The PCT leases a number of health centres and clinics to primary care contractors and care homes to care providers.

	2012-13 £000	2011-12 £000
Recognised as income		
Rental Revenue	**5,539**	5,506
Contingent rents	**0**	0
Total	**5539**	5,506
Receivable:		
No later than one year	**541**	5,506
Between one and five years	**0**	0
After five years	**0**	0
Total	**541**	5,506

7. Employee benefits and staff numbers

The staff costs of South East Essex PCT and South West Essex PCT (which form the South Essex Cluster) are shared and split on a weighted capitation basis, with South East Essex PCT recognising 46% of the staff costs and South West Essex PCT recognising 54%.

7.1 Employee benefits

	2012-13								
				Permanently employed			Other		
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Employee Benefits - Gross Expenditure									
Salaries and wages	11,372	7,731	3,641	8,480	6,178	2,302	2,892	1,553	1,339
Social security costs	689	540	149	689	540	149	0	0	0
Employer Contributions to NHS BSA - Pensions Division	935	704	231	935	704	231	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	46	46	0	46	46	0	0	0	0
Termination benefits	393	0	393	393	0	393	0	0	0
Total employee benefits	13,435	9,021	4,414	10,543	7,468	3,075	2,892	1,553	1,339
Less recoveries in respect of employee benefits (table below)	(1,052)	(1,024)	(28)	(1,052)	(1,024)	(28)	0	0	0
Total - Net Employee Benefits including capitalised costs	12,383	7,997	4,386	9,491	6,444	3,047	2,892	1,553	1,339
Employee costs capitalised	0	0	0	0	0	0	0	0	0
Gross Employee Benefits excluding capitalised costs	13,435	9,021	4,414	10,543	7,468	3,075	2,892	1,553	1,339
Recognised as:									
Commissioning employee benefits	13,435			10,543			2,892		
Provider employee benefits	0			0			0		
Gross Employee Benefits excluding capitalised costs	13,435			10,543			2,892		

	2012-13								
				Permanently employed			Other		
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Employee Benefits - Revenue									
Salaries and wages	868	845	23	868	845	23	0	0	0
Social Security costs	78	76	2	78	76	2	0	0	0
Employer Contributions to NHS BSA - Pensions Division	106	103	3	106	103	3	0	0	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other Post Employment Benefits	0	0	0	0	0	0	0	0	0
Other Employment Benefits	0	0	0	0	0	0	0	0	0
Termination Benefits	0	0	0	0	0	0	0	0	0
TOTAL excluding capitalised costs	1,052	1,024	28	1,052	1,024	28	0	0	0

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	11,593	9,524	2,069
Social security costs	887	887	0
Employer Contributions to NHS BSA - Pensions Division	1,214	1,214	0
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	79	79	0
Termination benefits	2,123	2,123	0
Total gross employee benefits	15,896	13,827	2,069
Less recoveries in respect of employee benefits	0	0	0
Total - Net Employee Benefits including capitalised costs	15,896	13,827	2,069
Employee costs capitalised	0	0	0
Gross Employee Benefits excluding capitalised costs	15,896	13,827	2,069
Recognised as:			
Commissioning employee benefits	15,896		
Provider employee benefits	0		
Gross Employee Benefits excluding capitalised costs	15,896		

7.2 Staff Numbers

	2012-13			2011-12		
	Total Number	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number
Average Staff Numbers						
Medical and dental	10	5	5	20.80	11.60	9.20
Ambulance staff	0	0	0	0.00	0.00	0.00
Administration and estates	187	169	18	210.90	202.00	8.90
Healthcare assistants and other support staff	2	2	0	3.20	3.20	0.00
Nursing, midwifery and health visiting staff	21	12	9	12.50	11.40	1.10
Nursing, midwifery and health visiting learners	1	1	0	0.80	0.80	0.00
Scientific, therapeutic and technical staff	0	0	0	4.40	4.40	0.00
Social Care Staff	0	0	0	0.00	0.00	0.00
Other	0	0	0	0.00	0.00	0.00
TOTAL	221	189	32	252.60	233.40	19.20
Of the above - staff engaged on capital projects	0	0	0	0	0	0

Current year has been shown as whole number in accordance with the Manual for Accounts.

7.3 Staff Sickness absence and ill health retirements

	2012-13 Number	2011-12 Number
Total Days Lost	2,471	14,554
Total Staff Years	378	1,535
Average working Days Lost	6.5	9.5

Information on Staff Sickness absence is based on the calendar years 2011 and 2012.

	2012-13 Number	2011-12 Number
Number of persons retired early on ill health grounds	0	0

	£000s	£000s
Total additional pensions liabilities accrued in the year	0	0

7.4 Exit Packages agreed during 2012-13

	2012-13			2011-12		
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
	Number	Number	Number	Number	Number	Number
Less than £10,000	4	0	4	5	3	8
£10,001-£25,000	3	1	4	2	6	8
£25,001-£50,000	3	0	3	2	4	6
£50,001-£100,000	3	0	3	2	9	11
£100,001 - £150,000	1	0	1	3	0	3
£150,001 - £200,000	0	0	0	1	0	1
>£200,000	1	0	1	2	0	2
Total number of exit packages by type (total cost	15	1	16	17	22	39
	£s	£s	£s	£s	£s	£s
Total resource cost	765,356	16,025	781,381	1,201,907	921,114	2,123,021

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 South West Essex PCT 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.

The following is a summary of the redundancies as a result of the national restructure across Essex. In addition to these Essex wide numbers there maybe some Exit packages local to the individual PCTs.

	2012-13		
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
	Number	Number	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 (total cost	66	0	66
	£000s	£000s	£000s
Total resource cost	3,706	0	3,706

7.5 Pension costs

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

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2013, is based on the valuation data as 31 March 2012, updated to 31 March 2013 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

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

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

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

8. Better Payment Practice Code

8.1 Measure of compliance

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**14,953**	**53,346**	13,882	51,401
Total Non-NHS Trade Invoices Paid Within Target	**12,302**	**44,555**	12,297	43,933
Percentage of NHS Trade Invoices Paid Within Target	82.27%	83.52%	88.58%	85.47%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**4,263**	**523,408**	4,009	522,391
Total NHS Trade Invoices Paid Within Target	**3,335**	**515,708**	3,446	515,714
Percentage of NHS Trade Invoices Paid Within Target	78.23%	98.53%	85.96%	98.72%

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

	2012-13 £000	2011-12 £000
Amounts included in finance costs from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**0**	0

9. Investment Income

There is no Rental or Interest income in 2012-13 or 2011-12.

10. Other Gains and Losses

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Gain/(Loss) on disposal of assets other than by sale (PPE)	(617)	(95)	(522)	0
Gain/(Loss) on disposal of assets other than by sale (intangibles)	0	0	0	0
Total	(617)	(95)	(522)	0

11. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest				
Interest on obligations under PFI contracts:				
- main finance cost	1,706	0	1,706	1,732
- contingent finance cost	223	0	223	165
Interest on late payment of commercial debt	0	0	0	0
Other interest expense	0	0	0	0
Total interest expense	1,929	0	1,929	1,897
Other finance costs	0	0	0	0
Provisions - unwinding of discount	37		37	61
Total	1,966	0	1,966	1,958

12.1 Property, plant and equipment

2012-13	Land	Buildings excluding dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:								
At 1 April 2012	**11,732**	**36,302**	**818**	**1,826**	**18**	**1,874**	**1,221**	**53,791**
Additions of Assets Under Construction			0					**0**
Additions Purchased	0	239		0	0	443	0	**682**
Additions Leased	0	0		0	0	0	0	**0**
Reclassifications	(7)	82	(818)	(26)	0	623	(10)	**(156)**
Disposals other than for sale	0	(221)	0	(1,380)	0	(357)	(391)	**(2,349)**
Upward revaluation/positive indexation	265	1,216	0	0	0	0	0	**1,481**
Impairments/negative indexation	0	(815)	0	(2)	0	(10)	0	**(827)**
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	**0**
At 31 March 2013	**11,990**	**36,803**	**0**	**418**	**18**	**2,573**	**820**	**52,622**
Depreciation								
At 1 April 2012	**0**	**2,940**	**0**	**888**	**6**	**1,426**	**871**	**6,131**
Reclassifications	0	76		(29)	0	0	(47)	**0**
Reclassifications as Held for Sale	0	0		0	0	0	0	**0**
Disposals other than for sale	0	(218)		(792)	0	(357)	(365)	**(1,732)**
Upward revaluation/positive indexation	0	0		0	0	0	0	**0**
Impairments	0	655	0	44	0	159	3	**861**
Reversal of Impairments	0	(1,422)	0	0	0	0	0	**(1,422)**
Charged During the Year	0	1,149		163	2	358	154	**1,826**
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	**0**
At 31 March 2013	**0**	**3,180**	**0**	**274**	**8**	**1,586**	**616**	**5,664**
Net Book Value at 31 March 2013	**11,990**	**33,623**	**0**	**144**	**10**	**987**	**204**	**46,958**
Purchased	11,990	33,623	0	144	10	987	204	**46,958**
Donated	0	0	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	0	0	**0**
Total at 31 March 2013	**11,990**	**33,623**	**0**	**144**	**10**	**987**	**204**	**46,958**
Asset financing:								
Owned	11,990	15,535	0	144	10	987	204	**28,870**
Held on finance lease	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	18,088	0	0	0	0	0	**18,088**
PFI residual: interests	0	0	0	0	0	0	0	**0**
Total at 31 March 2013	**11,990**	**33,623**	**0**	**144**	**10**	**987**	**204**	**46,958**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	**5,057**	**5,283**	**0**	**4**	**0**	**0**	**0**	**10,344**
Movements (specify)	283	(16)	0	(3)	0	0	0	**264**
At 31 March 2013	**5,340**	**5,267**	**0**	**1**	**0**	**0**	**0**	**10,608**

Additions to Assets Under Construction in 2012-13

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

12.2 Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:								
At 1 April 2011	**11,768**	**37,004**	**147**	**1,813**	**18**	**1,858**	**1,157**	**53,765**
Additions - purchased	0	246	819	13	0	16	0	**1,094**
Reclassifications	(190)	274	(148)	0	0	0	64	**0**
Disposals other than by sale	0	(900)	0	0	0	0	0	**(900)**
Revaluation & indexation gains	154	0	0	0	0	0	0	**154**
Impairments	0	(322)	0	0	0	0	0	**(322)**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluatio	0	0	0	0	0	0	0	**0**
At 31 March 2012	**11,732**	**36,302**	**818**	**1,826**	**18**	**1,874**	**1,221**	**53,791**
Depreciation								
At 1 April 2011	**0**	**2,558**		**659**	**3**	**911**	**702**	**4,833**
Reclassifications		0		0	0	0	0	**0**
Reclassifications as Held for Sale	0	0		0	0	0	0	**0**
Disposals other than for sale	0	(900)		0	0	0	0	**(900)**
Upward revaluation/positive indexation	0	(62)		0	0	0	0	**(62)**
Impairments	0	166	0	0	0	0	0	**166**
Reversal of Impairments	0	0	0	0	0	0	0	**0**
Charged During the Year	0	1,178		229	3	515	169	**2,094**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluatio	0	0	0	0	0	0	0	**0**
At 31 March 2012	**0**	**2,940**	**0**	**888**	**6**	**1,426**	**871**	**6,131**
Net Book Value at 31 March 2012	**11,732**	**33,362**	**818**	**938**	**12**	**448**	**350**	**47,660**
Purchased	11,732	33,362	818	938	12	448	350	**47,660**
Donated	0	0	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	0	0	**0**
At 31 March 2012	**11,732**	**33,362**	**818**	**938**	**12**	**448**	**350**	**47,660**
Asset financing:								
Owned	11,732	16,310	818	938	12	448	350	**30,608**
Held on finance lease	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	17,052	0	0	0	0	0	**17,052**
PFI residual: interests	0	0	0	0	0	0	0	**0**
At 31 March 2012	**11,732**	**33,362**	**818**	**938**	**12**	**448**	**350**	**47,660**

12.3 Property, plant and equipment

Note 1.6 summarises the PCT's valuation policy in respect of property, plant and equipment. Up until 2008-09 the PCT's accounting policy was for non-current assets to be valued every five years, with indexation applied annually in between. From 1 April 2009, in line with HM Treasury guidance this policy has been changed to 5 year valuations and no indexation in year. Consequently these assets were subject to formal revaluation by the District Valuer as at 1 April 2009. This was on a Modern Equivalent Asset basis.

Due to the fluctuation in the property prices a DV valuation of all Freehold properties was carried out by the District Valuer at 31 March 2013. This was on a Modern Equivalent Asset basis. There has been revaluations and impairments recognised in the period, £827k of impairments and £1,481k of revaluations charged to revaluation reserve and £861k of impairments and £1,422k revaluations charged to SOCNE, and and such transactions are considered routine.

Non-current assets are depreciated or amortised to write off their costs, less any residual value over which the PCT expects to obtain economic benefits or service potential from the individual 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.

13.1 Intangible non-current assets

2012-13	Software internally generated £000	Software purchased £000	Total £000
At 1 April 2012	**0**	**812**	**812**
Additions - purchased	0	4	**4**
Reclassifications	0	156	**156**
Impairments	0	(4)	**(4)**
In-year transfers to/from NHS bodies	0	0	**0**
At 31 March 2013	**0**	**968**	**968**
Amortisation			
At 1 April 2012	**0**	**326**	**326**
Impairments charged to operating expenses	0	46	**46**
Charged during the year	0	375	**375**
In-year transfers to NHS bodies	0	0	**0**
At 31 March 2013	**0**	**747**	**747**
Net Book Value at 31 March 2013	**0**	**221**	**221**
Net Book Value at 31 March 2013 comprises			
Purchased	0	221	**221**
Donated	0	0	**0**
Government Granted	0	0	**0**
Total at 31 March 2013	**0**	**221**	**221**

Revaluation reserve balance for intangible non-current assets

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

13.2 Intangible non-current assets

2011-12	Software internally generated £000	Software purchased £000	Total £000
At 1 April 2011	**0**	**812**	**812**
Additions - purchased	0	0	**0**
Reclassifications	0	0	**0**
Impairments	0	0	**0**
In-year transfers to/from NHS bodies	0	0	**0**
At 31 March 2012	**0**	**812**	**812**
Amortisation			
At 1 April 2011	**0**	**30**	**30**
Impairments charged to operating expenses	0	0	**0**
Charged during the year	0	296	**296**
In-year transfers to NHS bodies	0	0	**0**
At 31 March 2012	**0**	**326**	**326**
Net Book Value at 31 March 2012	**0**	**486**	**486**
Net Book Value at 31 March 2012 comprises			
Purchased	0	486	**486**
Donated	0	0	**0**
Government Granted	0	0	**0**
Total at 31 March 2012	**0**	**486**	**486**

13.3 Intangible non-current assets

The PCT's accounting policies in respect of Intangible non-current assets are set out in Notes 1.7 and 1.8.

All intangible non-current assets held by the PCT are software licenses, which are capitalised at cost, and

	Min Life Years	Max Life Years
Intangible Assets		
Software Licences	0	2
Property, Plant and Equipment		
Buildings exc Dwellings	0	54
Plant & Machinery	0	9
Transport Equipment	4	4
Information Technology	0	6
Furniture and Fittings	0	8

Open Market Value of Assets at balance sheet date	**Land**	**Buildings excl. dwellings**	**Dwellings**
	£000s	**£000s**	**£000s**
Open Market Value at 31 March 2013	0	0	0

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

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000
Property, Plant and Equipment impairments and reversals taken to SoCNE			
Loss or damage resulting from normal operations	140	140	0
Over-specification of assets	0	0	0
Abandonment of assets in the course of construction	0	0	0
Total charged to Departmental Expenditure Limit	140	140	0
Unforeseen obsolescence	713		713
Loss as a result of catastrophe	0		0
Changes in market price	(1,414)		(1,414)
Total charged to Annually Managed Expenditure	(701)		(701)
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Loss or damage resulting from normal operations	0		
Over Specification of Assets	0		
Unforeseen obsolescence	55		
Loss as a result of catastrophe	0		
Changes in market price	772		
Total impairments for PPE charged to reserves	827		
Total Impairments of Property, Plant and Equipment	266	140	(701)
Intangible assets impairments and reversals charged to SoCNE			
Loss or damage resulting from normal operations	0	0	0
Over-specification of assets	0	0	0
Total charged to Departmental Expenditure Limit	0	0	0
Unforeseen obsolescence	46		46
Loss as a result of catastrophe	0		0
Changes in market price	0		0
Total charged to Annually Managed Expenditure	46		46
Intangible Assets impairments and reversals charged to the Revaluation Reserve			
Loss or damage resulting from normal operations	0		
Over-specification of assets	0		
Unforeseen obsolescence	0		
Loss as a result of catastrophe	0		
Changes in market price	4		
Total impairments for Intangible Assets charged to Reserves	4		
Total Impairments of Intangibles	50	0	46
Financial Assets charged to SoCNE			
Loss or damage resulting from normal operations	0	0	0
Total charged to Departmental Expenditure Limit	0	0	0
Loss as a result of catastrophe	0		0
Other	0		0
Total charged to Annually Managed Expenditure	0		0
Financial Assets impairments and reversals charged to the Revaluation Reserve			
Loss or damage resulting from normal operations	0		
Loss as a result of catastrophe	0		
TOTAL impairments for Financial Assets charged to reserves	0		
Total Impairments of Financial Assets	0	0	0
Non-current assets held for sale - impairments and reversals charged to SoCNE.			
Loss or damage resulting from normal operations	0	0	0
Abandonment of assets in the course of construction	0	0	0
Total charged to Departmental Expenditure Limit	0	0	0
Unforeseen obsolescence	0		0
Loss as a result of catastrophe	0		0
Changes in market price	0		0
Total charged to Annually Managed Expenditure	0		0
Total impairments of non-current assets held for sale	0	0	0
Inventories - impairments and reversals charged to SoCNE			
Loss or Damage Resulting from Normal Operations	0	0	0
Total charged to Departmental Expenditure Limit	0	0	0
Unforeseen Obsolescence	0		0
Loss as a Result of a Catastrophe	0		0
Changes in Market Price	0		0
Total charged to Annually Managed Expenditure	0		0
Total impairments of Inventories	0	0	0
Investment Property impairments charged to SoCNE			
Loss or Damage Resulting from Normal Operations	0	0	0
Total charged to Departmental Expenditure Limit	0	0	0
Unforeseen Obsolescence	0		0
Loss as a Result of a Catastrophe	0		0
Changes in Market Price	0		0
Total charged to Annually Managed Expenditure	0		0
Total Investment Property impairments charged to SoCNE	0	0	0
Investment Property impairments and reversals charged to the Revaluation Reserve			
Loss or Damage Resulting from Normal Operations	0		
Over Specification of Assets	0		
Unforeseen Obsolescence	0		
Loss as a Result of a Catastrophe	0		
Changes in Market Price	0		
TOTAL impairments for Investment Property charged to Reserves	0		
Total Investment Property Impairments	0	0	0
Total impairments charged to Revaluation Reserve	831		
Total impairments charged to SoCNE - DEL	140	140	0
Total impairments charged to SoCNE - AME	(655)		(655)
Overall Total Impairments	316	140	(655)
Of which:			
Impairment on revaluation to "modern equivalent asset" basis	(1,274)	140	(1,414)

Following a review of the PCT's Property, Plant and Equipment Non-Current Assets as at 31st March 2013 as a result of property maintenance and impairment of £655k was taken into the PCT's Statement of Comprehensive Net Expenditure.

15 Investment property

The PCT has no Investment Properties at 31 March 2013 (2012 £nil)

16 Commitments

The PCT has no Capital or Other Financial Commitments at 31 March 2013 (2012 £nil)

17 Intra-Government and other balances

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with other Central Government Bodies	1,594	0	5,064	0
Balances with Local Authorities	205	0	54	0
Balances with NHS Trusts and Foundation Trusts	489	0	11,766	0
Balances with bodies external to government	198	0	32,101	0
At 31 March 2013	**2,486**	**0**	**48,985**	**0**
prior period:				
Balances with other Central Government Bodies	836	0	3,457	0
Balances with Local Authorities	703	0	749	0
Balances with NHS Trusts and Foundation Trusts	397	0	6,071	0
Balances with bodies external to government	1,462	0	27,854	0
At 31 March 2012	**3,398**	**0**	**38,131**	**0**

18 Inventories

The PCT has no inventories at 31st March 2013 (31st March 2012 £nil)

19.1 Trade and other receivables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
NHS receivables - revenue	**327**	0	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**1,448**	1,054	**0**	0
Non-NHS receivables - revenue	**373**	505	**0**	0
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**25**	1,704	**0**	0
Provision for the impairment of receivables	**(25)**	(89)	**0**	0
VAT	**276**	178	**0**	0
Other receivables	**62**	46	**0**	0
Total	**2,486**	3,398	**0**	0
Total current and non current	**2,486**	3,398		
Included above:				
Prepaid pensions contributions	**0**	0		

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

19.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	**51**	50
By three to six months	**0**	55
By more than six months	**0**	53
Total	**51**	158

19.3 Provision for impairment of receivables

	2012-13 £000	**2011-12 £000**
Balance at 1 April 2012	**(89)**	(61)
Amount written off during the year	**80**	0
Amount recovered during the year	**0**	0
(Increase)/decrease in receivables impaired	**(16)**	(28)
Balance at 31 March 2013	**(25)**	(89)

20 NHS LIFT investments

The PCT has no NHS LIFT Investments at 31 March 2013 (31 March 2012 £nil).

21 Other financial assets - Current

The PCT has no Other Financial Assets at 31 March 2013 (31 March 2012 £nil).

22 Other current assets

The PCT has no Other Current Assets at 31 March 2013 (31 March 2012 £nil).

23 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**61**	146
Net change in year	**18,383**	(85)
Closing balance	**18,444**	61
Made up of		
Cash with Government Banking Service	**18,442**	59
Commercial banks	**0**	2
Cash in hand	**2**	0
Cash and cash equivalents as in statement of financial position	**18,444**	61
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**18,444**	61

The PCT has £nil Patients' money held by the PCT, not included above (2011-12 £nil).

24 Non-current assets held for sale

	Land	Buildings, excl. dwellings	Total
	£000	£000	£000
Balance at 1 April 2012	0	0	**0**
Plus assets classified as held for sale in the year	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	**0**
Transfers (to)/from other public sector bodies	0	0	**0**
Revaluation	0	0	**0**
Balance at 31 March 2013	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2013	**0**	**0**	**0**
Balance at 1 April 2011			**0**
Plus assets classified as held for sale in the year	0	0	**0**
Less assets sold in the year	0	0	**0**
Less impairment of assets held for sale	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	**0**
Balance at 31 March 2012	0	0	**0**
Liabilities associated with assets held for sale at 31 March 2012	0	0	**0**

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

At 31 March 2012	0
At 31 March 2013	0

25 Trade and other payables

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Interest payable	**0**	0		
NHS payables - revenue	**239**	0	**0**	0
NHS payables - capital	**37**	156	**0**	0
NHS accruals and deferred income	**16,303**	9,369	**0**	0
Family Health Services (FHS) payables	**13,919**	13,454		
Non-NHS payables - revenue	**325**	593	**0**	0
Non-NHS payables - capital	**203**	647	**0**	0
Non-NHS accruals and deferred income	**17,570**	13,902	**0**	0
Social security costs	**97**	0		
VAT	**0**	0	**0**	0
Tax	**154**	2		
Payments received on account	**0**	0	**0**	0
Other	138	8	0	0
Total	**48,985**	38,131	**0**	0
Total payables (current and non-current)	**48,985**	**38,131**		

Other payables include £0 (2011-12: £0) in respect of payments due in future years under arrangements to buy out the liability for early retirements over 5 instalments; and £120,561 (2011-12: £72) in respect of outstanding pensions contributions at 31 March 2013.

26 Other liabilities

The PCT has no Other Liabilities at 31 March 2013 (31 March 2012 £nil).

27 Borrowings

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Bank overdraft - Government Banking Service	**0**	0		
PFI liabilities:				
Main liability	**474**	446	**26,970**	27,445
Lifecycle replacement received in advance	**0**	0	**0**	0
Total	**474**	**446**	**26,970**	**27,445**
Total other liabilities (current and non-current)	**27,444**	**27,891**		

Borrowings/Loans - Payment of Principal Falling Due in:

	DH	Other	Total
	£000s	**£000s**	**£000s**
0 - 1 Years	0	474	**474**
1 - 2 Years	0	503	**503**
2 - 5 Years	0	1,708	**1,708**
Over 5 Years	0	24,759	**24,759**
TOTAL	**0**	**27,444**	**27,444**

28 Other financial liabilities

The PCT has no Other Financial Liabilities at 31 March 2013 (31 March 2012 £nil).

29 Deferred income

The PCT has no deferred income at 31 March 2013 (31 March 2012 £nil).

30 Finance lease obligations

The PCT has no finance lease obligations at 31 March 2013 and 31 March 2012 except for the imputed finance lease obligation in respect of the Brentwood Community Hospital PFI scheme, which is disclosed under Note 34.1 and 34.2.

31 Finance lease receivables as lessor

The PCT does not carry any Finance lease obligations as a Lessor.

32 Provisions

Comprising:

	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	**5,979**	223	1,536	333	0	1,526	1,328	1,033
Arising During the Year	**5,583**	9	201	77	0	5,277	19	0
Utilised During the Year	**(1,843)**	(16)	(1,031)	(26)	0	0	(236)	(534)
Reversed Unused	**(790)**	0	0	(46)	0	0	(744)	0
Unwinding of Discount	**37**	7	21	8	0	0	1	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	**8,966**	**223**	**727**	**346**	**0**	**6,803**	**368**	**499**
Expected Timing of Cash Flows:								
No Later than One Year	**2,333**	**16**	**63**	**26**	**0**	**1,361**	**368**	**499**
Later than One Year and not later than Five Years	**5,824**	**66**	**253**	**63**	**0**	**5,442**	**0**	**0**
Later than Five Years	**809**	**141**	**411**	**257**	**0**	**0**	**0**	**0**

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

The expected timing of cashflows have been estimated based on historic levels of expenditure and therefore actual expenditure may fluctuate from that which has been included in the accounts.

There were a number of new provisions arising in year. These related to :
- Provision for additional continuing care claims in process at 31 March 2013 (£5,277k)

The category "Other" includes the following provisions:
- A provision for a GP claim (£315k)
- Provision for NHSLA related claims from Community Services (£53k)

33 Contingencies

Further information has been included in Note 1.1 regarding the Estimation Uncertainty of the Continuing Healthcare Provision.

34 PFI and LIFT - additional information

	31 March 2013 £000	31 March 2012 £000
34.1 Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI		
Total charge to operating expenses in year - OFF SOFP PFI	0	0
Service element of on SOFP PFI charged to operating expenses in year	1,870	1,824
Total	1,870	1,824
Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI		
No Later than One Year	1,917	1,870
Later than One Year, No Later than Five Years	8,158	7,959
Later than Five Years	56,283	58,399
Total	66,358	68,228

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

	31 March 2013 £000	31 March 2012 £000
Estimated Capital Value of Project - off SOFP PFI	0	0
Value of Deferred Assets - off SOFP PFI	0	0
Value of Reversionary Interest - off SOFP PFI	0	0

34.2 Imputed "finance lease" obligations for on SOFP PFI contracts due		
Analysed by when PFI payments are due		
No Later than One Year	2,152	2,152
Later than One Year, No Later than Five Years	8,609	8,609
Later than Five Years	43,605	45,757
Subtotal	54,366	56,518
Less: Interest Element	(26,921)	(28,627)
Total	27,445	27,891

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

	31 March 2013 £000	31 March 2012 £000
Payments committed to in respect of off SOFP LIFT and the service element of on SOFP LIFT.		
LIFT Scheme Expiry Date:		
No Later than One Year	0	0
Later than One Year, No Later than Five Years	0	0
Later than Five Years	0	0
Total	0	0

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

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

Imputed "finance lease" obligations for on SOFP LIFT Contracts due	31 March 2013 £000	31 March 2012 £000
No Later than One Year	0	0
Later than One Year, No Later than Five Years	0	0
Later than Five Years	0	0
Subtotal	0	0
Less: Interest Element	0	0
Total	0	0

35 Impact of IFRS treatment - 2012-13

	Total £000	Admin £000	Programme £000
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g. LIFT/PFI)			
Depreciation charges	386	0	386
Interest Expense	1,929	0	1,929
Impairment charge - AME	0		0
Impairment charge - DEL	0	0	0
Other Expenditure	1,870	0	1,870
Revenue Receivable from subleasing	0	0	0
Total IFRS Expenditure (IFRIC12)	4,185	0	4,185
Revenue consequences of LIFT/PFI schemes under UK GAAP / ESA95 (net of any sublease income)	(60)	0	(60)
Net IFRS change (IFRIC12)	4,125	0	4,125

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

36 Financial Instruments

Financial risk management

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

Currency risk

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

Interest rate risk

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

Credit Risk

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

Liquidity Risk

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

36.1 Financial Assets	At 'fair value through profit and loss' £000	Loans and receivables £000	Total £000
Embedded derivatives	0		**0**
Receivables - NHS		327	**327**
Receivables - non-NHS		410	**410**
Cash at bank and in hand		18,444	**18,444**
Other financial assets	0	0	**0**
Total at 31 March 2013	**0**	**19,181**	**19,181**
Embedded derivatives	0		0
Receivables - NHS		0	0
Receivables - non-NHS		462	462
Cash at bank and in hand		61	61
Other financial assets	0	0	0
Total at 31 March 2012	0	523	523

36.2 Financial Liabilities	At 'fair value through profit and loss' £000	Other £000	Total £000
Embedded derivatives	0		**0**
NHS payables		16,579	**16,579**
Non-NHS payables		32,406	**32,406**
PFI & finance lease obligations		27,444	**27,444**
Other financial liabilities	0	0	**0**
Total at 31 March 2013	**0**	**76,429**	**76,429**
Embedded derivatives	0		0
NHS payables		9,525	9,525
Non-NHS payables		28,606	28,606
PFI & finance lease obligations		27,891	27,891
Other financial liabilities	0	0	0
Total at 31 March 2012	0	66,022	66,022

The carrying value of the financial instruments is the same as the fair value.

37. Related party transactions 2012-13

Details of related party transactions with individuals are as follows:

Name	Relationship	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
		£	£	£	£
Dr A Chopra	GP with the Ghajed Practice and employed as the Medical Director at the PCT	1,039,516	-	1,120	-
Dr N Tresidder	GP at his own Practice and employed as the Assistant Medical Director at the PCT	1,355,150	-	-	-

During the year the PCT has contracted with South Essex Partnership NHS Foundation Trust. Dawn Scrafield (Director of Finance of the PCT Cluster) is married to the Deputy Chief Finance Officer of South Essex partnership NHS Foundation Trust.

The Department of Health is regarded as a related party. During the year South East Essex PCT has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. The following is a list of NHS organisations with transactions in excess of £1m. These include related parties with the Specialised Commissioning Group, which is hosted by South East Essex PCT

Barking, Havering and Redbridge Trust
Barts and the London NHS Trust
Basildon and Thurrock University Hospital NHS Foundation Trust
Dartford and Gravesham NHS Trust
East Of England NHS Trust
Mid Essex Hospital Services NHS Trust
North East London Foundation Trust
Royal National Orthopedic Hospital Trust
South East Essex PCT
South Essex Partnership Foundation Trust
Southend Univeristy Hospital Foundation Trust
West Essex PCT

In addition, the PCT has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Thurrock Borough Council and Essex County Council.

37. Related party transactions 2011-12

Details of related party transactions with individuals are as follows:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£	£	£	£
Dr A Chopra (Medical Director)	1,062,916	-	23,266	-
Dr N Tresidder (Assistant Medical Director)	1,223,624	-	57,367	-

The PCT has contracted with South East Essex Primary Care Trust and South Essex Partnership NHS Foundation Trust. Dawn Scrafield's partner was Director of Finance for South East Essex PCT from April 2011 to September 2011 and then Assistant Chief Finance Officer at South Essex Partnership Foundation Trust from November 2011 to March 2012.

The Department of Health is regarded as a related party. During the year South East Essex 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.

Barking, Havering and Redbridge Trust
Barts and the London NHS Trust
Basildon and Thurrock University Hospital NHS Foundation Trust
Dartford and Gravesham NHS Trust
East Of England Ambulance Trust
Havering PCT
Mid Essex Hospitals NHS Trust
Mid Essex PCT
North East Essex PCT
North East London Foundation Trust
Royal Free Hampstead Trust
Royal National Orthopedic Hospital Trust
South East Essex PCT
South Essex Partnership Foundation Trust
Southend Univeristy Hospital Foundation Trust
West Essex PCT

In addition, the PCT has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Thurrock Unitary Authority and Essex County Council.

38 Losses and special payments

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

	Total Value of Cases £s	Total Number of Cases
Losses - PCT management costs	79,910	15
Special payments - PCT management costs	72409	14
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	79,910	15
Total special payments	72,409	14
Total losses and special payments	152,319	29

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	5,124	5
Special payments - PCT management costs	35260	6
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	5,124	5
Total special payments	35,260	6
Total losses and special payments	40,384	11

Details of cases individually over £250,000
There were no individual losses over £250,000

39 Third party assets

The PCT does not hold any third party assets.

40. Pooled budgets

The PCT does not have any pooled budgets,

41. Cashflows relating to exceptional items

There was no cashflow relating to exceptional items.

42. Events after the end of the reporting period

The financial statements on pages 1 to 4 were authorised for issue by the Audit Sub Committee on behalf of the Department of Health on 3 June 2013 following the demise of the PCT on the 31st March 2013.

42.1 Events after the end of the reporting period

The FMA forms include an (unaudited) analysis of the closing assets and liabilities and identify which organisations these balances are estimated to transfer to, with the net balances being as follows:

Future Body	£000s
Department of Health	-28,591
Clinical Commissioning Groups	-7,757
NHS England	893
NHS Trusts	0
Special Health Authorities, NDPBs & Other	0
NHS Foundation Trusts	8,890
NHS Property Services	9,279
Community Health Partnerships	0
Other	0
Balances held by PCT as 31st March 2013	**-17,286**

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 future bodies.

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

Future Body	Responsibilities
Clinical Commissioning Groups	Acute Care, Mental Health, Community Services, GP Prescribing
NHS England	Primary Care, Specialised Services, Offender Health, Military Health
Central Eastern Commissioning Support Unit	Management Services
NHS Property Services	Ownership and management of all premises
Local Authorities (Essex, Thurrock & Southend)	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 and other entities on 1st April 2013. These were considered operational at the year end, and so have not been impaired in the PCT books. It is for the successor body to consider whether, in 2013-14, it is necessary to review these for impairment.

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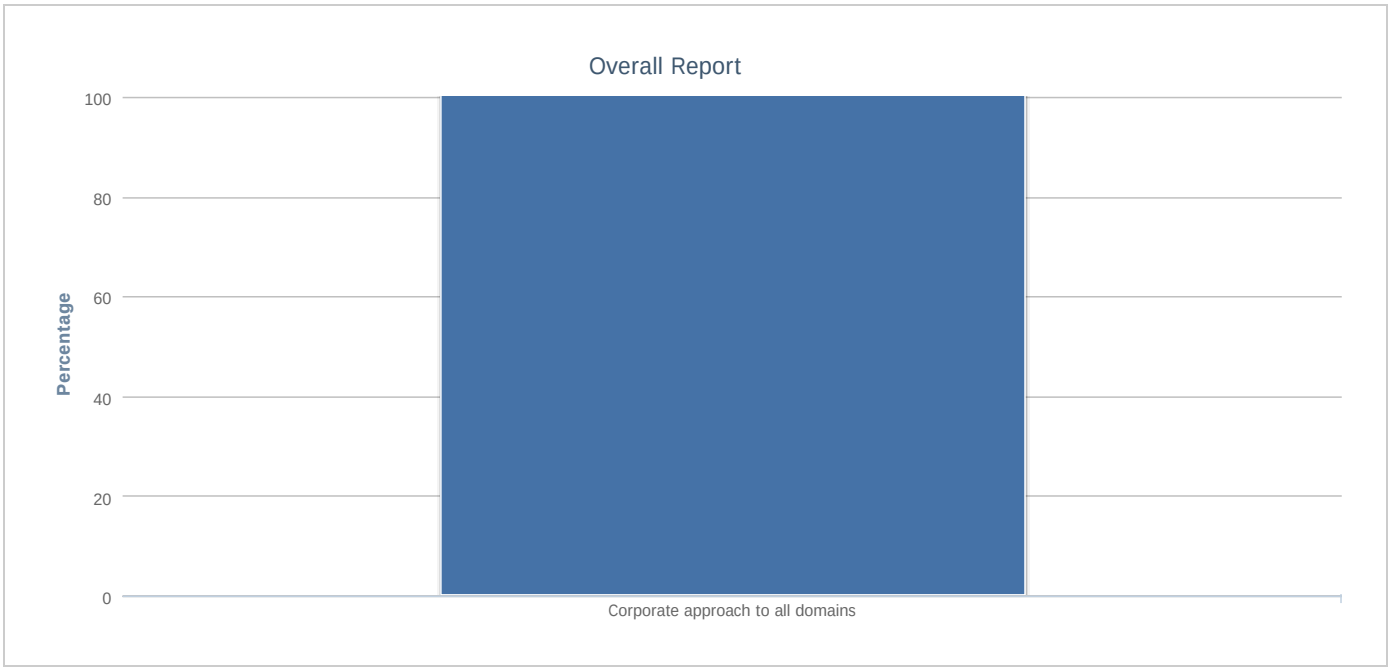

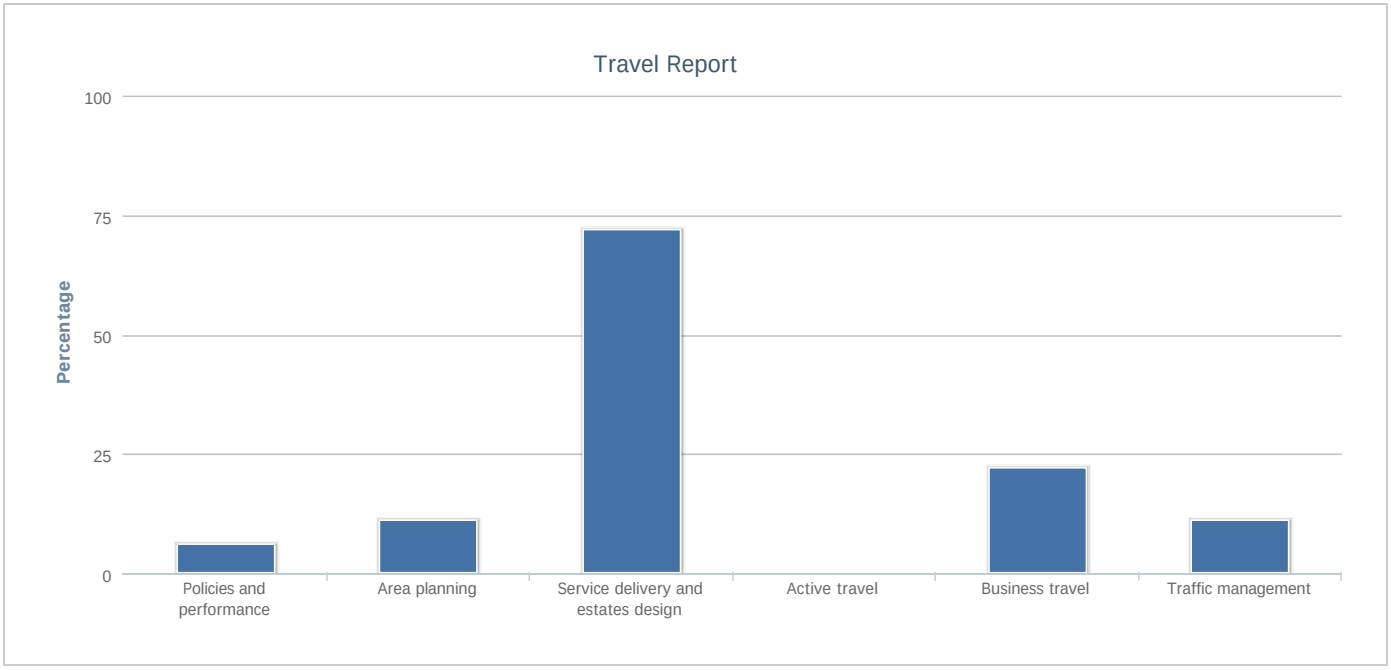

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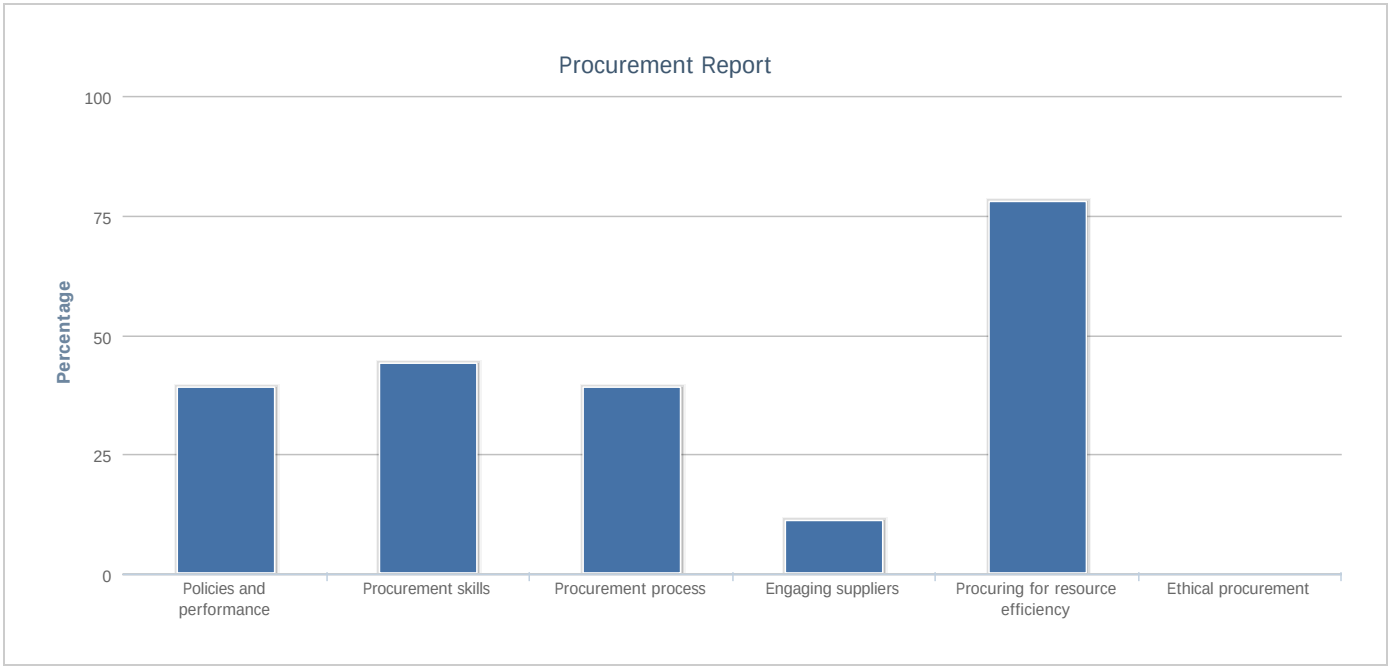

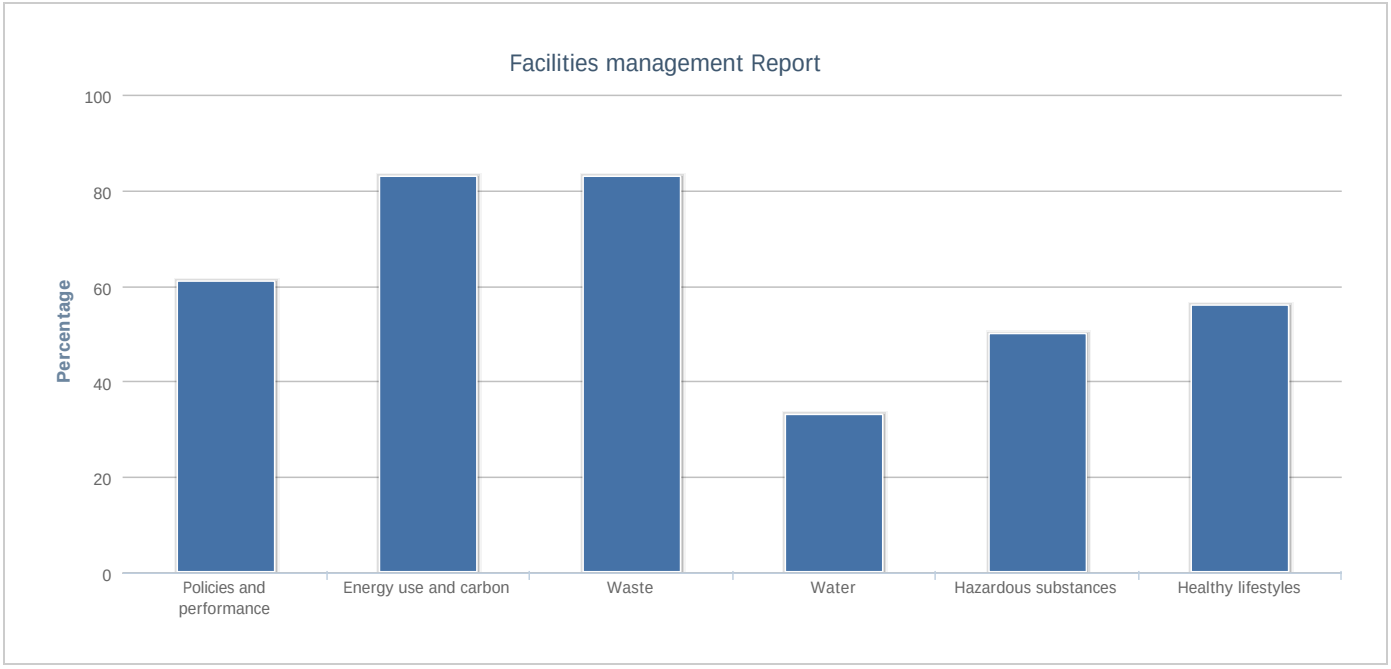

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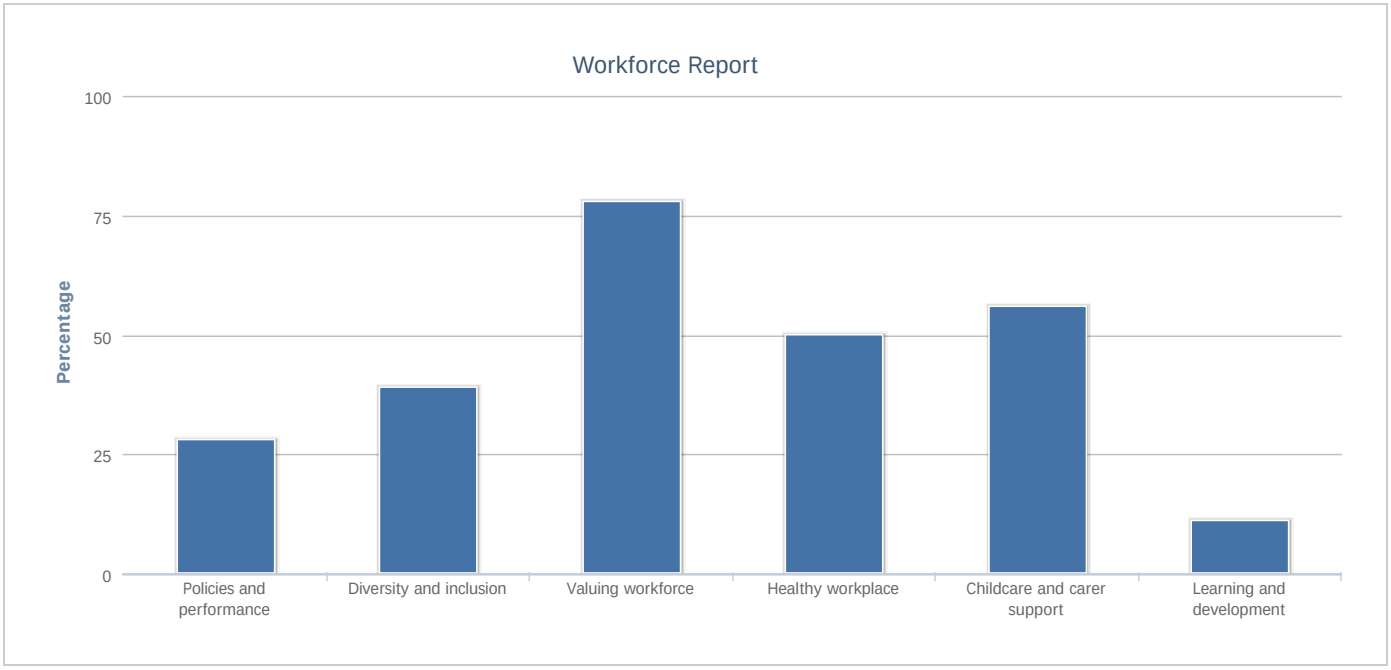

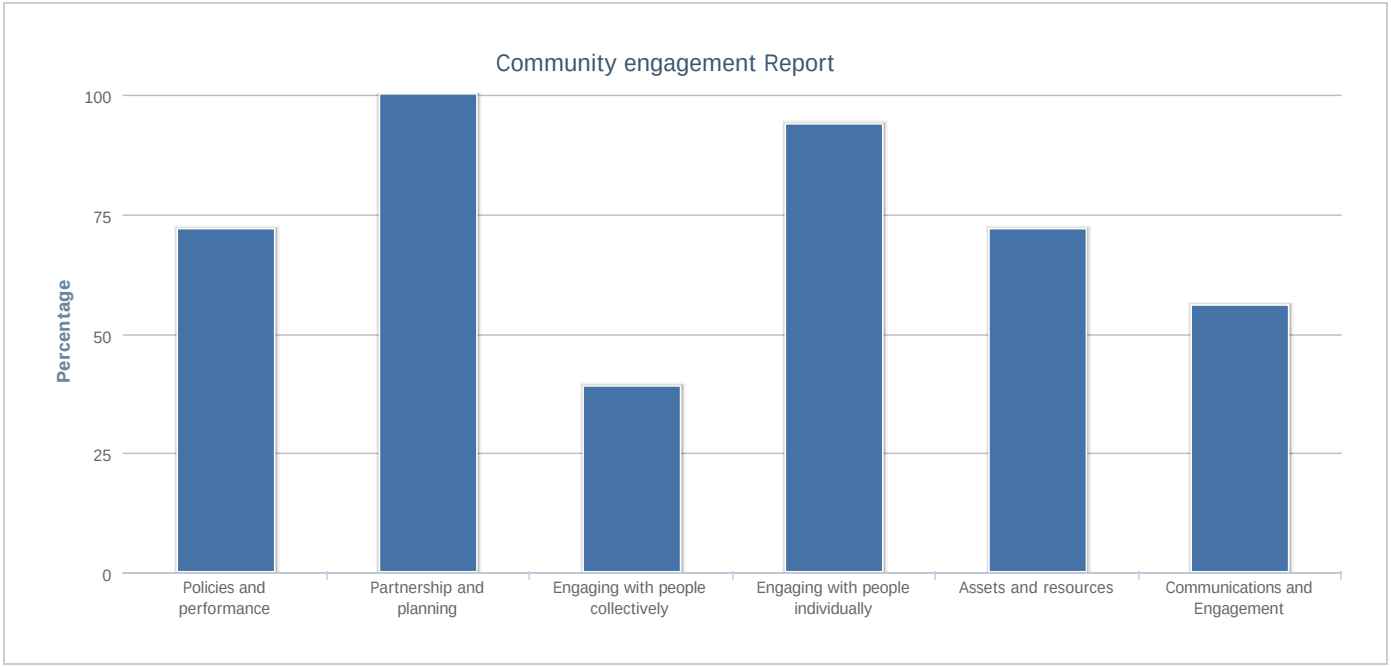

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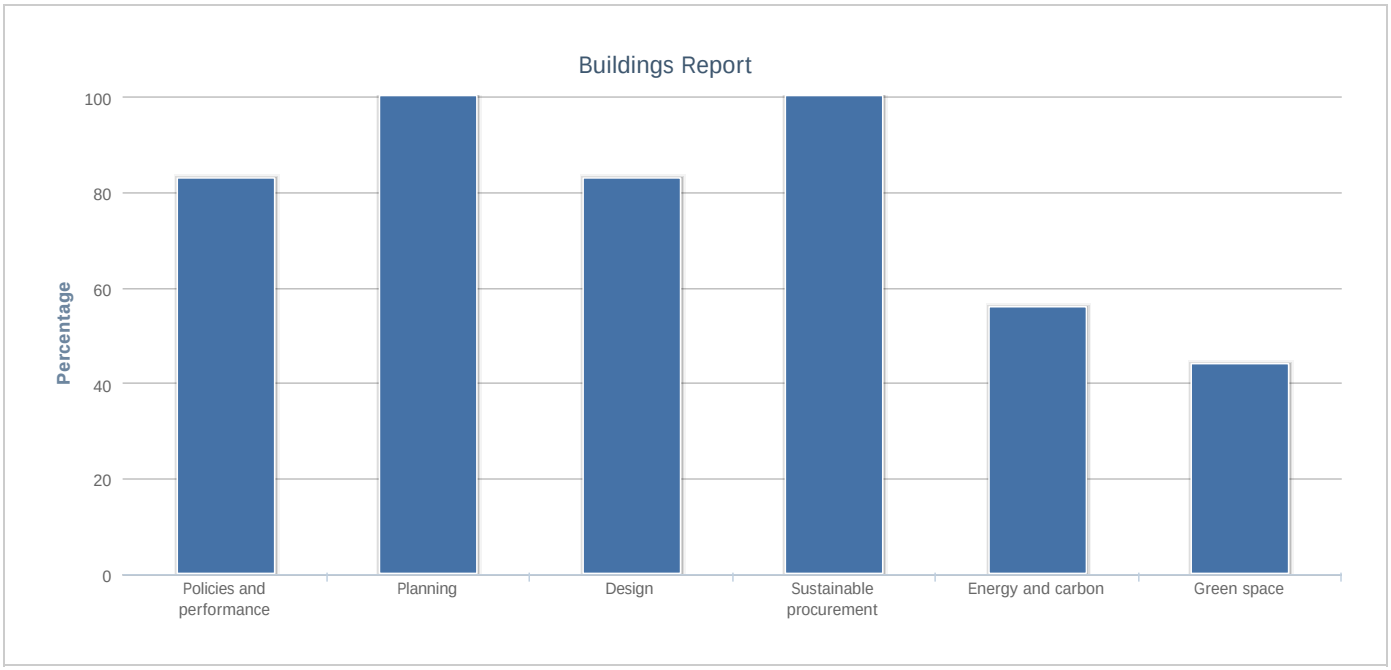
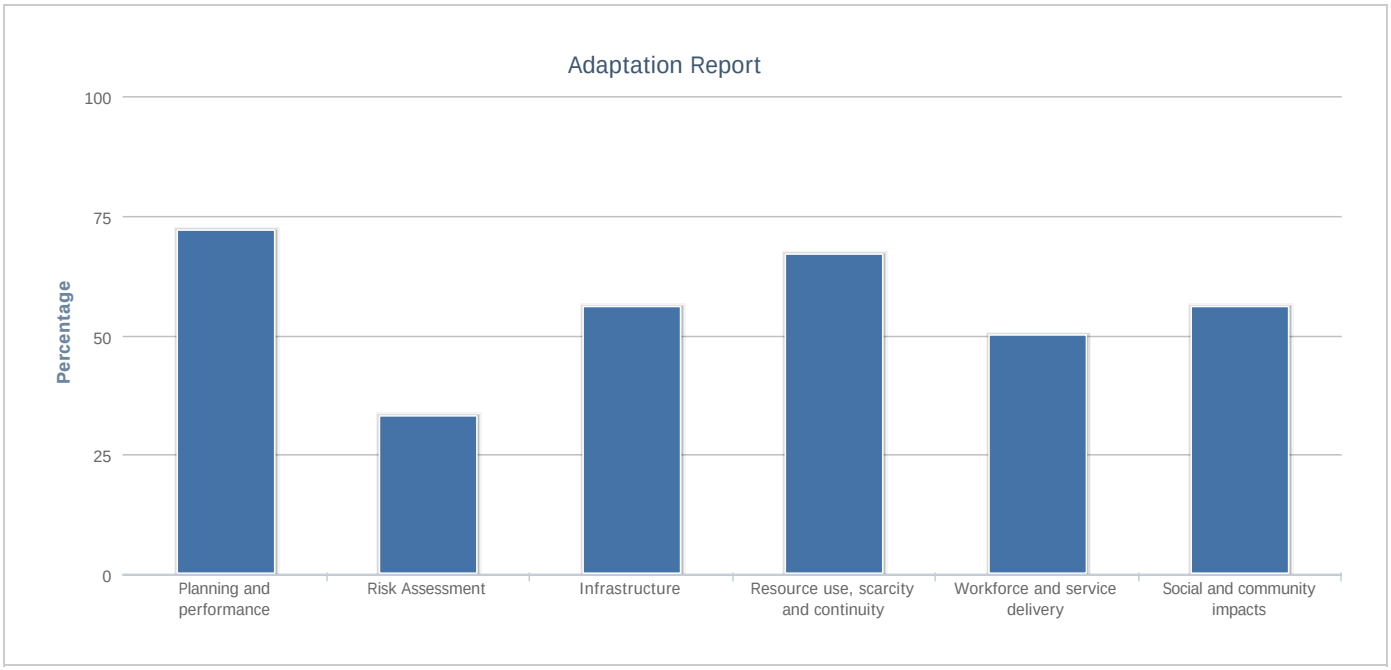
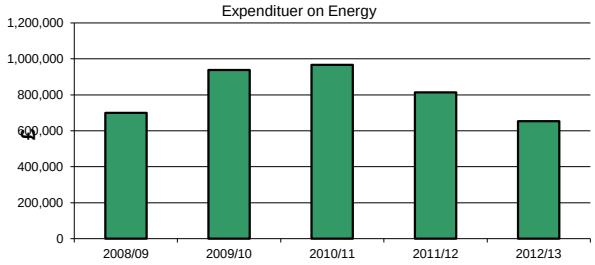




Appendix D

Sustainability Report

20%



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

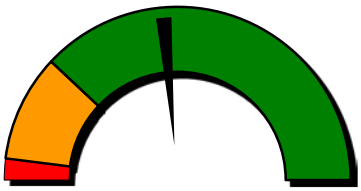
There is also a financial benefit which comes from reducing our energy bill.

By reducing our energy costs by 20% in 2012/13, we have saved £160,756, the equivalent of 29 hip operations.

£0,000

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

309 tonnes



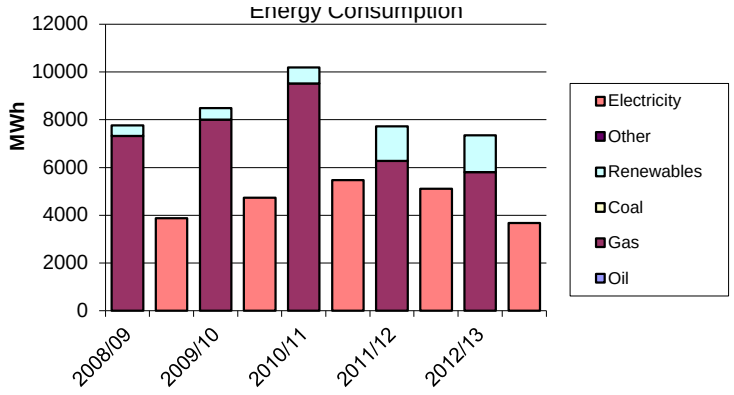
Percentage of Waste Recycled

We recover or recycle 309.17 tonnes of waste, which is 45% of the total waste we produce.

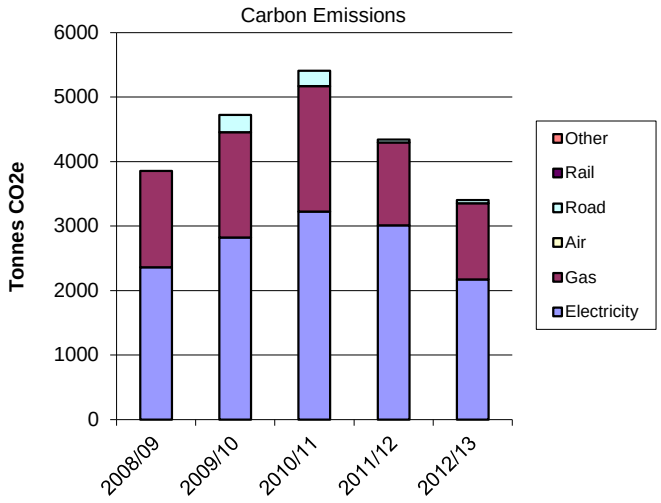
Energy Consumption

Our total energy consumption has fallen during the year, from 12,830 to 11,028 MWh

Our relative energy consumption has changed during the year, from 0.62 to 0.53 MWh/square metre.



Renewable energy represents 14.0% of our total energy use. We do not generate any energy. We have made arrangements to purchase electricity generated from renewable sources



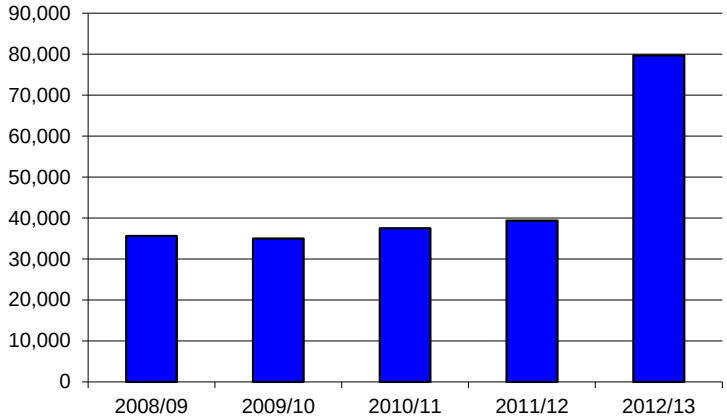
Our measured greenhouse gas emissions have reduced by 0,938 tonnes this year.

0

Water consumption in cubic metres

Our water consumption has increased by 40,314 cubic meters in the recent financial year.

In 2012/13 we spent £61,806 on water.

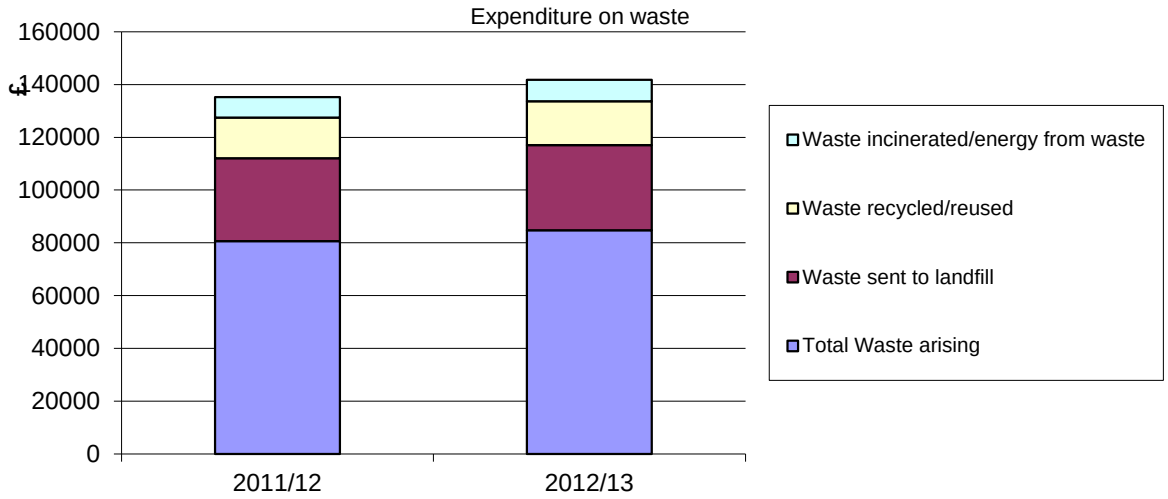


During 2012/13 our gross expenditure on the CRC Energy Efficiency Scheme was n/a

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

During 2012/13 our total expenditure on business travel was £71,394.

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 fulfils 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 both the potential need to adapt the organisation's activities and 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 is set out within our policies on sustainable procurement.

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

Margaret Hathaway 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.