Department of Health

NHS

South East Essex Primary Care Trust

2012-13 Annual Report and Accounts

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South East Essex Primary Care Trust

2012-13 Annual Report

NHS South East Essex
and NHS South West Essex

South East Essex PCT

Annual Report 2012/13

Contents

Foreword from Chair and Chief Executive

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

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

In 2011, we joined forces with NHS South West 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 East Essex finished the financial year with a surplus of £0.2m

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 disestablishment 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 East Essex is a primary care trust (PCT) for people who live in South Essex. As your local NHS we were allocated a budget every year for our local population. We used 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 East Essex has a GP-registered population of approximately 365,500 covering the boroughs of Castle Point and Southend-on-Sea and the district of Rochford.

We have a diverse geographical and demographic make-up, featuring significant areas of countryside in the Castle Point and Rochford areas, alongside the large urban settlement of Southend, which has over 10 times the average population density than Essex as a whole.

The borough of Castle Point and the district of Rochford have certain 'strategic' services such as social service, highways and education provided by Essex County Council, while the borough of Southend-on-Sea is a unitary authority (which means it is responsible for the provision of all local government services and is independent of Essex County Council). Therefore, NHS South East Essex is charged with working in partnership with both of these authorities, to ensure that inequalities in health and social care provision are avoided.

Our place in the NHS
NHS South East 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 West 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: Southend University Hospitals NHS Foundation Trust, 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 East Essex facts and figures

Location of our headquarters	Phoenix Court, Christopher Martin Road, Basildon, SS14 3HG The south east Essex Public Health team are based at • Southend-on-Sea Borough Council offices, Civic Centre, Southend • Essex County Council, County Hall, Chelmsford
Communities covered	The area has two 'top tier' local authorities (a county council and a unitary authority) along with two borough councils: • Southend-on-Sea Borough Council • Essex County Council o Castle Point Borough Council o Rochford District Council The borough of Castle Point and the district of Rochford have certain 'strategic' services such as social services, highways and education provided by Essex County Council, while the borough of Southend-on-Sea is a unitary authority.
Population (GP registered)	We serve a GP-registered population of approximately 365,500.
Type of area	South east Essex has fewer people between the ages of 20 and 44 than the England average, and has the greatest numbers of those over the age of 55.
Budget	£597m
No. of employees	276.91 WTE (Whole Time Equivalents) (This figure includes East of England Specialised Commissioning Group staff who were hosted by NHS South East Essex).
No. of Clinical Commissioning Groups in south east Essex	Two: • Castle Point and Rochford • Southend
No. of GP practices	64
No. of Primary Care Centres	Four: • Leigh Primary Care Centre, 918 London Road, Leigh

	on Sea, SS9 3NG • Central Canvey Primary Care Centre, Long Road, Canvey Island, SS8 OJA • Valkyrie Road Primary Care Centre, 50 Valkyrie Road, Westcliff, SS0 8BU • North Road Primary Care Centre, 183-195 North Road, Westcliff, SS0 7AF
No. of GP-led health centres (equitable access centre, open seven days a week, 12 hours a day, walk-in appointments)	One: St Luke's Health Centre, Pantile Avenue, Southend on Sea, SS2 4BD
No. of community pharmacies	75 plus one internet pharmacy
No. of opticians practices (including mobile)	55
No. of dental surgeries	39 dental practices
Main provider of acute hospital services	Southend University Hospital NHS Foundation Trust
Community services name and head office	South Essex Partnership University NHS Foundation Trust, Trust Head Office, The Lodge, The Chase, Wickford, SS11 7XX
Mental health and learning disabilities provider	South Essex Partnership University NHS Foundation Trust
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 East Essex began working closely together with NHS South West 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.	• South Essex Partnership University NHS Foundation Trust • Partnership arrangements with voluntary organisations.
Hospital services: This includes outpatient clinics, operations and emergency care.	• Southend University Hospital NHS Foundation Trust • Basildon and Thurrock University Hospitals NHS Foundation Trust • Mid Essex Hospital Services NHS 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.	• South Essex Partnership University NHS Foundation Trust • Partnership arrangements with voluntary organisations.
Specialist health services: This includes 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.

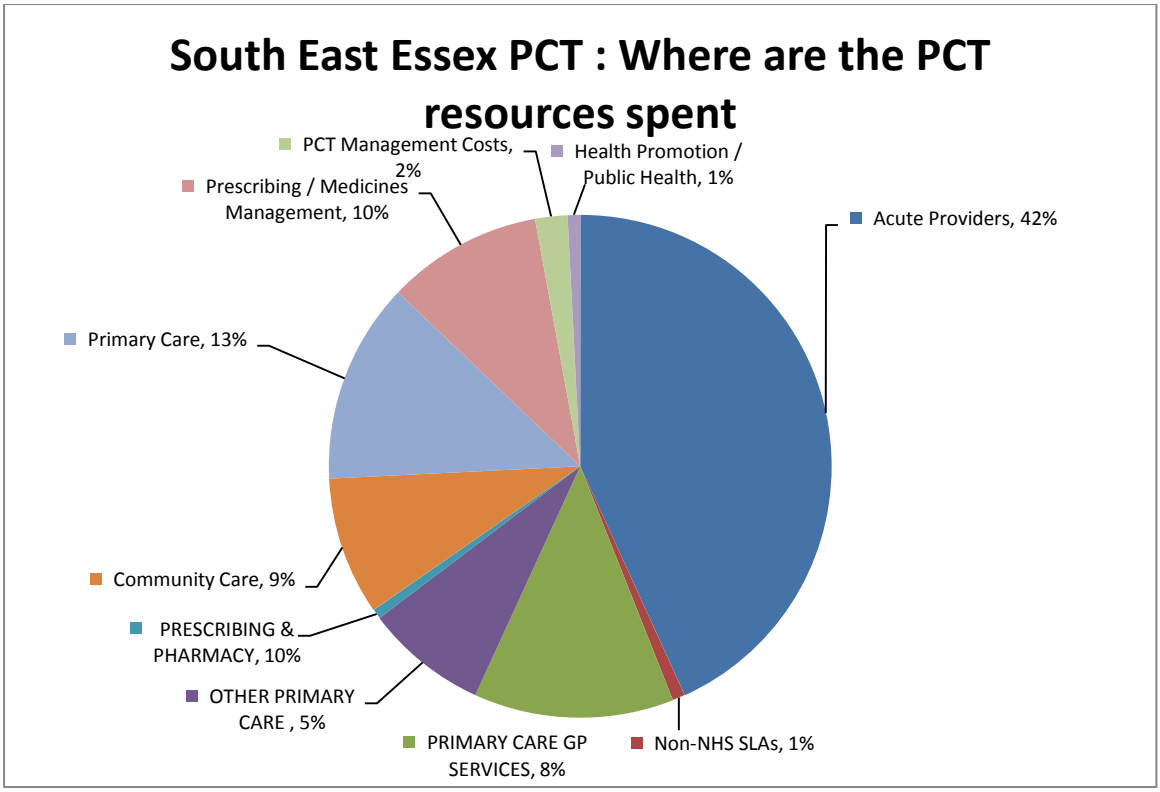
* We host the East of England Specialised Commissioning Group which is accountable to all 13 PCTs in the East of England. It covers a population of over five million people.

How your money was spent

In 2012/13, NHS South East Essex achieved its financial responsibilities and delivered financial balance at the year end. The total budget for 2012/13 was £597million and at year-end we carried forward a small surplus of £0.2 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 tough 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.
Dr Rupert Halliday Medical Director, South East Essex (to 30 June 2012) Committees: Quality and Governance Declarations of interest: Partner in Valkyrie Surgery, Westcliff on Sea; shareholder in Fortis Healthcare. My wife is Kate Halliday, Estates Planning Officer. My practice is leasing space in the new Valkyrie Road premises. She leads on developing this.
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, the NHS England (formerly called NHS Commissioning Board), 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 (formerly 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 East 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.

Castle Point and Rochford CCG (CP&R CCG)
Authorisation - Since April 2012, the CCG governing body (acting as a sub-committee of the PCT Board) have been focusing on securing authorisation as a statutory body responsible for commissioning health care and health well-being services for the populations of Castle Point and Rochford. The outcome was successful and the CCG became fully authorised on 1 April 2013, with only 13 conditions still to be addressed with optimism that these will be fully addressed by end of the first quarter in 2013/14.

CP&R CCG has 28 member GP practices and has a registered GP population of approximately 177,000. The CCG is clinically led and eight local GPs have been appointed to its governing body.

Integrated planning 2013/14 - The CCG is currently finalising its comprehensive integrated plan for next year. This is informed by national planning guidance 2013-14, financial allocations 2013-14, the Joint Strategic Needs Assessment and associated strategy, CCG vision, values and priorities. The CCG has been working closely with its partners at Essex County Council to ensure its plans are truly integrated so that it can deliver the best possible health outcomes for the population of Castle Point and Rochford.

Patient and Public engagement - The CCG's emerging Commissioning Reference Group (CRG), their forum for patient and public engagement was established in September 2012. The role of the CRG is to provide a voice for patients, the public, carers and other stakeholders to ensure that the views of these groups are understood and acted on. The CRG is progressing apace with a comprehensive workplan for 2013-14, which includes the publication of the CCG Communications and Engagement strategy.

For more information about Castle Point and Rochford CCG visit:
www.castlepointandrochfordccg.nhs.uk

Southend CCG
Southend CCG became authorised as a statutory body on 1 April 2013 having been judged to be competent against 119 nationally determined criteria, with only 6 conditions which the CCG is fully confident it will meet. The CCG is a clinically led organisation has 37 member practices and eight local GPs on its governing body - two of whom hold the offices of Chair and the Accountable Officer for the CCG.

Southend CCG covers a population of 173,600 and a geographical area that is coterminous with Southend Borough Council. Together with partners, patients and the public, the CCG will plan and commission local health services.

During the authorisation process the CCG was congratulated by the national team for the "impressive clinical and service improvements that the CCG had made to clinical pathways for the benefit of patients. Southend CCG will be building on the successes of the past year to ensure patients receive '*Personalised Quality Care first time'* through integrated working with hospital and community services, Southend Borough council, GPs and the voluntary sector.

For further information about Southend CCG visit:
www.southendccg.nhs.uk

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

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

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

NHS Central Eastern CSU was formed by bringing together two separate predecessor bodies Hertfordshire Integrated CSU and Essex CSU – following the appointment of David Stout as the Managing Director of both CSUs in October 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 formally established 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 formally transferred from PCTs to Local Authorities. This transition had already started with South East Essex public health teams being co-located with Local Authorities – Essex County Council and Southend-on-Sea Borough 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 clinical commissioning groups, directors of public health, children's services and adult social services and a representative of local Healthwatch (the new patients' representative body).

Essex Health and Wellbeing Board
Plans for the formal establishment of the Essex Health and Wellbeing Board as a committee of Essex County Council on 1 April 2013 continued throughout 2012/13. A shadow board met on six occasions. Membership initially included GPs who were Board members for each of the five 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 CB (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.

Southend Health and Wellbeing Board
During 2012 Southend's Shadow Health and Well Being Board met regularly to develop a cohesive and coordinated approach to meeting the needs of people across Southend. This has culminated in a joint strategy which sets out nine key health and wellbeing ambitions and builds on the successes already achieved through partnership working to create a healthier and more fulfilling future for our population. This will guide its approach and take it to 2015. A formal consultation on the strategy took place between October and December 2012 and feedback was received from over 60 organisations across the borough. There was general agreement with all nine ambitions, the strongest support expressed for improving mental wellbeing, promoting healthy lifestyles and a positive start in life. The strategy, which was approved by Southend Council's Cabinet in March 2013, sets out where the Board will target future resources over the coming years. It will be taken forward through underpinning action plans by the Southend Health and Well Being Board from April 2013 onwards.

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/nhsconstitution

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. Meanwhile, the executive summary for all NHS South Essex Board papers made reference to which aspects of the NHS Constitution were 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 continued to meet statutory deadlines to respond to complaints and this was supported by the PCT's Patient Advice and Liaison Service.

Improving Care

Mental Health Services

The South East Essex PCT Mental Health Team has made various improvements to patient care by implementing the following key projects in South East 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 them to the appropriate service (e.g. mental health, memory service, Social Services, Alzheimer's Society, district nursing)
- identifying and managing risk factors that could 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 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.

Improving Access to Psychological Therapies (IAPT)

Many people who have long term conditions also experience anxiety and depression. In 2012 we commissioned a specialist psychological support service pilot within the stroke services and the long term condition team. This aims to improve the quality of the service offered and patient outcomes.

A key aspect of this pilot is to determine whether the introduction of psychological assessment and intervention in the stroke pathway results significant improvements in patient reported outcomes.

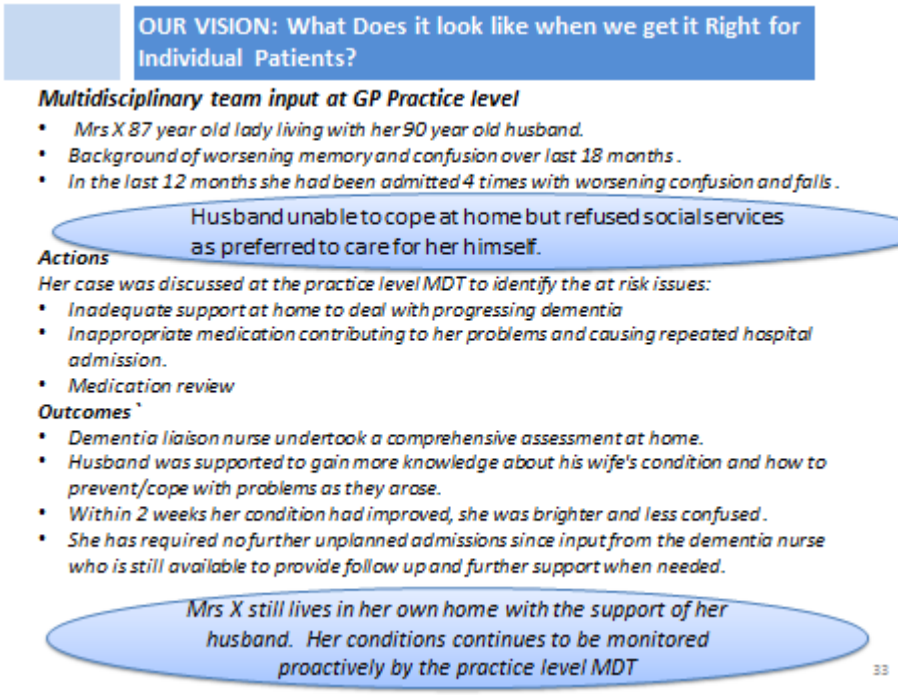
Older People's Services

CCGs have made a commitment to reduce inequalities for the population of South East Essex. The difference in life expectancy between the most affluent and the most deprived electoral wards is 8.6 years.

South East Essex also has a significant demographic challenge looming. 18.3% of the population is aged over 65years and there is a predicted increase of 5% for those aged over the age of 85 by 2020. The burden of disease is predicted to rise across all long term conditions by 9-11% by 2015.

We have been working in partnership with local authorities, the voluntary sector, patients and public to address the impact of these challenges and to improve services for older people.

The real life example for Mr and Mrs X below demonstrates how through working together, agencies have enabled an elderly couple to receive a comprehensive assessment of their needs and coordinated care to meet those needs whilst remaining in the comfort of their own home.



The practice level Multi-Disciplinary Team is just one example of how professionals have been bought together around the needs of patients. Other developments include:

- a single telephone number for professionals to access a range of coordinated health and social care services for their clients
- East of England Ambulance service has worked with clinicians to develop a car manned with very skilled Emergency Care Practitioners who are able to assess diagnose and treat patients in their own homes, enabling many patients to remain at home rather than be transported to hospital

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 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.

Autistic Spectrum Disorder (ASD) provision (South East Essex)
The project is aimed at developing a process to ensure that patients in South Essex are able to access diagnostic testing for ASD from a local service with the development of the existing STAARS Service in South West Essex and repatriation of current tertiary activity for South East Essex.

Historically there was no local provider in South East Essex to undertake ASD assessments for children over five years of age. The only pathway in place was to refer to Great Ormond Street Hospital at a cost of £10,000 per assessment. We have put an interim measure in place for children and young people to be assessed at the NAS Lorna Wing Centre in Bromley at a reduced cost of £2,580 per assessment and with their assistance developing and capacity building our local service.

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

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.

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

Both Local Authorities have very similar timelines for implementation:

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

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 a 0 – 19 Service aiming to: reduce unnecessary 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 (Sexual Assault Referral Centre) 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 plans to open 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.

Ensuring Quality

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

In 2012/3 we:

- 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 services
- 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 promote efficient use of resources

Improving quality, patient safety and experience

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

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

Key findings - The key finding was 'The Inquiry finds that the 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 and 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 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.

Patient Safety Thermometer
The PCT supported the National Patient Safety Thermometer initiative and 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 and this information is retrieved from the National Safety Thermometer data base monthly 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 has been taken forward for 2013/2014.

The latest results for the Patient Safety Thermometer can be found at: 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 2012/2013.

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 (BTUH) and South Essex Partnership University NHS Foundation Trust (SEPT). Information and presentations were also received from North East London NHS Foundation Trust (NEFLT) and Southend University Hospital NHS Foundation Trust (SUHFT).

Recommendations:
The recommendations noted that there is an overall commitment to delivering the ambition across the cluster, and 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 of the importance of the ambition
- Further education of CCGs and GPs to understand 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 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, 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 patient experience and that it was to 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? 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 experience could be measured. Initially this was rolled

out to the acute providers BTUH and SUHFT and going forward will be implemented within the other providers including SEPT mental health, NELFT and SEPT community.

The cluster PCT has also been proactive in challenging the providers when these numbers of detractors increase 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 are 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 reported position for SUHFT was 89.

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 and supports initiatives for review of processes and data and the development of improvement plans and can be viewed through the link below.
http://www.qie.eoe.nhs.uk/mortalitys.aspx

The latest SUHFT mortality indicator score published in January 2013 is 103. Trusts aim for a SHMI result of 100 or less based on the calculation used and therefore the Southend CCG is working closely with the Trust to monitor the indicator and reduce the indicator score.

Serious Incidents
The cluster PCT was responsible for monitoring the quality and safety of services commissioned and had clear, defined criteria of which incidents fall under the requirement to be reported as Serious Incidents (SIs) in line with the NHS Midlands and East Strategic Health Authority (SHA).

All confidential serious incident information was passed to the successor bodies as part of the handover of confidential information.

The PCTs stressed within their policy and through contracting processes that 'near misses' related to these incidents must also be reported and that when an organisation was in doubt whether an incident constitutes an SI it should be reported and may later be retracted if inappropriate, this ensured timely and robust reporting and also 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 and forms part of the contract with the 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 and 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 PCT cluster had a responsibility to publicly report Never Events as part of their annual quality reporting arrangements, identifying the frequency and type of events that have occurred in commissioned services and a summary of the types of actions that these providers have implemented following root cause analysis or significant event audit.

There have been 6 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 sets out 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 – 2013

South East Essex	2010-2011	2011-2012	2012-2013
PCT Ceiling	133	82	70
PCT Actual	76	79	77
SUHFT Ceiling	65	26	26
SUHFT Actual	26	32	25

MRSA Information 2010 -2013

South East Essex	2010-2011	2011-2012	2012-2013
PCT Ceiling	8	5	4
PCT Actual	3	6	6
SUHFT Ceiling	3	1	1
SUHFT Actual	2	1	3

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 BTUH
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.

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 patient and nurse diabetes knowledge and satisfaction with the consultation and to identify changes in well-being and indicators for possible depression. This study was available for 2-3 practices in South West/East

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

Southend Hospital University NHS Foundation Trust

The hospital was visited by the Care quality Commission on 19 October 2012 and reviewed seven Outcomes.

- Outcome 02: Before people are given any examination, care, treatment or support, they should be asked if they agree to it
- Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights
- Outcome 06: People should get safe and coordinated care when they move between different services
- Outcome 09: People should be given the medicines they need when they need them, and in a safe way
- Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare
- Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills
- Outcome 17: People should have their complaints listened to and acted on properly

The Trust was found to be fully compliant with the seven Outcomes assessed.

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
Designate Doctor Looked After Children	In post	In post
Named GP	In post	In post
Designate Doctor Child Death	In post	In post

Key Issues: Report re: Gateway ref 18350; Savile Allegation
Letters have been sent on to all main Provider organisations and, at the request of the SCCN 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.

Building for the future

Two new primary care centres for Westcliff
During 2012/13, two brand new primary care centres opened in Westcliff - one in North Road and the other in Valkyrie Road.

South East Essex PCT had previously identified Westcliff as an area in urgent need of investment due to the poor quality of its primary care estate which had limited capacity to deliver community services. In order to address this, the PCT developed an ambitious estates development programme which identified the need for two new primary care centres in the Westcliff area. The aim of these centres would be to provide modern fit-for-purpose buildings which enable a greater range of services to be delivered in a local setting to provide better access to healthcare for all the residents of Southend.

In 2012 the construction of these buildings began. Patients, staff and residents were involved throughout the entire development from plans on paper to choosing the names for the new centres.

Valkyrie Road Primary Care Centre opened its doors in January 2013 and saw The Valkyrie Surgery and their patients move in.

The centre provides a range of other services including a pharmacy, podiatry clinics, podiatric surgery outpatients, minor operations, speech and language therapy and ultrasound services. The centre also has meeting facilities which are available for hire. It is hoped that many more services will use the building in the future.

North Road Primary Care Centre opened in February 2013 and is now home to West Road Surgery, Central Surgery and New Westborough Surgery (formerly Dr Gul's Surgery).

This centre also provides a range of services including a pharmacy, podiatry and leg ulcer clinics and speech and language therapy. Again, there are conference facilities available.

It is hoped that these new centres will not just be places to visit when people are ill but will become centres of their community, a place to go for a coffee, to enjoy the art work done by local schools, colleges and patients, a place that belongs to the whole community.

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 QIPP partners:

Health
- East of England Ambulance Service NHS Trust
- Clinical Commissioning Groups (CCGs)
- South West Essex PCT (NHS South West Essex)
- South Essex Partnership University NHS Foundation Trust (SEPT)
- Southend University Hospital NHS Foundation Trust (SUHFT)

Social care
- Essex County Council
- Southend-On-Sea Borough 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 East 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: SPOR – a single point of referral, DIST – Dementia Intensive Support Team, Community Geriatrician with community and practice level multi-disciplinary teams (MDTs) and also the rollout of Caretrak. 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) and primary care services. Discussions have taken place with the hospital trusts, community providers and CCGs.

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 (JSNA)
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.

Southend JSNA
Southend-on-Sea Borough Council has continued to update the Southend Data Observatory with emerging data from the 2011 Census. The JSNA process in Southend has focussed on delivering specific products tailored to needs of different audiences. In the year that CCGs take over responsibility for commissioning a wide range of health care services for their populations, the Southend JSNA was able to

provide Southend CCG with a comprehensive overview of local health priorities in Southend and an analysis of the usage and value for money of a range of clinical services in Southend. The major benefit to the population in this year was the use of the JSNA to inform the priorities of the Southend Health and Wellbeing Strategy and the Southend CCG integrated plan. Both documents and their related action plans, are central to addressing disadvantages and improving outcomes for the population of Southend

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.

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

Encouraging Change4life activities for adults and children
Currently, two thirds of adults in south east Essex are overweight or obese and the proportion of children who are obese and overweight is of concern.

During 2012/13:

- We have increased access to MEND courses (Mind, Exercise, Nutrition… Do it!) run at local children's centres. These sessions encourage children and their families to adopt healthier eating habits and increase their levels of physical activity.

- Through our voluntary grant programme we have supported a project to encourage healthier lifestyles for older members of our community and for carers. This project included the promotion of physical activity and a holistic approach to improving wellbeing for carers.

- NHS South East Essex has continued to work in partnership with our local authority leisure services to ensure the continued provision of exercise on referral (supervised exercise on prescription from a health practitioner) and health walks.

Mo and the Secret Smokers
In June 2012, the fourth book in the Mo series – "Mo and the Secret Smokers" was launched. This new children's book was produced by Turning Tides, a project managed by Southend Association of Voluntary Services as part of a collaborative venture with NHS South Essex, Essex County Fire and Rescue Service and

Olympus KeyMed. This book is about the dangers that cigarettes pose to children and includes important fire safety messages. The book has been distributed free to participating schools in Southend.

Health trainers
In 2012/13 our NHS health trainers have continued to help improve the health and wellbeing of our community and prevent social isolation. Health trainers offer free one to one support and information to local people who want to improve their health and prevent future ill-health by changing their lifestyle. Although everyone can access health trainer support, a specific priority was given to residents in the St Luke's and Kursaal wards (Southend) and Central ward (Canvey Island) where there were greater health inequalities. The health trainer team have been assisting local people to access mainstream health services, or supporting them to make important lifestyle changes.

A smoke free future
Our stop smoking service offers free help and advice to smokers who live and work across south east Essex. The team has helped over 23,000 smokers kick the habit, since the service began.

Promoting healthy relationships
People of all ages are at risk of infections passed on during sexual contact. These infections include HIV, chlamydia and herpes. Our staff continue to work extremely hard to raise the profile of various conditions and how people can protect themselves and others from infection. We have used a variety of media to provide the public with information advice and support. This work includes a comprehensive media advertising campaign on South Essex buses. The PCT also supports a dedicated website where people can access specific information on sexual health – www.thekwc.nhs.uk – with online, up to date and accurate information about sexual health and contraception.

Early identification of ill health
Screening is a process of identifying apparently healthy people who may be at increased risk of a disease or condition. They can then be offered information, further tests and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition.

Preventing the causes of ill health
Immunisation is a way of protecting adults and children against serious disease such as ensuring young women under 18 have had an HPV vaccination. Our role is to ensure local people have had access to screening and immunisation programmes that deliver services in line with national guidance.

Preventing cardiovascular disease
We have continued to offer free NHS health checks in general practices for those aged 40 to 74 who do not have an existing diagnosis of heart disease, stroke, diabetes or chronic kidney disease. These checks aim to identify those at risk of developing disease and help them with lifestyle changes or treatment choices that may prevent the development of disease.

To help working people that may not have had the time to attend regular clinic sessions, health checks and lifestyle support have also been offered to people at community events, in shopping centres and their places of work.

Cancer screening – it really does save lives
NHS South Essex has continued to run campaigns this year to encourage all eligible women to have a mammogram and/or cervical smear. We have worked to raise the awareness of the importance of breast and cervical screening.

We have continued to offer bowel cancer screening every two years to all men and women aged 60 to 69 and have actively promoted the national bowel cancer awareness campaign "let's be clear about cancer". We have commissioned new services and technologies and digital mammography is now available from the Southend Breast Screening service at its site in Southend Hospital.

Combating alcohol problems
During 2012/13, we have worked closely with Southend Hospital to develop plans to introduce an alcohol liaison nursing service. This service will help to provide advice to people attending hospital and where relevant, signpost anyone that might be drinking at level harmful to health to appropriate services.

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 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
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 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 are appropriate and relevant.

LINk (Local Involvement Network)
We have continued to have a strong working relationship with the LINk locality group for South East Essex, with a representative from NHS South Essex regularly attending their public meetings. The chair of the LINk locality group had 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 (PPI) 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 community representatives will be invited to attend meetings on an ad hoc basis for discussions on specific topics. 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.

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 (DES) agreement 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 the 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 Southend Overview and Scrutiny Committees, and give regular briefings, updates and presentations to members.

Patient and Public Voice Group
This group has had presentations and discussions on the PCT's and CCGs' projects and plans, with some good debate taking place. Topics this year have also included medicines management, a new pathway for DVT (Deep Vein Thrombosis) and the new NHS landscape. Members have been encouraged to register their interest with the two CCGs in south east Essex, so that they can continue to be informed of and involved in the work of the CCGs.

Southend Ethnic Minority Forum
We have continued to work with the Southend Ethnic Minority Forum and the Essex Asian Women's Association, and have encouraged these organisations to engage with the CCGs.

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.

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 and 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 East 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 National 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 (year to date) 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.

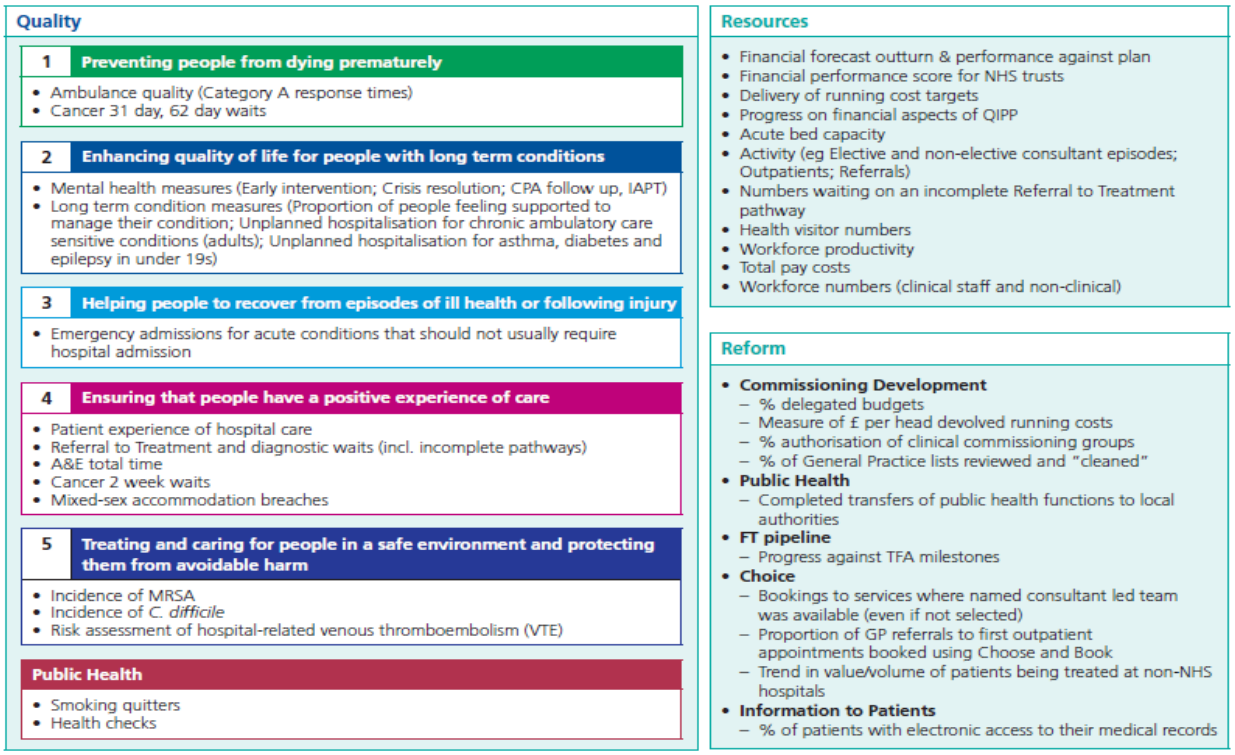
NHS South East Essex achieved a delivery yield of 55%. This has been achieved through the implementation of a number of work programmes, including better control of prescribing. The medicines management workstream has been working with GP's to understand drug costs and ways to use resources more cost 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.

In the planned care workstream CCGs in South East Essex have been working to drive down GP referrals by enhancing peer review sessions and the utilisation of a referral gateway. CCGs have also implemented a schedule of targeted practice support to drive down inappropriate referrals. A dermatology outpatient AQP (Any Qualified Provider) community service developed and procured in 2012/13 will be up and running from April 2013.

In 2012/13 CCGs in the NHS South East Essex have increased GP engagement in the unplanned care workstream. Practice level MDT sessions have been rolled out and starting to demonstrate good outcomes. GP referrals into SPOR is increasing month on month. The unplanned care workstream did not achieve savings planned in 2012/13. But as GP engagement increases and efforts continue to reduce unnecessary admissions and A&E attendances, CCGs are expecting these schemes to deliver savings 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	SE 548 SW 675	@ Q2 SE 331

Treatment teams	S 1223	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 BDO LLP, who are NHS South East 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 East 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 one serious untoward incident relating to information governance at NHS South East 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
Aug 12	GP Practice papers found in car park	Name, address, date of birth and NHS number	17	SHA, PCT, ICO and patients informed

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.	
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents.	1
IV	Unauthorised disclosure	
V	Other	

Financial Overview 2012/2013

South East Essex PCT

Financial Duties

NHS South East Essex achieved its statutory financial duties recording a surplus of £0.2m by the end of the financial year. This met the target surplus set for NHS South East Essex by East of England Strategic Health Authority of £0.2m. 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	555,818	565,560	597,168
	Limit	556,911	566,439	597,381
Remain with Capital Resource Limit	Performance	289	696	689
	Limit	290	862	1,875
Remain within Cash Limit	Performance	553,480	555,383	567,887
	Limit	553,481	563,752	591,321

Capital Expenditure

The PCT had a capital resource limit of £1,875k for 2012/13 and spent £689k on its capital programme along with external funding of £13,091k for the new premises developments through LIFT.

The capital expenditure was on the following developments

Description	£000
Development of new health centre Valkyrie Road	7,036
Development of new health centre North Road	6,439
GP IT Refresh	305

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, BDO LLP (previously PKF (UK) LLP and referred to herein as BDO), as part of their annual review of the PCT's accounts. The PCT received an unqualified value for money 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	**19,575**	**110,972**
Total Non-NHS Trade Invoices Paid Within Target	**18,285**	**106,708**
Percentage of NHS Trade Invoices Paid Within Target	93.41%	96.16%
NHS Payables		
Total NHS Trade Invoices Paid in the Year	**6,197**	**1,185,330**
Total NHS Trade Invoices Paid Within Target	**5,443**	**1,162,533**
Percentage of NHS Trade Invoices Paid Within Target	87.83%	98.08%

Audit arrangements
BDO are our external auditors, appointed by the Audit Commission. The total planned fee for 2012/13 audit was £116,280 for the PCT and £46,800 for specialised services. This was £205,060 and £62,240 respectively in 2011/12.

Audit fees in respect of specialist commissioning reflect the fact that the PCT hosts, and accounts for, the cost of the East of England Specialised Commissioning Group. This element of the audit fees are recharged to the other 12 PCTs in the East of England. No other work was carried out by BDO during 2012/13.

Pension liabilities
The PCT's annual accounts detail the accounting policy adopted regarding the NHS pension scheme liabilities and this can be found in note 7.5 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 East 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 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 West Essex PCT and South East 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:

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%.

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

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.

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 no reported lapses of data security.

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 East 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 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 PCT is also host to the East of England Specialised Commissioning Group (SCG) which commissions high cost and low volume health services on behalf of all PCTs in the region. The East of England SCG clustered with the East and West Midlands SCG to work as one specialised commissioning group known as the Midlands and East Specialised Commissioning Group (M&ESCG). The SCG has its own audit plan, based on the key risks it faces as an organisation, and the implementation of any recommendations arising from these audits is monitored by the Audit Committee

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.

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 (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 EAST ESSEX PRIMARY CARE TRUST

Financial statements

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

This report is made solely to the Accountable Officer for South East Essex Primary Care Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

Respective responsibilities of the Signing Officer and Finance Signing Officer, and 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 Primary Care Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Primary Care Trust; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

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

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

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

Opinion on other matters

In our opinion:

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

Matters on which we report by exception

We have nothing to report in respect of the following other matters which the Code of Audit Practice for local NHS bodies (March 2010) requires us to report to you, if:

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

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

Respective responsibilities of the Primary Care Trust and auditors

The Primary Care Trust is responsible for putting in pace proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy of these arrangements.

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

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

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

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

Conclusion

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

Certificate

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

David Eagles

David Eagles
for and on behalf of BDO LLP
Ipswich, UK
7 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 East 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 69 to 76.

There are no elements of remuneration, other than the benefits in kind detailed from pages 69 to 76, 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 East Essex PCT
Salary 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										
Katherine Kirk	Chair	2	15-20	-	-	-	30-35	-	-	-
Beryl Furr	Non Executive Director (until 30/11/2011)	1	-	-	-	-	5-10	-	-	-
Phil Stepney	Non Executive Director (until 30/11/2011)	1	-	-	-	-	5-10	-	-	-
Gill Hind	Non Executive Director	3	5-10	-	-	-	5-10	-	-	-
Tony Le-Masurier	Non Executive Director	3	0-5	-	-	-	5-10	-	-	-
Rob Peters (Audit Committee Chair)	Non Executive Director	3	10-15	-	-	-	10-15	-	-	-
Roger Sinden	Non Executive Director	3	0-5	-	-	-	5-10	-	-	-
Anthony Cox	Non Executive Director (from 01/12/2011)	3	0-5	-	-	-	0-5	-	-	-
Glynis Cheers	Non Executive Director (from 01/12/2011)	3	0-5	-	-	-	0-5	-	-	-

Mel Porter	Non Executive Director (from 01/12/2011)	3	5-10	-	-	-	0-5	-	-	-
Board Officer Members										
Andrew Pike	Chief Executive	2	50-55	-	-	-	65-70		0-5	
Russ Platt	Director of Commissioning & Contracting (to 25/05/2011)	1	-	-	-	-	15-20	-	-	-
David Griffiths	Director of Finance IM&T and Estates (to 25/05/2011)	1	-	-	-	-	10-15		0-5	
Jackie Brown	Interim Director of Strategy, Productivity & Performance to 25/05/2011	1	-	-	-	-	15-20	-	-	-
Dawn Scrafield	Director of Finance & Performance (from 26/05/2011) Acting Director of Finance, South West Essex to 25/05/2011	2	35-40	-	-	-	40-45		0-5	
Tom Abell	Director of Commissioning (Operations) (from 26/05/2011 to 01/04/2013)	3	0-5	-	-	-	35-40	-	-	-
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	-	-	-	40-45	-	-	-

Luella Dixon	Human Resources Project Director (from 1/09/2010)	5	40-45	0-5	-	1	35-40	-	-	-
Pol Toner	Director of Quality and Patient Experience (from 04/07/2011)	3	30-35	-	-	-	30-35	-	-	-
Margaret Hathaway	Commercial Director (from 26/05/11 to 01/05/2013)	3	45-50	-	-	-	30-35			
Dr Andrea Atherton	Director of Public Health	3	85-90	-	-	-	95-100		0-5	
Alison Cowie	Director of Public Health, South West Essex (from 26/05/2011 to 31/03/2013)	3,5	20-25	0-5	-	1	-	-	-	-
Dr Rupert Halliday	Medical Director		-	60-65	-	-	55-60	-	-	-
Mike Saad	CCG Lead CPR		15-20	-	-	-	-	-	-	-
Paul Husselbee	CCG Lead Southend		-	75-80	-	-	-	-	-	-
Bilquis Agha	CCG Lead Southend		-	30-35	-	-	-	-	-	-
Professional Executive Committee (PEC) Members	(for comparator use as PEC no longer in existance)									
Dr Sunil Gupta	Associate Medical Director	1	60-65	-	-	-	35-40	-	-	-
Mark Bulmore	Pharmacy Member	1	-	-	-	-	5-10	-	-	-
Dr Brian Houston	Deputy PEC Chair	1	-	-	-	-	15-20	-	-	-

Nikki Livermore	Nurse Member until (21/10/2011)	1	-	-	-	-	0-5	25-30	-	-
Dr Haroon Siddique	GP Member	1	-	-	-	-	5-10	-	-	-
Jane Foster-Taylor	Nurse Member	1	-	-	-	-	5-10	45-50	-	-
Officer Members, Midlands and East Specialised Commissioning Group (SCG)										
Dr Paul Watson	Chair (July2010 to 31/03/2013)	4	10-15	-	-	-	20-25	-	-	-
Catherine O'Connell	Chief Operating Officer	4	115-120	10-15	-	5	150-155	-	-	-
Dr Matthew Thalanany	Director of Public Health to (31/08/2011)	4	-	-	-	-	50-55	-	-	-
Veronica Watson	Director of Finance & Business Management	4	95-100	-	-	-	95-100	-	-	-
Carole Theobald	Director of Commissioning	4	85-90	-	-	-	85-90	-	-	-
Ruth Ashmore	East of England Perinatal Network Director	4	65-70	-	-	-	65-70	-	-	-
David Freeman	Director of Communications & Corporate Business	4	70-75	-	-	4	65-70	-	-	-

Note1: Some Non Exective and board directors information has been included as a comparator to previous years reports . They ceased their Non Executive Duties and board duties in 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 (£145-£150k) , DawnScrafield (£110k-£115k), Ian Stidson (£90k-£95k), Pol Turner (£95k-£100k) Note no recharge was made to the North cluster the charge and the total of these costs were incurred by SEE and SWE PCT.

Note 3 : The Members of the Cluster Board who have been apportioned across SWE PCT and SEE PCT at 50% each are Tom Abell (£0-£5k), Luella Dixon(£85k-£90k) Margaret Hathaway(£95k-£100k), Katherine Kirk(£35k-£40k),Tony Le-Masurier(£5k-£10k),Gill Hind(£10k-£15k), Glynis cheers (£5k-£10k), Anthony Cox (£5k-10k) , Roger Sinden (£5k-£10k), Rob Peters (£20k-£25k) and Alison Cowie(£95k-£100k). Dr Andrea Atherton (£110k-£115k), 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: The East of England Sector of the Midlands and East SCG is hosted by South East Essex PCT. It operates as an internal segment of the PCT under clearly defined governance arrangements and an Establishment Agreement signed by all 13 PCTs in East of England. The remuneration of other Officers on the Board responsible for the Midlands East and Midlands West sectors have been excluded from this report.

Note 5 : Alison Cowie and Luella Dixon have been on secondment from West Essex ,the charge has been reflected in both South West Essex and South East Essex remuneration

Note 6. Dr Sunil Gupta is no longer a member of PEC but part of the Essex Cluster board as CCG representative of Castle Point and Rochford

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 £000)
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'00
DAWN SCRAFIELD	1	0-2.5	0-2.5	20-25	65-70	265	249	16	-
DAVID FREEMAN	4	0-2.5	0-2.5	10-15	30-35	139	29	110	-
ANDREA ATHERTON	1	0-2.5	0-2.5	30-35	95-100	602	591	11	-
ANDREW PIKE	1	0-2.5	0-2.5	50-55	150-155	944	932	12	-
CAROLE THEOBALD	4	0-2.5	2.5-5	25-30	85-90	512	480	32	-
VERONICA GELDARD	4	0-2.5	0-2.5	30-35	100-105	602	580	22	-
IAN STIDSTON	1	0-2.5	0-2.5	20-25	70-75	427	413	15	-
MARGARET HATHAWAY	1	0-2.5	2.5-5	10-15	40-45	222	192	30	-
RUTH ASHMORE	4	0-2.5	0-2.5	25-30	75-80	463	458	5	-
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	-
POL TONER	1	0-2.5	0-2.5	15-20	45-50	238	221	17	-

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. Andrea Atherton was temporarily working on behalf of South West Essex, but remained empoyed by South East Essex. In order to avoid any 'double-count', any pension entitlements have been included in the Annual report of West Essex and South East Essex PCTs and readers should refer to those reports for details.

SCG Officers (note 3)

The members under the pension disclosure are part of the SCG board which is an arm's Length body of South East Essex PCT that operated as an internal segment of the PCT under clearly defined governance arrangements.

Cash Equivalent Transfer Values

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

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

Real Increase in CETV

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

Pay multiples disclosure

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

The banded remuneration of the highest paid director in the South Essex Cluster in the financial year 2012-13 was £85,000-90,000 (2011-12, £100,000-105,000). This was **2.61** times (2011-12, 6.97 times) the median remuneration of the workforce, which was **£34,189** (2011-12, £14,712).
The actual full cost of the highest paid director for the South Essex Cluster was £110,000-115,000.

In 2012-13, **20** (2011-12, 1) employees received remuneration in excess of the highest-paid director. Remuneration **above the share of the highest paid director** ranged from £89,519 to £144,810
(restated for staff in excess of highest paid director in 2011-12 £108,696)
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

In 2012-13 the highest paid director remains the same as the prior year, but has been adjusted for their cost to the entity rather than their individual total remuneration.

Due to a clarification of guidance full time apportionment of staff has been applied in the current year which has increased the median where previously an apportionment was applied between the South East and South West cluster.

The combination of the reduced highest paid director and increased median has resulted in significantly reduced pay multiple ratio.

It must be noted that the organisation has undergone a significant cluster change throughout Essex
This has led to a change in the management arrangement of senior directors in SWE and SEE PCT's who have had 30% of their time apportioned to North Essex cluster

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]

[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

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 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.

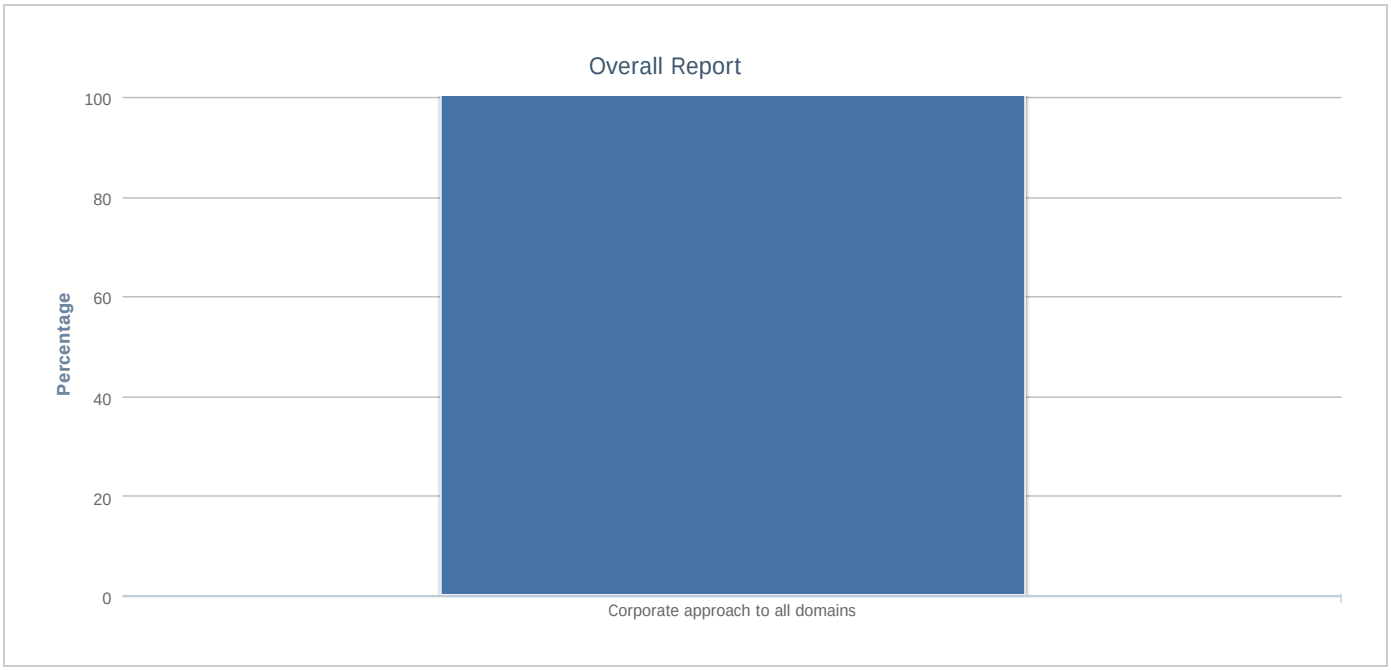
Appendices attached:

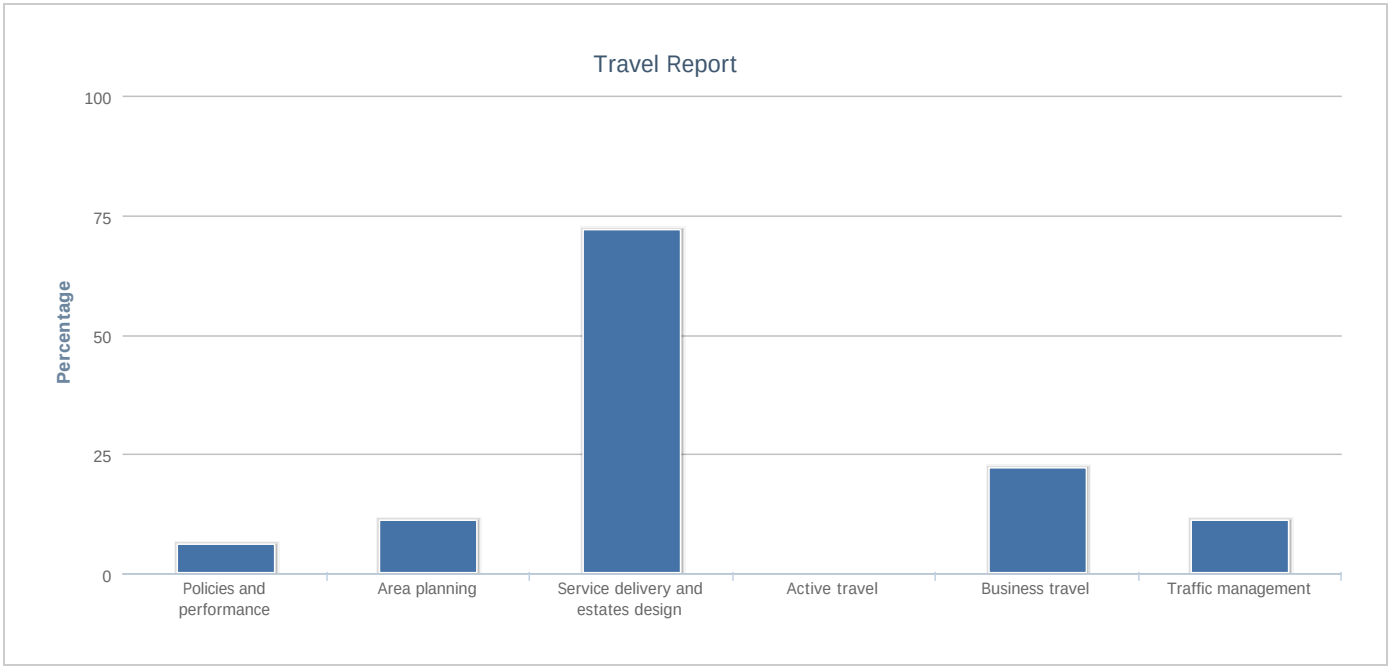
Financial Statements
(Appendix B)

Good corporate citizen report
(Appendix C)

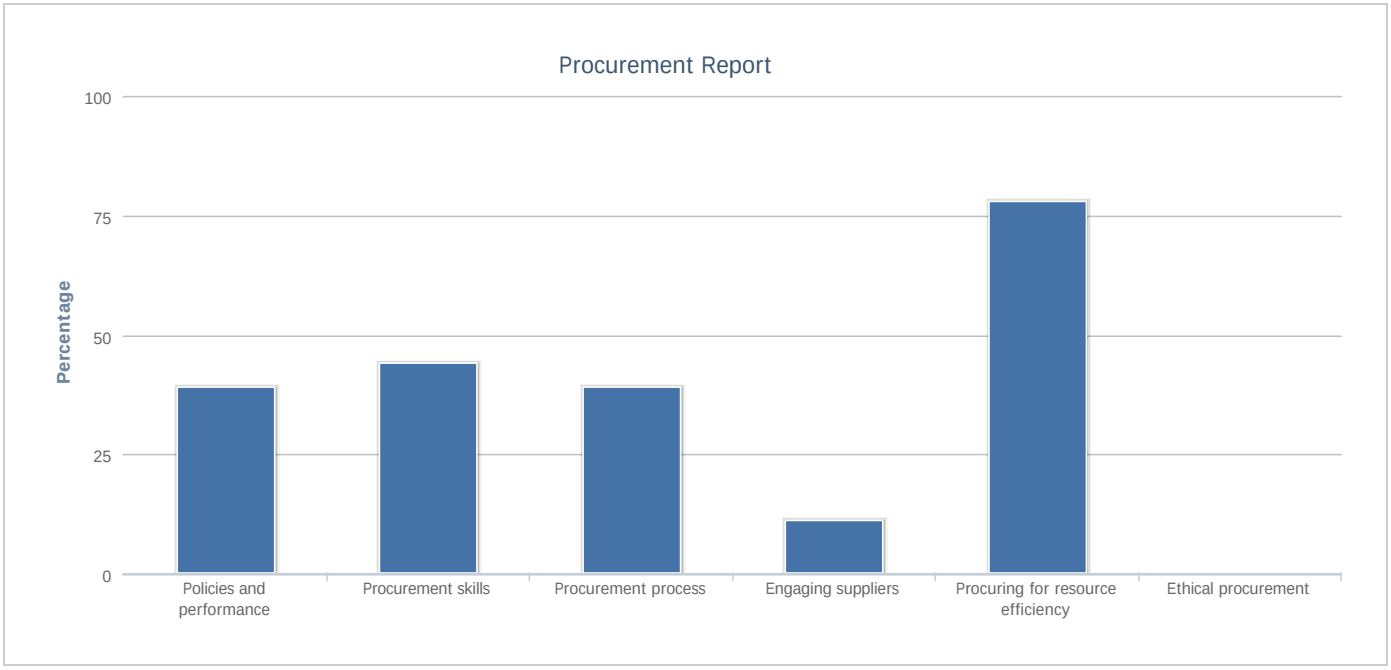
Sustainability Report
(Appendix D)

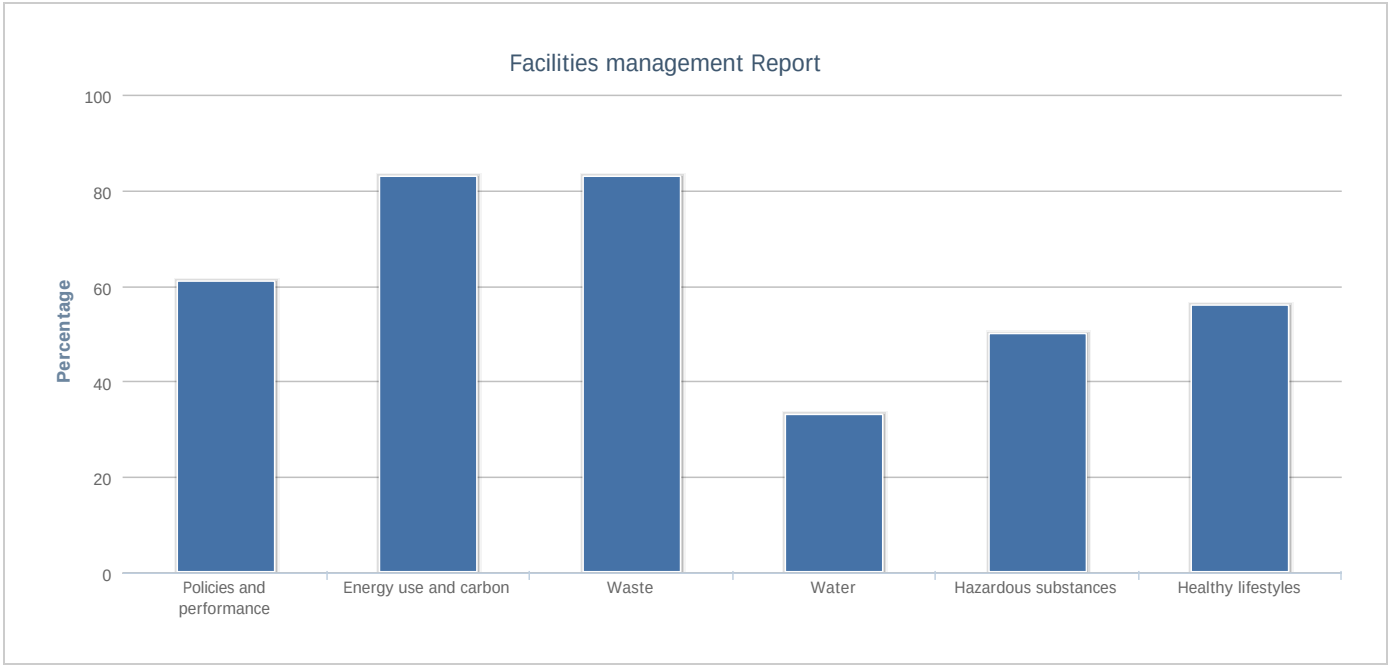
Making you a good Good Corporate Citizen



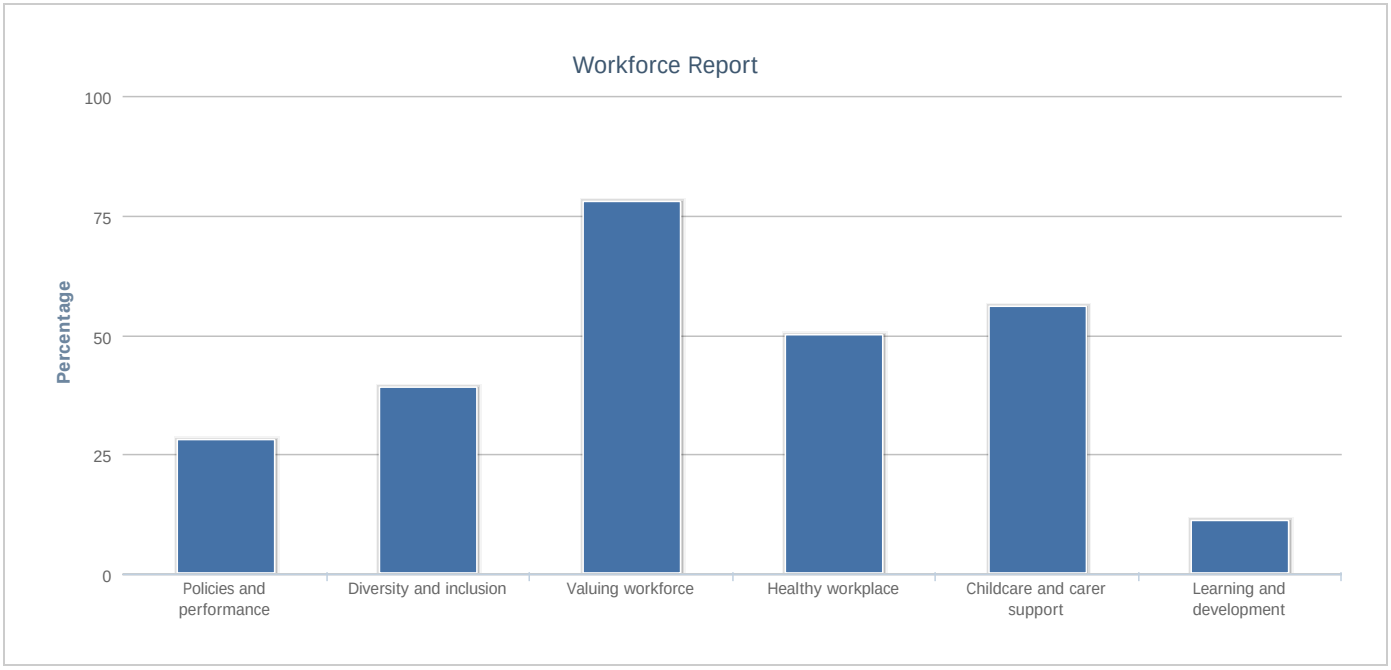


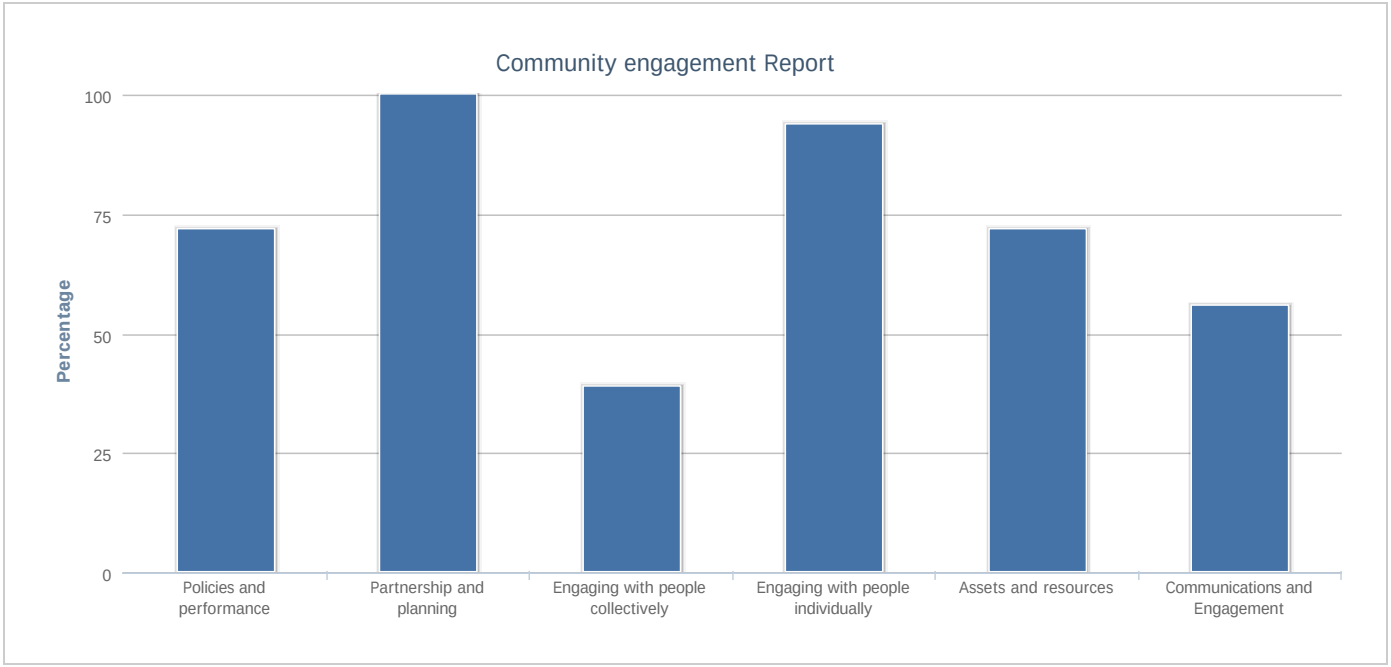
Making you a good Good Corporate Citizen





Making you a good Good Corporate Citizen





Making you a good Good Corporate Citizen

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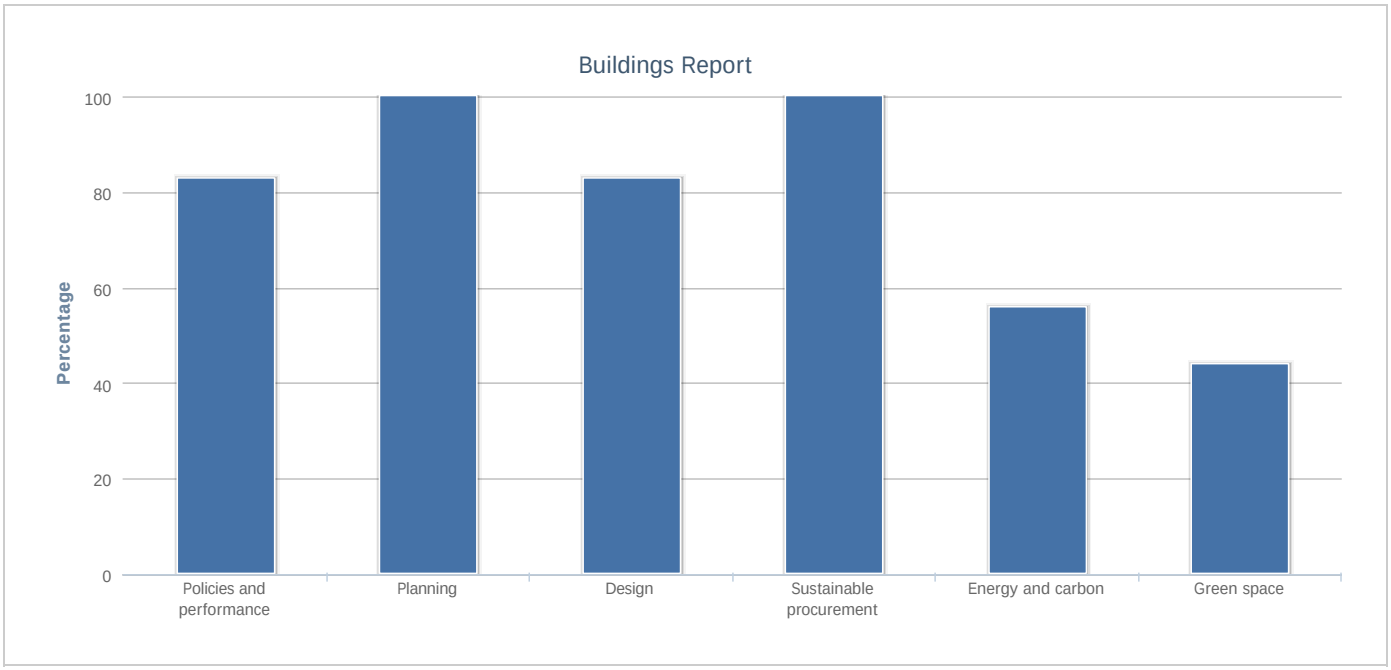
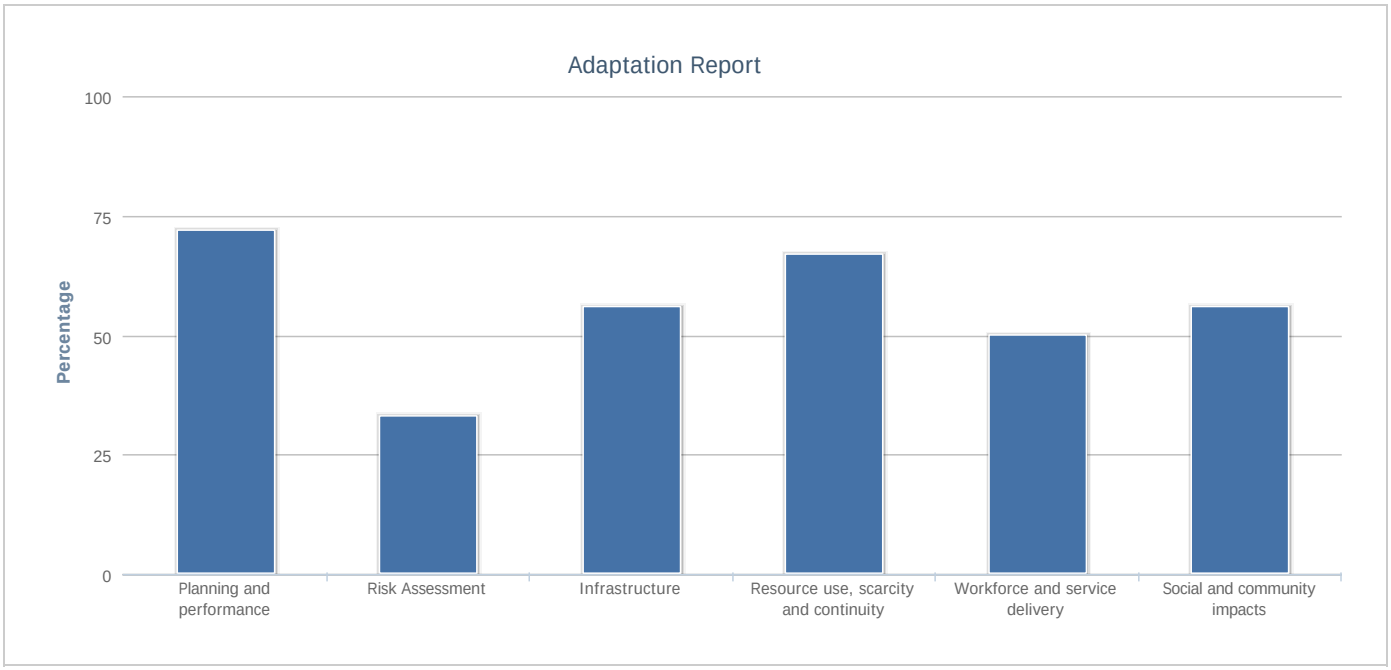
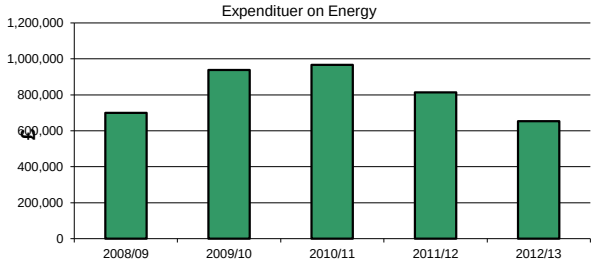




Appendix D

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

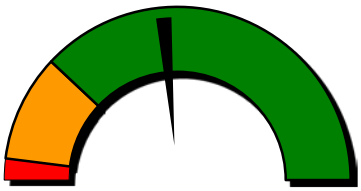
There is also a financial benefit which comes from reducing our energy bill.

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



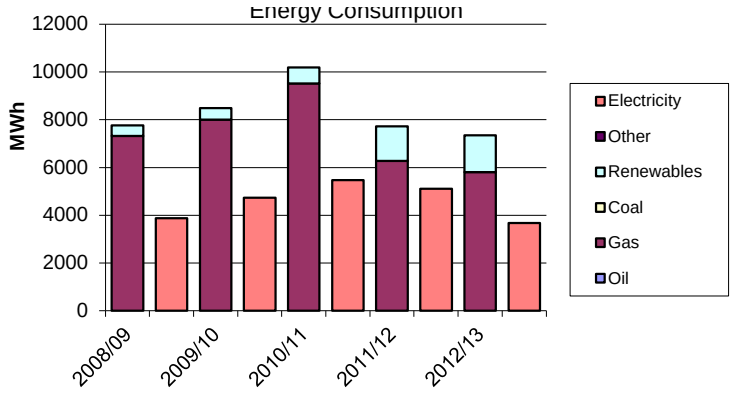
Percentage of Waste Recycled

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

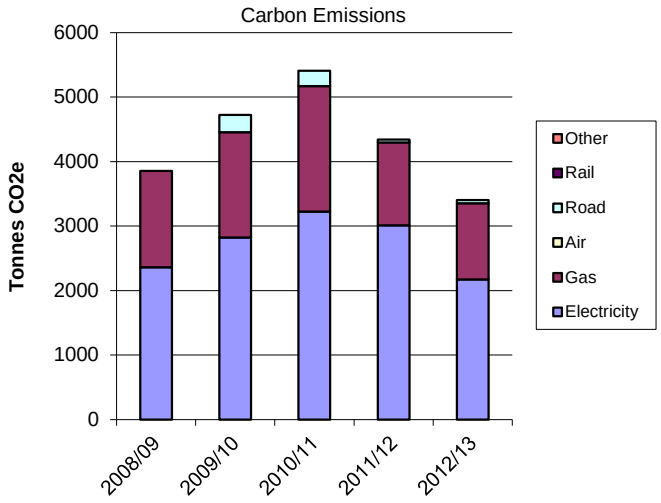
Energy Consumption

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.

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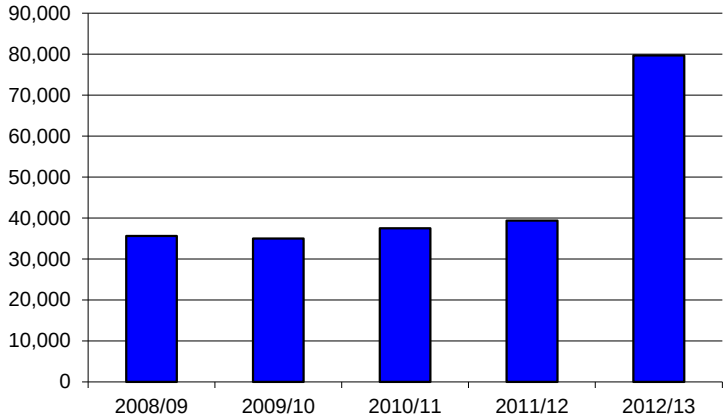
Water consumption in cubic metres

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

In 2012/13 we spent £61,806 on water.

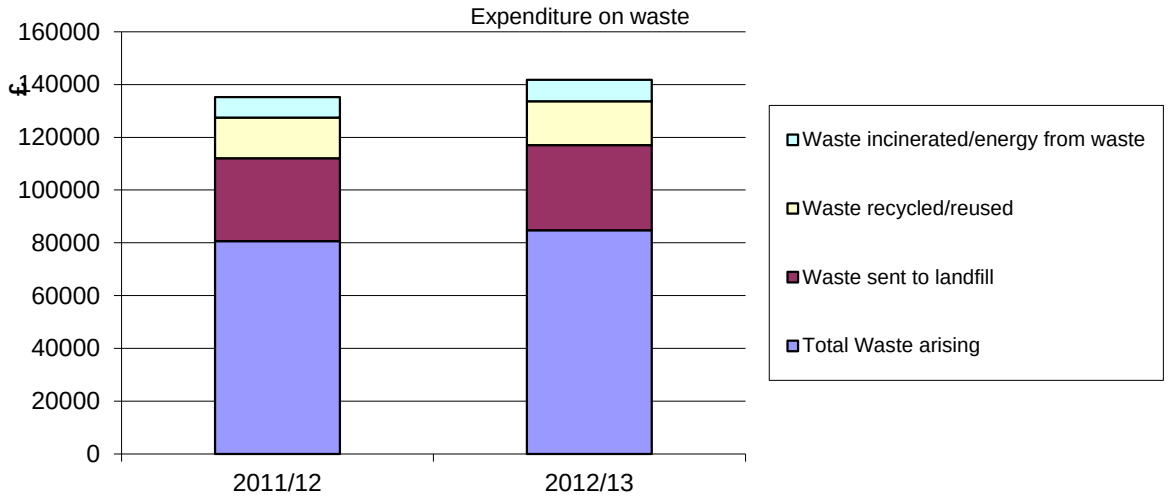


During 2012/13 our gross expenditure on the CRC Energy Efficiency Scheme was n/a

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.

Department of Health

NHS

South East Essex Primary Care Trust

2012-13 Accounts

Published to gov.uk, in PDF format only.

www.gov.uk/dh

South East 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: A Pike

Date: 4/6/13

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 EAST 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 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 organistion'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 West Essex PCT and South East 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

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

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.

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 no reported lapses of data security.

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 East 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 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 PCT is also host to the East of England Specialised Commissioning Group (SCG) which commissions high cost and low volume health services on behalf of all PCTs in the region. The East of England SCG clustered with the East and West Midlands SCG to work as one specialised commissioning group known as the Midlands and East Specialised Commissioning Group (M&ESCG). The SCG has its own audit plan, based on the key risks it faces as an organisation, and the implementation of any recommendations arising from these audits is monitored by the Audit Committee

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.

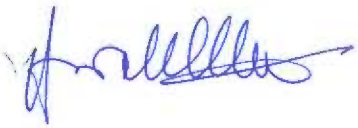
Significant issues

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.

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: 

Date: 4/6/13

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

Financial statements

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

This report is made solely to the Accountable Officer for South East Essex Primary Care Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

Respective responsibilities of the Signing Officer and Finance Signing Officer, and 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 Primary Care Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Primary Care Trust; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

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

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

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

Opinion on other matters

In our opinion:

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

Matters on which we report by exception

We have nothing to report in respect of the following other matters which the Code of Audit Practice for local NHS bodies (March 2010) requires us to report to you, if:

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

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

Respective responsibilities of the Primary Care Trust and auditors

The Primary Care Trust is responsible for putting in pace proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy of these arrangements.

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

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

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

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

Conclusion

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

Certificate

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

BDO LLP

David Eagles

for and on behalf of BDO LLP

Ipswich, UK

7 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	**14,567**	13,260
Other costs	5.1	**1,350,047**	1,231,339
Income	4	**(767,971)**	(679,608)
Net operating costs before interest		**596,643**	564,991
Investment income	9	**(53)**	(37)
Other (Gains)/Losses	10	**10**	0
Finance costs	11	**1,012**	606
Net operating costs for the financial year		**597,612**	565,560
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		**597,612**	**565,560**
Of which:			
Administration Costs			
Gross employee benefits	7.1	**11,106**	10,280
Other costs	5.1	**7,471**	8,479
Income	4	**(6,950)**	(5,613)
Net administration costs before interest		**11,627**	**13,146**
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**0**	47
Net administration costs for the financial year		**11,627**	**13,193**
Programme Expenditure			
Gross employee benefits	7.1	**3,461**	2,980
Other costs	5.1	**1,342,576**	1,222,860
Income	4	**(761,021)**	(673,995)
Net programme expenditure before interest		**585,016**	**551,845**
Investment income	9	**(53)**	(37)
Other (Gains)/Losses	10	**10**	0
Finance costs	11	**1,012**	559
Net programme expenditure for the financial year		**585,985**	**552,367**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**0**	0
Net (gain) on revaluation of property, plant & equipment	**(198)**	0
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*	**597,414**	**565,560**

*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 42 form part of this account.

Statement of Financial Position at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	12	**26,789**	15,475
Intangible assets	13	**13**	89
investment property	15	**0**	0
Other financial assets	21	**410**	390
Trade and other receivables	19	**0**	0
Total non-current assets		**27,212**	15,954
Current assets:			
Inventories	18	**0**	0
Trade and other receivables	19	**31,320**	26,868
Other financial assets	36.1	**0**	0
Other current assets	22	**0**	0
Cash and cash equivalents	23	**23,019**	52
Total current assets		**54,339**	26,920
Non-current assets held for sale	24	**0**	326
Total current assets		**54,339**	27,246
Total assets		**81,551**	43,200
Current liabilities			
Trade and other payables	25	**(82,609)**	(51,217)
Other liabilities	26,28	**0**	0
Provisions	32	**(1,696)**	(3,497)
Borrowings	27	**(194)**	(22)
Other financial liabilities	36.2	**0**	0
Total current liabilities		**(84,499)**	(54,736)
Non-current assets plus/less net current assets/liabilities		**(2,948)**	(11,536)
Non-current liabilities			
Trade and other payables	25	0	0
Other Liabilities	28	0	0
Provisions	32	(6,640)	(4,811)
Borrowings	27	(19,748)	(6,896)
Other financial liabilities	36.2	0	0
Total non-current liabilities		**(26,388)**	(11,707)
Total Assets Employed:		**(29,336)**	(23,243)
Financed by taxpayers' equity:			
General fund		(31,991)	(25,910)
Revaluation reserve		2,655	2,667
Other reserves		0	0
Total taxpayers' equity:		**(29,336)**	(23,243)

The notes on pages 5 to 42 form part of this account.

The financial statements on pages 1 to 4 were approved by the Audit Committee on the 3 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 (Restated)	**(25,910)**	**2,667**	**0**	**(23,243)**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(597,612)			**(597,612)**
Net gain on revaluation of property, plant, equipment		198		**198**
Net gain on revaluation of intangible assets		0		**0**
Net gain on revaluation of financial assets		0		**0**
Net gain on revaluation of assets held for sale		0		**0**
Impairments and reversals		0		**0**
Movements in other reserves			0	**0**
Transfers between reserves	210	(210)		**0**
Release of Reserves to SOCNE		0		**0**
Reclassification Adjustments				
Transfers between Revaluation Reserve & General Fund in respect of assets transferred under absorption	0	0		**0**
Net actuarial gain/(loss) on pensions	0		0	**0**
Total recognised income and expense for 2012-13	**(597,402)**	**(12)**	**0**	**(597,414)**
Net Parliamentary funding	591,321			**591,321**
Balance at 31 March 2013	**(31,991)**	**2,655**	**0**	**(29,336)**
Balance at 1 April 2011	**(16,017)**	**2,667**	**0**	**(13,350)**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(565,560)			(565,560)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment		0		0
Net Gain / (loss) on Revaluation of Intangible Assets		0		0
Net Gain / (loss) on Revaluation of Financial Assets		0		0
Net Gain / (loss) on Assets Held for Sale		0		0
Impairments and Reversals		0		0
Movements in other reserves			0	0
Transfers between reserves	0	0		0
Release of Reserves to Statement of Comprehensive Net Expenditure		0		0
Reclassification Adjustments				
Transfers to/(from) Other Bodies within the Resource Account Boundary (Restated)	264	0	0	264
On disposal of available for sale financial assets	0	0	0	0
Net actuarial gain/(loss) on pensions	0		0	0
Total recognised income and expense for 2011-12	(565,296)	0	0	(565,296)
Net Parliamentary funding	555,403			555,403
Balance at 31 March 2012 (Restated)	**(25,910)**	**2,667**	**0**	**(23,243)**

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		(596,643)	(564,991)
Depreciation and Amortisation		1,141	1,104
Impairments and Reversals		1,740	0
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		(915)	(532)
Release of PFI/deferred credit		0	0
(Increase)/Decrease in Inventories		0	29
(Increase)/Decrease in Trade and Other Receivables		(4,609)	861
(Increase)/Decrease in Other Current Assets		0	0
Increase in Trade and Other Payables		31,493	6,346
(Increase)/Decrease in Other Current Liabilities		0	0
Provisions Utilised		(2,093)	(743)
Increase in Provisions		2,072	3,251
Net Cash Outflow from Operating Activities		(567,814)	(554,675)
Cash flows from investing activities			
Interest Received		53	47
(Payments) for Property, Plant and Equipment		(831)	(747)
(Payments) for Intangible Assets		0	0
(Payments) for Other Financial Assets		0	0
(Payments) for Financial Assets (LIFT)		(22)	(249)
Proceeds of disposal of assets held for sale (PPE)		326	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)		2	301
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		(472)	(648)
Net cash inflow/(outflow) before financing		(568,286)	(555,323)
Cash flows from financing activities			
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		(68)	(36)
Net Parliamentary Funding	3.5	591,321	555,403
Capital Receipts Surrendered		0	0
Capital grants and other capital receipts		0	(1)
Cash Transferred (to)/from Other NHS Bodies (free text note required)		0	0
Net Cash Inflow from Financing Activities		591,253	555,366
Net increase in cash and cash equivalents		22,967	43
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		52	9
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies		0	0
Cash and Cash Equivalents (and Bank Overdraft) at year end		23,019	52

1. Accounting policies

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

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

1.1 Accounting Conventions

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, 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 claims received in the year where there is sufficient information to quantify the future liability.

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 accrual is based on the estimated remaining liability that will be payable in 2013/14. (£12,305k)

The PCT has a new year end provision of £6.1m to cover expected liabilities in respect of retrospective claims for the reimbursement of nursing home costs (also known as "continuing healthcare" provision). These claims have not yet been fully processed but their likelihood of success has been estimated based on the information received to date and the main areas of notable estimation uncertainty within the calculated provision made in respect of these claims are:

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

The PCT is also reporting a contingent liability of £2m in respect of claims for which no provision has been made, which includes those for which insufficient information has been received to make an assessment of likelihood of ultimate success. This estimate is subject to the same main areas of estimation uncertainty as for the provision.

1. Accounting policies (continued)

1.2 Revenue and Funding

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

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

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

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

1.3 Pooled budgets

The PCT has entered into a pooled budget with Southend on Sea Borough Council. Under the arrangement funds are pooled under S75 of the NHS Act 2006 for the following activities:

- Cumberledge Intermediate Care Centre

The Pool for the Cumberledge Intermediate Care Centre is hosted by South East Essex PCT. As a commissioner of healthcare services, the PCT makes contributions to the pool, which are then used to purchase healthcare services. The PCT accounts for its share of the assets, liabilities, income and expenditure of the pool as determined by the pooled budget agreement.
A memorandum note to the accounts (Note 40) provides details of the joint income and expenditure for the pool hosted by the PCT.

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).
Since 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.
Expenses 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.

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. The most recent formal valuation by the District Valuer occurred as at 31st March 2013. This was on a Modern Equivalent Asset basis.

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.

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.

For all other assets, 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.

1.9 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.

1.10 Non-current assets held for sale

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

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

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

1.11 Inventories

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

1. Accounting policies (continued)

1.12 Cash and cash equivalents

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

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

1.13 Losses and Special Payments

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

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

1.14 Clinical Negligence Costs

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

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

1.15 Employee benefits

Short-term employee benefits

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

Retirement benefit costs

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

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

For further information please see Note 7.5.

1.16 Research and Development

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

1.17 Other expenses

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

1.18 Grant making

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

1.19 EU Emissions Trading Scheme

The PCT does not have an EU Emissions Trading Scheme.

1. Accounting policies (continued)

1.20 Contingencies

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

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

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

1.21 Leases

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

The PCT as lessee

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

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

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

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

The PCT as lessor

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

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

1.22 Provisions

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

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

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

1. Accounting policies (continued)

1.23 Financial Instruments

Financial assets

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

Financial assets are initially recognised at fair value.

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

Financial assets at fair value through profit and loss

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

Held to maturity investments

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

Available for sale financial assets

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

Loans and receivables

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

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.

1.24 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 LIFT 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 LIFT 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) LIFT assets, liabilities, and finance costs
LIFT assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially, prior to the asset being in operation, at the lower of fair value or the present value of the minimum lease payments in accordance with the principles of IAS 17. When the LIFT assets become operational they 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 LIFT liability is recognised at the same time as the LIFT assets are recognised.The assets are measured initially at the present value of the minimum lease payments, prior to the asset being in operation, and is subsequently measured as a finance lease liability when the assets being operational 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.

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.

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

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

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

2 Operating segments

	Residual PCT Commissioning		EOE Specialised Commissioning		Castle Point & Rochford CCG		Southend CCG		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	**2012-13 £000**	2011-12 £000
Expenditure	**208,039**	585,467	**750,123**	659,132	**202,123**		**204,329**		**1,364,614**	1,244,599
Surplus/(Deficit)										
Segment surplus/(deficit)	**10,888**	879	**0**	0	**(11,554)**		**895**		**229**	879
Common costs	**0**	0	**0**	0	**0**		**0**		**0**	0
Surplus/(deficit) before interest	**10,888**	**879**	**0**	**0**	**(11,554)**		**895**		**229**	879
Net Assets:										
Segment net assets	**(29,336)**	(20,831)	**0**	(1,478)					**(29,336)**	(22,309)

The PCT operates with 4 (2 in 2011/12) internal segments, each with clearly defined governance arrangements; 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 segements there are clearly defined governance arrangements, being to commission healthcare services for the residents of South East Essex. In addition the PCT accounts for East of England Specialised Commissioning Group (EoE SCG), which commissions specialised health services on behalf of the 13 Primary Care Trusts in the East of England.

East of England Specialised Commissioning Group operate on a trading account basis. Income is either recharged to the Commissioning segment of the PCT for services delivered or commissioned on behalf of South East Essex patients, or received from external organisations.

Under the Establishment Agreement governing the operation of the East of England Specialised Commissioning Group, South East Essex, as host PCT, is not liable for any under or over-spends on Specialised Services which are recharged or shared with all PCTs in the East of England.

3. Financial Performance Targets

3.1 Revenue Resource Limit

The PCTs' performance for the year ended 2012-13 is as follows:	2012-13 £000	2011-12 £000
Total Net Operating Cost for the Financial Year	597,612	565,560
Net operating cost plus (gain)/loss on transfers by absorption	0	
Adjusted for prior period adjustments in respect of errors	0	0
Revenue Resource Limit	597,841	566,439
Underspend Against Revenue Resource Limit (RRL)	229	879

3.2 Capital Resource Limit

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

	2012-13 £000	2011-12 £000
Capital Resource Limit	1,875	862
Charge to Capital Resource Limit	504	696
Underspend Against CRL	1,371	166

3.3 Provider full cost recovery duty

Note no longer relevant

3.4 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	591,321	555,383
Cash Limit	591,321	563,752
Underspend Against Cash Limit	0	8,369

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

	2012-13 £000	2011-12 £000
Total cash received from DH (Gross)	514,730	477,091
Less: Trade Income from DH	0	0
Less/(Plus): movement in DH working balances	0	18
Sub total: net advances	514,730	477,109
(Less)/plus: transfers (to)/from other resource account bodies	0	0
Plus: cost of Dentistry Schemes (central charge to cash limits)	13,949	14,117
Plus: drugs reimbursement (central charge to cash limits)	62,642	64,177
Parliamentary funding credited to General Fund	591,321	555,403

4 Miscellaneous Revenue

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Dental Charge income from Contractor-Led GDS & PDS	**4,268**	0	4,268	4,177
Prescription Charge income	**2,741**	0	2,741	2,595
Strategic Health Authorities	**367**	60	307	549
NHS Trusts	**24**	0	24	108
NHS Foundation Trusts	**477**	0	477	1,130
Primary Care Trusts - Other	**3,321**	1,383	1,938	2,460
Primary Care Trusts - Lead Commissioning *	**745,582**	3,764	741,818	659,310
NDPBs and Others (CGA)	**10**	0	10	0
Department of Health - Other	**0**	0	0	113
Recoveries in respect of employee benefits	**756**	756	0	0
Local Authorities	**5,392**	61	5,331	6,091
Patient Transport Services	**1**	0	1	0
Rental revenue from operating leases	**3,228**	152	3,076	2,330
Other revenue	**1,804**	774	1,030	745
Total miscellaneous revenue	**767,971**	**6,950**	**761,021**	**679,608**

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	69,653		69,653	65,814
Non-Healthcare	797	797	0	1,122
Total	70,450	797	69,653	66,936
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts *	186,152	80	186,072	153,286
Goods and services (other, excl Trusts, FT and PCT))	264	248	16	4,055
Total	186,416	328	186,088	157,341
Goods and Services from Foundation Trusts *	839,464	580	838,884	765,966
Purchase of Healthcare from Non-NHS bodies	93,769		93,769	84,766
Expenditure on Drugs Action Teams	1,602		1,602	1,742
Non-GMS Services from GPs	136	113	23	182
Contractor Led GDS & PDS (excluding employee benefits)	18,824		18,824	19,008
Chair, Non-executive Directors & PEC remuneration	134	134	0	99
Executive committee members costs	15	15	0	97
Consultancy Services	1,051	935	116	643
Prescribing Costs	54,905		54,905	53,872
G/PMS, APMS and PCTMS (excluding employee benefits)	45,330	3	45,327	44,658
New Pharmacy Contract	12,701		12,701	12,843
General Ophthalmic Services	3,486		3,486	3,652
Supplies and Services - Clinical	8,639	124	8,515	7,793
Supplies and Services - General	734	725	9	214
Establishment	984	472	512	1,017
Transport	907	0	907	108
Premises	6,312	2,562	3,750	6,629
Impairments & Reversals of Property, plant and equipment	1,740	0	1,740	0
Depreciation	1,065	181	884	1,006
Amortisation	76	59	17	98
Impairment of Receivables	6	0	6	(13)
Research and Development Expenditure	41	0	41	0
Audit Fees	257	257	0	386
Other Auditors Remuneration	0	0	0	23
Education and Training	133	122	11	172
Grants for capital purposes	619	0	619	385
Other	251	64	187	1,716
Total Operating costs charged to Statement of Comprehensive Net Expenditure	1,350,047	7,471	1,342,576	1,231,339

* The increase in expenditure with NHS Trusts and Foundation Trusts is largely as a result of the increase in the services commissioned through the Specialised Commissioning Group, which is hosted by South East Essex PCT.

Employee Benefits (excluding capitalised costs)				
Employee Benefits associated with PCTMS	427	0	427	570
Trust led PDS and PCT DS	0	0	0	0
PCT Officer Board Members	373	373	0	755
Other Employee Benefits	13,767	10,733	3,034	11,935
Total Employee Benefits charged to SOCNE	14,567	11,106	3,461	13,260
Total Operating Costs	1,364,614	18,577	1,346,037	1,244,599

Analysis of grants reported in total operating costs				
For capital purposes				
Grants to fund Capital Projects - GMS	292	0	292	385
Grants to Local Authorities to Fund Capital Projects	327	0	327	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	619	0	619	385
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	619	0	619	385

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	11,627	11,305	322
Weighted population (number in units)*	340,001	340,001	340,001
Running costs per head of population (£ per head)	£ 34.20	£ 33.25	£ 0.95
PCT Running Costs 2011-12			
Running costs (£000s)	13,216	11,846	1,370
Weighted population (number in units)	340,001	340,001	340,001
Running costs per head of population (£ per head)	£ 38.87	£ 34.84	£ 4.03

* 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	45,757	45,228
Prescribing costs	54,905	53,872
Contractor led GDS & PDS	18,824	19,008
General Ophthalmic Services	3,486	3,652
New Pharmacy Contract	12,701	12,843
Non-GMS Services from GPs	0	182
Total Primary Healthcare purchased	**135,673**	134,785
Purchase of Secondary Healthcare		
Learning Difficulties	6,772	6,064
Mental Illness	59,448	59,708
Maternity	16,654	15,673
General and Acute	279,677	251,974
Accident and emergency	11,650	9,554
Community Health Services	34,369	35,220
Other Contractual	25,799	24,179
Total Secondary Healthcare Purchased	**434,369**	402,372
Grant Funding		
Grants for capital purposes	619	385
Total Healthcare Purchased by PCT	**570,661**	**537,542**
Healthcare from NHS FTs included above	282,777	279,457

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	0	2,260	0	**2,260**	2,095
Contingent rents	0	0	0	**0**	0
Sub-lease payments	0	0	0	**0**	0
Total	**0**	**2,260**	**0**	**2,260**	**2,095**
Payable:					
No later than one year	0	1,773	35	**1,808**	1,755
Between one and five years	0	6,298	21	**6,319**	5,910
After five years	0	7,506	0	**7,506**	7,409
Total	**0**	**15,577**	**56**	**15,633**	**15,074**

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	**3,228**	2,330
Contingent rents	**0**	0
Total	**3,228**	2,330
Receivable:		
No later than one year	**1,511**	2,669
Between one and five years	**1,165**	2,151
After five years	**2,864**	4,250
Total	**5,540**	9,070

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%. During 2012/13 following the reorganisation of the NHS, Executive Directors were not cross charged to new NHS bodies as the old NHS entity structure remained liable for these costs up until 31st March 2013.

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	11,424	9,046	2,378	9,658	8,105	1,553	1,766	941	825
Social security costs	948	863	85	948	863	85	0	0	0
Employer Contributions to NHS BSA - Pensions Division	1,250	1,115	135	1,250	1,115	135	0	0	0
Other employment benefits	82	82	0	82	82	0	0	0	0
Termination benefits	863	0	863	863	0	863	0	0	0
Total employee benefits	14,567	11,106	3,461	12,801	10,165	2,636	1,766	941	825
Less recoveries in respect of employee benefits (table below)	(756)	(756)	0	(756)	(756)	0	0	0	0
Total - Net Employee Benefits including capitalised costs	13,811	10,350	3,461	12,045	9,409	2,636	1,766	941	825
Employee costs capitalised	0	0	0	0	0	0	0	0	0
Gross Employee Benefits excluding capitalised costs	14,567	11,106	3,461	12,801	10,165	2,636	1,766	941	825
Recognised as:									
Commissioning employee benefits	14,567			12,801			1,766		
Provider employee benefits	0			0			0		
Gross Employee Benefits excluding capitalised costs	14,567			12,801			1,766		

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	623	623	0	623	623	0	0	0	0
Social Security costs	58	58	0	58	58	0	0	0	0
Employer Contributions to NHS BSA - Pensions Division	75	75	0	75	75	0	0	0	0
TOTAL excluding capitalised costs	756	756	0	756	756	0	0	0	0

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	10,723	8,146	2,577
Social security costs	758	758	0
Employer Contributions to NHS BSA - Pensions Division	1,074	1,074	0
Other employment benefits	74	74	0
Termination benefits	631	631	0
Total gross employee benefits	13,260	10,683	2,577
Less recoveries in respect of employee benefits	0	0	0
Total - Net Employee Benefits including capitalised costs	13,260	10,683	2,577
Employee costs capitalised	0	0	0
Gross Employee Benefits excluding capitalised costs	13,260	10,683	2,577
Recognised as:			
Commissioning employee benefits	13,260		
Provider employee benefits	0		
Gross Employee Benefits excluding capitalised costs	13,260		

7.2 Staff Numbers

	2012-13 Total Number	2012-13 Permanently employed Number	2012-13 Other Number	2011-12 Total Number	2011-12 Permanently employed Number	2011-12 Other Number
Average Staff Numbers						
Medical and dental	8	5	3	7	4	3
Ambulance staff	0	0	0	0	0	0
Administration and estates	236	218	18	271	222	49
Healthcare assistants and other support staff	0	0	0	0	0	0
Nursing, midwifery and health visiting staff	11	10	1	8	5	3
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	0	0	0	2	2	0
Social Care Staff	0	0	0	0	0	0
Other	0	0	0	0	0	0
TOTAL	255	233	22	287	233	54

7.3 Staff Sickness absence and ill health retirements

	2012-13 Number	2011-12 Number
Total Days Lost	1,708	7,542
Total Staff Years	334.9	900.0
Average working Days Lost	5.10	8.38

The above staff sickness absence and ill health retirement figures include provider staff for 2011/12 as provided by the DH. 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	1	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
Lees than £10,000	5	0	5	2	5	7
£10,001-£25,000	7	0	7	0	10	10
£25,001-£50,000	4	0	4	0	3	3
£50,001-£100,000	4	0	4	1	4	5
£100,001 - £150,000	1	0	1	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total number of exit packages by type	21	0	21	3	22	25
	£s	£s	£s	£s	£s	£s
Total resource cost	701,360	0	701,360	63,261	567,916	631,177

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 East 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.

	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
Lees than £10,000	11	0	11
£10,001-£25,000	18	0	18
£25,001-£50,000	12	0	12
£50,001-£100,000	18	0	18
£100,001 - £150,000	5	0	5
£150,001 - £200,000	2	0	2
>£200,000	2	0	2
Total number of exit packages by type	68	0	68
	£000s	£000s	£000s
Total resource cost	3,635	0	3,635

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	**19,575**	**110,972**	14,920	110,203
Total Non-NHS Trade Invoices Paid Within Target	**18,285**	**106,708**	13,720	103,281
Percentage of NHS Trade Invoices Paid Within Target	93.41%	96.16%	91.96%	93.72%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**6,197**	**1,185,330**	5,536	1,079,938
Total NHS Trade Invoices Paid Within Target	**5,443**	**1,162,533**	4,532	1,059,614
Percentage of NHS Trade Invoices Paid Within Target	87.83%	98.08%	81.86%	98.12%

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

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

	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

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Rental Income				
PFI finance lease revenue (planned)	0	0	0	0
PFI finance lease revenue (contingent)	0	0	0	0
Other finance lease revenue	0	0	0	0
Subtotal	0	0	0	0
Interest Income				
LIFT: equity dividends receivable	0	0	0	0
LIFT: loan interest receivable	53	0	53	37
Subtotal	53	0	53	37
Total investment income	53	0	53	37

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)	(10)	0	(10)	0
Total	(10)	0	(10)	0

11. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest				
Interest on obligations under finance leases	0	0	0	0
Interest on obligations under LIFT contracts:				
- main finance cost	963	0	963	532
Other interest expense	0	0	0	0
Total interest expense	963	0	963	532
Other finance costs	0	0	0	0
Provisions - unwinding of discount	49		49	74
Total	1,012	0	1,012	606

12.1 Property, plant and equipment

2012-13	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:									
At 1 April 2012	2,518	12,879	0	0	128	0	4,145	301	19,971
Additions of Assets Under Construction				0					0
Additions Purchased	0	128	0		37	0	499	166	830
Additions Donated	0	0	0	0	0	0	0	0	0
Additions Government Granted	0	0	0	0	0	0	0	0	0
Additions Leased	1,495	11,596	0		0	0	0	0	13,091
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassifications as Held for Sale	0	0	0	0	0	0	0	0	0
Cumulative Depreciation netted off following revaluation	0	(1,256)	0	0	0	0	0	0	(1,256)
Upward revaluation/positive indexation	51	147	0	0	0	0	0	0	198
Impairments/negative indexation	0	0	0	0	0	0	0	0	0
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	0
At 31 March 2013	4,064	23,494	0	0	165	0	4,644	467	32,834
Depreciation									
At 1 April 2012	0	1,020	0	0	128	0	3,085	263	4,496
Reclassifications	0	0	0		0	0	0	0	0
Reclassifications as Held for Sale	0	0	0		0	0	0	0	0
Cumulative Depreciation netted off following revaluation	0	(1,256)	0		0	0	0	0	(1,256)
Upward revaluation/positive indexation	0	0	0		0	0	0	0	0
Impairments	135	1,577	0	0	14	0	14	0	1,740
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Charged During the Year	0	452	0		1	0	576	36	1,065
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	0
At 31 March 2013	135	1,793	0	0	143	0	3,675	299	6,045
Net Book Value at 31 March 2013	3,929	21,701	0	0	22	0	969	168	26,789
Purchased	3,929	21,701	0	0	22	0	969	168	26,789
Donated	0	0	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	3,929	21,701	0	0	22	0	969	168	26,789
Asset financing:									
Owned	1,894	5,526	0	0	22	0	969	168	8,579
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP LIFT contracts	2,035	16,175	0	0	0	0	0	0	18,210
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	3,929	21,701	0	0	22	0	969	168	26,789

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	689	1,975	0	0	0	0	0	3	2,667
Movements (specify)	49	(61)	0	0	0	0	0	0	(12)
At 31 March 2013	738	1,914	0	0	0	0	0	3	2,655

Additions to Assets Under Construction in 2012-13

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

12.2 Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:									
At 1 April 2011	2,518	12,713	0	0	247	0	3,564	301	19,343
Additions - purchased	0	166	0	0	0	0	581	0	747
Additions - donated	0	0	0	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Revaluation & indexation gains	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Reversals of impairments	0	0	0	0	0	0	0	0	0
In-year transfers to/from NHS bodies	0	0	0	0	(119)	0	0	0	(119)
Cumulative dep netted off cost following revaluation	0	0	0	0	0	0	0	0	0
At 31 March 2012	2,518	12,879	0	0	128	0	4,145	301	19,971
Depreciation									
At 1 April 2011	0	638	0		131	0	2,490	234	3,493
Reclassifications		0	0		0	0	0	0	0
Reclassifications as Held for Sale	0	0	0		0	0	0	0	0
Disposals other than for sale	0	0	0		0	0	0	0	0
Upward revaluation/positive indexation	0	0	0		0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Charged During the Year	0	382	0		0	0	595	29	1,006
In-year transfers to/from NHS bodies	0	0	0	0	(3)	0	0	0	(3)
Cumulative dep netted off cost following revaluation	0	0	0	0	0	0	0	0	0
At 31 March 2012	0	1,020	0	0	128	0	3,085	263	4,496
Net Book Value at 31 March 2012	2,518	11,859	0	0	0	0	1,060	38	15,475
Purchased	2,518	11,859	0	0	0	0	1,060	38	15,475
Donated	0	0	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0	0	0
At 31 March 2012	2,518	11,859	0	0	0	0	1,060	38	15,475
Asset financing:									
Owned	1,843	5,991	0	0	0	0	1,060	38	8,932
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP LIFT contracts	675	5,868	0	0	0	0	0	0	6,543
PFI residual: interests	0	0	0	0	0	0	0	0	0
At 31 March 2012	2,518	11,859	0	0	0	0	1,060	38	15,475

13.1 Intangible non-current assets

2012-13	Software internally generated £000	Software purchased £000	Licences & trademarks £000	Patents £000	Development expenditure £000	Total £000
At 1 April 2012	0	417	0	0	0	417
At 31 March 2013	0	417	0	0	0	417
Amortisation						
At 1 April 2012	0	328	0	0	0	328
Charged during the year	0	76	0	0	0	76
At 31 March 2013	0	404	0	0	0	404
Net Book Value at 31 March 2013	0	13	0	0	0	13
Net Book Value at 31 March 2013 comprises						
Purchased	0	13	0	0	0	13
Total at 31 March 2013	0	13	0	0	0	13

13.2 Intangible non-current assets

2011-12	Software internally generated	Software purchased	Licences & trademarks	Patents	Development expenditure	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2011	0	417	0	0	0	417
At 31 March 2012	0	417	0	0	0	417
Amortisation						
At 1 April 2011	0	230	0	0	0	230
Charged during the year	0	98	0	0	0	98
At 31 March 2012	0	328	0	0	0	328
Net Book Value at 31 March 2012	0	89	0	0	0	89
Net Book Value at 31 March 2012 comprises						
Purchased	0	89	0	0	0	89
Donated	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0
Total at 31 March 2012	0	89	0	0	0	89

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,

13.4 Economic Lives of Non-Current Assets

	Min Life Years	Max Life Years
Intangible Assets		
Software Licences	0	1
Licences and Trademarks	0	0
Patents	0	0
Development Expenditure	0	0
Property, Plant and Equipment		
Buildings exc Dwellings	4	50
Dwellings	0	0
Plant & Machinery	5	5
Transport Equipment	0	0
Information Technology	0	3
Furniture and Fittings	0	8

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

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000
Property, Plant and Equipment impairments and reversals taken to SoCNE			
Loss or damage resulting from normal operations	0	0	0
Over-specification of assets	0	0	0
Abandonment of assets in the course of construction	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen obsolescence	0		0
Loss as a result of catastrophe	0		0
Other	0		0
Changes in market price	1,740		1,740
Total charged to Annually Managed Expenditure	**1,740**		**1,740**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Loss or damage resulting from normal operations	0		
Over Specification of Assets	0		
Abandonment of assets in the course of construction	0		
Unforeseen obsolescence	0		
Loss as a result of catastrophe	0		
Other	0		
Changes in market price	0		
Total impairments for PPE charged to reserves	**0**		
Total Impairments of Property, Plant and Equipment	**1,740**	**0**	**1,740**
Total Impairments charged to Revaluation Reserve	0		
Total Impairments charged to SoCNE - DEL	0	0	0
Total Impairments charged to SoCNE - AME	1,740		1,740
Overall Total Impairments	**1,740**	**0**	**1,740**
Of which:			
Impairment on revaluation to "modern equivalent asset" basis	**0**	0	0

Following a review of the PCT's Properly, Plant and Equipment Non-Current Assets as at 31 March 2013 an impairment of £1,740k was taken into the PCT's Statement of Comprehensive Net Expenditure.

There are no comparators for this note as there were no impairments or reverals recognised in 2011-12.

15 Investment property

No investment property to report.

16 Commitments

16.1 Capital commitments

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

	31 March 2013 £000	31 March 2012 £000
Property, plant and equipment	0	30
Intangible assets	0	0
Total	0	30

16.2 Other financial commitments

The PCT has entered into non-cancellable contracts (which are not leases or PFI contracts or other service

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

17 Intra-Government and other balances

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with other Central Government Bodies	19,841	0	20,072	0
Balances with Local Authorities	21	0	855	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	7,828	0	32,230	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	2,950	0	28,772	0
At 31 March 2013	**30,640**	**0**	**81,929**	**0**
prior period:				
Balances with other Central Government Bodies	10,361	0	6,774	0
Balances with Local Authorities	0	0	836	0
Balances with NHS Trusts and Foundation Trusts	12,952	0	17,218	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	3,962	0	25,862	0
At 31 March 2012	**27,275**	**0**	**50,690**	**0**

18 Inventories

The PCT has no inventories.

19.1 Trade and other receivables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000 Restated	31 March 2013 £000	31 March 2012 £000
NHS receivables - revenue	10,717	6,855	0	0
NHS receivables - capital	0	156	0	0
NHS prepayments and accrued income	16,787	15,822	0	0
Non-NHS receivables - revenue	2,719	3,446	0	0
Non-NHS receivables - capital	0	1	0	0
Non-NHS prepayments and accrued income	1,116	600	0	0
Provision for the impairment of receivables	(184)	(178)	0	0
VAT	165	73	0	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables	0	93	0	0
Total	31,320	26,868	0	0
Total current and non current	31,320	26,868		
Included above:				
Prepaid pensions contributions	0	0		

A prior period adjustment has been made due to the overstatement of NHS receivables of £407k and the understatement of NHS payables of £527k. This was due to the Community Healthcare merger reserve being recalculated in 2012-13, with the necessary transfer to SEPT during 2011-12 reducing from £1,198k to £264k. This has impacted on the opening General Fund balance, which has changed by £934k from (£24,976k) to (£25,910k). This restated balance is in the Statement of Financial Position and Statement of Changes in Taxpayers Equity comparatives. The changes to the opening NHS Receivables and NHS Payables have also impacted on the Note 36 comparatives Financial Assets and Liabilities.

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	5,603	895
By three to six months	330	82
By more than six months	423	111
Total	6,356	1,088

19.3 Provision for impairment of receivables

	2012-13 £000	2011-12 £000
Balance at 1 April 2012	(178)	(191)
Amount written off during the year	0	0
Amount recovered during the year	0	0
(Increase)/decrease in receivables impaired	(6)	13
Balance at 31 March 2013	(184)	(178)

20 NHS LIFT investments

	Loan £000	Share capital £000	Total £000
Balance at 1 April 2012	**388**	**2**	**390**
Additions	**22**	**0**	**22**
Disposals	**0**	**0**	**0**
Loan repayments	**(2)**	**0**	**(2)**
Revaluations	**0**	**0**	**0**
Loans repayable within 12 months	**0**	**0**	**0**
Balance at 31 March 2013	**408**	**2**	**410**
Balance at 1 April 2011	440	2	442
Additions	249	0	249
Disposals	(301)	0	(301)
Loan repayments	0	0	0
Revaluations	0	0	0
Loans repayable within 12 months	0	0	0
Balance at 31 March 2012	**388**	**2**	**390**

21.1 Other financial assets - Current

The PCT has no Other financial assets - current.

21.2 Other Financial Assets (LIFT Investments) - Non Current

	31 March 2013 £000	31 March 2012 £000
Opening balance 1 April	**390**	390
Additions	22	0
Revaluation	0	0
Impairments	0	0
Impairment Reversals	0	0
Transferred to current financial assets	0	0
Repayment of LIFT loan	(2)	0
Transfers (to)/from Other Public Sector Bodies in year	0	0
Total Other Financial Assets - Non Current	**410**	390

21.3 Other Financial Assets - Capital Analysis

	31 March 2013 £000	31 March 2012 £000
Capital Expenditure	**22**	0
Capital Income	**(2)**	0

22 Other current assets

The PCT has no current assets.

23 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**52**	9
Net change in year	**22,967**	43
Closing balance	**23,019**	52
Made up of		
Cash with Government Banking Service	**23,019**	51
Commercial banks	**0**	1
Cash in hand	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**23,019**	52
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**23,019**	52
	0	0

24 Non-current assets held for sale

	Land	Buildings, excl. dwellings	Dwellings	Asset Under Construction and Payments on Account	Plant and Machinery	Transport and Equipment	Information Technology	Furniture and Fittings	Intangible Assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Balance at 1 April 2012	0	326	0	0	0	0	0	0	0	326
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	0	**0**
Less assets sold in the year	0	(326)	0	0	0	0	0	0	0	(326)
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from other public sector bodies	0	0	0	0	0	0	0	0	0	**0**
Revaluation	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2013	0	0	0	0	0	0	0	0	0	0
Liabilities associated with assets held for sale at 31 March 2013	0	0	0	0	0	0	0	0	0	0
										0
Balance at 1 April 2011	0	326	0	0	0	0	0	0	0	326
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2012	0	326	0	0	0	0	0	0	0	326
Liabilities associated with assets held for sale at 31 March 2012	0	0	0	0	0	0	0	0	0	0

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

At 31 March 2012	0
At 31 March 2013	0

25 Trade and other payables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000 Restated	31 March 2013 £000	31 March 2012 £000
Interest payable	0	0		
NHS payables - revenue	23,893	16,621	0	0
NHS payables - capital	0	0	0	0
NHS accruals and deferred income	27,849	7,898	0	0
Family Health Services (FHS) payables	14,161	11,921		
Non-NHS payables - revenue	5,067	5,050	0	0
Non-NHS payables - capital	4	105	0	0
Non-NHS accruals and deferred income	10,943	8,836	0	0
Social security costs	152	0		
VAT	0	0	0	0
Tax	236	0		
Payments received on account	0	0	0	0
Other	304	786	0	0
Total	82,609	51,217	0	0
Total payables (current and non-current)	**82,609**	**51,217**		

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 £170,928 (2011-12: £0) in respect of outstanding pensions contributions at 31 March 2013.

26 Other liabilities

The PCT has no other liabilities.

27 Borrowings

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
Bank overdraft - Government Banking Service	0	0		
Bank overdraft - commercial banks	0	0		
PFI liabilities:				
Main liability	0	0	0	0
Lifecycle replacement received in advance	0	0	0	0
LIFT liabilities:				
Main liability	194	22	19,748	6,896
Lifecycle replacement received in advance	0	0	0	0
Finance lease liabilities	0	0	0	0
Other (describe)	0	0	0	0
Total	194	22	19,748	6,896
Total other liabilities (current and non-current)	**19,942**	**6,918**		

Borrowings/Loans - Payment of Principal Falling Due in:

	DH £000s	Other £000s	Total £000s
0 - 1 Years	0	194	194
1 - 2 Years	0	201	201
2 - 5 Years	0	588	588
Over 5 Years	0	18,959	18,959
TOTAL	0	19,942	19,942

31 March 2012

Borrowings/Loans - Payment of Principal Falling Due in:

	DH £000s	Other £000s	Total £000s
0 - 1 Years	0	22	22
1 - 2 Years	0	18	18
2 - 5 Years	0	28	28
Over 5 Years	0	6,850	6,850
TOTAL	0	6,918	6,918

28 Other financial liabilities

The PCT has no other financial liabilities.

29 Deferred income

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Opening balance at 1 April 2012	**363**	363	**0**	0
Deferred income addition	**0**	0	**0**	0
Transfer of deferred income	**(363)**	0	**0**	0
Current deferred Income at 31 March 2013	**0**	363	**0**	0
Total other liabilities (current and non-current)	**0**	**363**		

30 Finance lease obligations

The PCT does not carry any Finance Lease obligations as a Lessee

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	Continuing Care £000s	Other £000s	Redundancy £000s
Balance at 1 April 2012	**8,308**	183	2,023	293	4,260	1,404	145
Arising During the Year	**2,702**	9	242	35	1,846	37	533
Utilised During the Year	**(2,093)**	(15)	(1,132)	(10)	0	(936)	0
Reversed Unused	**(630)**	0	0	0	0	(107)	(523)
Unwinding of Discount	**49**	6	35	8	0	0	0
Change in Discount Rate	**0**	0	0	0	0	0	0
Transferred (to)/from other Public Sector bodies	**0**	0	0	0	0	0	0
Balance at 31 March 2013	**8,336**	**183**	**1,168**	**326**	**6,106**	**398**	**155**
Expected Timing of Cash Flows:							
No Later than One Year	**1,696**	**15**	**93**	**13**	**1,221**	**199**	**155**
Later than One Year and not later than Five Years	**896**	**61**	**231**	**51**	**0**	**398**	**155**
Later than Five Years	**5,744**	**107**	**844**	**262**	**4,885**	**(199)**	**(155)**

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at 31 March 2013	490
As at 31 March 2012	726

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 was one new provision arising in year relating to additional continuing care claims in process at 31 March 2013 £1,846k.

The category "Other" includes the following provisions:
- Provision for Onerous Contracts £398k

33 Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities		
Equal Pay	**0**	0
Contingent Liability for Continuing Healthcare	**(2,031)**	(6)
Net Value of Contingent Liabilities	**(2,031)**	(6)
Contingent Assets		
Contingent Assets	**0**	0
Net Value of Contingent Assets	**0**	0

Contingent Liabilities for 2012/13 includes anticipated costs of claims received for retrospective continuing healthcare claims received up to and including the 30th September 2012 deadline.

34 PFI and LIFT - additional information

34.1 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	80	46
Total	80	46

Payments committed to in respect of off SOFP LIFT and the service element of on SOFP LIFT.	31 March 2013 £000	31 March 2012 £000
LIFT Scheme Expiry Date:		
No Later than One Year	545	187
Later than One Year, No Later than Five Years	2,506	862
Later than Five Years	24,132	6,778
Total	27,183	7,827

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	1,912	525
Later than One Year, No Later than Five Years	7,487	2,040
Later than Five Years	47,932	16,111
Subtotal	57,331	18,676
Less: Interest Element	(37,389)	(11,758)
Total	19,942	6,918

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	179	0	179
Interest Expense	963	0	963
Impairment charge - AME	0		0
Impairment charge - DEL	0	0	0
Other Expenditure	279	0	279
Revenue Receivable from subleasing	0	0	0
Total IFRS Expenditure (IFRIC12)	1,421	0	1,421
Revenue consequences of LIFT/PFI schemes under UK GAAP / ESA95 (net of any sublease income)	(1,309)	0	(1,309)
Net IFRS change (IFRIC12)	112	0	112

Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12	
Capital expenditure 2012-13	13,091
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 is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The PCT has no overseas operations. The PCT therefore has low exposure to currency rate fluctuations.

Interest rate risk

PCTs are not permitted to borrow outside of approved arrangements, such as LIFT. The PCT therefore has low exposure to interest-rate fluctuations

Credit Risk

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

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

36.1 Financial Assets	At 'fair value through profit and loss' £000	Loans and receivables £000	Available for sale £000	Total £000
Embedded derivatives	0	0	0	**0**
Receivables - NHS	0	24,290	0	**24,290**
Receivables - non-NHS	0	2,719	0	**2,719**
Cash at bank and in hand	0	23,019	0	**23,019**
Other financial assets	0	0	410	**410**
Total at 31 March 2013	**0**	**50,028**	**410**	**50,438**
		Restated		
Embedded derivatives	0	0	0	0
Receivables - NHS	0	7,011	0	7,011
Receivables - non-NHS	0	3,447	0	3,447
Cash at bank and in hand	0	52	0	52
Other financial assets	0	93	390	483
Total at 31 March 2012	0	10,603	390	10,993

36.2 Financial Liabilities	At 'fair value through profit and loss' £000	Other £000	Total £000
Embedded derivatives	0	0	**0**
NHS payables	0	44,028	**44,028**
Non-NHS payables	0	18,552	**18,552**
Other borrowings	0	0	**0**
PFI & finance lease obligations	0	19,942	**19,942**
Other financial liabilities	0	304	**304**
Total at 31 March 2013	**0**	**82,826**	**82,826**
		Restated	
Embedded derivatives	0	0	0
NHS payables	0	16,621	16,621
Non-NHS payables	0	17,076	17,076
Other borrowings	0	0	0
PFI & finance lease obligations	0	6,918	6,918
Other financial liabilities	0	786	786
Total at 31 March 2012	0	41,401	41,401

37.1 Related party transactions 2012/13

Details of related party contracted transactions with individuals are as follows:

	Relationship	Payments to Related Party £	Receipts from Related Party £	Amounts owed to Related Party £	Amounts due from Related Party £
Dr A Atherton	Spouse is a GP in Leigh on Sea at Houston and Partners Surgery	1,570,992	-	-	-
	Spouse is a Director for Fortis Healthcare	851,596	7,414	-	-
	Spouse is a Director of Atrium Clinic	270	-	-	-
	Spouse is Medical Director for Southend CCG (see below)				
Dr S Gupta	GP in Benfleet at Trotter, Hiscock and Partners Surgery	1,567,608	-	-	-
Dr R Halliday	GP in Westcliff on Sea at Chisnell and Partners Surgery	1,799,279	40,750	-	-
M Hathaway	Director of South East Essex LIFT Ltd (exec appointment in May 2011)	-	-	-	-
	Director of South East Essex Fundco Ltd (exec appointment in May 2011)	1,331,271	-	-	-
V Watson (Specialised Commissioning Group)	Spouse is CEO for North Essex Mental Health Partnership FT	5,636,354	-	243,446	444,006

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.

A number of CCGs were awarded sub committee status within the PCT during the year. These are Southend CCG (sub committee since December 2011) and Castle Point and Rochford CCG (sub committee since March 2012). There were no significant decisions made by the sub committees on behalf of the PCT during the year and as such they are not regarded as related parties.

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
Bedford Hospitals NHS Trust
Bedfordshire PCT
Basildon and Thurrock University Hospital NHS Foundation Trust
Cambridge (Addenbrookes) Foundation Trust
Cambridgeshire PCT
Chelsea and Westminster Foundation Trust
Colchester Hospital University Foundation Trust
Croydon PCT
Cambridgeshire and Peterborough NHS Foundation Trust
East and North Hertfordshire PCT
East and North Hertfordshire NHS Trust
East of England Ambulance Trust
Great Ormond Street Hospital Trust
Great Yarmouth and Waveney PCT
Guy's and St Thomas' NHS Foundation Trust
Hertfordshire PCT
Hertfordshire Partnership NHS Foundation Trust
Homerton Hospital Foundation Trust
Imperial College Healthcare NHS Trust
Ipswich Hospital NHS Trust
James Paget University Hospital Foundation Trust
Luton Teaching PCT
Mid Essex Hospital NHS Trust
Norfolk and Waveney MH Foundation Trust
Norfolk PCT
Norfolk and Norwich University Hospital Foundation Trust
North East Essex PCT
North Essex Partnership NHS Foundation Trust
North West London Hospital Trust
Nottinghamshire Healthcare NHS Trust
Papworth Hospital NHS Foundation Trust
Peterborough PCT
Queen Elizabeth Hospital King's Lynn Foundation Trust
Royal Brompton and Harefield Foundation Trust
Royal Free London NHS Foundation Trust
Royal Marsden Hospital NHS Foundation Trust
Royal National Orthopaedic Hospital Trust
Sheffield Teaching Hospital Foundation Trust
South Essex Partnership Foundation Trust
South West Essex PCT
Southend University Hospital Foundation Trust
St George's Healthcare Trust
Suffolk MH Partnership Trust
Suffolk PCT
University Hospital of Leicester NHS Trust
University Hospital Birmingham NHS Foundation Trust
University College London Foundation Trust

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	95,130	11
Special payments - PCT management costs	22,530	4
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	95,130	11
Total special payments	22,530	4
Total losses and special payments	117,660	15

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	477,612	12
Special payments - PCT management costs	16,000	2
Losses in respect of the provision of family practitioner services	0	0
Special payments in respect of he provision of family practitioner services	0	0
Total losses	477,612	12
Total special payments	16,000	2
Total losses and special payments	493,612	14

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

37.2 Related party transactions 2011/12

Details of related party contracted transactions with individuals are as follows:

	Relationship	Payments to Related Party £	Receipts from Related Party £	Amounts owed to Related Party £	Amounts due from Related Party £
Dr A Atherton	Spouse is a GP in Leigh on Sea at Houston and Partners Surgery	1,350,472	-	22,738	-
	Spouse is a Director for Fortis Healthcare	482,791	-	-	-
	Spouse is a Director of Atrium Clinic	2,484	-	-	-
	Spouse is Medical Director for Southend Estuary CCG (see below)				
D Griffiths	Director of South East Essex LIFT Ltd (April to October 2011)	526,402	-	-	-
	Director of South East Essex Fundco Ltd (April to October 2011)	866,572	-	-	-
Dr S Gupta	GP in Benfleet at Trotter, Hiscock and Partners Surgery	1,391,836	-	27,081	-
Dr R Halliday	GP in Westcliffe on Sea at Chisnell and Partners Surgery	1,577,268	40,750	24,813	-
M Hathaway	Director of South East Essex LIFT Ltd (exec appointment in May 2011)	526,402	-	-	-
	Director of South East Essex Fundco Ltd (exec appointment in May 2011)	866,572	-	-	-
V Watson (Specialised Commissioning Group)	Spouse is CEO for North Essex Mental Health Partnership FT	2,849,103	-	334,897	-

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

A number of CCGs were awarded sub committee status within the PCT during the year. As such they should be regarded as related parties. These are Southend Estuary CCG (sub committee since December 2011), Castle Point CCG (sub committee since February 2012) and Rayleigh and Rochford CCG (sub committee since 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. 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
Bedford Hospitals NHS Trust
Bedfordshire PCT
Basildon and Thurrock University Hospital NHS Foundation Trust
Cambridge (Addenbrookes) Foundation Trust
Cambridgeshire PCT
Chelsea and Westminster Foundation Trust
Colchester Hospitalital University Foundation Trust
Croydon PCT
Cambridgeshire and Peterborough NHS Foundation Trust
East and North Hertfordshire PCT
East and North Hertfordshire NHS Trust
East of England Ambulance Trust
Great Ormond Street Hospital Trust
Great Yarmouth and Waveney PCT
Guy's and St Thomas' NHS Foundation Trust
Hertfordshire Community University NHS Trust
Hertfordshire PCT
Hertfordshire Partnership NHS Foundation Trust
Homerton Hospital Foundation Trust
Imperial College Healthcare NHS Trust
Ipswich Hospitalital NHS Trust
James Paget University Hospital Foundation Trust
King's College Hospital Foundation Trust
Luton and Dunstable Hospitalital Foundation Trust
Luton PCT
Mid Essex Hospitals NHS Trust
Mid Essex PCT
Norfolk and Waveney MH Foundation Trust
Norfolk PCT
Norfolk and Norwich University Hospital Foundation Trust
North East Essex PCT
North Essex Partnership NHS Foundation Trust
North West London Hospital Trust
Nottinghamshire Healthcare NHS Trust
Papworth Hospitalital NHS Foundation Trust
Peterborough PCT
Queen Elizabeth Hospital King's Lynn Foundation Trust
Royal Brompton and Harefield Foundation Trust
Royal Free Hampstead Trust
Royal Marsden Hospitalital NHS Foundation Trust
Royal National Orthopedic Hospital Trust
Sheffield Teaching Hospital Foundation Trust
South Essex Partnership Foundation Trust
South West Essex PCT
Southend University Hospital Foundation Trust
St George's Healthcare Trust
Suffolk Mh Partnership Trust
Suffolk PCT
University Hospital of Leicester NHS Trst
University Hospital Birmingham NHS Foundation Trust
University College London Foundation Trust
West Essex PCT
West Hertfordshire Hospital Trust
West Kent PCT
West Suffolk Hospitalital Foundation Trust

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

39. Third party assets

The PCT does not hold any third party assets.

40. Pooled budgets

South East Essex PCT has 1 pooled budget arrangement with Southend on Sea Borough Council that is hosted by South East Essex PCT.

Cumberledge Intermediate Care Centre	2012-13 £000	2011-12 £000
Expenditure		
Contract Value	1,178	1,207
Total Costs	**1,178**	**1,207**
Funding		
NHS South East Essex	669	696
Southend on Sea Borough Council	509	511
Total Funding	**1,178**	**1,207**

41. Cashflows relating to exceptional items

There was no cashflow relating to exceptional items.

42. Events after the end of the reporting period

The FMA forms include an 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	£0
Department of Health	(54,922)
Clinical Commissioning Groups	(1,031)
NHS England	982
NHS Trusts	0
Special Health Authorities, NDPBs & Other	0
NHS Foundation Trusts	0
NHS Property Services	25,635
Community Health Partnerships	0
Other	0
Balances held by PCT as 31st March 2013	**(29,336)**

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 East 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
Community Health Partnerships	Ownership of LIFT 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.