Department of Health

NHS

Surrey Primary Care Trust

2012-13 Annual Report and Accounts

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Surrey Primary Care Trust

2012-13 Annual Report

NHS Surrey Annual Report 2012/13

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Foreword

Since 2006 NHS Surrey has been the body responsible for commissioning healthcare for the people of Surrey. Our role has been to plan, agree and monitor how services are delivered in Surrey. Commissioning is a key driver of improving the quality and efficiency of services and creating better outcomes for patients and we have done this through the One Plan for Surrey.

How we commission our services has become increasingly more important. Commissioning isn't a simple process; it takes in a range of information from assessing the health needs of our population, designing how and where patients should receive services, negotiating costs and contracts and putting in place processes to continually monitor the quality of the services provided.

The Health and Social Care Act 2012 signalled the most far reaching reform of the NHS since its inception. At the forefront of this major transition has been our ambition to leave the system in a better place with a seamless transfer of care for Surrey patients.

It has been a huge and unrelenting task to balance both improvements to patient care, live within our means and safely transfer as many of our staff as possible to the new architecture. We may not have achieved as much as we had wished but leaving safe care to our clinical commissioning groups and National Commissioning Board colleagues within a financially balanced system in Surrey is much to be proud of.

Every Surrey clinical commissioning group (CCG) has been authorised through an

intensive process of scrutiny by the NHS National Commissioning Board. Their commitment to clinical leadership and to ensuring the quality and on-going safety of services is welcome and will reassure patients as they shortly take on their statutory duties.

There is always more that can be done but the new CCGs together with local authorities and their public health colleagues are now well placed to build on the positive start that we have made.

A final year; achievements for 2012/13

We delivered Olympic success

The Olympic and Paralympic Games is the world's largest sporting event, and two major Olympic cycling events powered their way through Surrey in July 2012. Teams from across the world used Surrey's excellent range of 20 Olympic and five Paralympic accredited pre-Games training and preparation camps.

Surrey was host to the Olympic Road Cycling Road Race, and the men's and women's Olympic Road Cycling Time Trial races.

Emergency preparedness - we are ready

The risk of an emergency occurring in Surrey is relatively low. Nonetheless it's vital the county's public services are as well prepared as possible. During the Games, NHS Surrey had the responsibility to ensure it could deliver healthcare services as usual to patients, meet the bid commitments to provide free comprehensive healthcare to the "Games Family", and to provide appropriate contingency to respond to unplanned events during the period before, during and after the Games.

Surrey's services – including health, the police, fire and rescue, local authorities and the county council – are all members of Surrey's Local Resilience Forum. The forum helps ensure planning, training and responses to emergencies are co-ordinated and effective. We plan, take part in exercises and learn from the experiences of others to create robust plans for different scenarios. If the worst happens, we can react quickly

and work with our partners across Surrey to minimise risk or harm to people in the county. Our Major Incident Plan sets out how we will respond in an emergency. The plan is published on our website and fully complies with the requirements of the NHS Emergency Planning Guidance published in 2005 and all other relevant guidance.

The Olympics could have been our biggest emergency. Local hospitals, GP practices and NHS Surrey worked effectively together to make sure that the NHS delivered. A lot of effort went into making sure that emergency plans, day-to-day resilience and workforce plans were all fit for purpose for the duration of the Games.

Achieved the Queens Award for Nursing

Elaine Bromley, a matron at Walton Hospital has received the prestigious award of Queen's Nurse, presented by the Queen's Nursing Institute.

This award is held in high regard and is in recognition of Elaine's dedication to nursing. Elaine's specific interest is in caring for patients in residential homes in Hersham, Weybridge and Ottershaw.

The Queen's Nursing Institute is a registered charity dedicated to improving the nursing care of people in their own homes. Twice a year the Institute holds an award ceremony to celebrate the achievements of nurses who are making real impact on improving patient care in people's homes and communities.

Queen's Nurses considered as leaders and role models in the community and are champions of patient care.

NHS 111 is helping people get help more quickly 24/7

NHS 111 is making it easier for people to get help quickly when they have an urgent health need, 24 hours a day, 365 days a year,

If you phone 111, a trained call handler, supported by health professionals, provides you with a clinical assessment at the first point of contact, without the caller having to wait for a call back.

In Surrey, Sussex, Kent and Medway the NHS 111 is provided by a partnership between South East Coast Ambulance NHS Foundation Trust, and Harmoni. Harmoni, was appointed as following an open, and competitive tender process led by local GPs, and the Boards of NHS Surrey. NHS Sussex and Kent and Medway PCT Cluster agreed the preferred provider following an open, robust and competitive tender process for the service.

Resolution for Beeches Respite Care

Beeches Bungalow (known as 'Beeches') is a short-break respite service in Reigate. It offers day care, tea visits for children with learning disabilities and complex health needs aged 5-18 years old. It also offers overnight stays for children with learning disabilities and complex health needs aged 10-18.

This type of respite care contributes significantly to the wellbeing of these children and their families. It helps to maintain healthy families as they bring up children with extremely challenging behaviour. It is funded by NHS Surrey and is provided by Surrey and Boarders Partnership NHS Foundation Trust.

In April 2012 it was decided to close Beeches after a review found its occupancy rate was 60 per cent and had been falling over the previous three years. It was believed that this was due to wider support and choice now available to families in Surrey. We felt at the time that by closing the service, funds could be used to improve other community based services to benefit more families.

Following the concerns expressed by parents at the NHS Surrey's September board meeting, the Board requested that a full equality analysis to be carried out to see what would be the impact of the closing Beeches.

The equality report highlighted the importance and positive health impact of respite care to the whole of the family and the value that parents place on the high quality service provided by Surrey and Borders Partnership NHS Foundation Trust. However, the analysis also acknowledged more needs to be done to fully understand potential demand and whether current capacity for respite care is appropriate for children's needs.

It concluded that there was an opportunity for a full strategic review leading to improved services, better health and wellbeing, and greater value for money – consistent with the intention behind the original decision.

As a result the Board agreed, together with NHS Guildford and Waverley Clinical Commissioning Group as the lead NHS commissioner on behalf of all Surrey CCGs, to a joint and more detailed strategic review with Surrey County Council. This work is expected to conclude in 2013/14 with a further equality analysis and engagement with families and other stakeholders.

Worked with our voluntary sector partners to deliver outstanding care

At NHS Surrey it is our job is to look after the health and wellbeing of all people living and working in Surrey.

As commissioners we buy healthcare from many different organisations and this includes the voluntary sector to whom we owe a debt of gratitude. Working with local charities and the voluntary groups we are able to provide services that reach into the heart of communities. The voluntary sector, with its ear close to the ground, and strong ties with local people provide a vital adjunct to the traditional health sector.

The following examples illustrate the type of services we have been able to help provide for our local people.

TALK: People with Aphasia have a problem using language as a result of damage to parts of the brain. Common causes include stroke, severe head injury, brain tumour or conditions such as Alzheimer's.

TALK helps people with aphasia by running workshops in six locations throughout Surrey. The charity also has home visitors providing support to stroke recoverers who cannot leave their home.

TALK has 100 volunteers who have regular speech therapist-led training. The charity assist over 100 stroke recoverers with communications difficulties through activities such as music, quizzes art and outings which encourage recoverers to practice their

communication skills and improve their confidence.

Headway: Headway Surrey is the only organisation providing a comprehensive range of cognitive rehabilitation and support services for brain injury survivors, their families and carers, across the Surrey.

The services are open to anyone in Surrey and the surrounding areas, affected by a brain injury, both ABI (Acquired Brain Injury) and TBI (Traumatic Brain Injury), their families, carers and friends.

Operating from its resource centre in Stoughton, Guildford, the organisation's services include:

Centre-based cognitive rehabilitation and support which aim is to help brain injury survivors to build on a range of strategies and techniques allowing them to maximise their capabilities.

Community-based services takes place in the client's own home are at a venue chosen by them. The service has a focus on life-skills such as budgeting.

Independent Panel

We have had our challenges in reflecting our commissioning of this valuable sector to support our strategic priorities and we are indebted to the members of the Independent Panel who have supported us over the past two years to achieve this.

The Independent Panel expects its oversight of this important agenda to transfer to the Health and Well-Being Board which will enable a joint health and social care perspective. The Panel advised strongly in this last year of the PCT that there is much more that the NHS can and should do to engage more deeply and to encourage further participation in health given the quality and efficiencies the NHS continues to face.

Looking to the future, Surrey's clinical commissioning groups have agreed to commission their local voluntary sector colleagues in their locality including hospice care. Children's voluntary services will be commissioned by Guildford and Waverley

as the lead commissioner on behalf of all Surrey CCGs. Likewise mental health voluntary services are to be commissioned by North East Hampshire and Farnham. The remaining Surrey-wide services will be commissioned by North West Surrey.

Caring for carers

Recognising the value and importance of caring for carers, NHS Surrey continues to work with Action for Carers and Surrey County Council to ensure the NHS invested its allocated £1.9m in breaks for carers this year.

In Surrey there are approximately 106,000 adult carers and an estimated 12,000 young carers. Although support is available, findings from an adult carers' health survey highlight a number of areas for improvement. For example, 60% of Surrey carers who responded to the survey said they provide over 50 hours a week of unpaid care and 80% of carers also told us their caring role has damaged their health. And because these individuals are so dedicated to putting others first, their health and mental well-being often gets overlooked.

NHS Surrey has listened and has been one of the nation's leaders in making sure Surrey's carers have the help and support they need. This commitment has been recognised in a report by the Princess Royal Trust for Carers and Crossroads Care, which identifies Surrey as being one of the best areas in the country when it comes to supporting carers and by Health Minister Norman Lamb.

The funding enables GPs to directly refer carers for a health break. The scheme is hosted by Surrey Independent Living Council and is paid in the form of a carer's direct payment which can be used to buy care while they are on their break.

Created excellence for children's heart services

NHS Surrey was a member of the decision-making body, The Joint Committee of Primary Care Trusts (JCPCT), which decided how best to reorganize children's congenital heart services.

The JCPCT decided to create across the country centres of excellence for children's

heart surgery.

In the South Central region, which NHS Surrey is a part of, will have the South Central Specialist Surgical Centre made up of the following hospitals: Southampton General Hospital Potential Children's Cardiology Centre: John Radcliffe Hospital, Oxford.

The decision follows one of the largest consultations in the NHS's history: the comprehensive Safe and Sustainable clinically-led review of services.

Under changes, which start in 2014 the NHS will:

- create new networks of care to make sure services for children are more joined up and meet new national quality standards
- grow the majority of the highest ranking surgical centres in the country
- expand outreach services so children can receive their on-going care, including check-ups and appointments, closer to home
- Increase the number of children's specialist cardiac nurses and paediatricians with expertise in cardiology so that all children, no matter where they live, have access to consistent and high quality expert care.

Delivery and transition

Despite this year of change there has been an unremitting focus on the delivery of our health services.

Quality, Quality, Quality

The publication of Francis Report reminded us that we cannot afford to stop listening to patients and their families and in particular the most vulnerable in our society.

In February, NHS Surrey Board welcomed the publication of the report by Sir Robert Francis QC. This was the second Francis inquiry, which specifically looked at existing compliance and monitoring schemes, the evidence presented and

conclusions drawn from the first inquiry. The Francis Report's recommendations have critical implications for every part of the NHS.

In anticipation, NHS Surrey has been working to improve early warning signs, as well as looking at how we listen to what patients and their families have to tell us and using information from formal complaints and incident reporting. We have looked closely the quality arrangements in every CCG so that the transfer of responsibility is safe and seamless for Surrey's patients, for example, each of the CCGs in Surrey now has a director responsible for quality to make sure there is nominated leader for this vital area.

The Quality and Nursing leads from all Surrey CCGs are members of the Patient Safety sub-committee. The CCGs have agreed this committee should continue to meet to ensure there is a robust process for serious incident management through transistion.

Safeguarding children and vulnerable adults

At its heart the NHS remains committed to safeguarding the welfare of the most vulnerable in our society – children and vulnerable adults.

As the NHS undergoes its major programme of reform following the passage of the Health and Social Care Act 2012, it is essential that there is clarity about responsibilities in relation to safeguarding the most vulnerable people in our community. Within these new arrangements – there is capacity and capability to help drive continued improvement in practice and outcomes.

CCGs have been identified as the most appropriate bodies to take forward these new arrangements, and they should have in place systems in place to discharge these responsibilities. This includes:

- Plans to train staff in recognising and reporting safeguarding issues
- A clear line of accountability for safeguarding, properly reflected in the CCG governance arrangements

- Appropriate arrangements to co-operate with local authorities in the operation of the local safeguarding boards
- Securing the expertise of a designated doctor and nurse for safeguarding children and for looked after children and a designated paediatrician to review unexpected deaths in childhood
- Have a safeguarding adults lead and a lead for the Mental Capacity Act, supported by the relevant policies and training.

NHS Surrey has been instrumental in helping CCGs with the development of the new system. An agreement has been put in place to have the designated health professionals hosted within one CCG and appointments have been agreed for two designated nurses for safeguarding vulnerable adults to boost the effectiveness and assurance of the new safeguarding systems.

Preferred bidder for community services

February 1 saw the start of a new five-year contract, worth £117m, for Central Surrey Health to continue to deliver community services for 290,000 people living in Mole Valley, Epsom and Ewell, East Elmbridge and Banstead and surrounding villages.

Local community services provide essential care to people and their families and communities, from health promotion to end of life care. This care is provided in many different settings, closer to people's homes and at critical points in people's lives, and often to those in vulnerable situations.

Central Surrey Health was awarded the contract by NHS Surrey following a particularly robust procurement process and against tough competition. GPs from NHS Surrey Downs Clinical Commissioning Group were heavily involved in the process and played a vital part in setting the quality standards and services they want their patients to receive.

QIPP

Quality, Innovation, Productivity and Prevention (QIPP) is the large-scale

transformational programme for the NHS. It involves all NHS staff, clinicians, patients and the voluntary sector.

Its purpose is to improve the quality of care the NHS delivers while making up to £20billion across England of efficiency savings by 2014-15, which will be reinvested in frontline healthcare.

In Surrey, the QIPP programme has delivered over £111m of savings. We have been working with our CCG colleagues to make sure they remain on track to meet their QIPP savings targets.

How we are delivering QIPP

Urgent Care

Research told us that parents with small children were one of the largest groups of people inappropriately using urgent care services. Our Public Health team led on a project, using social marketing techniques, to target this group. The project focused on the Guildford area starting with the Fairlands Medical Centre, which had high rates of inappropriate use of urgent care services. The medical centre was the testing ground for the social marketing campaign which used parents' thoughts and understanding to develop tools to help parents change how they used local urgent care services.

Virtual Wards

All our CCGs have virtual wards. Farnham, which is part of North East Hampshire and Farnham Clinical Commissioning Group together with Surrey Heath and Bracknell and Ascot CCGs plan to roll out these models to enable earlier discharge and avoid admissions.

A virtual ward is a model of care, providing support out in the community to people with complex health and social care needs. The wards are similar to hospital wards but without the physical buildings.

Each CCG has its own way to delivering care, but the key requirement is that they are able to identify suitable patients for virtual ward care and they are supported 24/7 by community nursing team. Clinical Commissioning Groups are working closely with

local clinical teams to embed this new way of working into their clinical practices.

Medicines Management

This project involved the medicines management team working with GPs, care home staff and local community pharmacists to review patients' medication make sure prescription ordering was efficient and cost effective and reduce how much medicines were being wasted.

Medication reviews looked at what individual patients were being prescribed and the systems and processes used to transfer this information as the patient progressed through the healthcare system. The review included primary, secondary care and home settings.

To date the project has helped to make £32,167 in savings through 167 reviews of nursing home patient medications. A further 284 reviews are planned, with an average saving of £216 per review, this could result in a further saving of £71928, and by the end of the year this could total £104,095.

Epsom Hospital Transaction and Better Services Better Value programme

Epsom Hospital, as part of Epsom and St Helier University Hospitals NHS Trust, is an NHS London accountable trust. The proposed plan for the trust to become a foundation trust was a transactional route with Epsom hospital becoming part of Ashford and St Peter's Hospitals NHS Foundation Trust and St Helier, as part of St George's Healthcare NHS Trust.

Following an NHS London Board meeting at the end of October 2012 it was agreed that the proposed acquisition of Epsom Hospital by Ashford and St Peter's should be halted. Although the project received a high level of support from local people, patients and hospital staff, the parties involved have been unable to develop a financially viable plan for the future of the hospital as part of the merged trust.

Better Services Better Value

Better Services, Better Value (BSBV) is about re-organising how health services are

provided in south-west London and some parts of Surrey around Epsom. This is because the NHS faces a range of challenges such as financial pressures, more people living with long-term conditions and not enough senior doctors available round the clock in some of the most vital services.

BSBV initially looked at services in the south-west London area, including hospitals in Croydon, Kingston, St George's in Tooting and St Helier. The scope has since been widened to include Epsom Hospital following the halt to the transaction process above. This gives opportunity for the relevant Surrey clinical commissioning groups as the future accountable commissioners in the area, to design and influence the future of health services around Epsom. NHS Surrey Downs Clinical Commissioning Group is leading this from Surrey as approximately 80 per cent of their population currently access services in south west London.

The clinical advice from local doctors, nurses and midwives propose that there should be:

- three A&E departments, with all hospitals having an urgent care centre, either located with A&E or a stand-alone urgent care centre
- three maternity units led by obstetricians (senior maternity doctors) with midwifery led units alongside, which would be located in the same hospitals as the three A&Es
- further work on the feasibility of a separate stand-alone, midwife-led maternity unit
- a planned care centre for all inpatient surgery for the region, on a separate site from emergency care, also providing day case surgery for the local population
- outpatient and day surgery facilities in all five hospitals
- these proposals would support an expansion in services provided outside hospital, as near to where people live as possible, including in GP surgeries, community health settings and at home.

These are clinical recommendations from local doctors and nurses only. The detail of how they would work in practice, what it would mean in terms of patient travel times

and the potential location of services and NHS staff is still to be worked through. This work continues and when formal recommendations are agreed by the six CCGs in south west London and Surrey Downs, a formal three month public consultation will take place later on in 2013.

For more information please see: http://www.bsbv.swlondon.nhs.uk/

Implementation of the Health and Social Care Act 2012

The Health and Social Care Act 2012 established clinical commissioning groups and as of 31 March 2013, NHS Surrey will cease to exist. The responsibility of commissioning for healthcare in Surrey will be transferred to CCGs and to the NHS National Commissioning Board while our public health responsibilities transfer to the local authority and to Public Health England.

Over the past year, we have been working closely with our emerging CCGs to transfer vital knowledge and skills so as of April 2013; they are in a position to take up the commissioning mantle.

The NHS Surrey Transition Assurance Committee has had the responsibility of overseeing this transition, reporting regularly on progress to the NHS Surrey Board.

Clinical Commissioning Groups

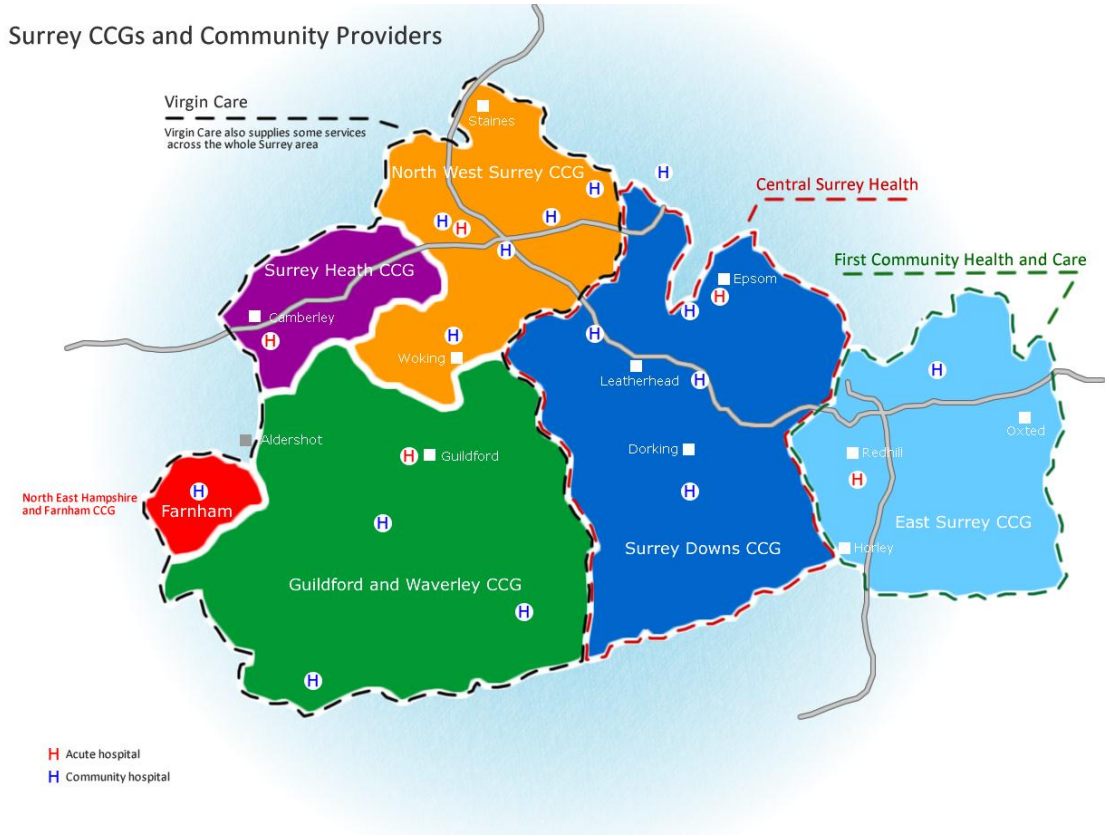
Over the past year, six CCGs have emerged across Surrey. These are:

- NHS North West Clinical Commissioning Group
- NHS Surrey Downs Clinical Commissioning Group
- NHS East Surrey Clinical Commissioning Group
- NHS Guilford and Waverly Clinical Commissioning Group
- NHS Surrey Health Clinical Commissioning Group
- NHS North East Hampshire and Farnham Clinical Commissioning Group

Each CCG is led by a team of likeminded clinicians dedicated to commissioning the best possible locally based services and will be authorised with their 'license to operate' from 1 April following an extensive process of application and scrutiny. There are three outcomes to the decision on authorisation: authorised; authorised with conditions; or established but not authorised (shadow CCG).

One Surrey CCG has also been issued with legal directions, meaning the NHS Commissioning Board, and in some cases neighbouring CCGs, will provide more formal development support, underpinned by legally-binding instructions. The effect of a direction is to either direct how the CCG must work with another CCG or the NHS Commissioning Board to exercise functions.

- NHS Guildford and Waverley — fully authorised
- NHS North West Surrey — 2 conditions (lifted as of 22 March 2013)
- NHS Surrey Downs — 7 conditions
- NHS Surrey Heath — 7 conditions
- NHS North East Hampshire and Farnham — 8 conditions
- NHS East Surrey — 17 conditions and 1 legal direction



Commissioning Support Units

Commissioning support services or CSUs bring together a range of specialist skills and knowledge to the non-clinical side of commissioning. The purpose is to help the clinicians leading CCGs to use their strengths to focus on enabling change and improvement locally.

Emerging CSUs underwent a checkpoint process which was an assessment designed to make sure that new CSUs were on track to be able to deliver high quality and affordable management support for their customers.

NHS Surrey worked on developing commissioning support until Checkpoint 1 in January 2012 and as part of that assurance process, wished to partner with another emergent commissioning support unit. Surrey subsequently joined with Sussex and this CSU serves two of Surrey's CCGs; Guildford and Waverley and East Surrey. Surrey Downs and Surrey Heath are purchasing support from Commissioning Support South and North West Surrey from Commissioning Support South London.

National NHS Staff consultation

July saw the start of a national programme to consult with NHS employees about the implementation of the NHS reforms.

We have worked closely with our Joint Negotiation and Consultative Committee and using our regular staff communications channels to make sure our staff remained involved and informed from the very start of the reforms. This was a very long and difficult time for our staff as they faced uncertain futures. It is a testament to their strength and dedication to the NHS that they continued to work hard through this period of change to deliver for patients and help shape a new era of the NHS.

National HR Framework and local processes

The journey of sending staff from the statutory PCT to multiple sender organisations has been arduous but successful in its ambitious timetable. While difficult for individual members of staff, the HR team have delivered the mammoth task of supporting employees, interpreting policy and enabling job matching and transfers.

At the beginning of 2012/13, the PCT employed 414 whole time establishments. By the first of April 2013, 329 staff will have transferred successfully to receiver organisations and a minority of 40 will have been made redundant.

Public Health

The Health and Social Care Act (2012) made provisions for the transfer of local public health functions from the NHS to local authorities. From April 2013, Surrey County Council will be responsible for protecting and promoting the public's health, funded by a ring-fenced grant. These new responsibilities are supported by the transfer of specialist public health staff from the NHS to provide professional leadership for public health.

In April 2012, NHS Surrey public health staff relocated to Surrey County Council; a year before the authority officially was scheduled to take responsibility for public health. Surrey was one of the first wave councils to implement the new reforms. During this 'shadow' year, the team have been formally employed by NHS Surrey and have been making preparations for transition while delivering existing NHS programmes.

The overall aim of the public health team is to protect and improve health and wellbeing and reduce health inequalities in communities. The role also includes dealing with public health emergencies and supporting GPs who are forming into groups to take responsibility for planning and buying services.

No member of the public health team who will have transferred legally by 1 April 2013 has been made redundant.

For more information, please see the public health annual report: *Hidden disadvantages in Surrey, Taking action on poor well-being.*

Staff equalities and future opportunities

We have worked hard over the past six and a half years to be an employer of choice and that meant making sure no job applicants or employees are unfairly disadvantaged on the grounds of age, disability, sex, gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity or trade union membership, or any other factors that are not relevant to their capability or potential.

We have carried this forward in our matching and transfer work to ensure we have honoured our commitment to tackling discrimination, promoting equality and diversity and protecting human rights. These principles are at the heart of the NHS - they underpin the NHS constitution and we believe all our staff have a role to play. Our Equality Impact Assessment process have helped us ensure we engage with both our staff and service users with regards equality and equity of access.

Like every organisation, we monitor staff sickness and report it annually:

Fuller detail in reported within our Annual Accounts, however a summary of staff absence is reported below;

2012 (calendar year)

- Total FTE working day; 280,471
- Days lost to sickness absence; 14,716

- Average sick days per FTE; 11.8

Leaving a lasting legacy for future organisations

Over the part we have been working with the full knowledge that NHS Surrey in its current form would no longer exist and the majority of our commissioning role would be handed over to CCGs. The major legacy is in leaving behind services which are safe and in which Surrey patients have confidence.

However, since 2006, a wealth of commissioning knowledge and data has been accumulated and part of our role has been to make sure that this knowledge is available for the new organisations so they can take over their vital functions of commissioning patient quality and safety, finance and QIPP from April 2013.

The creation and implementation of a detailed transition plan has been the responsibility of the Acting Director of Governance, Transition and Corporate Reporting (including performance). A Quality in Transition document and a legacy document has been integral to this plan. Individuals, teams and departments have over the course of the year contributing to the development of this important plan. It's our way of capturing the corporate mind and creating a tangible asset we can pass on to our successors.

Both these documents are available on www.surreyhealth.nhs.uk

Directors Report

Our Board

The Board is accountable for performance, patient safety, quality, finance,

engagement and governance. Membership of the Board during the year:

Non-executive directors (all were voting members)

Chairman David Clayton-Smith

Sarah Betteley

Peter Gordon

Rodney Gritten, Deputy Chairman and Chairman of the Quality and Performance Committee

Graham Hanson, Deputy Chairman and Chairman of the Transition Assurance Committee (member of audit committee)

David Lewis, Chairman of the Audit Committee

Dr Jonathan Morgan (member of audit committee)

Ghislaine Watson-Hopkinson (member of audit committee)

Executive directors (v denotes voting member)

Anne Walker, Chief Executive (v)

Dr Akeem Ali, Joint Director of Public Health with Surrey County Council (v)

Maggie Ioannou, interim Director of Nursing, Quality and Safety (v)

Malachy McNally, Acting Director of Finance (v)

Dr John Omany, Medical Director (v)

Helena Reeves, Director of Communications (v)

Justin Dix, Acting Director for Governance, Transition and Corporate including performance reporting (v)

Ali Kalmis, Acting Director of QIPP

In attendance

Cliff Bush OBE, Chair of Surrey LINk

Ian Miller, interim Director of Turnaround

A declaration of Board members' interests can be found in the summary financial information, later in this report.

Principles for Remedy

We adopt the approach recommended by the Parliamentary and Health Service Ombudsman in its 'Principles for Remedy' guidance when we respond to complaints or concerns. This guidance summarises best practice for public sector organisations to put things right when they have gone wrong. The principle focus is on being customer-focused, open and accountable, acting fairly, and seeking continuous improvement.

To ensure issues and complaints are resolved quickly and well, we have had a customer care model that unites our Patient Advice and Liaison Service, complaints team and corporate colleagues. This approach proved effective in resolving issues quickly and effectively, often simply through a phone call. Being fair and equitable to all is a fundamental principle behind our approach, in line with the Ombudsman's guidance on Good Administration. The team worked closely with colleagues in the Continuing Healthcare team to ensure any queries or concerns about retrospective reviews are dealt with consistently by all parts of the organisation.

PALS - resolving problems

Our Patient Advice and Liaison Service has been hugely successful and the first place people went if they have a question or concern related to health or their care. Each month the team gave advice, information and offer reassurance to more than

250 callers.

As well as sign-posting people to local services, the team resolved issues quickly and effectively. They always looked for opportunities to further improve services based on the experiences they hear about directly from patients.

Compliments and complaints – getting it right and putting it right

We always aimed to get it right first time. We didn't always succeed and when we didn't, our aim was to put things right as quickly as possible and learn any lessons.

In 2012/13 we received 158 complaints. 14 of them related to us, 102 to primary care, 16 to hospital care, 10 were about mental health services and 8 about "Out of Hours" GP services. Some of these complaints were multiple organisations complained about in one letter so they may appear in two categories (i.e. GP and hospital). We also received 1 compliment relating to the helpfulness of one of the PALs managers.

Sustainability

Like organisations throughout the NHS, we had a responsibility to address social, economic and environmental challenges. We were responsible for a substantial amount of NHS estate and managing it well minimises any potentially negative impact on the environment or local communities.

In future the responsibility for the NHS estate that previously was 'owned' by primary care trusts, lies with the newly established NHS Property Services Limited. This is wholly owned as a limited company by the Department of Health and ensures that the NHS asset remains within public ownership.

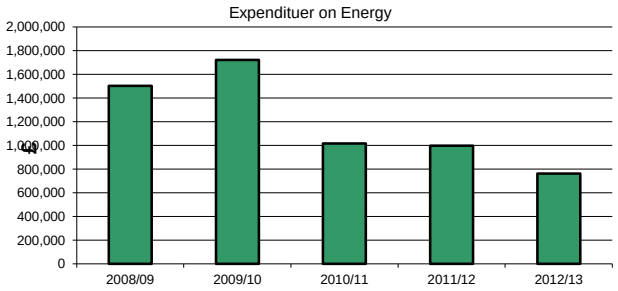
Leadership for sustainability comes at Board level from our Acting Finance Director and ensures that sustainability issues have visibility and ownership at the highest level of the organisation. As part of our commitment to reducing carbon emissions, a

major work programme has been underway maintaining and where possible, upgrading, the property we manage. This has been a major part of our community services procurement programmes and includes work to replace boilers, water heaters and pipes, with lighting systems forming part of the work over the past year.

More recently we have been working with our primary care colleagues to ensure their premises are fit under the CQC requirements.

Carbon footprint

24%



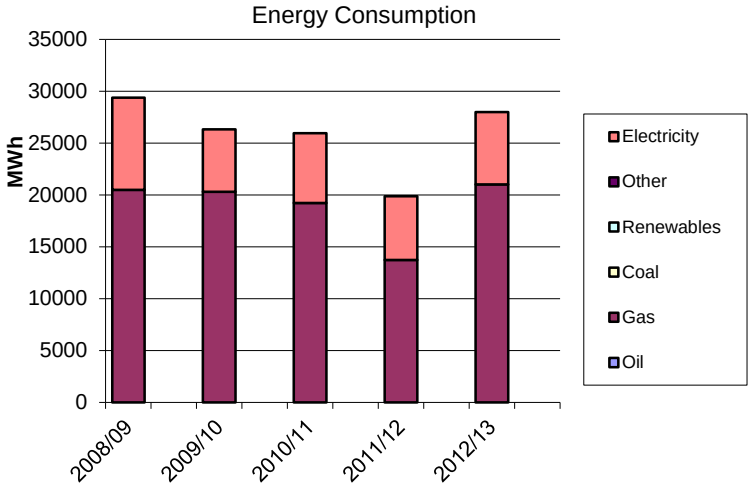
The NHS aims to reduce its carbon footprint by 10% between 2009 and 2015. Reducing the amount of energy used in our organisation contributes to this goal

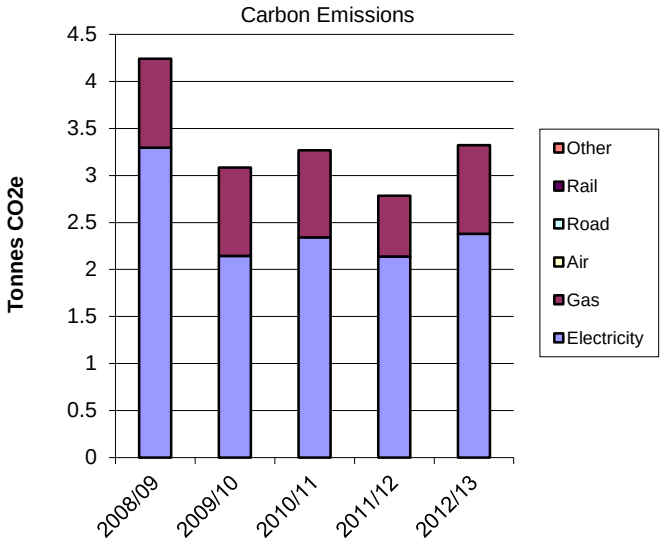
There is also a financial benefit which comes from reducing our energy bill.

By reducing our energy costs by 24% in 2012/13, we have saved £234,784, the equivalent of 42 hip operations

Our total energy consumption has risen during the year, from 19,884 to 27,984 MWh

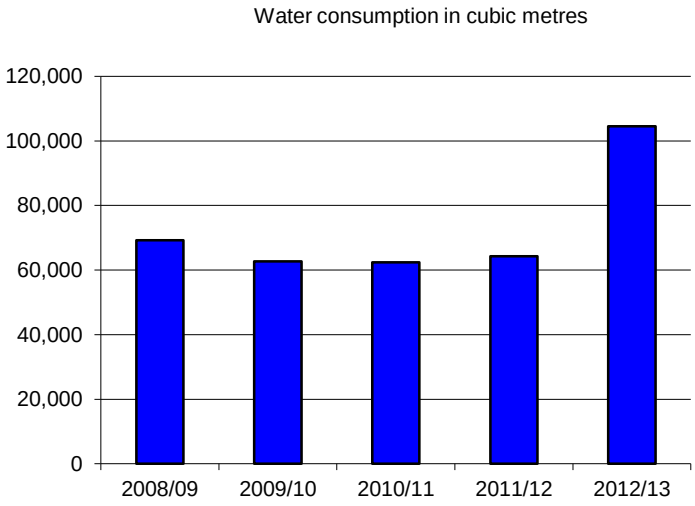
Our relative energy consumption has changed during the year, from 0.26 to 0.36 MWh/square metre.





Our measured greenhouse gas emissions have increased by 0,001 tonnes this year.

We do not currently collect data on our annual Scope 3 emissions.

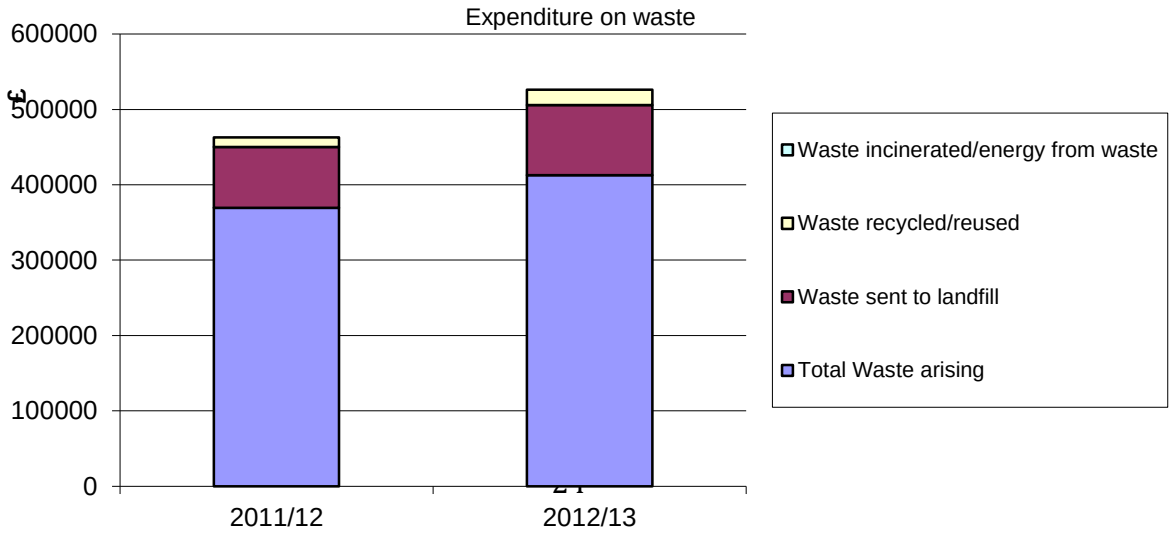


Our water consumption has increased by 40,280 cubic meters in the recent financial year.

In 2012/13 we spent £217,509 on water.

During 2012/13 our total expenditure on business travel was £2,580,900.

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.

Freedom of Information - open, honest accountability

There is now better access to information about the NHS and healthcare than ever before. Our website www.surreyhealth.nhs.uk has played a key role in making sure we are open and transparent about how we do business and how we make decisions. Making sure we respond well to requests for information has underpinned our approach.

We have well established information governance procedures in place and received almost 343 requests for information in 2012/13. These are usually made under the Freedom of Information Act, with others relating to the Data Protection or Health Records Acts.

We have recently made a return to NHS South that demonstrates we have no open requests to transfer on 31 March 2013 which again shows our commitment to openness and transparency within the timelines set by the Act.

Serious incidents and information breaches - keeping data safe

We have clear policies and procedures in place to safeguard patient data while it is in our care. The NHS takes data security very seriously and if any breach occurs it is automatically dealt with as a “Serious Incident”. This means we are required to report it to our NHS strategic health authority and to the Information Commissioner’s Office. In 2012/13 NHS Surrey had two data incidents to report.

One involved basic information that may have been compromised. Information was being held on an old computer hard drive that was sent for destruction but was wrongly recycled instead. NHS Surrey wrote to 60 patients to alert them that some

information about them may have been compromised. A clinical risk assessment concluded there was no clinical risk to patients and this was independently verified.

Our decision to inform patients took into account the NHS Constitution pledge that NHS organisations should tell patients whenever information about them has been compromised in any way even when no harm was done.

In the second case a member of staff had their vehicle broken into, and items were stolen. These included a locked case containing 20 sets of Stop Smoking Service Client records. All the patients affected were immediately informed of this and further action was taken to ensure this type of incident could not be repeated, including revisions to the PCT's Transportation of Records Guidance and to clinic records storage criteria.

Reporting and learning from serious incidents

Ensuring our patients and our staff are safe has been paramount.

Every year of our operation all staff took part in mandatory health and safety awareness training. Thanks to the culture we have developed, staff knew to report any accidents or incidents that occur, and even any 'near misses' where the outcome could have been more serious and will take this learning into their new roles in the future.

As well as monitoring our own internal procedures, we also monitored the arrangements in place across Surrey trusts to make sure our patients are receiving the high standard of care we would want and expect. Trusts are required to notify us of any serious incidents and these were regularly reported to NHS Surrey's Board who sought assurances that the appropriate action has been taken.

Operating and financial review

Statutory Financial Duties

In 2012/13 NHS Surrey has continued to invested in a wide range of healthcare services. In addition to this NHS Surrey has also driven through a range of efficiency savings releasing resources for front line services. NHS Surrey has met its statutory financial duty to breakeven in 2012/13.

PCTs are required to achieve three main statutory financial duties. Surrey's performance against each is summarised below:

Revenue Resource Limit (RRL): to contain revenue expenditure within the notified RRL of £1,774.322m For 2012/13 the PCT has under spent £0.2m against the RRL.

Capital Resource Limit (CRL): to contain capital expenditure within the notified CRL of £17.605m. For 2012/13 the PCT under spent £1.0m against the CRL.

Cash Limit: the PCT contained receipts and payments within the annual cash limit published by the Department of Health of £1,786.64m. Compared to its cash limit the PCT spent £1,786.64m.

Other Financial Duties

In addition to the three statutory duties PCTs are expected meet the requirements of the Better Payments Practice Code, PCTs are expected to achieve the target of payment of invoices within 30 days of receipt of goods or a valid invoice. The target is 95% of invoices paid within creditor terms. The PCT paid 89.55% (95.5% in 2011/12) of all valid invoices by the due date or within 30 days of receipt of a valid invoice in 2012/13.

Further details of the PCTs performance against its statutory and other financial duties are set out in the financial commentary and summary financial statements below.

The financial statements detailed in this report are a summary of the information in NHS Surrey's Annual Accounts. A full copy of the accounts is available, including the Statement on Internal Control, from:

NHS Surrey Legacy Team

Cedar Court

Guildford Road

Leatherhead

Surrey

KT22 9AE

Financial Performance 2012/13

Financial balance

The key features of the PCT's financial performance in 2012/13 were:

- In year budget pressures of £38m in relation to acute services commissioning budgets
- In year budget pressures of £1.1m on primary care prescribing budgets
- In year budget pressures of £2.7m on corporate and CCG transition costs

While offsetting these in year costs pressures with;

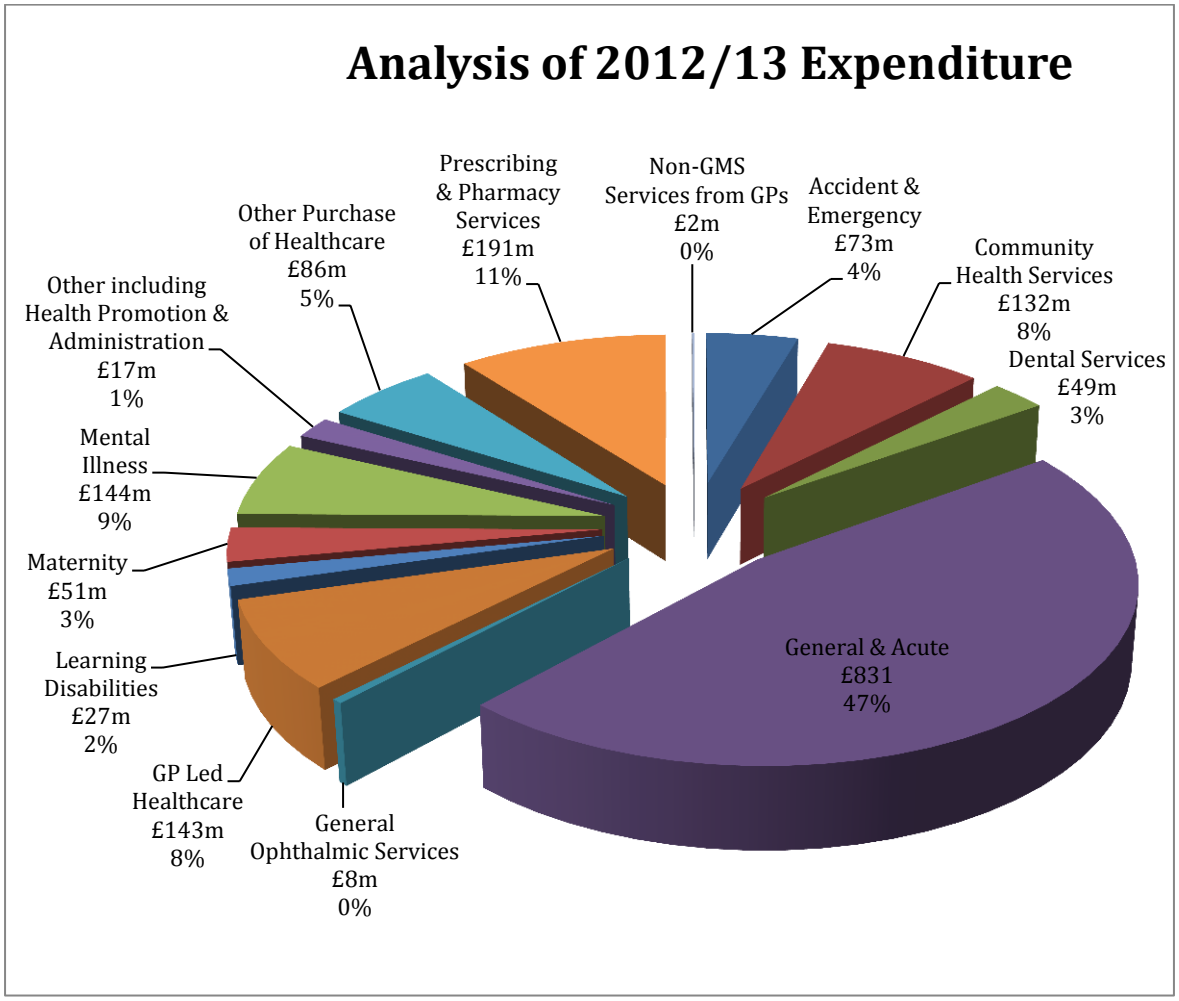
- Full use of the PCT contingency funds of £41.9m
- Underspend of £0.1m on Community Services Contracting

QIPP

For 2013/13 the Surrey health economy QIPP challenge totalled £94.3m of which £26m was required to be delivered by local trusts with the balance to be delivered by NHS Surrey. Of the £63.1m NHS Surrey QIPP Programme, £45.7m was cash releasing and £17.4m related to tariff efficiency schemes which effectively needed to reduce cost through improved ways of working. The PCT met its QIPP target through delivery of QIPP schemes, implementation of financial recovery plans by

CCGs and use of contingency funds where available.

The chart below shows a breakdown of the key areas of expenditure for the financial year April 2012 to March 2013.



Further details of our financial performance are shown in the following summarised annual accounts for the financial year ending 31 March 2013.

The attached accounts have been subject to audit by KPMG 15 Canada Square, London, E14 5GL and an unqualified true and fair audit opinion has been received. Details of the audit fees relating to the financial year can be found in note 5.1 to the accounts. Our internal audit services were provided by South Coast Audit.

Looking forward into 2013/14

In previous years this annual report has looked forward to summarise the opportunities and challenges that would face the PCT in the new year. As Surrey PCT hands over management of Surrey Health services to a range of successor organisations, including NHS England Area Team, CCGs and the local authority these will now meet these challenges and opportunities.

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.

Amanda Fadero

Designated Signing Officer

7 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.

Amanda Fadero Designated Signing Officer

Marie Farrell Finance Signing Officer

7 June 2013

INDEPENDENT AUDITOR'S REPORT TO THE SIGNING OFFICER OF NHS SURREY ON THE SUMMARY FINANCIAL STATEMENT

We have examined the summary financial statement for the year ended 31 March 2013 set out on pages 34 to 43.

This report is made solely to the Signing Officer of NHS Surrey in accordance with Part II of the Audit Commission Act 1998. Our audit work has been undertaken so that we might state to the Signing Officer of the Primary Care Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Signing Officer of the Primary Care Trust for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of directors and auditor

The Signing Officer is responsible for preparing the Annual Report. Our responsibility is to report to you our opinion on the consistency of the summary financial statement within the Annual Report with the statutory financial statements.

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

Basis of opinion

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

Opinion

In our opinion the summary financial statement is consistent with the statutory financial statements of NHS Surrey for the year ended 31 March 2013 on which we have issued an unqualified opinion.

Fleur Nieboer for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
15 Canada Square
London E14 5GL

7 June 2013

Financial Statements as at 31 March 2013

Statement of Comprehensive net expenditure

	2012/13 £000	2011/12 £000
Commissioning		
Employee benefits	**27,271**	22,091
Other costs	**1,795,540**	1,617,483
Income	**(50,734)**	(44,810)
Provider		
Employee benefits	**0**	90,951
Other costs	**0**	26,910
Income	**0**	(19,750)
PCT net operating costs before interest	**1,772,077**	1,692,915
Investment income	**0**	(8)
Other (Gains)/Losses	**0**	0
Finance costs	**2,034**	2,027
Net operating costs for the financial year	**1,774,111**	1,694,934

Statement of Financial Position (Balance Sheet)

	2012/13 £000	2011/12 £000
Non-current Assets		
Property, plant and equipment	**162,354**	160,267
Trade and other receivables	**123**	131
Current Assets		
Trade and other receivables	**6,549**	17,659
Cash and cash equivalents	**12,383**	5
Total Current Assets	**18,932**	17,664
Current Liabilities		
Trade and other payables	**(107,540)**	(105,158)
Provisions and borrowings	**(2,663)**	(5,751)
Net Current Assets (Liabilities)	**(110,203)**	(110,909)
Total Assets less Current Liabilities	**71,206**	67,153
Non-current Liabilities		
Provisions	**(8,766)**	(12,151)
Borrowings	**(17,909)**	(18,497)
Total Assets Employed	**44,531**	36,505
Financed by: Taxpayers Equity		
General fund	**(4,293)**	(17,345)
Revaluation reserve	**48,824**	53,850
Donated asset reserve	**0**	0
Total Taxpayers Equity	**44,531**	36,505

Statement of Cash Flows

	2012/13 £000	2011/12 £000
Operating Activities		
Net cash outflow from operating activities	**(1,754,646)**	(1,685,817)
Cash flows from investing activities		
Payments to purchase property, plant and equipment	**(16,758)**	(6,956)
Proceeds of disposal of assets held for sale	**0**	0
Proceeds of disposal PPE and intangible assets	**0**	0
Interest received	**0**	8
Net cash inflow(outflow) before financing	**(1,771,404)**	(1,692,765)
Cash flows from financing activities		
Net Parliamentary Funding	**1,786,640**	1,692,666
Capital grants received	**0**	0
Capital element of payments in respect of finance leases	**(538)**	(491)
Net cash inflow(outflow) from financing	**1,786,102**	1,692,175
Net increase/(decrease) in cash and cash equivalents	**14,698**	(590)
Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year	**(2,315)**	(1,725)
Cash (and) cash equivalents (and bank overdrafts) at the end of the financial year	**12,383**	(2,315)

Statement of Changes in Taxpayers Equity

	2012/13 £000	2011/12 £000
Balance at start of financial year	**36,505**	37,812
Net operating cost for the year	**(1,774,111)**	(1,694,934)
Net (loss)/gain on revaluation of property, plant and equipment	**(4,503)**	961
Receipt of donated or government granted assets	**0**	0
Impairments and reversals	**0**	0
Release of reserves to SoCNE	**0**	0
Non-cash charges – cost of capital	**0**	0
Total recognised income and expense for year	**(1,778,614)**	(1,656,161)
Net Parliamentary funding	**1,786,640**	1,692,666
Balance at end of financial year	**44,531**	36,505

Note 3. Financial Performance Targets

Note 3.1 Revenue Resource Limit

The PCT's performance for 2012/13 is as follows:

	2012/13 £000	2011/12 £000
Total net operating cost for the financial year	**1,774,111**	1,694,934
Less: Non discretionary expenditure	**0**	0
Operating Cost less non discretionary expenditure	**1,774,111**	1,694,934
Final Revenue Resource Limit for the year	**1,774,322**	1,695,962
Under/(over) spend against Revenue Resource Limit	**211**	1,028

Note 3.2 Capital Resource Limit

The PCT is required to keep within its Capital Resource Limit

	2012/13 £000	2011/12 £000
Gross Capital Expenditure	**16,608**	7,601
Less: net book value of disposals to NHS bodies	**(0)**	(0)
Less: net book value of disposals to non NHS bodies	**(0)**	(0)
Less: donations	**(0)**	(0)
Charge against the Capital Resource Limit	**16,608**	7,601
Capital Resource Limit	**17,605**	8,864
(Over)/under spend against Capital Resource Limit	**997**	1,263

Note 3.3 Provider Full Cost Recovery Duty

The PCT is required to recover full costs in relation to its provider functions.

The PCT provider function transferred to a new provider wef 1st April 2012

	2012/13 £000	2011/12 £000
Provider gross operating cost	**0**	117,861
Less: income relating to provider functions	**0**	(19,710)
Net Provider Operating Costs	**0**	98,151
Less: costs met from PCT's own allocation	**0**	(97,047)
Under/(over) recovery of costs before interest	**0**	1,104
Finance Costs	**0**	1
Under/(over) recovery of costs	**0**	1,105

Note 5.1 Running Costs

	Commissioning Services *	**Public Health**	**Total**
PCT Running Costs 2012-13			
Running costs (£000s)	30,704	2,734	33,438
Weighted population (number in units)	952,852	952,852	952,852
Running costs per head of population (£ per head)	32.22	2.87	35.09
PCT Running Costs 2011-12			
Running costs (£000s)	24,365	2,609	26,974
Weighted population (number in units)	952,852	952,852	952,852
Running costs per head of population (£ per head)	25.57	2.74	28.31

* Includes costs that will transfer to NHS England.

Running costs were separately identified for the first time in 2010/11. Running costs are the costs of the PCT which do not relate to the purchase of healthcare.

Note 7.2 Staff Numbers

	2012-13			2011-12		
	Total	Permanently employed	Other	Total	Permanently employed	Other
	Number	Number	Number	Number	Number	Number
Average Staff Numbers						
Medical and dental	5	5	0	83	74	8
Ambulance staff	0	0	0	0	0	0
Administration and estates	324	255	69	777	704	73
Healthcare assistants and other support staff	13	13	0	539	441	98
Nursing, midwifery and health visiting staff	40	33	8	863	787	77
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	33	29	4	450	420	30
Social Care Staff	0	0	0	0	0	0
Other	0	0	0	18	18	0
TOTAL	416	335	81	2,730	2,444	286
Of the above - staff engaged on capital projects	10	3	7	0	0	0

Note 7.3 Staff Sickness

	2012/13 Number	2011/12 Number
Total Days Lost	14,716	24,548
Total Staff Years	1,247	2,640
Average working Days Lost	11.8	9.3

Note 7.4 Exit Packages Agreed

Exit package cost band (including any special payment element)	2012-13 *Number of compulsory redundancies	2012-13 *Number of other departures agreed	2012-13 Total number of exit packages by cost band	2011-12 *Number of compulsory redundancies	2011-12 *Number of other departures agreed	2011-12 Total number of exit packages by cost band
	Number	Number	Number	Number	Number	Number
Less than £10,000	8	0	**8**	2	0	**2**
£10,001-£25,000	11	0	**11**	2	2	**4**
£25,001-£50,000	9	0	**9**	2	0	**2**
£50,001-£100,000	7	0	**7**	1	0	**1**
£100,001 - £150,000	4	0	**4**	0	0	**0**
£150,001 - £200,000	2	0	**2**	0	0	**0**
>£200,000	1	0	**1**	0	0	**0**
Total number of exit packages by type	42	**0**	**47**	**7**	**2**	**9**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Total resource cost	2,186	0	**2,186**	190	32	**222**

This note provides an analysis of Exit Packages agreed during the year. Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Where the PCT has agreed early retirements, the additional costs are met by the PCT and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.
This disclosure reports the number and value of exit packages taken by staff leaving in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

Note 8 Better Payment Practice Code

Note 8.1 Better Payment Practice Code – measure of compliance

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, which is later.

	2012/13 Number	**2012/13 £000**	2011/12 Number	2011/12 £000
Non-NHS Payables				
Total bills paid in the year	**51,077**	**499,713**	65,892	376,274
Total bills paid within target	**46,108**	**486,015**	63,252	365,983
Percentage of bills paid within target	**90.27%**	**97.26%**	95.99%	97.27%
NHS Payables				
Total bills paid in the year	**7,636**	**1,072,451**	7,585	996,595
Total bills paid within target	**6,469**	**1,032,077**	6,945	989,505
Percentage of bills paid within target	**84.72%**	**96.24%**	91.56%	99.29%
Total				
Total bills paid in the year	**58,713**	**1,572,164**	73,477	1,327,869
Total bills paid within target	**52,577**	**1,518,092**	70,197	1,355,488
Percentage of bills paid within target	**89.55%**	**96.56%**	95.54%	98.73%

Note 11 Finance Costs

	2012/13 £000	2011/12 £000
Finance Leases	**56**	57
PFI contracts	**1,751**	1,718
Provisions – unwinding of discount	**193**	217
Late payment of commercial debt	**0**	1
Other interest expense	**34**	34
Other finance costs	**0**	0
Total	**2,034**	2,027

Auditors Remuneration

The fee for the External Auditors statutory audit in 2012/13 was £192k.

Pension 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 accounted for as a defined contribution scheme and the cost of the scheme is equal to the contributions payable to the scheme for the accounting period.
Further details around pension liabilities can be found in the Annual Accounts at Note 7.5 Pension Costs, and also within the notes to the table on 'Pension Benefits of Senior Managers' within the Remuneration Report contained within this Annual Report.

Remuneration Report

Under Chapter 6 of Part 15 of the Companies Act 2006, as interpreted for the public sector, NHS bodies are required to prepare a remuneration report containing information about the remuneration for 'senior managers' within their organisation. Senior managers for this purpose are defined as 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates of departments.' It is no longer a requirement to secure the consent of named individuals to the disclosure in this report, although this has been obtained.

The Chair and Non-Executive Directors of the Primary Care Trust are appointed by the Appointments Commission, which also determines the remuneration for these positions.

The Remuneration Committee has delegated authority from the Board in relation to the appointment, remuneration, performance review and termination arrangements of, Very Senior Managers (VSM) and other senior management arrangements in NHS Surrey. The Remuneration Committee takes account of appropriate national guidance and some decisions, for example the remuneration of VSMs, are subject to approval by the Remuneration Committee of the Strategic Health Authority (SHA).

The Remuneration Committee comprises:

David Clayton Smith (Chairman)

Rodney Gritten

David Lewis

Jonathan Morgan

For the purposes of the Pay Framework for Very Senior Managers, NHS Surrey is classified as a Level 4 PCT (based upon its local population). The period of notice for people on VSM contracts within the Primary Care Trust is three months. The Remuneration Committee agrees the specific salary details for senior managers within this framework and also considers the individual performance bonus payments

and annual uplifts that are payable in line with the framework, having proper regard to the PCT's circumstances and performance. There was no salary uplift for those on VSM employment contracts in 2012/13 in line with national guidance.

With regard to the Medical Director and Director of Public Health posts the Remuneration Committee agrees specific salary details in accordance with the Consultants Contract (2003). All other senior managers are on national 'Agenda for Change' terms and conditions of service.

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 NHS Surrey in the financial year 2012-13 was £165-170k (£165 - £170K in 2011-12). This was 4.1 times (6 times in 2011-12) the median remuneration of the workforce, which was £40,157 (£27,625 in 2011-12). This ratio has changed as a result of the transfer of a significant number of NHS Surrey employees to an alternative health care provider on the 31 March 2012.

In 2012-13, 0 (2011-12, 0) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £16k to £166k (2011-12 £13k to £166k).

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.

Salary and Pension tables

Salaries and allowances

Name and title		2012-13			2011-12		
	Salary (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000	Bonus Payments (bands of £5,000) £000	Benefits in kind (Rounded to the nearest £00) £00	Salary (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000	Benefits in kind (Rounded to the nearest £00) £00
Anne Walker Chief Executive	**165-170**	**0**	**0**	**5**	**165-170**	**0**	**2**
Paul Bennett Deputy Chief Executive (Until April 2012)	**5-10**	**0**	**0**	**2**	**105-110**	**0**	**2**
Dr Akeem Ali Director of Public Health	**125-130**	**0**	**0**	**5**	**125-130**	**0**	**5**
Maggie Ioannou Interim Director of Nursing, Quality and Safety (see Note 1)	**15-20**	**0**	**0**	**0**	**N/A**	**N/A**	**N/A**
Justin Dix Acting Director of Governance (From April 2012)	**75-80**	**0**	**0**	**2**	**N/A**	**N/A**	**N/A**
Alexandra Kalmis Acting Director of QIPP and Contracts (From April 2012)	**105-110**	**0**	**0**	**4**	**N/A**	**N/A**	**N/A**
Malachy McNally Finance Director	**105-110**	**0**	**0**	**1**	**0-5**	**0**	**0**
Dr John Omany Clinical Director	**55-60**	**80-85**	**0**	**0**	**55-60**	**80-85**	**0**

Helena Reeves Director of Communications and Corporate Management	**80-85**	**0**	**0**	**2**	**80-85**	**0**	**0**
David Clayton-Smith Chairman	**25-30**	**N/A**		**5**	**35-40**	**N/A**	**5**
Rodney Gritten Non Executive Director	**15-20**	**N/A**		**5**	**5-10**	**N/A**	**3**
Sarah Betteley Non Executive Director	**5-10**	**N/A**		**0**	**5-10**	**N/A**	**0**
Peter Gordon Non Executive Director	**10-15**	**N/A**		**1**	**5-10**	**N/A**	**2**
Graham Hanson Non Executive Director	**15-20**	**N/A**		**2**	**5-10**	**N/A**	**2**
David Lewis Non Executive Director	**10-15**	**N/A**		**5**	**5-10**	**N/A**	**3**
Dr Jonathan Morgan Non Executive Director	**10-15**	**N/A**		**3**	**5-10**	**N/A**	**4**
Ghislaine Watson-Hopkinson Non Executive Director	**5-10**	**N/A**		**0**	**5-10**	**N/A**	**0**

Note 1 Zenon Consulting Ltd has been paid £72,222.33 in fees for the services of Maggie Ioannou from April 2012 to December 2012. From January 2013 to March 2013 Maggie Ioannou was paid on NHS Surrey payroll.

Note 2 In line with paragraph 2.56 of the Department of Health Manual for Accounts payments made during 2012-13 to the Turnaround Director have not been disclosed

Pension Benefits

Name and title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at aged 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2013 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2013 £000	Cash Equivalent Transfer Value at 31 March 2012 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £000
Anne Walker Chief Executive	**0-(2.5)**	**(2.5)-(5)**	**60-65**	**185-190**	**1225**	**1150**	**15**	**10**
Paul Bennett Deputy Chief Executive	**0-(2.5)**	**0-(2.5)**	**30-35**	**90-95**	**523**	**522**	**(2)**	**(1)**
Dr Akeem Ali Director of Public Health	**0-2.5**	**2.5-5**	**10-15**	**30-35**	**153**	**127**	**20**	**13**
Malachy McNally Finance Director	**0-2.5**	**5-7.5**	**45-50**	**135-140**	**904**	**800**	**62**	**41**
Dr John Omany Clinical Director	**0-2.5**	**0-2.5**	**25-30**	**85-90**	**628**	**580**	**18**	**12**
Justin Dix Acting Director of Governance	**N/A**	**N/A**	**15-20**	**25-30**	**244**	**N/A**	**N/A**	**N/A**
Alexandra Kalmis Acting Director of QIPP and Contracts (From April 2012)	**N/A**	**N/A**	**0-5**	**0-5**	**26**	**N/A**	**N/A**	**N/A**
Helena Reeves Director of Communications & Corporate Management	**0-2.5**	**0-2.5**	**10-15**	**40-45**	**285**	**253**	**19**	**13**

Table showing details of off payroll engagements at a cost of over £58,200 pa that were in place as of 31 January 2012

	NHS Surrey
Number in place on 31 January 2012	2
of which	
Number that have since come onto the organisations payroll	1
Number that have since been re-negotiated/re-engaged to include contractual clauses allowing NHS Surrey to seek assurances as to their tax obligations	1
Total	2

There were no new off payroll engagements over the period between 23 August 2012 and 31 March 2013, for more than £220 per day and more than 6 months.

Cash Equivalent Transfer Values

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

The CETV figure, and from 2005-06 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.

REGISTER OF MEMBERS INTERESTS

ORGANISATION	TYPE	PURPOSE	NATURE OF INTEREST
DAVID CLAYTON-SMITH, CHAIRMAN			
The Fairtrade Foundation	Charity	Tackling poverty in third world countries	Chairman
Health Insights Ltd	Private Company	Self-care education material	Director
RODNEY GRITTEN, NON-EXECUTIVE DIRECTOR			
Surrey Downs Clinical Commissioning Group	NHS Organisation	Commissioning of healthcare	Interim Lay Member for Governance
JONATHAN MORGAN, NON-EXECUTIVE DIRECTOR			
No relevant interests to declare			
GHISLAINE WATSON-HOPKINSON, NON-EXECUTIVE DIRECTOR			
• Crown Prosecution Service		Senior Crown Prosecutor	Lawyer
• Government Equalities Office		Member of the Ambassador's Network	Diversity Ambassador
• Royal Naval Reserve Combined Cadet Force		Lieutenant CCF	Adult supervisor
• Appointments Commission	Arms length body of Dept of Health	Member of the Appointments Commission Diversity Forum.	
DAVID LEWIS, NON-EXECUTIVE DIRECTOR			
• Kent Police Authority		Regulation and funding of Kent Police	Treasurer (part time)
• NHS Kent and Medway	Primary Care Trust Cluster		Non-Executive Director and Joint Audit Chair
• Wittersham Parish Council			Vice Chair
GRAHAM HANSON, NON-EXECUTIVE DIRECTOR			

No relevant interests to declare			
SARAH BETTELEY NON-EXECUTIVE DIRECTOR			
Deva Medical Electronics Ltd	Deva is a small business which distributes and services medical electronic equipment to equipment to NHS hospitals and National Blood Service	Provide consultancy advice on general strategy and update to their comms service and infrastructure	Non Executive Director
PETER GORDON NON-EXECUTIVE DIRECTOR			
Surrey Lifelong Learning Partnership			Trustee/Director
PDG1 Ltd			Owner/Director
Surrey Community Action			Trustee/Non-Executive Chairman
Queen Elizabeth's Foundation for Disabled People			Trustee
Surrey Economic Partnership Ltd			Non Executive Director
ANNE WALKER, CHIEF EXECUTIVE			
No relevant interests to declare			
MALACHY MCNALLY, EXEC DIRECTOR			
No relevant interests to declare			
DR AKEEM ALI EXEC DIRECTOR			
Halo Leisure Ltd	Social Enterprise	Non Remunerated	Board member

HELENA REEVES, EXEC DIRECTOR			
No relevant interests to declare			
MAGGIE IOANNOU EXEC DIRECTOR			
• MIBSD Ltd	Limited Company	Consultancy	Director
• Zenon Consulting	Limited Company	Consultancy	Associate
JOHN OMANY MEDICAL DIRECTOR			
No relevant interests to declare			
JUSTIN DIX EXEC DIRECTOR			
Woking International Dance festival	Charity	Promotion of dance and dance events in Woking and wider Surrey area(occasional interaction with NHS bodies or health funding)	Non-Executive Director
ALEXANDRA KALMIS EXEC DIRECTOR			
No relevant interests to declare			

Department of Health

NHS

Surrey Primary Care Trust

2012-13 Accounts

Published to gov.uk, in PDF format only.

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Surrey Primary Care Trust

2012-13 Accounts

Foreword to the Accounts

These accounts for the year ended 31st March 2013 have been prepared by the Surrey Primary Care Trust under section 98 (2) of the National Health Service Act 1977 (as amended by section 24 (2), schedule 2 of the National Health Service and Community Care Act 1990) in the form which the Secretary of State has, with the approval of Treasury, directed.

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
- 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;
- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the net operating cost, recognised gains and losses and cash flows for the year.

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

Signed .....Designated Signing Officer

Name.....Amanda T. Fahey.....

Date.....06.06.13.....

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
- 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.

06/06/13 Date ..... Signing Officer

06/06/13 Date Marie Farrell ..... Finance Signing Officer

NHS SURREY 2012/13
Annual Governance Statement

Insert name of organisation: Surrey Primary Care Trust

Organisation Code: U5P5

Governance Statement

Scope of responsibility

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

The Chairman's key responsibility is to provide leadership to the Board to ensure its effectiveness on all aspects of its role and setting its agenda. The Chairman also provides a source of support to the Chief Executive and is responsible for my annual performance review.

NHS Surrey works with the Strategic Health Authority, (initially this was with NHS South East Coast and from October 2011, NHS South of England Cluster) and partner organisations and participates in regular strategic, planning and performance improvement discussions. Throughout the year we have held a range of meetings with key provider and partner organisations to review objectives across the health economy and to manage risks to delivery. These include:

1. Monthly meetings of the Surrey Transformation Board which includes all Surrey trust chief executives (including director level representation from Surrey County Council Social Services).
2. Performance meetings with the Strategic Heath Authority.
3. Monthly contract performance meetings (addressing finance, activity and quality) with all hosted contracts.
4. Transformation Boards for key partners around each acute hospital hub.
5. Meetings with emerging Clinical Commissioning Groups, the Area Teams of the National Health Service Commissioning Board and Surrey County Council.
6. Monthly Transition Governance Meetings with South East Strategic Health Authority Cluster.

Actions are agreed at these meetings to ensure that collective and individual objectives are progressed in line with NHS Surrey's overall operating plan, both delivery and the requirements of transition.

As Accountable Officer I have established a scheme of delegation that aligns directors to key areas such as patient safety (Director of Nursing) and patient engagement (Director of Communications), working with the voluntary sector (Director of Communications), and the Director of Contracting and QIPP responsible for commissioned trusts. Lay members and representatives of LINKs and local authorities sit on key Board committees.

I ensure that all significant initiatives meet the requirements for consultation and engagement with the public, as part of a wider commitment to public engagement. The Chairman of LINKS is included at the Board table at every meeting and also attends Board seminars. There has been input from the wider community on all major procurement processes through this route during 2012/13. All Board meetings also invite questions and comments from the public and this option is taken up and questions from the public are evidenced in Board minutes.
The Chief Executive of NHS South of England Strategic Health Authority is responsible for monitoring the performance of NHS Surrey but also fulfils an important role in supporting and providing career development and mentorship for me as Surrey's Chief Executive.

NHS Surrey has a five year strategic commissioning plan, an annual operating plan, including sustainable delivery of QIPP and a set of strategic commissioning intentions which have been approved by the Board. The PCT has also worked with Clinical Commissioning Groups to deliver sustainable Quality, Innovation, Productivity and Prevention (QIPP) plans. These documents and the operating framework have been instrumental in developing the organisational objectives. The Board objectives have been mapped into the assurance framework and linked with the risk register. During the course of the year, performance reporting, quality and risk were linked together through the Patient Safety and Quality Report and the Corporate Assurance Report presented to the Quality and Performance Committee bi-monthly and then the Board.

The governance framework of the organisation

The Board has ultimate responsibility for ensuring that there is an adequate risk management framework for Surrey Primary Care Trust (known as NHS Surrey). NHS Surrey is a single PCT Cluster and has worked as such since its formation in October 2006. The Board has delegated specific responsibilities to the Chief Executive, Audit Committee, Remuneration Committee, Clinical Executive Committee (CEC), Transition Assurance Committee and Quality and Performance Committee. The six Clinical Commissioning Groups have also been sub committees of the Board.

The Board reviews its effectiveness throughout the year through a series of seminars focusing on key issues, and through reviews by the Chairman with monthly meetings with non executives. As a result of this Board Committee terms of reference have been amended and director portfolios amended (January 2012). Non executives have been given additional hours and aligned to key priorities. An additional lay member was in place for part of the year to ensure that the Board can deliver cluster requirements. I have worked closely with the Chairman on these changes.

The Board also conducts a formal review of the effectiveness of its Assurance Framework at the end of the year as part of preparing the assurance framework for the subsequent year. This was done at the April 2012 Quality and Performance Committee as part of its delegated role. There have been ongoing reviews during the year which were received by both Quality and Performance Committee and the Board. A workshop took place in October 2012 to between Officers and Non executives to review and align the Trust risk register with the Board Assurance Framework

Each committee is required as part of its terms of reference to monitor effectiveness and the attendance of its members. There were no issues with the effectiveness, quoracy or attendance in this period.

2012/13 has been a transitional year for the PCT due to the changes set out in the Health and Social Care Act. The executive director portfolios changed at the start of the year with changes in personnel and the need to create a fit for purpose organisation. The Chief Operating Officer role ceased in March 2012. The Director of QIPP and Contracts and Director of Governance, Transition & Corporate Reporting (including Performance) were established as interim roles and appointments were made in April 2012.

The Transition Assurance Committee was created to provide assurance to the Board that during the transitional period to the end of March 2013, NHS Surrey maintained its ability to function safely and effectively and is handing over its functions in a timely, consistent and appropriate fashion to its successor bodies. The March 2013 Board meeting approved the final transfer documents and risk register prior to these being handed over to the CCGs and NHS England for the 1st April 2013. The CCGs were present at this meeting and acknowledged and accepted the hand over form the PCT Board. The committees of the Board have standing agendas of reporting to assure the Board on the governance of the Organisation.

The Transition Assurance Committee receives reports from transition work streams covering;

- Health and Wellbeing Board development
- Health Watch development
- Clinical Commissioning Groups
- NHS Commissioning Board (focusing on field force)
- Commissioning support arrangements
- Public Health transition
- Transforming community services
- People management and organisation development
- Finance
- Estates

- Contracts
- Information technology/management
- Communications
- Statutory shut down

The Quality and Performance Committee receives the following reports :

- Patient Safety and Quality report
- Corporate Assurance report
- One Plan Delivery/QIPP report
- Finance report
- Contract Performance report
- Board Assurance Framework
- Corporate Risk Register
- Business Continuity, Emergency Planning
- Minutes from subcommittees, external and other committee assurance covering:
  - Patient Safety sub Committee
  - Health Policy Group
  - Surrey Immunisation and Vaccination Committee
  - Surrey Healthcare Associated Infections leads
  - One Plan Delivery Board
  - Health and Safety Group
  - Information Governance sub Committee
  - Joint Negotiating and Consultative Committee

The Audit Committee receives audit reports assessing the effectiveness of all aspects of organisational business and the minutes of other committees. The Board receives assurance reports on all committee business.

NHS Surrey also established a sub committee of the Deaprtment of Health's Audit and Risk Committee to review and approve the Annual Accounts and Annual Report. This sub committee comprises the PCT Chairman, the Audit Committee Chairman and one further NED. The commitee plans to meet on two occassions, in April and in June 2013 and will also receive the external auditors report (ISA260).

The Board reviews its corporate governance at each meeting (the corporate governance report) and through the Audit Committee. The corporate governance report and the register of members' interests highlight issues with standards of conduct. The code of conduct is not a separate document but is embedded in the PCT's standing orders. A number of amendments have, however, been made to committees and the role of the Clinical Executive as a result, and have influenced the development of Clinical Commissioning Groups. The PCT standing orders are regularly reviewed and amended over the lifetime of the PCT. Any deviations from the Standing Orders such as tender waivers are recorded in the Board minutes.

In addition to my personal responsibility, the Acting Director of Governance, Transition & Corporate Reporting (including performance) was the director lead for risk management, Board level governance and transition during 2012/13. The Acting Director of Governance, Transition & Corporate Reporting (including performance) led on the development and implementation of the Risk Management Strategy, the Assurance Framework and the Risk Register, integrated governance and risk management. The Risk Manager is responsible for coordinating the organisation's risk management strategy and operational processes. The Director of Nursing, Quality and Patient Safety acts as the Director of Infection Prevention and Control and Accountable Officer Controlled Drugs. The Medical Director is the Caldicott Guardian and the Director of Public Health is the Senior Information Risk Owner for the PCT. The Acting Director of QIPP and Contracting is responsible for the delivery of the QIPP agenda.

The Clinical Governance Strategy is led by the Medical Director and the Director of Nursing and through the Quality and Performance Committee the risk, performance, and governance agendas are reviewed jointly enabling an integrated governance approach. All of the above is overseen by the Board of NHS Surrey.

Day to day responsibility for risk management has been delegated to executive directors. The aspects of risk they are responsible for are outlined in the Risk Strategy. All directors are responsible for ensuring there are robust processes in place for identifying and managing risks within their areas of responsibility. The Quality and Performance Committee receives and approves a monthly report on new additions to the risk register, requests for closures of risks and any escalating risks. The Quality and Performance Committee is well placed to co-ordinate common risks across the organisation as a whole and provides a strong and appropriate level of challenge when required. The Quality and Performance Committee also reviews the Board Assurance Framework prior to its review by the Board.

The Risk Management Strategy was reviewed in May 2012 and formally approved by the Board in June 2012. The Risk Management Strategy specifies the organisational framework and intent for managing risk within NHS Surrey. It defines the responsibilities of the chief executive and executive team and details the committees responsible for managing risk. Risk management underpins all activities undertaken by NHS Surrey and robust corporate and directorate processes are in place to enable the proactive identification and management of risks. The risks are recorded and performance managed using the directorate and corporate risk registers.

NHS Surrey successfully achieved Level One compliance with the NHSLA's level one Risk Management Standards in March 2010. The assessment is a provider based assessment and as a commissioning organisation NHS Surrey is not required to be reassessed.

Induction is mandatory for all staff and includes risk management, incident reporting, fire, health and safety, counter fraud, security and information governance awareness training. An ongoing programme of risk management training for permanent staff is provided via training programmes and specific risk training awareness sessions are also provided as part of the training and development programme for managers in both the commissioning and provider arm of the organisation. The training programme focuses on a variety of risk management issues including the outcome of risk assessments, incidents and experiences along with individual's responsibility for incident and near miss reporting and adherence to the organisational policies to ensure safe working practice. Training in aspects of organisational risk has also been provided for all members of NHS Surrey Board.

NHS Surrey continues to report to the National Reporting and Learning System (NRLS) and information on incidents and the associated learning is shared. There is a robust process in place for the notification of and management of serious incidents both within the organisation and externally to the Strategic Health Authority. Since April 2008, NHS Surrey has been responsible for the performance management of all serious incidents reported by its commissioned services. The Quality and Performance Committee and the Board receive a performance management report on serious incidents within each Patient Safety and Quality Report.

Risk assessment

The Risk Management Strategy is based on the principle that it is impossible to eradicate risk completely; the aim is to anticipate, manage and mitigate risk as thoroughly as possible. This must be done in a manner that provides staff with the confidence that the organisation seeks to learn from and not to allocate blame unfairly when incidents occur.

The strategy sets out the principles that staff are asked to use in assessing the likelihood and then the impact of an event occurring, identifying the need to develop a response plan for all identified risks, including a timescale for implementing the plan and the responsible officer. The policy also identifies the line reporting and accountability arrangements for risk management.

Each risk is scored using the risk scoring matrix based on the NPSA Risk Matrix published in January 2008 and which was formally adopted as part of the revised Risk Strategy approved in July 2008, July 2009 and May 2012. All risks are evaluated in terms of their impact on individuals and the impact on the organisation in terms of service delivery, resources and user confidence. Risks are given a score based on the outcome of the evaluation. The process for recording, reviewing and reporting of risks, including the process for the escalation of risks to the corporate risk register are outlined in the Risk Strategy. Responsibility for risk management sits within directorates and a system for regular review of the risk register by the Quality and Performance Committee is in place.

The Quality and Performance Committee has responsibility for evaluating and endorsing action plans to reduce risks and for ensuring action plans are progressed as planned.

The highest scoring risks identified within the Risk Register relate to Healthcare Funding, achievement of performance indicators and Service delivery. Updates on actions being taken and controls in place to mitigate these risks are reported to Quality and Performance Committee and then to the Board as part of the Corporate Risk register update which updates the Committee and the Board on all the high scoring risks (those scored at 15 and over). The risk register has been scrutinised and prepared for specific risk identified for closure or transfer to new organisations for 1 April 2013.

A risk management strategy implementation plan is contained within the Risk Strategy. This forms the framework for taking embedded practice forward and for monitoring and reviewing progress. The risk management strategy implementation plan is reviewed six monthly by the Quality and Performance Committee.

There is a risk management training programme in place which concentrates on ensuring staff understand the concept of organisational risk as well as in their specific work environment and feel equipped to recognise and to manage it. All new staff are informed of risk management processes as part of induction training. They are informed about the risk assessment structure and processes in place, the risk assessments used, and provided with an outline of their responsibility in the reporting, assessing and managing risks.

118 new risks were identified in 2012/13. Of these 56 were graded as high risks and related to QIPP delivery (17), Transition (34) and Olympics related (5). As at the end of March 2013 there are seven remaining transition and two remaining QIPP related risks. All Olympic risks have been mitigated and closed. Updates on actions being taken and controls in place to mitigate risks are reported to Quality and Performance Committee and then to the Board as part of the Corporate Risk register updates which updates the Committee and the Board on all the high scoring risks (those scored at 15 and over).

The risk and control framework

NHS Surrey put in place an Assurance Framework for 2012/13 corporate business and reporting processes to ensure appropriate and timely provision of information to the right forums to enable effective decision making and safe and robust systems of work. The Assurance Framework demonstrates:

The principal and corporate objectives of NHS Surrey

The risks to achievement of these objectives

The controls and measures in place to mitigate risks

Sources of Board Assurance

Plans to redress gaps in controls and assurance

Ownership of each risk.

The assurance framework has been developed with the Cluster Executive Management Team and approved by the Board. It is supported by the Risk Management Strategy, Standing Orders, Scheme of Delegation and the risk register. The Corporate Risk Register, the Patient Safety and Quality report and the Corporate Assurance Report are aligned to the Board Assurance Framework and they provide the executive team and Board with ongoing assurance that any gaps in controls and assurances are being actively managed. During the year gaps in assurance were noted on the following: sign up and implementation of the One Plan; delivery of the agreed financial plan; lack of clarity on transition running costs; failure to align staff to emerging Clinical Commissioning Groups or the Commissioning Support Service; existing or future customers not wishing to use the Commissioning Support Service; failure to deliver the transfer of community services to new bodies and the alignment of public health staff with Surrey County Council.

The assurance framework and risk register have been regularly reviewed by the Quality and Performance Committee and the Board and the gaps in assurance are understood and have been managed through active risk mitigation. These are being reviewed as part of the year end closure process.

The focus has been upon the overarching objectives for the organisation as follows:

- Work with successor bodies to effectively manage transition
- Deliver the Annual Plan through and in collaboration with successor bodies
- Support staff through effective people transition arrangements
- Ensure patient safety and quality is maintained and enhanced across Surrey

- Manage major procurements and change programmes and their legacy effectively

- Ensure that our infrastructure and business continuity arrangements are robust and support organisational closure

The Board is alerted to high risks and receives assurances of actions to mitigate risks in the following ways:

Patient Safety and Quality Report

Corporate Assurance Report

QIPP reports

Financial reports and annual accounts

Corporate Risk Register

Patient Advice and Liaison Service (PALS) reports

Complaints handling

Incident reporting and pending/current claims

Reports from external regulatory bodies

Inspection visits

Serious Incident performance reports within the Patient Safety and Quality report.

Minutes and exception reporting from Board committees and sub committees.

Audit Reports.

Issues identified by transition

There are active programmes within the organisation to prevent and proactively manage risks. These include counter fraud arrangements (with specific Board training on the new Bribery Act); Health and Safety preventive inspections and visits; estates statutory compliance programmes; support to staff to actively identify risks to delivery, and a monthly review of risk registers at Directorate and Board level.

Potential risks are identified in the Assurance Framework and through risks and issues logs for specific projects. Manifest risks are managed through the risk register and active risk management processes.

The key processes linking public stakeholders with the risk management process are:

Development workshops for emerging Clinical Commissioning Groups

Board Seminars jointly with emerging Clinical Commissioning Groups

Consultation processes with partner organisations

Co-design events linked to the development of new services

Patient Advice and Liaison Service (PALS)

Complaints Officers

Patient and public involvement and consultation processes

Non-Executive Directors helping the Board to be sure that it is working in the public interest and keeping its patients and the public properly informed.

A lay member of the public is invited to all Quality and Performance Committee meetings and two lay members are invited to the Patient Safety sub Committee. The Chairman of Surrey LINk (Local Involvement Network) is invited to attend all public and private Board meetings.

Care Quality Commission (CQC) Essential Standards of Quality and Safety – 2011/12 inspections

All issues relating to CQC inspections in the previous year were subject to appropriate assurance, resolved and closed and therefore are not relevant to the 2012/13 Annual Governance Statement

Clinical

Significant progress has been made in the following areas;

- Elimination of mixed sex accommodation.
- Improving standards of care of patients with dementia.
- Significant reduction in incidents of healthcare associated infections.
- Increase in levels of risk assessment for Venus Thromboembolism.
- Continuing improvement in standards of Stroke care.

Providers continue to operate the safe care triangle (an "early warning" mechanism), enabling proactive management of the quality and safety of care within the organisation and submits safe nursing metrics enhancing quality and performance reporting. This will be regularly reviewed by Clinical Commissioning Groups and strengthened in line with the Francis Report recommendations.

There has been a robust approach to transition of quality responsibilities to new commissioning organisations. All Clinical Commissioning Groups have a Quality Lead in post that is part of the governing body.

A work programme has been in place since November 2012 and a formal set of meetings between NHS Surrey Quality Performance Committee and individual Clinical Commissioning Groups has taken place in January 2013 where the Quality Transition Legacy Document will be signed off as final transition assurance.

This has been followed up with detailed mobilisation plans. Achievement of these assured at the Final Quality and Performance Committee on the 14th March. This report was presented to the final NHS Surrey Trust Board on the 22nd March 2013 where the Quality Transition Legacy Document was signed off as final transition assurance.

NHS Pension Scheme regulations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the schemes regulations are complied with. This includes ensuring deductions from salary, employer's contributions and payments into the scheme are in accordance with the Scheme rules and that Pension Scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Compliance with equality, diversity and human rights legislation

Control measures are in place to ensure that all the organisation obligations under equality, diversity and human rights legislation are complied with. All NHS Surrey Board members have received a comprehensive Equality and Diversity information pack outlining their responsibilities and signposting further training and information sources. An annual report is produced to present progress and to meet legislative duties. The organisation approved three Equality Objectives in March 2012 which set out the priorities for equality, diversity and human Rights during the transition process, in order to meet the legal requirements of the Equality Act 2010.

Information Governance and Data Security loss

NHS Surrey submitted evidence as proof of compliance for the 2012-2013 Information Governance Toolkit to the Department of Health. The submission met the requirements given, except for the very challenging requirement to train 95% of staff annually in information governance. We worked hard to meet the target by offering information governance sessions at induction, online and by face to face training sessions, and by stressing the importance of information governance and training to all staff. The Information Governance Toolkit submission confirmed that we operated within the requirements of the Information Governance Statement of Compliance. The Trust reported one significant information incident to the Information Commissioner in 2012/13: an incident concerning the destruction of certain data. The loss of 20 items of patient identifiable data from our Stop Smoking team was reported to the Board.

Assurance provided by Internal Audit

The Trust's independent Internal Audit service operates in accordance with the NHS Internal Audit Standards and delivers an Internal Audit plan as approved by the Trust's Audit Committee. Throughout 2012/13 the Audit Committee has reviewed the assurance provided from Internal Audit, with respect to controls and processes in place throughout the year. An internal audit plan for the period 1st April 2012 to 31st March 2013 was developed and regularly reviewed, to provide management and the Audit Committee with independent assurance on the adequacy of the Trust's system of internal control.
To support this Governance Statement the Head of Internal Audit has, based on the planned work carried out during the year, provided an internal audit opinion of 'significant assurance'. The results of our audit work were a predominance of significant over limited assurance opinions. The audits receiving 'limited' assurance opinions were mostly in areas of known weakness, where Internal Audit has been used to help drive improvement:

- Criminal Records Bureau (CRB) Healthcheck Review
- Primary Care – Ongoing Assurance and Healthcheck Review
- COIN Governance and Security Model Review
- Information Governance Toolkit (IGT) v10 Review, due to a lack of IG Toolkit evidence submitted by GP Practices

Action plans have been developed to address the audit recommendations and these have been approved and are performance managed by the Audit Committee. Those audit recommendations outstanding at 31st March 2013 will be transferred to the relevant receiving bodies.

Controls have continued to operate effectively for the core governance and financial systems during a time of significant change and therefore pressure on staff.

Estates

The PCT continued to make significant capital investment to maintain statutory compliance status within its estate in areas of fire, asbestos, legionella, fixed wiring and health and safety. The PCT annually reviews the risk adjusted backlog maintenance plan and ensure the continued investment where necessary.

The PCT has undertaken risk assessments and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that the organisation's obligations under the Climate Change Act and the Adaption Reporting requirements are complied with. The NHS Surrey Board is signed up to the county-wide Surrey Strategic Partnership Climate Change Strategy. Estates projects relating to carbon reduction and emergency preparedness include an ongoing replacement of key mechanical and electrical infrastructure that significantly reduces the use of natural resources and carbon emissions. Several boilers and hot and cold water systems have been replaced to significantly improve the performance of critical infrastructure.

Transition and Reform

The NHS Surrey Board delegated responsibilities for the implementation of the NHS Health and Social Care Act 2012 to the Transition Assurance Committee (TAC). The TAC membership includes two non-executives, key executives of the PCT Cluster management team, senior representatives of Surrey County Council and representatives from local Health Watch.

As CCGs will be an integral part of the future landscape, the views and issues from CCGs, on transition matters are:

- Separate CCG Leads meetings, of which the Chair of TAC and the Transition Programme Director are members, and;

- The emerging CCG Governing Committees which are committees of the PCT Cluster Board. The CCG Governing Committees will include PCT Cluster executives and non-executive members. Clinical Commissioning Groups attend NHS Surrey Trust Board.

The Acting Director of Governance, Transition & Corporate Reporting (including performance) was responsible for the management of the transition process to the new commissioning arrangements.

Control is further enhanced through:

- regular formal meetings, programme reporting on national and regionally determined milestones and managing of the programme through best practice methodology and

- Non-executive members sitting on other key committees, for example, the Audit Committee and the Quality and Performance Committee.

To ensure the Cluster keeps pace with the rapidity of change, horizon scanning mechanisms are in place.

Localised risks for NHS Surrey will be maintained on the Corporate Risk Register and managed through the work stream reporting and reviewed at TAC.

All minutes of TAC meetings are sent to the Audit Committee and the Transition Programme has been reviewed by internal audit who have concluded that the PCT's transition governance arrangements and internal programmes supporting closure are effective, comprehensive and are being appropriately implemented on a timely basis.

A recommendation was raised relating to the need to integrate risk management more prominently within the transition governance arrangements.

Continuing Health Care

During 2012/13 significant progress has been made in reducing continuing care assessments, to below 250 by Dec 2012. Additional time limited capacity has been identified to enable this to be achieved. However continung care assessments continue to be a significant issue as set out below.

Risks around organisational change

Risks relating to the changes arising from the 2012 NHS Health and Social Care Act have been built into the delivery of the PCT's Annual Plan. The PCT has managed potential loss of staff associated with the move to Clinical Commissioning Groups. Although this did not emerge as a significant control issue in 2011/12 it was a more significant issue for 2012/13. The Board managed these risks through its assurance and internal control processes and outcomes were regularly reviewed in the Transition Assurance Committee (TAC). In particular the development of CCGs and the Commissioning Support Unit were carefully managed to ensure that the capacity (particularly contracting, information management and clinical expertise) was retained and / or made available for delivery of the plan.

A final report on the transition process was presented to the final board meeting on the 22nd March 2013 and this set out the achievement of transition and the residual risks for the legacy year 2013/14.

Financial balance

The PCT's initial financial plan for 2012/13 was for an under spend of £10m on its revenue resource limit of £1,774m. This plan was subsequently changed with the support of the NHS South of England Strategic Health Authority to a requirement to achieve breakeven on the revenue resource limit. The PCT achieved this financial objective in 2012/13 and has delivered a final under spend of £211k. The key features of the PCT's financial performance in 2012/13 were:

- In year budget pressures of £38m in relation to acute services commissioning budgets
- In year budget pressures of £1m on primary care prescribing budgets
- In year budget pressures of £2m resulting from additional expenditure within corporate budgets as a consequence of the changes associated with the implementation of the NHS Health and Socail Care Act 2012

While offsetting these in year costs pressures with;

- Full use of the PCT contingency funds of £16m
- Under spending within CCG contigency budgets of £5m
- Under spending within other contracting spend and discretionary budgets of £20m

QIPP

The PCT had a challenging QIPP plan to deliver in 2012/13. In March 2012 the PCT submitted a plan to the SHA made up of £45.7M of QIPP projects and £48.6M of tariff efficiency savings. In October 2012 financial recovery plans were submitted by CCG to help mitigate the growing QIPP requirement caused predominately by acute over performance. NHS Surrey the QIPP target set out above.

For assurance purposes and to support the monitoring of QIPP in year we have run bi-weekly QIPP Delivery Boards. These have been attended by CCG's and the SHA and focused on particular work streams or areas of concern at that point. The Transformation tracker which tracked progress of key transformational change was completed by CCG's and work stream leads and submitted to the SHA on a monthly basis. The last report was submitted on the 5th February and the PCT has a file for legacy purposes of all submissions made.

Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the Internal Audit's work. The Head of Internal Audit opinion for 2011/12 for NHS Surrey was that there is significant assurance that there is a generally sound system of internal control, designed to meet the PCT's objectives and that controls are generally being applied consistently.

Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance.

The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage risks to the organisation achieving its principal objectives have been reviewed.

My review is also informed by:

- Reports received in accordance with the agreed internal audit plan and feedback from the Audit Committee
- Reports from our external auditors
- Periodic meetings with the Care Quality Commission
- Care Quality Commission Inspection visits and surveys
- QIPP reporting
- The Patient Safety and Quality Report
- The Corporate Assurance Report.

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
Audit Committee
Clinical Executive Committee
Quality and Performance Committee
Transition Assurance Committee
Clinical Commissioning Committees
Executive Management Team
Internal Audit
External Audit
Local Counter Fraud Team.

Systems in place to maintain and review effectiveness of systems of internal control include:
Board agreed objectives and key indicators
Use of the Board Assurance Framework
The Integrated Assurance report
A Board committee and sub-committee structure to support integrated governance
Robust risk management processes
Use of the Risk Register as a management tool
Review of risk processes taking account of NHSLA and NPSA guidance
Weekly/ daily executive management team meetings to address current priority issues
Performance reporting to the Board, Clinical Commissioning Executive and Executive/ Cluster Management Team.

Significant issues:

Data Loss Security Incidents

There were two serious incidents in 2012/13. In June 2012, the Trust was informed that certain data sent for secure destruction had not been properly destroyed. This incident was reported to the Information Commissioner and is still being investigated.

In January 2013, a member of staff had their vehicle broken into, and items were stolen. These included a locked case containing 20 sets of Stop Smoking Service client records. All the patients affected were informed of this, and furthermore steps were immediately taken to ensure that this incident could not be repeated, including revisions to the trust Transportation of Records Guidance and to clinic venue records storage criteria. This incident was reported to the Board

Transition

An internal audit of the Transition and Reform programme was undertaken by South Coast Audit concluding that, in general, the controls in place were operating effectively. Feedback on the Transition Plan was also received from NHS South of England which has been favourable. However, certain risks, issues and concerns around the programme should be noted.

Programme control risks:

Corporate programme risks relating to transition have been:

- As the pace of change from the transition increased, it could potentially have impacted upon the delivery of Quality, Innovation, Productivity and Prevention (QIPP) programme
- There was potential impact on patient care during the transition if key elements of patient safety and quality had not been given sufficient focus.
- There was risk of loss of key workforce due to staff leaving the organisation.
- NHS Surrey risked leaving a legacy debt for emerging organisations impacting on future sustainability of the health system.
- The staff and non-staff transition costs associated with the transition needed to be estimated and budgeted for. Inadequate financial provision made for the transition and dissolution of the PCT may have placed the PCT under financial pressure.

- February staff mapping shows 45% of PCT employees in commissioning/ contracting roles, who could transfer to commissioning support. However, Clinical Commissioning Groups may operate differently, with fewer employees or may choose to buy or share services from elsewhere. This could have impacted on the number of redundancies or numbers to be redeployed.
- Risk of 'cutting across the work of the PCT Board', during 2012-13 or creating confusion
- Risk that the Shadow Health and Wellbeing Board's role was not properly understood and
- Clinical Commissioning Groups not being able to agree a configuration in terms of number, size and population coverage that makes them viable
- There were significant issues with financial risk that could have undermined Clinical Commissioning Groups viability
- Significant conflict of interest issues were identified that could have delayed Clinical Commissioning Groups development
- Skills were not aligned to the emerging bodies as the change process moved forward
- It was not possible to address staff turnover issues and the resulting gaps in the core and statutory functions of the organisation
- The new bodies may have recruited their staff from other sectors and there are significant numbers of PCT staff who could not be redeployed as a result
- Risk that existing and potential customers would not wish to purchase services.

- Failure to have a robust health and safety system in place through Transition may have impacted on safety and the NHS Surrey's compliance with legislative requirements
- There is a divergence in the priorities of agencies that caused significant issues with transition
- Commissioning Clinical Commissioning Groups may not have supported the agreed strategic direction of the PCT and Surrey County Council

Commissioning Support Unit issues

The Clinical Commissioning Groups are free to choose their provider of commissioning support. This has resulted in three separate CSUs operating in Surrey, the implications of which have been identified in the Directors' final report. The Surrey and Sussex CSU has had four different individuals in the lead role of Managing Director. This has made the transfer of staff and responsibility for delivery of core commissioning support from October 2012 onwards more challenging for the PCT.

QIPP

As set out above, the PCT had a challenging QIPP programme to deliver in 2012/13. Although this was satisfactorily concluded, the management team and Board invested considerable resources and organisational capacity through delivery meetings and a constant focus at executive, committee and board level in order to deliver it.

Signature

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.

Signing Officer : Name Amanda Fadero

Organisation: Surrey Primary Care Trust

Signature: 

Date: 06.06.13

South Coast Audit

APPENDIX B

HEAD OF INTERNAL AUDIT OPINION ON THE EFFECTIVENESS OF THE SYSTEM OF INTERNAL CONTROL AT NHS SURREY FOR THE YEAR ENDED 31 MARCH 2013

FORMAL OPINION OF THE HEAD OF INTERNAL AUDIT

Roles and responsibilities

The whole Board is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The NHS Chief Executive, in his capacity as Accounting Officer for the NHS in the Department of Health (DH), requires SHA, PCT and NHS Trust Accountable Officers to give him assurance about the stewardship of their organisations. In previous years this assurance was received mainly from Statements on Internal Control completed by NHS Accountable Officers. Accountable Officers should include the Annual Governance Statement in their annual report and accounts.

The governance statement draws together position statements and evidence on governance, risk management and control, to provide a more coherent and consistent reporting mechanism. There is no set template for the governance statement as the DH is encouraging each NHS organisation to set reporting in the context of its functions and operating environment. However, there are key elements that must be covered. This is to ensure compliance with Treasury guidance and to ensure that the NHS Chief Executive is able to draw the assurance he needs to sign an overarching NHS governance statement.

In accordance with NHS Internal Audit Standards, the Head of Internal Audit (HoIA) is required to give an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (that is, the organisation's system of internal control). The HoIA achieves this through a risk-based plan of work, agreed with senior management and approved by the Audit Committee, which should provide a reasonable level of assurance, subject to the inherent limitations described below.

The opinion does not imply that Internal Audit have reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led Assurance Framework. As such, it is one component that the Board takes into account in making its Governance Statement.

The Head of Internal Audit Opinion

The purpose of my annual HoIA Opinion is to contribute to the assurances available to the Accountable Officer and the Board, which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control. This Opinion will in turn help the Board in completing its Annual Governance Statement.

My opinion is set out as follows:

1. Overall opinion;
2. Basis for the opinion;
3. Commentary.

My **overall opinion** is that

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

The **basis** for forming my opinion is as follows:

1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and

2. An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that we have reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

Additional areas of work that may support the opinion will be determined locally but are not required for DH purposes, for example:

3. Any reliance that is being placed upon third party assurances.

The **commentary** that follows gives the context for my opinion and together with the opinion should be read in its entirety.

The design and operation of the Assurance Framework and associated processes

As part of the annual core assurance work undertaken by Internal Audit we have completed a review of the NHS Surrey Board Assurance Framework (BAF) and Risk Management process for 2012/13 to inform the Head of Internal Audit opinion. We gave 'Significant Assurance' regarding the design, adequacy and effectiveness of the Trust's Assurance Framework and Risk Management processes and the extent to which the Board and management determine, assess, manage and monitor risks. We again noted that the BAF has not been reviewed at Audit Committee, but has been regularly presented to the Quality and Performance Committee of the Board. The Transition Risk Register has also been managed by the Transition Assurance Committee (TAC).

In order to assist the PCT in facilitating an orderly handover to receiving organisations, the recommendations arising from our work were presented in the form of lessons to be learnt for CCGs.

The range of individual opinions arising from risk-based audit assignments, contained within risk-based plans that have been reported throughout the year

We compiled the 2012/13 Internal Audit Plan based on our understanding of the needs of the organisation, with reference to the Assurance Framework, and from an assessment involving senior PCT management and the Audit Committee.

Certain core systems need an annual review, either because they are fundamental Financial Systems (upon which External Audit seek to place reliance on our work), or where annual assurance is needed by management. Core financial work consists of audits of the Trust's main Financial System, Sales and Purchase Ledger and the Payroll/Electronic Staff Records (ESR) system. Other core work includes the review of the Trust's Assurance Framework and supporting risk management processes.

The results of the audits completed this year are a predominance of 'significant' levels of assurance (as shown by the chart below), mainly on the fundamental control areas of finance, risk management and governance.

In areas where we were only able to give 'limited' assurance, we recognise that at least in part these were identified for review because they were known areas of concern, which reflects a mature approach to seeking independent assurance from Internal Audit in order to help drive improvements.

We were able to provide **significant assurance** in the following areas:

- For the critical financial assurance work, across a range of core financial systems, we have given significant assurance that most of the expected key controls were in place and operating effectively.

- Our review of Serious Incidents (SIs) found that there were adequate and effective processes for monitoring and performance managing SIs (focusing on the timeliness of the closure of incidents), and that the PCT was making adequate preparation for the handover of this responsibility to its successor organisations. The Trust needed to ensure that timescales for closure of SIs are realistic and adhered to.

- Our review of the Quality and Outcomes Framework (QOF) found effective processes and controls underpinning the validity and approval of QOF payments, and that those payments were accurate and timely.

- We found Continuing Care to be managed effectively and that the controls in place to manage identified risks were adequate and effective.

- Our review of Medicines Management found adequate and effective processes for the management of independent contractors' prescribing costs.

- The contract management review found a generally strong system of effective arrangements for the performance management of the PCT's non-NHS healthcare providers.

- The Information Governance Toolkit (IGT) v10 Review found a generally sound IG Framework designed to meet NHS Surrey's objectives until the IG responsibilities are formally handed over to the CCGs.

- There was generally good progress being made with the implementation of audit recommendations. The key recommendations which remained outstanding and were to be transferred to receiving bodies relate to the following:

  - Continuing Healthcare (receiving body-Surrey Downs CCG)
  - Probity Checks/post payment verification checks on QOF payments (receiving body-NHS Commissioning Board)
  - CRB Checks for Staff (mainly Continuing Healthcare Staff (receiving body-Surrey Downs CCG)

  - CRB Checks for Primary Care Contractors (receiving body-NHS Commissioning Board)

We gave **limited assurance** in the following areas:

- The audit of Primary Care found that the PCT faced a significant challenge following the its decision to replace all existing dental contracts with a standard 2009 Department of Health contract template. There was also a need to identify whether or not signed copies of GMS/PMS contracts exist (perhaps in hard-copy format) and to ensure that any unsigned contracts are signed as soon as possible. A total of 37 optometry contracts required either the contract to be re-issued (due to being unable to locate a copy of the original) or a contract variation to be signed and agreed.

- The audit of CRB checks found apparent gaps in CRB checks for PCT staff and a lack of clarity over which staff require the check, particularly during the transition period and the handover to successor organisations. There was a need for an effective notification system to be in place to highlight those PCT staff where CRB clearances are due to expire, and a need to ensure that CRB checks have been carried out on all GMS/PMS primary care contractors that appear on the Surrey performers list.

- The audit of the COIN Governance and Security Model found a lack of complete URL filtering and implementation of penetration test recommendations.

- The audit of the Information Governance Toolkit (IGT) v10 Review found that due to early stages of the CCGs' IG Framework developments, we were unable to review any evidence submitted to the IG Toolkit and there was a lack of IG Toolkit evidence submitted by GP Practices.

Remedial action plans were agreed for each of the areas described.

Any reliance being placed upon third party assurances

During the year I have liaised with the Trust's External Auditors and the nominated LCFS. In support of my Opinion I have taken into consideration the following third party assurances as well as key internal performance outcomes as reported by management, including the work of the Transition Assurance Committee which Internal Audit attended:

I have considered Internal Audit reviews of the Primary Care Support Service, hosted by East Sussex Downs and Weald PCT, where these relate to areas of activity undertaken on NHS Surrey's behalf. These include GP Pensions, Data Repository Review, Business Continuity, Dental Performers List, and GMS Payments. There were no specific concerns relating to NHS Surrey arising from these reviews.

At the time preparing this review we had not received the NHS SBS ISAE 3402 (due in April 2013) and this will be taken into account in preparing my opinion. This is a report by Grant Thornton (GT), the independent service auditors, of their annual audit in which they review the design and operating effectiveness of certain specified controls related to SBS's core Financial and Accounting services to its clients. The report covers Purchase to Pay, Order to Cash, Accounting to Reporting and associated general IT controls, for the period 1 April 2012 to 31 March 2013. There will also be a separate ISAE report in relation to payroll for the same period.

Giles Parratt
Head of Internal Audit
18th March 2013

INDEPENDENT AUDITOR'S REPORT TO THE SIGNING OFFICER OF SURREY PCT

We have audited the financial statements of NHS Surrey for the year ended 31 March 2013 on pages 30 to 71. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England. We have also audited the information in the Remuneration Report that is subject to audit.

This report is made solely to the Signing Officer of NHS Surrey in accordance with Part II of the Audit Commission Act 1998. Our audit work has been undertaken so that we might state to the Signing Officer of the PCT those matters we are required to state to her in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the responsible officer of the PCT for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of Signing Officer and auditor

As explained more fully in the Statement of Signing Officer's Responsibilities set out on page 3, the Signing Officer is responsible for the preparation of financial statements which 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 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 PCT's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the PCT; 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.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of Surrey PCT as at 31 March 2013 and of its expenditure and income 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 regularity prescribed by the Code of Audit Practice 2010 for local NHS bodies

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 other matters prescribed by the Code of Audit Practice 2010 for local NHS bodies

In our opinion:

- the part of the Remuneration Report subject to audit has been properly prepared 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; and
- the information given in the director's report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Code of Audit Practice 2010 for local NHS bodies requires us to report to you if:

- in our opinion, the Governance Statement does not reflect compliance with the Department of Health's requirements;
- any referrals to the Secretary of State have been made under section 19 of the Audit Commission Act 1998; or
- any matters have been reported in the public interest under the Audit Commission Act 1998 in the course of, or at the end of, the audit.

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

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

We have undertaken our audit in accordance with the Code of Audit Practice 2010 for local NHS bodies, having regard to the guidance issued by the Audit Commission in November 2012. We have considered the results of the following:

- our review of the Governance Statement; and
- the work of other relevant regulatory bodies or inspectorates, to the extent that the results of this work impact on our responsibilities at the PCT; and
- our locally determined risk-based work relating to PCT abolition and the transition to new local commissioning arrangements.

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 Surrey PCT in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission.

Fleur Nieboer for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
15 Canada Square
Canary Wharf
London E14 5GL
7th 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	**27,271**	113,042
Other costs	5.1	**1,795,540**	1,644,393
Income	4	**(50,734)**	(64,520)
Net operating costs before interest		**1,772,077**	1,692,915
Investment income	9	**0**	(8)
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**2,034**	2,027
Net operating costs for the financial year		**1,774,111**	1,694,934
Net (gain)/loss on transfers by absorption		**0**	0
Net operating costs and transfer gains/losses for the financial year		**1,774,111**	1,694,934
Of which:			
Administration Costs			
Gross employee benefits	7.1	**20,553**	17,594
Other costs	5.1	**15,395**	11,943
Income	4	**(2,510)**	(2,653)
Net administration costs before interest		**33,438**	26,884
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**0**	89
Net administration costs for the financial year		**33,438**	26,973
Programme Expenditure			
Gross employee benefits	7.1	**6,718**	95,448
Other costs	5.1	**1,780,145**	1,632,450
Income	4	**(48,224)**	(61,867)
Net programme expenditure before interest		**1,738,639**	1,666,031
Investment income	9	**0**	(8)
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**2,034**	1,938
Net programme expenditure for the financial year		**1,740,673**	1,667,961

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**4,735**	3,183
Net (gain) on revaluation of property, plant & equipment	**(232)**	(961)
Total comprehensive net expenditure for the year	**1,778,614**	**1,697,156**

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	**162,354**	160,267
Trade and other receivables	19	**123**	131
Total non-current assets		**162,477**	160,398
Current assets:			
Trade and other receivables	19	**6,549**	17,659
Cash and cash equivalents	23	**12,383**	5
Total current assets		**18,932**	17,664
Non-current assets held for sale	24	**0**	0
Total current assets		**18,932**	17,664
Total assets		**181,409**	178,062
Current liabilities			
Trade and other payables	25	**(107,540)**	(105,158)
Provisions	32	**(2,075)**	(2,893)
Borrowings	27	**(588)**	(2,858)
Total current liabilities		**(110,203)**	(110,909)
Non-current assets plus/less net current assets/liabilities		**71,206**	67,153
Non-current liabilities			
Provisions	32	(8,766)	(12,151)
Borrowings	27	(17,909)	(18,497)
Other financial liabilities	36.2	0	0
Total non-current liabilities		**(26,675)**	(30,648)
Total Assets Employed:		**44,531**	36,505
Financed by taxpayers' equity:			
General fund		(4,293)	(17,345)
Revaluation reserve		48,824	53,850
Other reserves		0	0
Total taxpayers' equity:		**44,531**	36,505

The notes on pages 34 to 71 form part of this account.

The financial statements on pages 30 to 33 were approved by the Audit Committee convening as a sub committee of the Department of Health Audit and Risk Committee on 6th June and signed on its behalf by

Signing Officer:  Date: 06 . 06 . 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	**(17,345)**	**53,850**	**0**	**36,505**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(1,774,111)	0	0	**(1,774,111)**
Net gain on revaluation of property, plant, equipment	0	232	0	**232**
Impairments and reversals	0	(4,735)	0	**(4,735)**
Transfers between reserves*	523	(523)	0	**0**
Total recognised income and expense for 2012-13	(1,773,588)	(5,026)	0	**(1,778,614)**
Net Parliamentary funding	1,786,640		0	**1,786,640**
Balance at 31 March 2013	**(4,293)**	**48,824**	**0**	**44,531**
Changes in taxpayers' equity for 2011-12				
Balance at 1 April 2011	(15,421)	53,233	0	**37,812**
Net operating cost for the year	(1,694,934)	0	0	**(1,694,934)**
Net gain on revaluation of property, plant, equipment	0	961	0	**961**
Transfers to/(from) other bodies within the group	344	(344)	0	**0**
Total recognised income and expense for 2011-12	(1,710,011)	53,850	0	**(1,656,161)**
Net Parliamentary funding	1,692,666	0	0	**1,692,666**
Balance at 31 March 2012	**(17,345)**	**53,850**	**0**	**36,505**

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		**(1,772,077)**	(1,692,915)
Depreciation and Amortisation		**5,369**	5,885
Impairments and Reversals		**4,649**	1,408
Other Gains / (Losses) on foreign exchange		**0**	0
Donated Assets received credited to revenue but non-cash		**0**	0
Government Granted Assets received credited to revenue but non-cash		**0**	0
Interest Paid		**(1,841)**	(1,810)
Release of PFI/deferred credit		**0**	0
(Increase)/Decrease in Inventories		**0**	0
(Increase)/Decrease in Trade and Other Receivables		**11,118**	(5,692)
(Increase)/Decrease in Other Current Assets		**0**	0
Increase/(Decrease) in Trade and Other Payables		**2,532**	9,560
(Increase)/Decrease in Other Current Liabilities		**0**	0
Provisions Utilised		**(5,046)**	(2,989)
Increase/(Decrease) in Provisions		**650**	736
Net Cash Inflow/(Outflow) from Operating Activities		**(1,754,646)**	(1,685,817)
Cash flows from investing activities			
Interest Received		**0**	8
(Payments) for Property, Plant and Equipment		**(16,758)**	(6,956)
(Payments) for Intangible Assets		**0**	0
(Payments) for Other Financial Assets		**0**	0
(Payments) for Financial Assets (LIFT)		**0**	0
Proceeds of disposal of assets held for sale (PPE)		**0**	0
Proceeds of disposal of assets held for sale (Intangible)		**0**	0
Proceeds from Disposal of Other Financial Assets		**0**	0
Proceeds from the disposal of Financial Assets (LIFT)		**0**	0
Loans Made in Respect of LIFT		**0**	0
Loans Repaid in Respect of LIFT		**0**	0
Rental Revenue		**0**	0
Net Cash Inflow/(Outflow) from Investing Activities		**(16,758)**	(6,948)
Net cash inflow/(outflow) before financing		**(1,771,404)**	(1,692,765)
Cash flows from financing activities			
Other Loans Received		0	0
Other Loans Repaid		0	0
Other Capital Receipts		0	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		(538)	(491)
Net Parliamentary Funding		1,786,640	1,692,666
Capital Receipts Surrendered		0	0
Capital grants and other capital receipts		0	0
Cash Transferred (to)/from Other NHS Bodies (free text note required)		0	0
Net Cash Inflow/(Outflow) from Financing Activities		**1,786,102**	1,692,175
Net increase/(decrease) in cash and cash equivalents		**14,698**	(590)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		(2,315)	(1,725)
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		**12,383**	(2,315)

1. Accounting policies

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

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

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

1.1 Accounting Conventions

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

Transforming Community Services (TCS) transactions
Under the TCS initiative, services historically provided by PCTs have transferred to other providers. The provider services of Surrey PCT delivered by Surrey Community Health transferred to the operation Virgin Care on 1st April 2012. As this was a transfer of services to a Non NHS body merger accounting is not applicable. Surrey PCT did not have responsibility for any direct provision of, or accounting for, provider services during 2012/2103.

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

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

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

-The PCT moved to the Modern Equivalent Asset (MEA) valuation basis for land and building property assets on 1st April 2009. The MEA basis of valuation is an estimation technique rather than an accounting policy. The MEA valuation was prepared by the District Valuer (DV). The PCT is required to consider the value of its property, plant and equipment at the end of the accounting period to ensure the carrying value of each asset is not significantly different from its fair value.

- The PCT valued its building assets at 31st March 2010 based on the movement of the Building Cost Information Services (BCIS) index during that year and obtained valuation information from the District Valuer for land based upon a representative sample of land assets across Surrey.

- For 2010/11, and going forward, the PCT agreed to the methodology of the DV providing a full revaluation of 20% of the estate and for the PCT to apply the same valuation changes across the entire estate. This would be a rolling exercise allowing the entire estate to be revalued by the DV over a five year period. For 2012/13 this valuation technique has resulted in an de**crease** of some 2.1% for land assets and a **decrease** of 4.25% in respect of building assets

- The closure of the PCT on 31st March 2013 has resulted in a review of equipment assets taking into account materiality, nature of operational use and inheriting organisation on 1st April 2013. This has resulted in the transfer out of the non current asset heading of equipment assets at the year end, reflecting their inventory nature and operational use by organisations other than the PCT.

1. Accounting policies (continued)

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

- Under Income and Expenditure Recognition principles, the PCT has reflected the estimated values notified to it by other NHS bodies for work in progress at the year end, that is, partially completed spells. Where main providers have not notified the PCT of a value an estimation has been made. In line with other estimates, revisions to accounting estimates are recognised in the period in which the estimate is revised. For partial spells, revisions to estimates are made at the accounting year end and the effect of the revision will be reflected in the period being closed. On 1st April 2013 partially completed spells balances will be transferred to Clinical Commissioning Groups (CCGs). ***This means that any changes to estimated values at 31st March 2013 will be accounted for in the next financial year by CCGs, and will be effected by a revised estimation at the next accounting period end in the balance sheet of CCGs.*** These year end estimation revisions are not expected to provide material differences from one period end to the next and therefore will have a minimal effect on the Statement of Comprehensive Net Earnings (SOCNE).

- Under IAS 19 Employee benefits, the PCT reflected the estimated values of compensated absences owed to employees at the 2011/2012 year end, that is, the accumulated value of annual leave due to employees at the financial year end, which was carried forward to the 2012/2013 financial year. As the PCT ceased to exist at 31st March 2013 compensated absences are not reflected in the period being closed. The opening balances for compensated absences were taken back to the SOCNE in year.

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.

The PCT did not have deferred income at the year end.

1.3 Care Trust Designation
Surrey Primary Care Trust is not a designated Care Trust. Care Trusts are designated by the Secretary of State under s45 of the Health and Social Care Act 2001 and provide joint activities with Local Authorities.

1.4 Pooled budgets
The PCT has entered into a pooled budget with Surrey County Council. Under the arrangement funds are pooled under S75 of the NHS Act 2006 for community equipment services, and child and adolescent mental health services. A memorandum note to the accounts provides details of the joint income and expenditure.

The pool is hosted by Surrey County Council. As a commissioner of healthcare services, the PCT makes contributions to the pool, which are then used to purchase healthcare services. The PCT accounts for its share of the assets, liabilities, income and expenditure of the pool as determined by the pooled budget agreement.

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

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

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

1. Accounting policies (continued)

1.7 Property, Plant & Equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation

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

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

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

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

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

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

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

Subsequent expenditure

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

1. Accounting policies (continued)

1.8 Intangible Assets

Recognition

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

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

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

Measurement

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

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

1.9 Depreciation, amortisation and impairments

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

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

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

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

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

1. Accounting policies (continued)

1.10 Donated assets

Following the accounting policy change outlined in the Treasury FREM for 2011-12, a donated asset reserve is no longer maintained. Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.11 Government grants

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

1.12 Non-current assets held for sale

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

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

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

1.13 Inventories

No inventories are held by the PCT.

1.14 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.

1.15 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).

1.16 Clinical Negligence Costs

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

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

1. Accounting policies (continued)

1.17 Employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period was not recognised in the financial statements as employees were required to take all leave in year.

Retirement benefit costs

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

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

1.18 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.

1.19 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.

1.20 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.

1.21 EU Emissions Trading Scheme

EU Emission Trading Scheme allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income are valued at fair value at the end of the reporting period.

The PCT is registered under the scheme but is currently not required to participate in EU Emissions Trading Scheme allowances.

1.22 Contingencies

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

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

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

1. Accounting policies (continued)

1.23 Leases

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

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.

1.24 Foreign exchange

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

1.25 Provisions

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

The PCT retains liability towards the NHS Pensions Agency (now part of the Business Services Authority) for the settlement of early reitrement pension commitments of predecessor organisations. NHS bodies do not have access to the forecast cash flows for these early retirements and the PCT has made use of the NHSPA factor tables in calculating the year end pensions liability.

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

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

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

1. Accounting policies (continued)

1.26 Financial Instruments

Financial assets

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

Financial assets are initially recognised at fair value.

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

Financial assets at fair value through profit and loss

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

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. The PCT considers that the fair value of an asset is equivalent to its carrying value.

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 deemed relevant by the PCT.

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. The PCT considers that the fair value of a liability is equivalent to its carrying value.

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

1.27 Private Finance Initiative (PFI) and NHS LIFT transactions

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

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

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

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

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

There are several sub leases to other NHS bodies in relation to the PFI property. These sub leases are all short term operating leases.

1. Accounting policies (continued)

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

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

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

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

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

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

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

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

1. Accounting policies (continued)

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

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

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

1.29 Going Concern
As a consequence of the Health and Social Care Act 2012, the Surrey PCT will be dissolved on 31 March 2013. Its functions will be transferred to various new or existing public sector entities.

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

As a result, the Board of Surrey PCT have prepared these financial statements on a going concern basis.

2 Operating segments

The operating sectors indentified for disclosure mirror the main reporting format for financial information provided to the Board in the Finance Board Report. It reflects the major groupings by which the organisation monitors its financial income and expenditure. The PCT's primary business objective is the provision of health care services on behalf of it resident population. The provision of healthcare can be broken down into types linked to major areas of healthcare specialty, namely 'Acute', 'Other Contracting' and Primary Care and Prescribing'. The balance of PCT income and expenditure is attributed to a segment entitled 'Other', the major component of which covers Corporate responsibilites.

The PCT is primarly a purchaser of services. As such income is not a material factor within any of the reported operating segments.

	Segment Acute Contracting		Segment Other Contracting		Segment Primary Care		Segment Corporate Expenses		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	**942,690**	887,564	**398,914**	412,185	**396,893**	408,002	**84,314**	43,799	**1,822,811**	1,751,550
Surplus/(Deficit)										
Segment surplus/(deficit)	**(38,022)**	(6,207)	**113**	(8,735)	**(1,093)**	(3,699)	**39,213**	19,669	**211**	1,028
Common costs	**0**	0	**0**	0	**0**	0	**0**	0	**0**	0
Surplus/(deficit) before interest	**(38,022)**	**(6,207)**	**113**	**(8,735)**	**(1,093)**	**(3,699)**	**39,213**	**19,669**	**211**	1,028
Revenue from External Customers	**2,215**	2,230	**2,837**	23,163	**29,831**	28,932	**15,851**	10,195	**50,734**	64,520
Segment Interest received	**0**	0	**0**	0	**0**	8	**0**	0	**0**	8
Segment Interest paid	**0**	0	**0**	1	**0**	0	**2,034**	2,027	**2,034**	2,028
Segment Depreciation & Amortisation	**0**	0	**0**	0	**0**	0	**5,369**	5,885	**5,369**	5,885
Net Assets:										
Segment net assets	**906,884**	0	**401,864**	0	**425,649**	0	**146,897**	0	**1,881,294**	0

3. Financial Performance Targets

3.1 Revenue Resource Limit

	2012-13 £000	2011-12 £000
The PCTs' performance for the year ended 2012-13 is as follows		
Total Net Operating Cost for the Financial Year	**1,774,111**	1,694,934
Adjusted for prior period adjustments in respect of errors	**0**	0
Revenue Resource Limit	**1,774,322**	1,695,962
Under/(Over)spend Against Revenue Resource Limit (RRL)	**211**	1,028

Prior period adjustments in respect of errors		**2012-13 £000 Admin**	**2012-13 £000 Programme**
Narrative explanation of the adjustment;			
Value of additional (charge)/credit to revenue in 2012-13	0	0	0
Under/(Over)spend Against Revenue Resource Limit (RRL), adjusted for local prior period adjustment	211		

3.2 Capital Resource Limit

	2012-13 £000	2011-12 £000
The PCT is required to keep within its Capital Resource Limit.		
Capital Resource Limit	**17,605**	8,864
Charge to Capital Resource Limit	**16,608**	7,601
(Over)/Underspend Against CRL	**997**	**1,263**

3.3 Provider full cost recovery duty

	2012-13 £000	2011-12 £000
The PCT is required to recover full costs in relation to its provider functions.		
Provider gross operating costs	**0**	117,861
Provider Operating Revenue	**0**	(19,710)
Net Provider Operating Costs	**0**	98,151
Costs Met Within PCTs Own Allocation	**0**	(97,047)
Under/(Over) Recovery of Costs	**0**	**1,104**

The PCT did not have any Provider functions during 2012/2013.

3.4 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**1,786,640**	1,692,666
Cash Limit	**1,786,640**	1,692,666
Under/(Over)spend Against Cash Limit	**0**	**0**

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

	2012-13 £000	2011-12 £000
Total cash received from DH (Gross)	1,584,724	1,486,016
Less: Trade Income from DH	(22)	(22)
Less/(Plus): movement in DH working balances	9	0
Sub total: net advances	**1,584,711**	**1,485,994**
(Less)/plus: transfers (to)/from other resource account bodies (free text note required)	0	0
Plus: cost of Dentistry Schemes (central charge to cash limits)	34,587	33,146
Plus: drugs reimbursement (central charge to cash limits)	167,342	173,526
Parliamentary funding credited to General Fund	**1,786,640**	**1,692,666**

4 Miscellaneous income

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Fees and Charges	0	0	0	0
Dental Charge income from Contractor-Led GDS & PDS	13,909	0	13,909	12,033
Dental Charge income from Trust-Led GDS & PDS	0	0	0	91
Prescription Charge income	7,354	0	7,354	7,014
Strategic Health Authorities	1,028	78	950	1,771
NHS Trusts	125	138	(13)	1,643
NHS Foundation Trusts	956	712	244	4,694
Primary Care Trusts Contributions to DATs	0	0	0	0
Primary Care Trusts - Other	2,859	52	2,807	11,059
Primary Care Trusts - Lead Commissioning	0	0	0	0
English RAB Special Health Authorities	0	0	0	0
Other English Special Health Authorities	0	0	0	0
Department of Health - SMPTB	0	0	0	0
Department of Health - Other	22	20	2	22
Recoveries in respect of employee benefits	0	0	0	0
Local Authorities	2,875	344	2,531	5,947
Patient Transport Services	0	0	0	0
Education, Training and Research	7,179	4	7,175	9,328
Non-NHS: Private Patients	2	0	2	79
Non-NHS: Overseas Patients (Non-Reciprocal)	0	0	0	2
NHS Injury Costs Recovery	24	0	24	72
Other Non-NHS Patient Care Services	139	0	139	3,806
Charitable and Other Contributions to Expenditure	58	0	58	349
Receipt of donated assets	0	0	0	0
Receipt of Government granted assets	0	0	0	0
Rental income from finance leases	0	0	0	0
Rental income from operating leases	8,874	4	8,870	3,407
Other Income	5,330	1,158	4,172	3,203
Total miscellaneous income	50,734	2,510	48,224	64,520
Of rental income from finance leases above:				
Contingent rent	0	0	0	0
Other	0	0	0	0
Rental income from finance leases	0	0	0	0
Of rental income from operating leases above:				
Rental revenue	8,874	4	8,870	3,407
Contingent rent	0	0	0	0
Rental income from operating leases	8,874	4	8,870	3,407

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	**68,961**	0	68,961	74,861
Non-Healthcare	**3,954**	3,754	200	3,057
Total	**72,915**	3,754	69,161	77,918
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	**328,591**	5	328,586	302,772
Goods and services (other, excl Trusts, FT and PCT))	**255**	3	252	86
Total	**328,846**	8	328,838	302,858
Goods and Services from Foundation Trusts	**645,069**	92	644,977	597,131
Purchase of Healthcare from Non-NHS bodies	**300,278**	0	300,278	202,085
Expenditure on Drugs Action Teams	**3,005**	0	3,005	2,386
Non-GMS Services from GPs	**2,137**	0	2,137	2,430
Contractor Led GDS & PDS (excluding employee benefits)	**48,189**	0	48,189	46,636
Salaried Trust-Led PDS & PCT DS (excluding employee benefits)	**626**	0	626	795
Chair, Non-executive Directors & PEC remuneration	**141**	141	0	106
Consultancy Services	**5,001**	2,864	2,137	2,114
Prescribing Costs	**149,648**	0	149,648	156,787
G/PMS, APMS and PCTMS (excluding employee benefits)	**144,481**	0	144,481	143,382
Pharmaceutical Services	**1,547**	0	1,547	1,568
New Pharmacy Contract	**32,330**	0	32,330	32,634
General Ophthalmic Services	**7,634**	0	7,634	7,568
Supplies and Services - Clinical	**3,294**	2	3,292	10,565
Supplies and Services - General	**156**	52	104	2,855
Establishment	**1,341**	865	476	4,801
Transport	**191**	0	191	476
Premises	**14,423**	3,049	11,374	13,640
Impairments & Reversals of Property, plant and equipment	**4,649**	0	4,649	1,408
Depreciation	**5,369**	0	5,369	5,885
Impairment of Receivables	**221**	252	(31)	373
Audit Fees	**192**	192	0	319
Other Auditors Remuneration	**14**	14	0	93
Clinical Negligence Costs	**180**	0	180	183
Education and Training	**179**	0	179	1,300
Grants for capital purposes	**938**	0	938	500
Grants for revenue purposes	**11,648**	179	11,469	13,678
Other	**10,898**	3,931	6,967	11,919
Total Operating costs charged to Statement of Comprehensive Net Expenditure	1,795,540	15,395	1,780,145	1,644,393
Employee Benefits (excluding capitalised costs)				
Employee Benefits associated with PCTMS	**5**	0	5	6
Trust led PDS and PCT DS	**0**	0	0	1,144
PCT Officer Board Members	**1,095**	1,095	0	1,454
Other Employee Benefits	**26,171**	19,458	6,713	110,438
Total Employee Benefits charged to SOCNE	**27,271**	20,553	6,718	**113,042**
Total Operating Costs	**1,822,811**	35,948	1,786,863	1,757,435
Analysis of grants reported in total operating costs				
For capital purposes				
Grants to fund Capital Projects - GMS	**938**	0	938	500
Grants to Local Authorities to Fund Capital Projects	**0**	0	0	0
Grants to Private Sector to Fund Capital Projects	**0**	0	0	0
Grants to Fund Capital Projects - Dental	**0**	0	0	0
Grants to Fund Capital Projects - Other	**0**	0	0	0
Total Capital Grants	**938**	0	938	500
Grants to fund revenue expenditure				
To Local Authorities	**11,628**	159	11,469	13,666
To Private Sector	**0**		0	0
To Other	**20**	20	0	12
Total Revenue Grants	**11,648**	179	11,469	13,678
Total Grants	**12,586**	179	12,407	14,178

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**33,438**	**30,704**	**2,734**
Weighted population (number in units)	**952,852**	**952,852**	**952,852**
Running costs per head of population (£ per head)	**35.09**	**32.22**	**2.87**
PCT Running Costs 2011-12			
Running costs (£000s)	26,974	24,365	2,609
Weighted population (number in units)	952,852	952,852	952,852
Running costs per head of population (£ per head)	28.31	25.57	2.74

5.2 Analysis of operating expenditure by expenditure classification	2012-13 £000	2011-12 £000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	144,486	143,388
Prescribing costs	149,648	156,787
Contractor led GDS & PDS	48,189	46,636
Trust led GDS & PDS	626	1,939
General Ophthalmic Services	7,634	7,568
Department of Health Initiative Funding		0
Pharmaceutical services	1,547	1,568
Local Pharmaceutical Services Pilots		0
New Pharmacy Contract	32,330	32,634
Non-GMS Services from GPs	2,137	2,430
Other	0	0
Total Primary Healthcare purchased	**386,597**	392,950
Purchase of Secondary Healthcare		
Learning Difficulties	27,237	26,875
Mental Illness	120,029	144,160
Maternity	54,585	50,717
General and Acute	830,835	771,753
Accident and emergency	80,256	73,251
Community Health Services	140,121	132,127
Other Contractual	87,769	71,538
Total Secondary Healthcare Purchased	**1,340,832**	1,270,421
Grant Funding		
Grants for capital purposes	938	500
Grants for revenue purposes	11,648	13,678
Total Healthcare Purchased by PCT	**1,740,015**	1,677,549
PCT self-provided secondary healthcare included above	0	97,047
Social Care from Independent Providers	0	0
Healthcare from NHS FTs included above	642,209	594,181

6. Operating Leases

The PCT's lease arrangements cover photocopiers, franking machines, vending machines, lease cars, water coolers and property.

Most operating leases are on short terms contract terms. The maximum rental period for photocopiers is 6 years, with the majority on 5 year lease terms. Lease cars are on a maxuimum 3 year contract. Properties are generally on longer terms contracts.

Surrey PCT has entered into certain financial arrangements involving the use of GP premises. The PCT has considered these lease arrangements in relation to the following;

IAS 17 Leases

SIC 27 Evaluating the substance of transactions involving the legal form of a lease

IFRIC 4 Determining whether an arrangement contains a lease.

The PCT has determined that those defined as operatings leases must be recognised, but, as there is no defined term in the arrangement(s) entered into, it is not possible to analyse the arrangement(s) over financial years. The financial value included in the Operating Cost Statement for 2012/13 covering rents for GP premises is £10,527 (£10.539k in 2011/12)

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	130	2,442	76	2,648	2,603
Contingent rents	0	408	0	408	423
Sub-lease payments	0	0	0	0	0
Total	130	2,850	76	3,056	3,026
Payable:					
No later than one year	134	2,647	34	2,815	2,407
Between one and five years	536	6,702	31	7,269	8,426
After five years	3,786	15,822	0	19,608	20,121
Total	4,456	25,171	65	29,692	30,954

Total future sublease payments expected to be received: £11,051k.

6.2 PCT as lessor

PCT lease income relates to rental from properties including Health Centre rents.

	2012-13 £000	2011-12 £000
Recognised as income		
Rents	8,874	3,407
Contingent rents	0	0
Total	8,874	3,407
Receivable:		
No later than one year	8,874	3,339
Between one and five years	14,770	2,529
After five years	17,518	13,036
Total	41,162	18,904

7. Employee benefits and staff numbers

7.1 Employee benefits

	2012-13									2011-12		
				Permanently employed			Other					
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Permanently employed £000	Other £000
Employee Benefits - Gross Expenditure												
Salaries and wages	21,629	18,004	3,625	16,968	13,893	3,075	4,661	4,111	550	94,362	86,097	8,265
Social security costs	1,428	1,010	418	1,366	975	391	62	35	27	6,750	6,181	569
Employer contributions to NHS Pensions scheme	2,168	1,539	629	2,106	1,504	602	62	35	27	11,809	11,232	577
Other pension costs	0	0	0	0			0	0	0	0	0	0
Other post-employment benefits	0	0	0	0			0	0	0	0	0	0
Other employment benefits	0	0	0	0			0	0	0	0	0	0
Termination benefits	2,688	0	2,688	2,688		2,688	0	0	0	121	121	0
Total employee benefits	27,913	20,553	7,360	23,128	16,372	6,756	4,785	4,181	604	113,042	103,631	9,411
Less recoveries in respect of employee benefits (table below)	0	0	0	0	0	0	0	0	0	0	0	0
Total - Net Employee Benefits including capitalised costs	27,913	20,553	7,360	23,128	16,372	6,756	4,785	4,181	604	113,042	103,631	9,411
Employee costs capitalised	642	0	642	198	0	198	444	0	444	0	0	0
Net Employee Benefits excluding capitalised costs	27,271	20,553	6,718	22,930	16,372	6,558	4,341	4,181	160	113,042	103,631	9,411
Recognised as:												
Commissioning employee benefits	27,271	20,553	6,718	22,928	16,370	6,558	4,343	4,183	160	22,091	20,629	1,462
Provider employee benefits	0	0	0	0	0	0	0	0	0	90,951	83,002	7,949
Net Employee Benefits excluding capitalised costs	27,271	20,553	6,718	22,928	16,370	6,558	4,343	4,183	160	113,042	103,631	9,411
Employee Benefits - Income												
Salaries and wages	0	0	0	0	0	0	0	0	0	0	0	0
Social Security costs	0	0	0	0	0	0	0	0	0	0	0	0
Employer Contributions to NHS BSA - Pensions Division	0	0	0	0	0	0	0	0	0	0	0	0
Other pension costs	0	0	0	0	0	0	0	0	0	0	0	0
Other Post Employment Benefits	0	0	0	0	0	0	0	0	0	0	0	0
Other Employment Benefits	0	0	0	0	0	0	0	0	0	0	0	0
Termination Benefits	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL excluding capitalised costs	0	0	0	0	0	0	0	0	0	0	0	0

	2012-13			2011-12		
	Total £000	Permanently employed £000	Other £000	Total £000	Permanently employed £000	Other £000
Net Expenditure						
Salaries and wages	21,629	16,968	4,661	94,362	86,097	8,265
Social security costs	1,428	1,366	62	6,750	6,181	569
Employer contributions to NHS Pensions scheme	2,168	2,106	62	11,809	11,232	577
Other pension costs	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0
Termination benefits	2,688	2,688	0	121	121	0
Total employee benefits	27,913	23,128	4,785	113,042	103,631	9,411
Employee costs capitalised	642	198	444	0	0	0
Net Employee Benefits excluding capitalised costs	27,271	22,930	4,341	113,042	103,631	9,411
Recognised as:						
Commissioning Employment Benefits	27,271	22,930	4,341	22,091	20,629	1,462
Provider Employment Benefits	0	0	0	90,951	83,002	7,949
TOTAL - excluding capitalised costs	27,271	22,930	4,341	113,042	103,631	9,411

7.2 Staff Numbers

	2012-13 Total Number	Permanently Number	Other Number	2011-12 Total Number	Permanently Number	Other Number
Average Staff Numbers						
Medical and dental	5	5	0	83	74	8
Ambulance staff	0	0	0	0	0	0
Administration and estates	324	255	69	777	704	73
Healthcare assistants and other support staff	13	13	0	539	441	98
Nursing, midwifery and health visiting staff	40	33	8	863	787	77
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	33	29	4	450	420	30
Social Care Staff	0	0	0	0	0	0
Other	0	0	0	18	18	0
TOTAL	416	335	81	2,730	2,444	286
Of the above - staff engaged on capital projects	10	3	7	0	0	0

7.3 Staff Sickness absence and ill health retirements

	2012-13 Number	2011-12 Number
Total Days Lost	**14,716**	**24,548**
Total Staff Years	**1,247**	**2,640**
Average working Days Lost	11.80	9.30

	2012-13 Number	2011-12 Number
Number of persons retired early on ill health grounds	**2**	7
	£000s	£000s
Total additional pensions liabilities accrued in the year	**25**	794

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	**8**	0	**8**	2	0	**2**
£10,001-£25,000	**11**	0	**11**	2	2	**4**
£25,001-£50,000	**9**	0	**9**	2	0	**2**
£50,001-£100,000	**7**	0	**7**	1	0	**1**
£100,001 - £150,000	**4**	0	**4**	0	0	**0**
£150,001 - £200,000	**2**	0	**2**	0	0	**0**
>£200,000	**1**	0	**1**	0	0	**0**
Total number of exit packages by type (total cost	**42**	**0**	**42**	**7**	**2**	**9**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Total resource cost	**2,186**	**0**	**2,186**	190	32	222

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

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

7.5 Pension costs

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

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	**51,077**	**499,713**	65,892	376,274
Total Non-NHS Trade Invoices Paid Within Target	**46,108**	**486,015**	63,252	365,983
Percentage of Non NHS Trade Invoices Paid Within Target	90.27%	97.26%	95.99%	97.27%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**7,636**	**1,072,451**	7,585	996,595
Total NHS Trade Invoices Paid Within Target	**6,469**	**1,032,077**	6,945	989,505
Percentage of NHS Trade Invoices Paid Within Target	84.72%	96.24%	91.56%	99.29%

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**	1
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**0**	1

9. Investment Income

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Rental Income				
PFI finance lease revenue (planned)	0	0	0	0
PFI finance lease revenue (contingent)	0	0	0	0
Other finance lease revenue	0	0	0	0
Subtotal	0	0	0	0
Interest Income				
LIFT: equity dividends receivable	0	0	0	0
LIFT: loan interest receivable	0	0	0	0
Bank interest	0	0	0	0
Other loans and receivables	0	0	0	8
Impaired financial assets	0	0	0	0
Other financial assets	0	0	0	0
Subtotal	0	0	0	8
Total investment income	0	0	0	8

10. Other Gains and Losses

The PCT did not have any Other Gains and Losses during the year.

11. Finance Costs

	2012-13 £000	2012-13 £000	2012-13 £000	2011-12 £000
Interest				
Interest on obligations under finance leases	56	0	56	57
Interest on obligations under PFI contracts:				
- main finance cost	1,238	0	1,238	1,272
- contingent finance cost	513	0	513	446
Interest on obligations under LIFT contracts:				
- main finance cost	0	0	0	0
- contingent finance cost	0	0	0	0
Interest on late payment of commercial debt	0	0	0	1
Other interest expense	0	0	0	0
Total interest expense	1,807	0	1,807	1,776
Other finance costs	34	0	34	34
Provisions - unwinding of discount	193	0	193	217
Total	2,034	0	2,034	2,027

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	69,611	83,441	0	2,443	5,605	684	5,242	953	**167,979**
Additions Purchased	0	13,673	0	2,787	57	0	9	82	**16,608**
Additions Donated	0	0	0	0	0	0	0	0	**0**
Additions Government Granted	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	5,230	0	(5,230)	0	0	0	0	**0**
Reclassifications as Held for Sale	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	(457)	0	0	(5,662)	(684)	(5,251)	(1,035)	**(13,089)**
Upward revaluation/positive indexation	(15)	(4,394)	0	0	0	0	0	0	**(4,409)**
Impairments/negative indexation	(1,454)	(3,281)	0	0	0	0	0	0	**(4,735)**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from NHS Bodies	0	0	0	0	0	0	0	0	**0**
At 31 March 2013	**68,142**	**94,212**	**0**	**0**	**0**	**0**	**0**	**0**	**162,354**
Depreciation									
At 1 April 2012	0	0	0	0	3,216	207	3,420	869	**7,712**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassifications as Held for Sale	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	(457)	0	0	(5,662)	(684)	(5,251)	(1,035)	**(13,089)**
Upward revaluation/positive indexation	(15)	(4,626)	0	0	0	0	0	0	**(4,641)**
Impairments	15	1,404	0	0	1,649	347	1,120	114	**4,649**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Charged During the Year	0	3,679	0	0	797	130	711	52	**5,369**
Transfers to NHS Bodies	0	0	0	0	0	0	0	0	**0**
Cumulative dep'n adjustment following revaluation	0	0	0	0	0	0	0	0	**0**
At 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Net Book Value at 31 March 2013	**68,142**	**94,212**	**0**	**0**	**0**	**0**	**0**	**0**	**162,354**
Purchased	68,142	90,678	0	0	0	0	0	0	**158,820**
Donated	0	3,534	0	0	0	0	0	0	**3,534**
Government Granted	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2013	**68,142**	**94,212**	**0**	**0**	**0**	**0**	**0**	**0**	**162,354**
Asset financing:									
Owned	66,835	72,151	0	0	0	0	0	0	**138,986**
Held on finance lease	1,307	3,234	0	0	0	0	0	0	**4,541**
On-SOFP PFI contracts		18,827	0	0	0	0	0	0	**18,827**
PFI residual interests			0	0	0	0	0	0	**0**
Total at 31 March 2013	**68,142**	**94,212**	**0**	**0**	**0**	**0**	**0**	**0**	**162,354**

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	29,100	24,687	0	0	33	0	0	30	**53,850**
Movements (specify)	(1,454)	(3,509)	0	0	(33)	0	0	(30)	**(5,026)**
At 31 March 2013	27,646	21,178	0	0	0	0	0	0	**48,824**

Additions to Assets Under Construction in 2012-13

	£000
Land	0
Buildings excl Dwellings	2,787
Dwellings	0
Plant & Machinery	0
Balance as at YTD	**2,787**

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	68,860	86,656	0	1,068	7,263	686	4,223	1,101	**169,857**
Additions - purchased	0	4,279	0	1,953	4	5	1,360	0	**7,601**
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	87	0	0	(11)	0	0	(76)	**0**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals other than by sale	0	(574)	0	0	(1,651)	(7)	(341)	(72)	**(2,645)**
Revaluation & indexation gains	1,366	(4,439)	0	0	0	0	0	0	**(3,073)**
Impairments	(615)	(2,568)	0	0	0	0	0	0	**(3,183)**
Reversals of impairments	0	0	0	0	0	0	0	0	**0**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**69,611**	**83,441**	**0**	**3,021**	**5,605**	**684**	**5,242**	**953**	**168,557**
Depreciation									
At 1 April 2011	119	3,357	0	0	3,880	86	2,522	895	**10,859**
Reclassifications	0	31	0	0	(6)	0	0	(25)	**0**
Reclassifications as Held for Sale	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	(574)	0	0	(1,651)	(7)	(341)	(72)	**(2,645)**
Upward revaluation/positive indexation	(134)	(7,083)	0	0	0	0	0	0	**(7,217)**
Impairments	15	810	0	578	0	0	0	5	**1,408**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Charged During the Year	0	3,459	0	0	993	128	1,239	66	**5,885**
Transfers to NHS Bodies	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	0	0	0	578	3,216	207	3,420	869	8,290
Net Book Value at 31 March 2012	**69,611**	**83,441**	**0**	**2,443**	**2,389**	**477**	**1,822**	**84**	**160,267**
Purchased	69,611	79,685	0	2,443	2,263	463	1,822	80	**156,367**
Donated	0	3,756	0	0	126	14	0	4	**3,900**
Government Granted	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	69,611	83,441	0	2,443	2,389	477	1,822	84	**160,267**
Asset financing:									
Owned	68,292	60,571	0	2,443	2,389	477	1,822	84	**136,078**
Held on finance lease	1,319	3,111	0	0	0	0	0	0	**4,430**
On-SOFP PFI contracts	0	19,759	0	0	0	0	0	0	**19,759**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	69,611	83,441	0	2,443	2,389	477	1,822	84	**160,267**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction and 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 2011	28,216	24,878			107			32	**53,233**
Movements (specify)	884	(191)	0	0	(74)	0	0	(2)	**617**
At 31 March 2012	29,100	24,687	0	0	33	0	0	30	53,850

12.3 Property, plant and equipment

The PCT is required to review the value of its land and building assets at the end of the financial year. For 2012/13 the District Valuer provided a revaluation of 20% of the estate at 31 March 2013 on a Modern Equivalent Asset (MEA) basis. The PCT has applied the same percentage movements from the valuation changes across the entire estate. This valuation has resulted in an decrease of some 2.1% for land assets and a decrease of some 4.25% in respect of building assets.

The PCT is required to perform an annual Fixed Asset Verification Review which underpins the value of land, buildings and equipment reported within the PCT's annual accounts. This year end verification review has been performed in association with the review of properties that will transfer to NHS Property Services on 1st April 2013 when the PCT demises.

Department of Health advice issued in December 2010 removed delegated authority from the PCT for capital expenditure on property, plant and equipment. The PCT obtained approval from the SHA for all outstanding capital expenditure to enable its programme to be completed by March 2013.

Further Department advice issued on 16th February 2011 removed any delegated authority to enter into transcations (without SHA approval) in respect of property and facilities contracts.

13.1 Intangible non-current assets

The PCT holds no intangible no current assets.

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

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
Property, Plant and Equipment impairments and reversals taken to SoCNE				
Loss or damage resulting from normal operations	0	0	0	4
Over-specification of assets	0	0	0	0
Abandonment of assets in the course of construction	0	0	0	577
Total charged to Departmental Expenditure Limit	0	0	0	581
Unforeseen obsolescence	0	0	0	0
Loss as a result of catastrophe	0	0	0	0
Other	3,264	0	3,264	555
Changes in market price	1,385	0	1,385	272
Total charged to Annually Managed Expenditure	4,649	0	4,649	827
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve				
Loss or damage resulting from normal operations	0	0	0	0
Over Specification of Assets	0	0	0	0
Abandonment of assets in the course of construction	0	0	0	0
Unforeseen obsolescence	0	0	0	0
Loss as a result of catastrophe	0	0	0	0
Other	0	0	0	0
Changes in market price	4,735	0	4,735	3,183
Total impairments for PPE charged to reserves	4,735	0	4,735	3,183
Total Impairments of Property, Plant and Equipment	9,384	0	9,384	4,591
Total Impairments charged to Revaluation Reserve	4735	0	4,735	3,183
Total Impairments charged to SoCNE - DEL	0	0	0	581
Total Impairments charged to SoCNE - AME	4,649	0	4,649	827
Overall Total Impairments	9,384	0	9,384	4,591
Of which:				
Impairment on revaluation to "modern equivalent asset" basis	0	0	0	0
Donated and Gov Granted Assets, included above				
Donated Asset Impairments: amount charged to SOCNE - DEL	0	0	0	0
Donated Asset Impairments: amount charged to SOCNE - AME	80	0	80	0
Donated Asset Impairments: amount charged to revaluation reserve	95	0	95	0
Total Donated Asset Impairments	175	0	175	0
Government Granted Asset Impairments: amount charged to SoCNE - DEL	0	0	0	0
Government Granted Asset Impairments: amount charged to SoCNE - AME	0	0	0	0
Government Granted Asset Impairments: amount charged to revaluation reserve	0	0	0	0
Total Gov Granted asset Impairments.	0	0	0	0
TOTAL DONATED/GOVERNMENT GRANTED ASSET IMPAIRMENTS	175	0	175	0

15 Investment property

The PCT has no investment property

16 Commitments

16.1 Capital commitments

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

	31 March 2013	31 March 2012
	£000	£000
Property, plant and equipment	**1,119**	3,615
Intangible assets	**0**	0
Total	**1,119**	3,615

16.2 Other financial commitments

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

	31 March 2013	31 March 2012
	£000	£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	455	0	3,032	0
Balances with Local Authorities	178	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	418	0	26,070	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	5,498	123	78,438	0
At 31 March 2013	**6,549**	**123**	**107,540**	**0**
prior period:				
Balances with other Central Government Bodies	2,395	0	8,253	0
Balances with Local Authorities	2,353	0	2,884	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	3,653	0	20,698	0
Balances with Public Corporations and Trading Funds	0	0	1,082	0
Balances with bodies external to government	9,258	131	72,241	0
At 31 March 2012	**17,659**	**131**	**105,158**	**0**

18 Inventories

No inventories are held by the PCT.

19.1 Trade and other receivables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
NHS receivables - revenue	**700**	5,425	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**0**	0	**0**	0
Non-NHS receivables - revenue	**3,277**	7,630	**0**	0
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**1,105**	3,229	**123**	131
Provision for the impairment of receivables	**(742)**	(560)	**0**	0
VAT	**173**	623	**0**	0
Current part of PFI and other PPP arrangements prepayments and a	**0**	0	**0**	0
Interest receivables	**0**	0	**0**	0
Finance lease receivables	**0**	0	**0**	0
Operating lease receivables	**0**	0	**0**	0
Other receivables	**2,036**	1,312	**0**	0
Total	**6,549**	17,659	**123**	131
Total current and non current	**6,672**	17,790		
Included above:				
Prepaid pensions contributions	**0**	0		

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

19.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	**3,319**	3,430
By three to six months	**202**	258
By more than six months	**17**	5
Total	**3,538**	3,693

19.3 Provision for impairment of receivables

	2012-13 £000	2011-12 £000
Balance at 1 April 2012	**(560)**	(190)
Amount written off during the year	**39**	3
Amount recovered during the year	**0**	8
(Increase)/decrease in receivables impaired	**(221)**	(381)
Balance at 31 March 2013	**(742)**	(560)

Receivables impaired relate to invoiced receivables which were reviewed by age and circumstance as at 31 March 2013. A percentage probability of no recovery was applied if deemed appropriate.

Receivables impaired also covers employee benefits overpayments reviewed by age and circumstance as at 31 March 2013. A percentage probability of non recovery was applied if deemed appropriate.

20 NHS LIFT investments

The PCT does not have any NHS LIFT schemes.

21 Other financial assets

The PCT does not have any other financial assets.

22 Other current assets

The PCT does not have any other current assets.

23 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**5**	232
Net change in year	**12,378**	(227)
Closing balance	**12,383**	5
Made up of		
Cash with Government Banking Service	**12,352**	0
Commercial banks	**31**	0
Cash in hand	**0**	5
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**12,383**	5
Bank overdraft - Government Banking Service	**0**	(2,320)
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**12,383**	(2,315)
Patients' money held by the PCT, not included above	**16**	63

24 Non-current assets held for sale

The PCTdid not have any balances brought forward for Non Current Assets Held for Sale and there were no such transactions in year.

25 Trade and other payables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Interest payable	**0**	0	**0**	0
NHS payables - revenue	**28,679**	25,276	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**0**	0	**0**	0
Family Health Services (FHS) payables	**41,329**	43,338	**0**	0
Non-NHS payables - revenue	**14,799**	11,846	**0**	0
Non-NHS payables - capital	**650**	800	**0**	0
Non_NHS accruals and deferred income	**18,977**	19,715	**0**	0
Social security costs	**45**	1,086	**0**	0
VAT	**0**	0	**0**	0
Tax	**378**	1,150	**0**	0
Payments received on account	**0**	14	**0**	0
Other	**2,683**	1,933	0	0
Total	**107,540**	105,158	**0**	0
Total payables (current and non-current)	**107,540**	**105,158**		

26 Other liabilities

The PCT does not have any 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**	2,320	**0**	0
Bank overdraft - commercial banks	**0**	0	**0**	0
PFI liabilities:				
Main liability	**586**	538	**16,869**	17,455
Lifecycle replacement received in advance	**0**	0	**0**	0
LIFT liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**2**	0	**1,040**	1,042
Other (describe)	**0**	0	**0**	0
Total	**588**	**2,858**	**17,909**	**18,497**
Total other liabilities (current and non-current)	**18,497**	**21,355**		

28 Other financial liabilities

The PCT does not have any 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	**50**	84	**0**	0
Deferred income addition	**0**	50	**0**	0
Transfer of deferred income	**-50**	(84)	**0**	0
Current deferred income at 31 March 2013	**0**	50	**0**	0
Total other liabilities (current and non-current)	**0**	**50**		

30 Finance lease obligations

The PCT has one finance lease with outstanding liabilities relating to Emberbrook Health Centre. Contingent rent is determined on the basis of rent review. The lease contract extends to 2049.

Amounts payable under finance leases (Buildings)	Minimum lease payments		Present value of minimum lease payments	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Within one year	**56**	56	**2**	0
Between one and five years	**224**	224	**22**	16
After five years	**1,792**	1,848	**1,018**	1,026
Less future finance charges	**(1,030)**	(1,086)	**0**	0
Present value of minimum lease payments	**1,042**	1,042	**1,042**	1,042
Included in:				
Current borrowings			**2**	0
Non-current borrowings			**1,040**	1,042
			1,042	1,042

Amounts payable under finance leases (Land)	Minimum lease payments		Present value of minimum lease	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Within one year	**0**	0	**0**	0
Between one and five years	**0**	0	**0**	0
After five years	**0**	0	**0**	0
Less future finance charges	**0**	0	**0**	0
Present value of minimum lease payments	**0**	0	**0**	0
Included in:				
Current borrowings			**0**	0
Non-current borrowings			**0**	0
			0	0

Amounts payable under finance leases (Other)	Minimum lease payments		Present value of minimum lease	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Within one year	**0**	0	**0**	0
Between one and five years	**0**	0	**0**	0
After five years	**0**	0	**0**	0
Less future finance charges	**0**	0	**0**	0
Present value of minimum lease payments	**0**	0	**0**	0
Included in:				
Current borrowings			**0**	0
Non-current borrowings			**0**	0
			0	0

Finance leases as lessee	**31 March 2013 £000**	31 March 2012 £000
Future Sublease Payments Expected to be received	**0**	0
Contingent Rents Recognised as an Expense	**(34)**	(34)

31 Finance lease receivables as lessor

The PCT does not have any finance lease receivables.

32 Provisions

			Comprising:									
	Total £000s	Admin £000s	Programme £000s	Pensions to Former Directors £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Restructuring £000s	Continuing Care £000s	Equal Pay £000s	Agenda for Change £000s	Other £000s	Redundancy £000s
Balance at 1 April 2012	15,044	0	15,044	0	6,205	48	0	7,557	0	0	1,206	28
Arising During the Year	2,863	0	2,863	0	169	79	0	1,856	0	0	257	502
Utilised During the Year	(5,046)	0	(5,046)	0	(3,159)	(27)	0	(797)	0	0	(1,046)	(17)
Reversed Unused	(2,213)	0	(2,213)	0	0	(55)	0	(2,047)	0	0	(100)	(11)
Unwinding of Discount	193	0	193	0	174	0	0	0	0	0	19	0
Change in Discount Rate	0	0	0	0	0	0	0	0	0	0	0	0
Transferred (to)/from other NHS bodies	0	0	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2013	**10,841**	**0**	**10,841**	**0**	**3,389**	**45**	**0**	**6,569**	**0**	**0**	**336**	**502**
Expected Timing of Cash Flows:												
No Later than One Year	**2,075**		2,075	0	395	45	0	797	0	0	336	502
Later than One Year and not later than Five Years	**7,305**		7,305	0	1,533	0	0	5,772	0	0	0	0
Later than Five Years	**1,461**		1,461	0	1,461	0	0	0	0	0	0	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at 31 March 2013	2,569
As at 31 March 2012	2,571

£2,569k is included in the provisions of the NHSLA at 31/3/2013 in respect of clinical negligence provisions of the PCT (31/3/2012 £2,571k)

The legal claims provision of £45k relates to PCT claims dealt with by the NHS Litigation Authority (NHSLA).

The PCT legal claims provision is based on figures provided by the NHSLA. The NHSLA has also advised the PCT that a Contingent Liability of £25k (£30k in 2011/2012) is required to be disclosed with regard to Surrey PCT cases outstanding at 31st March 2013, and this forms part of the overall PCT Contingent Liability figure of £13,874k at note 33.

The Pensions Relating to Other Staff provision of £3,389k relates to the PCT's own pension provisions.

The PCT provision of £6,569k for continuing care liabilities covers liabilities of £6,569k where the PCT may be liable to pay retrospectively nursing home charges for certain named individuals who had previously funded their own healthcare requirements. The opening continuing care provision was £7,557k with £797k utilised in year. A year end assessment of retrospective claims has resulted in an increase in the provision of £1,856k which has been charged to the operating cost statement in the 2012/2013 accounts. A Contingent Liability of £13,849k for Retrospective Continuing Care (£5,317k in 2011/2012) is disclosed as part of the Contingent Liability figure of £13,874k at note 33. The overall assessment of retrospective continuing care cases outstanding at 31st March 2013 was £20,418k, however based on empirical evidence regarding the value of known claims that actually result in settled claims, only £6,569k of this amount is provided for, with the remaining amount shown as a Contingent Liability.

The other provision of £336k relates to the PCT's own other provisions covering £257k for COIN early termination costs, £5k employment tribunal provision, and £74k of other provisions.

The £502k for redundancy payments represents PCT employees.

The PCT has made payments during the year to clear the outstanding back to back provisions balances with local NHS Trusts.

All provisions made are based on a reasonable estimate of timing of cashflows, likelihood of occurrence and outcome, and an assessment of the financial impact of obligations as at 31st March 2013

33 Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities		
Equal Pay	**0**	**0**
NHSLA LTPS & PES Schemes	**(25)**	**(30)**
Continuing Care Liability	**(13,849)**	**(13,994)**
Employee Litigation Claims	**0**	**0**
Amounts Recoverable Against Contingent Liabilities	**0**	**0**
Net Value of Contingent Liabilities	**(13,874)**	(14,024)
Contingent Assets		
Contingent Assets	**0**	0
Net Value of Contingent Assets	**0**	0

The NHS Litigation Authority has advised the PCT that a Contingent Liability of £25,000 (£29,721 in 2011/12) is required to be disclosed with regard to Surrey PCT NHSLA cases outstanding at 31st March 2013, and this forms part of the overall PCT Contingent Liability figure of £13,874k.

A Contingent Liability of £3,649k (£5,317k in 2011/2012) is disclosed as part of the Contingent Liability figure of £13,849k. The overall initial assessment of Retrospective Continuing Care cases outstanding at 31st March 2013 was £10,218k, however based on empirical evidence regarding the value of known claims that actually result in settled claims, only part of this amount usually settles and this value has been provided as a provision in note 32. The remaining amount of the value of cases oustanding at 31st March 2013 is shown as a Contingent Liability.

A Contingent Liability of £10,200k is disclosed as part of the Contingent Liability figure of £13,849k. This is an estimate of the value of new applications that were received during 2012/2013 but the extent to which these result in a liability has not been able to be quantified as the basis of some applications is merely an intention to proceed with a claim rather than a specific verified claim. In the absence of a reasonable valuation or probability these new claims are shown as a Contingent Liability.

34 PFI and LIFT - additional information

The PCT has one PFI scheme covering the Farnham Hospital and Centre for Health building. The PCT has no LIFT schemes.

Farnham Hospital and Centre for Health was completed in 2003 as a local care centre housing GP practices, a renal dialysis satellite unit, inpatients and outpatient services, pharmacy services, social services, diagnotics, community and mental health services.

Norwich Union Public Private Partnership Fund hold a 100% equity share in the scheme.

The PCT entered into a 25 year finance lease in 2003/04 and payments comprise of two elements - imputed finance lease charges and service charges. Details of the imputed finance lease charges are contained in the table below. The lease payments are subject to annual adjustment in line with the movement in the Retail Price Index.

The lease expires in 2028 and at this point in time owenership of the asset will transfer to the PCT. Under IFRIC 12, the asset is treated as an asset of the PCT from the start date of the contact as the substance of the contract is that of a finance lease.

	31 March 2013 £000	31 March 2012 £000
34.1 Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI		
Total charge to operating expenses in year - OFF SOFP PFI	**0**	0
Service element of on SOFP PFI charged to operating expenses in year	**853**	823
Total	**853**	823
Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI		
No Later than One Year	**874**	844
Later than One Year, No Later than Five Years	**3,720**	3,592
Later than Five Years	**11,394**	12,232
Total	**15,988**	16,668

The estimated annual payments in future years are not expected to be materially different from those which the Trust is committed to make during the next year. The likely financial effect of this is:

	31 March 2013 £000	31 March 2012 £000
Estimated Capital Value of Project - off SOFP PFI	**0**	0
Value of Deferred Assets - off SOFP PFI	**0**	0
Value of Reversionary Interest - off SOFP PFI	**0**	0
34.2 Imputed "finance lease" obligations for on SOFP PFI contracts due		
No Later than One Year	**1,787**	1,775
Later than One Year, No Later than Five Years	**7,279**	7,226
Later than Five Years	**20,061**	21,902
Subtotal	**29,127**	30,903
Less: Interest Element	**(11,672)**	(12,910)
Total	**17,455**	17,993

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	533	0	533
Interest Expense	1,751	0	1,751
Impairment charge - AME	0	0	0
Impairment charge - DEL	0	0	0
Other Expenditure	911	0	911
Revenue Receivable from subleasing	(2,511)	0	(2,511)
Total IFRS Expenditure (IFRIC12)	684	0	684
Revenue consequences of LIFT/PFI schemes under UK GAAP / ESA95 (net of any sublease income)	(233)	0	(233)
Net IFRS change (IFRIC12)	451	0	451
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12			
Capital expenditure 2012-13	0	0	0
Average net assets relating to IFRIC12 schemes - IFRS	19,560	0	19,560
Average net assets relating to IFRIC12 schemes - UKGAA	4,261	0	4,261
UK GAAP capital expenditure 2012-13 (Reversionary Inter	553	0	553
Revenue costs of IFRS: all other expenditure associated with IFRS (e.g. finance leases)			
Depreciation charge	0	0	0 0
Interest expense	0	0	0
Impairment charge - AME	0	0	0
Impairment charge - DEL	0	0	0
Other expenditure	0	0	0
Total IFRS expenditure (non IFRIC12)	**0**	**0**	**0**
Revenue consequences under UK GAAP	0	0	0
Net IFRS change (non IFRIC12)	**0**	**0**	**0**
Capital consequences of IFRS all other expenditure associated with IFRS			
Capital expenditure 2012-13	0	0	0
Net assets relating to non-IFRIC12 IFRS - IFRS basis	0	0	0
Net assets relating to non-IFRIC12 IFRS - UKGAAP basis	0	0	0
UK GAAP capital expenditure 2012-13 (Reversionary Inter	0	0	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 PCThas no overseas operations. The PCT therefore has low exposure to currency rate fluctuations.

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

Credit Risk

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

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

36.1 Financial Assets	At 'fair value through profit and loss' £000	Loans and receivables £000	Available for sale £000	Total £000
Embedded derivatives	0			0
Receivables - NHS		700		700
Receivables - non-NHS		5,313		5,313
Cash at bank and in hand		12,383		12,383
Other financial assets	0	0	0	0
Total at 31 March 2013	0	18,396	0	18,396
Embedded derivatives	0	0		0
Receivables - NHS		5,425		5,425
Receivables - non-NHS		8,942		8,942
Cash at bank and in hand		5		5
Other financial assets	0	0	0	0
Total at 31 March 2012	**0**	**14,372**	**0**	**14,372**

36.2 Financial Liabilities	At 'fair value through profit and loss' £000	Other £000	Total £000
Embedded derivatives	0	0	0
NHS payables		28,679	28,679
Non-NHS payables		78,438	78,438
Other borrowings		0	0
PFI & finance lease obligations		18,497	18,497
Other financial liabilities	0	307	307
Total at 31 March 2013	0	125,921	125,921
Embedded derivatives	0	0	**0**
NHS payables		25,276	**25,276**
Non-NHS payables		77,632	**77,632**
Other borrowings		2,320	**2,320**
PFI & finance lease obligations		19,035	**19,035**
Other financial liabilities	0	153	**153**
Total at 31 March 2012	**0**	**124,416**	**124,416**

The value of financial assets or financial liabilities do not differ from their carrying amount.

37 Related party transactions

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

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

The Department of Health is the parent organisation and as such is regarded as a related party. During the year Surrey Primary Care Trust has had a significant number of material transactions with the Department, and other entities for which the Department is regarded as the parent Department. Entities with which Surrey Primary Care Trust had expenditure transactions greater than £1 milion are listed below.

	£000
Strategic Health Authorities:	
None	
NHS Primary Care Trusts:	
Croydon PCT	1,663
East Sussex Downs and Weald PCT	2,283
West Kent PCT	67,537
NHS Foundation Trusts:	
Ashford and St Peters Hospitals NHS Foundation Trust	184,539
Chelsea and Westminster Hospital NHS Foundation Trust	3,369
East Kent Hospitals University NHS Foundation Trust	2,549
Frimley Park Hospital NHS Foundation Trust	94,141
Guy's and St Thomas NHS Foundation Trust	12,811
Heatherwood and Wexham Park Hospitals NHS Foundation Trust	1,877
Kings College Hospitals NHS Foundation Trust	4,995
Moorfields Eye Hospitals NHS Foundation Trust	2,168
Queen Victoria Hospital NHS Foundation Trust	5,074
Royal Free London NHS FoundationTrust	2,037
Royal Surrey County NHS Foundation Trust	170,678
South East Coast Ambulance Service NHS Foundation Trust	2,858
Surrey and Borders Partnership NHS Foundation Trust	117,539
The Royal Marsden Hospital NHS Foundation Trust	22,585
University College London NHS Foundation Trust	11,346
University Hospital Southampton NHS Foundation Trust	1,545
NHS Trusts	
Barts Health NHS Trust	1,853
Brighton and Sussex University Hospital NHS Trust	4,171
Croydon Health Services NHS Trust	3,473
Epsom and St Helier University Hospital NHS Trust	109,980
Imperial College Healthcare NHS Trust	6,407
Kingston Hospital NHS Trust	27,856
Maidstone and Tunbridge Wells NHS Trust	3,225
Oxford University Hospitals NHS Trust	1,346
St Georges Healthcare NHS Trust	54,290
Surrey and Sussex Healthcare NHS Trust	103,016
The Royal National Orthopaedic Hospital NHS Trust	3,216
West Middlesex University NHS Trust	2,437
Western Sussex Hospitals NHS Trust	1,595

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 Surrey County Council for the provision of nursing home services, the Home Office for prison healthcare services, HM Revenue and Customs and the NHS Pension Authority.

The PCT has also received revenue payments from a number of charitable funds, including Surrey PCT Charitable Fund, certain of the trustees for which are also members of the PCT board. Surrey PCT Charitable Fund was transferred by Statutaory Instrument on 8th March 2013 to the trusteeship of the board of Surrey and Borders Partnership NHS 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	26,440	33
Special payments - PCT management costs	840	2
Losses in respect of the provision of family practitioner services	15	1
Special payments in respect of he provision of family practitioner services	0	0
Total losses	26,455	34
Total special payments	840	2
Total losses and special payments	27,295	36

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	13,804	37
Special payments - PCT management costs	16,813	9
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	13,804	37
Total special payments	16,813	9
Total losses and special payments	30,617	46

39 Third party assets

The PCT held £16k cash and cash equivalents at 31 March 2013 on behalf of patients (£63k at 31 March 2012). This is not an asset of the PCT and has been excluded from the balances reported in the Annual Accounts.

40 Pooled budgets

Surrey PCT has two pooled budget arrangements with Surrey County Council - Child and Adolescent Mental Health Scheme and Central Equipment Store (CES). These are hosted by the Council. The memorandum accounts for the pooled budgets showing the PCT's shares of the income and expenditure handled by the pooled budgets in the financial year are:

Consolidated Pooled Budgets Summary Per Surrey County Council	Year Ending 31st March 2013				Year Ending 31st March 2012			
	CAMHS £	CES £	DOM £	Total £	CAMHS £	CES £	DOM £	Total £
PCT Contribution	1,036,343	2,100,000	0	3,136,343	1,040,223	2,100,000	92,248	3,232,471
Spend	1,024,937	2,131,071	0	3,156,008	988,828	2,111,381	92,248	3,192,457
Net (under)/overspend	(11,406)	31,071	0	19,665	(51,395)	11,381	0	(40,014)
Assets								
General Debtors	0	122	0	122	0	107	0	107
Cash Imputed	146,015	161,959	0	307,974	340,235	191,498	0	531,733
Total Assets	146,015	162,081	0	308,096	340,235	191,605	0	531,840
Liabilities								
Trade Creditors	146,015	162,081	0	308,096	340,235	191,605	0	531,840
Other Creditors	0	0	0	0	0	0	0	0
Total Liabilities	146,015	162,081	0	308,096	340,235	191,605	0	531,840

41 Cashflows relating to exceptional items

The PCT made 2 revenue funded grants totalling £11,357k under section 256 agreements to Surrey County Council to support social care spend to provide healthcare benefits, reduce delayed transfers and support reablement services.

42 Events after the end of the reporting period

Primary Care Trusts (PCTs) will be abolished on 31 March 2013 as part of the changes to the NHS brought about by the Health and Social Care Act 2012.

The functions of the PCT will transfer to the following public sector bodies: