Department of Health

NHS

West Essex Primary Care Trust

2012-13 Annual Report and Accounts

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West Essex Primary Care Trust

2012-13 Annual Report

NHS
West Essex

West Essex PCT
Annual Report 2012/13

Contents

Foreword from Chair and Chief Executive

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

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

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

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

Despite a tough financial climate, NHS West Essex finished the financial year with a surplus of £1.2 million.

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

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

- Improvements in the health of community and health services
- Safer services
- Delivery of government targets of waiting times
- Improving the quality of and access to primary care
- Improved premises for primary care
- Achieving financial balance
- Establishing a successful transition to the new system

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

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

Dr Pam Donnelly
Chair

Andrew Pike
Chief Executive

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

About us

NHS West Essex is a Primary Care Trust (PCT) for people who live in west Essex. As your local NHS we are allocated a budget every year for our local population. We use this to plan, develop and commission (buy) healthcare services on your behalf.

Our main functions and responsibilities are to:

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

West Essex has a GP-registered population of approximately 293,000, covering the boroughs of Epping Forest, Harlow and Uttlesford.

The main health issues we face in west Essex are rising demands for healthcare due to population growth, increasing number of older people, new treatments, problems arising from obesity and smoking and mental health problems.

Our place in the NHS

NHS West Essex is one of the 13 PCTs in the East of England region. In 2011 it became part of a PCT cluster NHS North Essex (alongside NHS Mid Essex and NHS North East Essex covering north Essex).

We are accountable to our local population and to NHS Midlands and East Strategic Health Authority (previously East of England SHA), who monitor and evaluate our performance.

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

As commissioners, we plan and buy services from other NHS trusts and health care providers such as: Princess Alexandra Hospital, Whipps Cross University Hospital, Addenbrooke's Hospital and NHS South Essex Community Services.

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

NHS West Essex facts and figures

Location of our headquarters	Building 4, Spencer Close, St Margaret's Hospital, The Plain, Epping, Essex, CM16 6TN
Communities covered	Districts of Epping Forest, Harlow and Uttlesford, covering an area of approximately 390 square miles, from Buckhurst Hill to Steeple Bumpstead
Population (GP registered)	293,000
Type of area	NHS West Essex has some of the most affluent and some of the most deprived areas in the country. Harlow, for example, is in the 30% most deprived local authorities in England, while Uttlesford is in the 5% least deprived local authorities in England. (IMD 2010)
Budget	£449 million
No. of employees	270
Clinical Commissioning Groups	West Essex Clinical Commissioning Group
No. of GP practices	38
No. of Primary Care Centres	0
No. of GP-led health centres (equitable access centre, open seven days a week, 12 hours a day, walk-in appointments)	0
No. of community pharmacies	49
No. of opticians practices	29
No. of dental surgeries	33
Main providers of acute hospital services	The Princess Alexandra Hospital NHS Trust, Harlow Cambridge University Hospitals NHS Foundation Trust (Addenbrooke's) Mid Essex Hospital Services NHS Trust Whipps Cross University Hospital NHS Trust Barts and the London NHS Trust Barking, Havering and Redbridge Hospitals NHS Trust Other hospitals outside Essex
Community services providers	South Essex Partnership NHS Foundation Trust Central Essex Community Services Anglia Community Enterprise Nursing care homes Voluntary organisations Includes services from Saffron Walden Community

	Hospital and St Margaret's Hospital in Epping
Mental health and learning disabilities provider	North Essex Partnership NHS Foundation Trust North East London NHS Foundation Trust Cambridgeshire and Peterborough Foundation Trust Hertfordshire Partnership NHS Foundation Trust South Essex Partnership Foundation Trust Voluntary organisations
Main private hospitals providing NHS services	Rivers Hospital, part of the Ramsey Group Holly House

Background and changing role of PCT

In 2011 West Essex PCT began working closely together with NHS Mid and NHS North East Essex (our neighbouring Primary Care Trusts) in a 'cluster' arrangement known as NHS North Essex, under a single executive team.

This is a form of partnership working that enables us to eliminate duplication, learn from each other and reduce some of the costs associated with the management of two primary care trusts. Each PCT remains a separate statutory body.

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

Primary Care Trusts remain accountable until 31 March 2013, when their functions will be taken over by the newly established NHS Commissioning Board, Clinical Commissioning Groups, local authorities, NHS Commissioning Support Unit and the NHS Property Company. This is the biggest change to how healthcare is delivered in a generation. GPs and other health professionals will now be working together with experienced NHS managers to decide how commissioning decisions are made.

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

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

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

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

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

Where we buy your healthcare

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

Type of healthcare	Where we buy it from on your behalf
Primary care: Your first point of contact for most NHS care.	• Local General Practices • Dentists • Pharmacists • Opticians and • Other provider primary care businesses.
Community services: This includes, district nursing, health visiting, speech and language therapy, podiatry, school nursing.	South Essex Partnership NHS Foundation Trust Central Essex Community Services Anglia Community Enterprise Nursing care homes Voluntary organisations Includes services from Saffron Walden Community Hospital and St Margaret's Hospital in Epping
Hospital services: This includes outpatient clinics, operations and emergency care.	Princess Alexandra Hospital NHS Trust Whipps Cross University Hospital Addenbrooke's Hospital
Mental health services: Includes, for example, psychological therapies, community mental health teams, and learning disability services.	North Essex Partnership NHS Foundation Trust North East London NHS Foundation Trust Cambridgeshire and Peterborough Foundation Trust Some voluntary organisations
Specialist health services: Includes, for example, treatment for specialist cardiac, renal, children's, neurosciences, cancer, genetics and many more.	East of England Specialised Commissioning Group commissions these services on our behalf from centres such as: Great Ormond Street Hospital, Addenbrooke's, Papworth Hospital, Barts and The London and a wide range of NHS and independent specialised service providers.
Emergency health services and transport.	East of England Ambulance Service NHS Trust Some voluntary organisations

How your money was spent on services in 2012/2013

Area of Spend	£000s
Acute hospital services	200,695
Specialised services	45,820
Community services	40,341
GP services	34,379
Medicines prescribed by GPs	39,665
Dental services	8,660
Services for people with learning disabilities	3,846
Mental health	34,755
Funded nursing/continuing healthcare services	13,069
Other services	19,411
Pharmacy services	7,486
General ophthalmic services	2,232
Corporate management and other corporate costs	14,125
Property Costs	2,385
Total	**466,867**

Our Board

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

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

Board Members

For the period 1 April 2012 to 30 March 2013 unless otherwise stated follow. Committee membership and governance structural change occurred due to changing of NHS North Essex Cluster directors and the departure of non-executive directors.

NHS North Essex – 2012/13 Board Members

Name	Designation	Start Date	End Date
Chris Paveley	Chairman	01/04/2012	31/12/2012
Pamela Donnelly	Non-Executive Director and Deputy Chair, Interim Chairman	01/04/2012 01/01/2013	31/12/2012 31/3/2013

Dr Qadir Bakhsh	Non-Executive Director	01/04/2012	30/11/2012
Renata Drinkwater	Non-Executive Director	01/04/2012	31/12/2012
Alan Hubbard	Non-Executive Director	01/04/2012	31/3/2013
Stephen King	Non-Executive Director	01/04/2012	31/3/2013
Jerry Wedge	Non-Executive Director and Chair Cluster Audit Committee	01/04/2012	31/3/2013
Tim Young	Non-Executive Director	01/04/2012	30/11/2012
Sheila Bremner	Chief Executive	01/04/2012	30/09/2012
Denise Hagel	Interim Director of Nursing	01/04/2012	30/09/2012
Adrian Marr	Director of Resources	01/04/2012	30/09/2012
Sallie Mills Lewis	Director of Delivery	01/04/2012	30/09/2012
Sarah Jane Relf	Director of Transformation and Governance	01/04/2012	30/09/2012
Dr. Mike Gogarty or Alison Cowie from 1/10/2012	Director of Public Health	01/04/2012	31/3/2013
Rob Gerlis	Chairman, WECCG	01/04/2012	31/3/2013
Donald McGeachy	Medical Director	01/04/2012	31/03/2013
Gary Sweeney	Chairman, NEECCG	01/04/2012	31/3/2013
Lisa Harrod-Rothwell	Chairman, MECCG	01/04/2012	31/3/2013
Luella Dixon	Director of Transition and Workforce	01/10/2012	31/3/2013
Margaret Hathaway	Commercial Director	01/10/2012	31/3/2013
Andrew Pike	Chief Executive and NCB LAT Director	01/10/2012	31/3/2013
Dawn Scrafield	Deputy CEO/Director of Finance, Performance & Operations	01/10/2012	31/3/2013
Ian Stidston	Director of Commissioning	01/10/2012	31/3/2013
Pol Toner	Director of Nursing	01/10/2012	31/3/2013
Chris Kerrigan	Director of Operations and Delivery	01/01/2013	31/3/2013

NHS North Essex – Declarations of Interest 2012/13 Board Members

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

	Practice, Chigwell Medical Centre (West Essex PCT) General Practitioner with Special Interest in Ophthalmology (West Essex PCT) Deputy Clinical Lead west and south west Essex Diabetic Eye Screening Programme (West Essex PCT)			
Sheila Bremner **Ended 30/09/2012**	Chief Executive NHS Mid Essex Chief Executive NHS North East Essex Chief Executive NHS West Essex Chief Executive Sponsor for Essex Commissioning Support Unit (VERBAL)	Nil	Nil	Nil
Alison Cowie	Director of Public Health NHS Mid Essex Director of Public Health NHS North East Essex Director of Public Health NHS West Essex	Nil	Nil	Secondment to July 2012 to NHS South West Essex Cluster
Luella Dixon	Director of Transition and Workforce NHS Mid Essex Director of Transition and Workforce NHS North East Essex	Essex CLAPA – husband treasury	Essex CLAPA – husband treasury	Nil

	Director of Transition and Workforce NHS West Essex			
Pamela Donnelly	Executive Director – Colchester Borough Council	Nil	Nil	Nil
Renata Drinkwater	Director, Capita Symonds Consulting (part of Capita Group PLC) Chief Executive, Expert Patients Programme Community Interest Company Director, Drinkwater Consulting Ltd (currently not trading)	Trustee, Expert Patient's Programme Charity Member, Diabetes UK	Director, Capita Symonds Consulting, Capita Symonds may contract with NHS Chief Executive, Expert Patients Programme Community Interest Company, EPP CIC may contract with the NHS	Nil
Rob Gerlis	GP Partner Ross Practice, Keats House, Harlow, Essex	Nil	Nil	Nil
Mike Gogarty	Director of Public Health, NHS Mid Essex Director of Public Health, NHS North East Essex Director of Public Health, NHS West Essex Director of Public Health – Health and Well being Board (VERBAL)	Director of Public Health Essex County Council	Nil	Nil

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

	NHS Mid Essex Interim Director of Nursing, NHS North East Essex Interim Director of Nursing, NHS West Essex Director Hagel House Ltd			
Lisa Harrod-Rothwell	Vice Chair and Board LMC member	Nil	Nil	Nil
Margaret Hathaway	Commercial Director NHS Mid Essex Commercial Director NHS North East Essex Commercial Director NHS West Essex	Nil	Director of South East Essex LIFT Ltd Director of Realise Health Ltd	Husband works as an IT project manager in South Essex PCT Cluster
Alan Hubbard	Chair, Essex Probation Trust Lay member (Commercial) Mid Essex Clinical Commissioning Group	Nil	Essex Probation Trust	Nil
Stephen King	None other than indirect via Pension and savings Lay member Governance, West Essex CCG.	Director RNIB Trustee Sightsavers International Trustee IAPB President Daisy Consortium		
Donald McGeachy	Medical Director, NHS Mid Essex Medical Director, NHS North East Essex Medical Director, NHS	Nil	Wife is a GP in Tillingham and holds a contract with NHS Mid Essex	Nil

	West Essex Interim Accountable Officer for Mid Essex Clinical part-time salaried GP and GPWSI employed by “The Practice plc.” Commissioning Group			
Adrian Marr **Ended 30/09/2012**	Director of Resources NHS North East Essex Director of Resources NHS West Essex Director of Resources NHS Mid Essex Executive Lead Director for of the local arm of the NHS Board (VERBAL)	Nil	Public Sector Director for RHL (Liftco) School Governor Holbrook High School	Nil
Sallie Mills Lewis **Ended 30/09/2012**	Director of Delivery NHS North East Essex Director of Delivery NHS West Essex Director of Delivery NHS Mid Essex Acting Managing Director – Essex Commissioning Support Services		Balkerne Garden Trust, Colchester (has contract with North East Essex PCT) Husband and Sallie are shareholders. Sister in law is the director	
Chris Paveley	Jacobite Limited Re-member Ltd Montal Computer Services Ltd Thurrock Thames Gateway	Firstsite, Colchester	Nil	Nil

	Development Corporation			
Andrew Pike	NCB LAT Director NHS Mid Essex NCB LAT Director NHS North East Essex NCB LAT Director NHS West Essex	Member of Extra21 Downs Syndrome Association Charity	Nil	Uncle – Joe Pike is an County Councillor for Essex County Council
Sarah Jane Relf **Ended 30/09/2012**	Director of Transition and Governance, NHS Mid Essex Director of Transition and Governance, NHS North East Essex Director of Transition and Governance, NHS West Essex Interim Director of Organisational and Relationship Development - Essex Commissioning Support Service	Nil	Nil	Nil
Dawn Scrafield	Deputy CEO/Director of Finance, Performance & Operations NHS Mid Essex Deputy CEO/Director of Finance, Performance & Operations NHS North East Essex Deputy CEO/Director of Finance, Performance &	Equal People Theatre Company - Treasurer	Husband is seconded to South Essex Partnership NHS Foundation Trust	GP is Dr Khan, Carnarvon Medical Centre

	Operations NHS West Essex Deputy			
Bryan Spencer	Nil	League of Friends of Halstead Hospital (ex Officio Committee member	Nil	Nil
Ian Stidson	Director of Commissioning NHS Mid Essex Director of Commissioning NHS North East Essex Director of Commissioning NHS West Essex	Nil	Nil	Nil
Gary Sweeney	Director for SHEL – non-profit making subsidiary of LMC supporting failing practices. Director paid for time	Member of the North Essex Local Medical Council	GPwSI providing Sigmoidoscopy services to NHS	
Pol Toner	Director of Nursing NHS North East Essex Director of Nursing NHS West Essex Director of Nursing NHS Mid Essex	Governor at St John Payne Catholic School Coach at Braintree Rugby Club		Wife is employed by NHS Mid Essex
Jerry Wedge	Trinity House Lay member North East Essex CCG	Nil	Nil	Nil
Tim Young	Board member, Colne Housing Society Ltd (from June 2012 – Chair from	Nil	Nil	Member of Colchester Borough Council Board Member Essex Probation

	September 2012) Non-Executive Director of Southend University Hospital NHS Foundation Trust (WEF 01/12/2012)			Wife is a member of Colchester Borough Council and Essex County Council School Governor for the Colchester Academy

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

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

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

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

Key issues for NHS West Essex during the year

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

The key areas of the Act are:

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

Source: www.parliament.co.uk

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

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

Clinical Commissioning Groups in west Essex
From 1 April 2013, CCGs will take over many of the duties of the PCTs and will become responsible for commissioning most health care – planning, buying and monitoring services to meet the needs of their local communities.

During 2012/13, CCGs have been working towards authorisation.

About West Essex Clinical Commissioning Group

West Essex Clinical Commissioning Group (CCG) will be the key statutory body responsible for the commissioning of health services in West Essex, taking over from West Essex PCT on 1 April 2013. It has been operating in shadow form since April 2012. As a CCG it has undergone a period of rapid development 2012/13 in preparation for this responsibility and will continue an important programme of development over the coming year.

The CCG is made up of 39 general practices from the localities of Epping Forest, Harlow and Uttlesford. It will manage an annual budget, of £300 million, to commission the majority of healthcare in the area for approximately 288,000 people. The financial challenge for the CCG over the next two years is £30m.
West Essex Clinical Commissioning Group (CCG) is aligned to the West Essex PCT (WEPCT) boundary.

It will commission services from a range of service providers. Its main hospital services are provided by The Princess Alexandra Hospital in Harlow, Addenbrooke's in Cambridge, Mid Essex Hospital Trust in Broomfield and Whipps Cross Hospital in north east London. Community services from South Essex Partnership Trust and Mental Health Services from North Essex Partnership Foundation Trust.

The CCG has made significant progress over the last twelve months laying the foundations for our future success and a sustainable commissioning organisation. It has successfully recruited to its Board, its Clinical Leadership Team, worked closely with the Essex Commissioning Support Unit (CSU) to secure services and through either alignment or recruitment starting to build a strong CCG team of staff. Alongside this it has maintained high levels of clinical engagement and good levels of engagement with its practices. The CCG will employ approximately 68 staff.

The current health system faces significant challenges over the coming years to ensure that services are sustainable against a backdrop of limited resources, ageing population base and continuing rise in demand and activity in acute services, well above demographic based estimates. In combination, this puts a major strain on the NHS and adult care. The health and social care landscape will need to change over the coming years to meet this challenge.

Contact West Essex CCG:
Building 4, Spencer Close
St. Margaret's Hospital
The Plain
Epping, Essex
CM16 6TN

Tel: 01992 566140
Fax: 01992 566148
Email: we.ccg@nhs.net

Commissioning Support Unit (CSU)

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

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

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

NHS Central Eastern CSU was formed by bringing together two separate predecessor bodies Hertfordshire Integrated CSU and Essex CSU – following the appointment of David Stout as the Managing Director of both CSUs in October 2012. It has three Business Units including Essex Commissioning Support which will provide services for CCGs in South Essex.

The CSU is led by:

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

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

NHS England

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

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

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

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

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

- specialised services

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

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

The Essex Area Team members will be based at:

Swift House
Hedgerows Business Park
Colchester Road
Springfield
Chelmsford
CM2 5PF

Tel: 01245 398770

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

Public Health moving to Local Authorities

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

Public Health England

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

NHS Property Services Ltd

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

Health and Wellbeing Boards

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

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

Health and Wellbeing Boards will be responsible for:

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

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

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

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

Throughout the year, the shadow board oversaw the update of the Joint Strategic Needs Assessment and the production of a Joint Health and Wellbeing Strategy. Both these documents were then used to support the CCGs in the development of their Commissioning Plans. During the final quarter of the year, the board dedicated significant time to carrying out its statutory duty to comment on the CCGs' Commissioning Plans. These also contained proposals for the integrated commissioning of health and social care services which formed the health and wellbeing theme of the Community Budget proposal to the government from Essex, Southend and Thurrock. The board also supported the establishment of Healthwatch Essex and the transfer of public health duties to Essex County Council.

Membership of Essex Shadow Health and Wellbeing Board:

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

NHS Commissioning Board Local Area Team Director (initially representing South Essex PCT cluster)	Andrew Pike
North Essex PCT cluster	Sheila Bremner (until July 2012)

NHS Constitution

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

NHS West Essex

To ensure that NHS West Essex is compliant with the NHS Constitution, we have nominated Dr Rob Gerlis as Constitution Champion. We are continuing to promote and have due regard to the NHS Constitution and it is the foundation of our principles and values (see section on Principles, Values and Priorities). Meanwhile, the executive summary for all NHS West Essex Board papers make reference to which aspects of the NHS Constitution are covered by that paper, which ensures that the NHS Constitution is referred to in our mainstream business.

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

Improving Care

Children's Services

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

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

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

Personal Health Budgets

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

This initiative offers:

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

East of England High Impact Pathways

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

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

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

Background

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

Essex/ Southend

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

Both LAs have very similar timelines for implementation:

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

Revised sexual abuse pathways within the Sexual Assault Referral Centre (SARC) and opening up to self referral – Essex wide all CCG's

- Agreed revised pathways for C&YP 0 – 5yrs, 5 – 11yrs, over 13 yrs in collaboration with statutory agencies and acute units. In line with plan for making the service more accessible the service as planned opens to self referral in April 2013.

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

The Future Model for Health Visiting Practice

It is proposed health visiting will be delivered at four differing levels led by health visitors but delivered by a range of partners so as to address the range of complex need that is present in today's society.

The first level - **Community** is about building community capacity and health visitors working with local communities to build resources that can support families that are sustainable long term.

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

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

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

Workforce Growth

The NHS Operating Framework for 2011/12 and supporting guidance set clear expectations for workforce and training growth for 2011/12.

It is estimated that some 6,000 additional health visitors will need to be trained over the period to 2015 to allow for retirements and other loss from the workforce and achieve 4,200 extra health visitors.

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

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

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

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

Planning has taken place in 2013/2014 to:

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

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

In older adult services, in line with the dementia strategy for Essex, all three PCT areas stabilised and invested in memory assessment services as a key part of the health

contribution to treating and caring for people with dementia. The diagnostic gap continues to decrease.

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

Investment in Improving Access to Psychological Therapies (IAPT) services has continued in line with DOH and NICE guidelines

There has been significant work taking place in Princess Alexandra Hospital around services for people with learning disability involving the Health Access Champions and other services users in the design and direction of services

The PCT is proud of the regular attendance of service users, patients and carers at the mental health and learning disability Programme Board to discuss and debate service quality, performance, changes and redevelopment.

Mental health and learning disability services in north Essex

Provider	Summary of services & comments
North Essex Partnership Foundation Trust (NEPFT) North Essex provider	A range of secondary mental health services including inpatient and community services for adults older adults and children and adolescents. .
Cambridge & Peterborough NHS Foundation Trust (CPFT) West and Mid Essex provider	Border related and specialist (including CAMH) Eating Disorder services CPFT also provides specialist CAMH Eating Disorder services for North Essex PCT's and IAPT services for Mid Essex PCT
North East London NHS Foundation Trust (NELFT) West Essex provider	Secondary mental health services
South Essex Partnership Foundation Trust (SEPT) North Essex provider and West Essex provider	Provision of community forensic services for North Essex and community learning disability services in West Essex
Care UK North Essex provider	Provision of nursing home services to support older people aged 65+ who have been identified as having NHS continuing healthcare needs and require long term nursing home placements.
Together[1] West Essex provider	The provision of supported accommodation continues to support a total of 5 ex-Clayburry patients.
Astracare Connolly House North Essex provider	Nursing home and hospital care mainly for people with dementia
Hertfordshire Partnership Foundation Trust North Essex provider	Assessment and treatment services for people with learning disability
Anglia Community Enterprise Mid and North East provider	Community services for people with learning disability
West Essex MIND Well Being Consortium West Essex provider	IAPT services
Health in Mind North East Essex provider	Rethink and NEPFT providing IAPT services
Tendring mental health support West Essex and North east Essex provider	Independent mental health advocacy services
Mid Essex MIND	Independent mental health advocacy services
Butterfly Farm North East Essex provider	Care farm
Basildon MIND North Essex provider	Forensic inpatient advocacy
Chelmsford MIND	Eating disorder services
Colchester MIND	Child and Adolescent services
COPE North East Essex provider	Eating disorder services

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

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

Improving quality, patient safety and experience

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

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

The overarching responsibilities within the quality teams are:

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

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

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

2. **Patient experience**, which includes:
   - Adult and Children Safeguarding (including authorisation of
   - Deprivation of Liberty requests under the Mental Capacity Act)
   - PCT PALS Service (Compliments and Complaints)
   - Eliminating Mixed Sex Accommodation
   - Implementation of the Patient Revolution (Friends & Families Test)

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

Patient Safety

Summary Hospital-level Mortality Indicator (SHMI)

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

The most recent data for 2012/13 show:

Princess Alexandra Hospital NHS Trust (PAH) at 107 (within normal range)

Never events

The PCT receives Serious Incident reports from all commissioned services and closely monitors the investigation and learning from these incidents.

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

There has been one Never Event reported to NHS West Essex by Princess Alexandra Hospital NHS Trust (Retained Foreign Object) since April 2012

Reducing Harm for Venous Thromboembolism (VTE)

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

VTE risk assessments at Princess Alexandra Hospital NHS Trust (PAH) have improved to meet the 95% stretch target.

Pressure ulcers

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

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

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

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

Clinical Audit

The quality and patient safety team continue to support and monitor the process and outcomes of clinical audit across all commissioned services. The PCT endeavours to underpin clinical audit and effectiveness within the umbrella of quality and patient safety to

ensure robust processes are in place, for continuously monitoring and improving clinical quality.

We aim to:

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

Patient experience

Patient experience surveys

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

All west Essex providers have participated in the regional Friends and Families Test initiative. The most recent score is as follows:

Net Promoter Score	Jan-13
The Princess Alexandra Hospital	86
SHA Average score	71
SHA Upper Quartile score	82

Dignity and respect: delivering same sex accommodation

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

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

Eliminating Mixed Sex Accommodation

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

Recognising breaches of policy

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

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

Reporting breaches of policy

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

Trusts within west Essex have delivered single sex accommodation since May 2012.

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Infection, Protection & Control (IPC)

The north Essex Infection Prevention and Control Team, covering west Essex:

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

Performance against the targets

It is important to note the very small numbers of cases that are being recorded, compared to previous years, and the year on year improvements that have been achieved. This does not mean however that the determination to continue to reduce Health Care Associated Infections is diminished in any way.

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

C. diff as at March 2013

	Cases 2011-12 Total	12-13 Ceiling	Cases 2012-13 Total
West Essex PCT	**67**	**58**	**52**
The Princess Alexandra Hospital	**16**	**14**	**15**

Ceilings within west Essex have proven very challenging during 2012/13

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

MRSA as at March 2013

	Cases 11-12 Total	12-13 Ceiling	Cases 12-13 Total
West Essex PCT	**5**	**3**	**5**
The Princess Alexandra Hospital	**1**	**1**	**2**

Ceilings within west Essex have proven very challenging during 2012/13

External Reviews

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

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

Compliments, concerns, complaints and queries

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

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

From April 2012 to January 2013, the PCT received a total of 41 complaints from patients or carers. In each case, NHS West Essex worked with the complainant and providers to achieve resolution in the majority of cases and to identify service improvements and learning outcomes.

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

The PCT Patient Advice & Liaison Service (PALS) provides fast help, information and advice to patients and the public in relation to local health services. The PALS Service handled a total of 964 contacts from April 2012 to January 2013.

Freedom of Information Requests

The Freedom of Information Act (2000) gives a general right of access to recorded information held by public authorities, subject to certain conditions and exemptions. NHS West Essex has complied with the Treasury guidance on setting charges for FOI requests. NHS West Essex received 301 FOI requests during 2012/13.

Ensuring best value

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

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

NHS West Essex has worked to optimize the resources available for the best outcomes for its population.

The PCT has done this by:

- Testing all investments against the priorities set out in the PCT and CCG integrated plans.
- Rigorous financial management and predictive modeling to allow the PCT the ability to flex its resources and shift funding to allow optimal local health gains and increase productivity and quality.
- Rigorous contract management to ensure optimal outcomes for a value for money investment.
- Benchmarking analysis to identify where the PCT currently invests disproportionately to its peers compared to outcomes obtained.
- Improved how we manage contracts to ensure appropriate levers and incentives in place and applied to gain best quality, productivity and value for money
- Used contestability where appropriate to market test services and award new contracts.
- Commenced scoping for integrated commissioning with Social Care
- Through its planning process highlighted areas suitable for local service redesign, innovation and development e.g. better use of assistive technology.
- Working effectively with all service providers by providing financial support and information to achieve the most clinically effective and cost effective approaches.

QIPP

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

- Improving quality and productivity
- Engaging and empowering staff

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

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

Key Health & Social Care Partners

The following are our key partners:

- East of England Ambulance Service NHS Trust
- Clinical Commissioning Groups comprising 39 GP practices
- West Essex PCT
- SEPT (South Essex Partnership University NHS Foundation Trust)
- Princess Alexandra Hospital NHS Trust
- North Essex Partnership NHS Foundation Trust
- Patient representatives & Local Involvement Networks (LINks)
- Voluntary services from various groups in west Essex
- Essex County Council

We have structured our activities in order to maximise engagement. The size and challenge of QIPP delivery required us, working with our partners, to constantly review our working arrangements to ensure momentum was maintained in its re-design work and the implementation of plans to reflect the needs and requirements that emerged through transition.

Development of our QIPP Plan

The QIPP Programme has been overseen by Programme Boards established around the following workstreams:

- Urgent Care
- Planned Care
- Long Term Conditions
- Older people including integration
- Medicines Management
- Mental Health & LD and Children's and Maternity (in collaboration with Mid and North East CCGs)

Each Programme Board was assigned objectives to support the delivery of QIPP and performance by which they were held to account by the CCG Finance & Performance Committee which had delegated responsibility from the CCG board to oversee the delivery of QIPP.

The role of our GP commissioning leads in QIPP delivery remains a critical success factor as we moved to new forms of commissioning over the year.

QIPP projects

Urgent Care projects aimed to reduce avoidable non-elective secondary care admissions through a number of key initiatives:

- Emergency Ambulatory Care pathway (EACP)
- A&E – Front Door
- Urgent Care in Primary Care

Planned Care initiatives aimed to deliver improved efficiencies in care pathways included the following;

- Diagnostic Deep Dive – improving access to and efficient use of diagnostics
- Decommissioning treatments of limited clinical effectiveness (TOLCE)
- Clinical Validation improvements
- OLA – shift of routine referral activity from London, shift of specialist activity from London, shift of routine procedures to community and primary care
- Decision aids

Older People QIPP schemes focussed on keeping older people well by providing integrated care closer to home and included avoiding urgent care hospital admissions through the introduction of following schemes:

- Integrated care (including SPoA / Care Homes / Case Management of older people / managing frequent hospital visitors to minimize repeat visits
- End of Life choices

Medicines Management and Prescribing QIPP schemes focussed on appropriate and cost effective, schemes included:

- Optimise implementation of NPC and regional PresQIPP initiatives
- Planning for patient expiries to optimise category M drugs savings
- Effective horizon scanning to manage variations and changes

Achievements have included:

- Medicines management initiatives have delivered continuing high quality prescribing benefits and delivered significant cost efficiencies in 2012/13
- Older people non elective admissions have been reduced significantly by improved case management initiatives including a more integrated approach to care provision.

- Planned care schemes have delivered earlier and more efficient access to diagnostic testing, more primary care based services and elimination of significant TOLCE treatments.

Taking into account the current and future needs of the population and the financial constraints, the system identified a number of opportunities for service redesign that offered scope to deliver better care and outcomes for less direct investment, for delivery through 2012/13 and 2013/14.

NHS West Essex achieved a delivery yield of 70%. This has been achieved through the implementation of a number of work programmes, including better control of prescribing. The medicines management scheme has been working with GP's to understand drug costs and ways to use resources more cost effectively. This has provided a good basis for further savings and improved management in 2013/14.

A number of planned care schemes have been implemented through reductions in renegotiation of current contracts to improve service costs.

The results in 2012/13 have provided a solid platform for further improvements and service re-design in 2013/14.

The 2012/13 financial challenge for QIPP was set at £20.5m. The CCG has achieved recurring savings of 70% of this target at £14.27m.

Working with our partners and public engagement

Working in partnership for better health

Joint Strategic Needs Assessment

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

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

The JSNA in Essex is coordinated through a JSNA Planning Group made up of partner organisations including the county council, clinical commission groups, Healthwatch and district councils. The group reports to the Business Management Group of the Health and Wellbeing Board.

Strategic JSNA products that have been published previously, and will be refreshed each year, include profiles based on our various geographies: countywide and district (x12), CCGs (x5), a Pharmaceutical Needs Assessment and a number of specialist topic reports.

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

Involving and listening to our patients and public engagement

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

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

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

- Recruiting local people and organisations to become members of each CCG. There are three levels of membership:
- Level 1 - receive information and news updates
- Level 2 - invitations to one-off projects such as readers group or specific forum for a project
- Level 3 - to become more involved and represent patients/public on regular groups such as Patient Reference Group or as Lay members to Board.
- Analysis of survey into effectiveness of the Patient Participation Groups at GP practices and subsequent report has been presented to Practice Managers across west Essex.
- Workshops around the integrated plan and three priority areas:
  Long term conditions
- Older people
- Urgent care
- Establishing links with Health and Wellbeing Board and enabling greater partnership working on engagement
- Establishing local Health Forums which are made up of patient, public,
- voluntary organisations and carers.

Improving the health of our population

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

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

Commissioning for health improvement

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

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

The core delivery of the Health Checks programme is through primary care whose engagement in this programme is vital in order to achieve successful outcomes. Maximising uptake of the programme is essential if prevalence of long term conditions is to be reduced which will result in significant efficiencies across the health and social care system through reduced demand for services

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

Reducing health inequalities

- **Essex County Travellers Unit (ECTU) -** The ECTU is an innovative way for partners to work together to address health inequalities that Gypsies and Travellers face and to deliver significant on-going benefits which could not be achieved by partners working in isolation. Early intervention and prevention, especially relating to the health deliverables of the unit, will help to reduce the cost that occurs as a result of poor health outcomes.

Equality and diversity and sustainability

Ensuring equality for all

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

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

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

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

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

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

Sustainability and caring for our environment

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

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

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

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

Having a robust Sustainable Development Management Plan helps us fulfill our commitment to conducting all aspects of its activities with due consideration to sustainability whilst providing high quality patient care. NHS North East Essex, West Essex and Mid Essex

continues to work closely with partners including our Clinical Commissioning Groups, other NHS organisations and Local Authorities, developing a community-wide approach to sustainability and carbon reduction and ensuring it is embedded in the legacy of the organisation.

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

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

Carbon Reduction Commitment Energy Efficiency Scheme (CRC)
NHS North East Essex and NHS West Essex registered as an information declarer for the CRC in 2010 as it uses less than 6,000 megawatt-hours (MWh) of electricity through its meters during 2008 (6,000 MWh emits approximately 3,333 tonnes of CO2). Therefore, all is required at this point is a simple information disclosure.

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

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

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

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

- Travel
- Procurement
- Facilities management
- Workforce
- Community engagement
- Buildings

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

Each question has three levels:

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

Table 1 – Good Corporate Citizenship Assessment Model

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

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

Carbon Management Plan
NHS North Essex, West Essex and Mid Essex continue to embrace and embed carbon management into its day-to-day processes as well as ensuring Clinical Commissioning Groups' key decisions will have due regard to their environmental impact.

Planning For Emergencies and Business Continuity Management

Emergency Planning

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

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

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

Business Continuity Management

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

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

Our staff

Consultation with staff

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

As a result of the changes the following staff transferred to the receiver organisations:

473 staff were transferred during this process.

35 staff from the North Essex Cluster were also made redundant as a result of the changes.

Support to staff

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

Equal Opportunities

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

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

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

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

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

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

	Main department
No. In place on 31 January 2012	1
Of which:	
No. that have since come onto the Organisation's payroll	
Of which:	
No. that have since been re-negotiated/re-engaged to include to include contractual clauses allowing the (department) to seek assurance as to their tax obligations	
No. that have not been successfully re-negotiated, and therefore continue without contractual clauses allowing the (department) to seek assurance as to their tax obligations	1
No that have come to an end	0
Total	1

Our performance

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

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

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

In terms of monitoring progress against QIPP for 2012/13, on a monthly basis as part of preparing the monthly financial performance report, the PCT prepares a forecast in delivery

of QIPP schemes. The 2011/12 position reported in the accounts was based on the data available at the time of completing the accounts and is as below.

Our performance against national targets 2012/13

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

Performance measures	Target / plan	Actual performance 2012/13 (Q3 YTD)	2011/12
Maximum time from referral to treatment			
% People treated with a stay in hospital within 18 weeks of referral by their GP	90%	93.0%	88%
% People treated (non-admitted) within 18 weeks of referral by their GP	95%	98.1%	97%
Reducing healthcare associated infections			
Number of *C Difficile* infections	58	47	67
Number of MRSA infections	3	3	5
Cancer treatment waiting times			
% People attending a first appointment within two weeks of an urgent referral by their GP for suspected cancer	93%	91.6%	94%
% People attending a first appointment within two weeks of an urgent referral by their GP for breast symptoms	93%	92.2%	94%
% People receiving treatment within 62 days of an urgent referral by their GP for suspected cancer	85%	77.6%	84%
% People receiving treatment within 31 days of a cancer diagnosis	96%	97.7%	98%
Improving care for strokes			
% People spending 90% of their treatment time on a special stroke unit	80%	90.4%	76%
Patients with a suspected transient ischaemic attack (TIA) seen and treated within 24 hours	60%	50%	66%
Reducing blood clots in the vein (VTE)			
% People admitted to hospital who are assessed for risk of VTE	90%	92.2%	92%
Accident & emergency department waiting times			
95% Patients seen in A&E within 4 hours	95%	93.4%	91%
95% Patients seen in A&E within 4 hours inc Urgent Care Centre	95%	94.9%	93%
Ambulance response times			
% Calls for life-threatening incidents resulting in a response within 8 minutes	95%	75%	75%

Improving mental health			
% People who have depression and/or anxiety disorders who receive psychological therapies	15%	1.3%	5.6%
% People who complete treatment who are moving to recovery	50%	53.1%	97.9%
Choice about where to die			
% Deaths at home, or place of residence (as opposed to in hospital)	N/A	42.6%	33%
Improving maternity care			
% Women seen by a midwife within by 12 weeks and 6 days of pregnancy	90%	86.5%	80%
% Women breastfeeding their babies at 6-8 weeks after birth	42.5%	43.9%	45.1%
Improving support for children and families Increasing number of Health Visitors	Target is to increase to 58 HVs by March 2015	46.75	42
Reducing smoking			
Number of people who quit smoking for more than 4 weeks after using NHS Stop Smoking Services	1,960	1139	1,743
NHS Health Checks			
% People who are eligible being offered a health check	17603	10131	13,829
% People who are eligible who received a health check	12798	6332	8,266

Areas of achievement and identified areas for improvement West Essex 2012/13

Stroke services have shown both achievement and a need for improvement. The proportion of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit has been above the national target each month of 2012/13. For this indicator we can also see an impressive improvement on last year's performance. However we remain below the national target for the proportion of people at high risk of stroke who experience a TIA and who are assessed and treated within 24 hours.

NHS West Essex have worked closely with providers to ensure comprehensive action plans are in place to work to improve performance in this area. From this we have seen achievement of this target for The Princess Alexandra Hospital in January. Ongoing work is also taking place with the Midlands and East Stroke Review. This has meant close working across all Essex CCG's as well as improving links with Hertfordshire to help to improve outcomes for stroke patients in the future. This will have a positive impact on performance at The Princess Alexandra Hospital.

Cancer Waiting Times Operating Standards for The Princess Alexandra Hospital and NHS West Essex continue to be closely monitored and managed by the West Essex CCG Cancer Board. Two week wait operating standards have continued to improve since October 2012

and, after in depth investigation, both The Princess Alexandra Hospital and NHS West Essex are now aware of the underlying issues which cause the majority of breaches.

The 31 day waits for first and subsequent treatment meet the operating standards most months, however, as the number of patients allocated to The Princess Alexandra Hospital for this target are very small, there is a very small margin of error below the required percentage. There is further work taking place to improve performance for 62 days waits across all trusts within the London Cancer Network and close monitoring and improvement programs to improve performance will continue through the West Essex CCG Cancer Board.

Waiting times in accident and emergency (A&E) services in The Princess Alexandra Hospital remain below the national target of 95% of people waiting four hours or less. The Princess Alexandra Hospital has a comprehensive plan to improve this position during 2013, supported by continued action from GPs to develop modern healthcare alternatives in the community and reduce the reliance on hospital services, where this is not necessary. Performance has improved on last year's achievement and latest data shows that The Princess Alexandra Hospital is very close to achieving the 95% threshold. This is an achievement that they are working hard to sustain and improve upon.

Performance in NHS West Essex has improved over the last 12 months. The percentage of people waiting 18 weeks or less for treatment without a hospital stay has been above the national target consistently throughout the year. Similarly, the same high performance can be seen for people requiring hospital treatment as an inpatient with patients waiting less than 18 weeks for treatment in hospital has shown improvement on last year's position.

More detailed information on our performance against the headline and supporting measures can be found on the PCT website.

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

Value for money assessment 2012/13

As part of the national changes, the Department of Health abolished the Use of Resources assessment for 2010/11 onwards and replaced it with a Value for Money (VFM) conclusion to be made by Ernst Young, who are NHS West Essex's external auditors.

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

Looking ahead

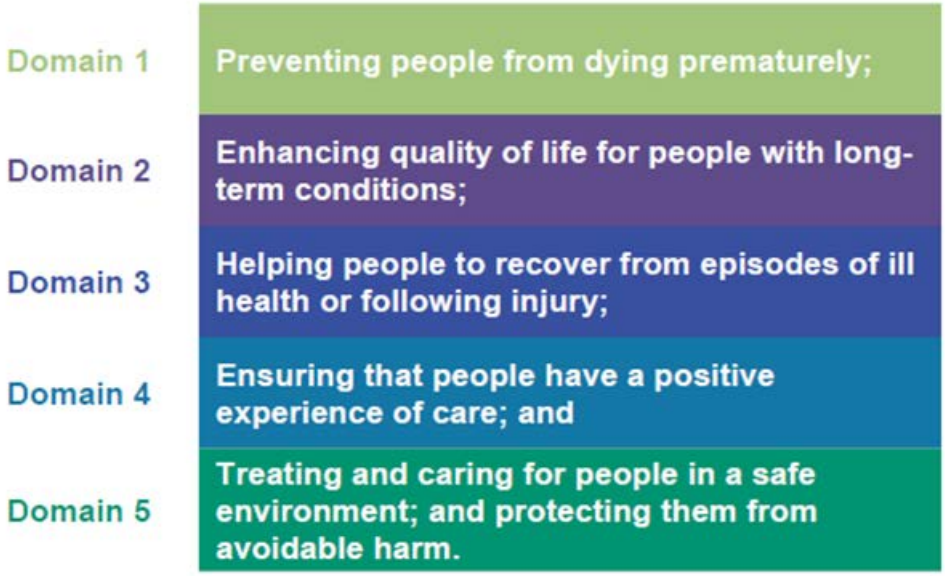
The White Paper, Equity and Excellence: Liberating the NHS set out how the improvement of healthcare outcomes for all will be the primary purpose of the NHS. This means ensuring that the accountabilities running throughout the system are focussed on the outcomes achieved for patients not the processes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

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

- to provide a national level overview of how well the NHS is performing;
- to provide an accountability mechanism between the Secretary of State for Health and the NHS Commissioning Board for the effective spend of some £95bn of public money; and

- to act as a catalyst for driving up quality throughout the NHS by encouraging a change in culture and behaviour.

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



NHS North Essex has been working with the CCGs in west Essex to support them to develop plans to achieve these priorities.

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

Planning for the future

As new organisations take over the responsibilities of NHS West Essex from 1 April 2013, the PCT has been working with these emerging organisations during 2012/13 to ensure a smooth transition and legacy handover.

Information Governance

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

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

Date of incident (month)	Nature of incident	Nature of data involved	Number of people potentially affected	Notification steps
April 2012	Facebook	Comment regarding Patient Name & town	1	SHA, ICO and Patient Notified. Member of staff dismissed

Summary of other personal data related incidents in 2012/13

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

Financial Review

Financial Duties

NHS West Essex achieved its statutory financial duties recording a surplus of £1.153m by the end of the financial year. This met the target surplus set for NHS West Essex by East of England Strategic Health Authority of £1.0m. The following table demonstrates the performance against these statutory duties over the past three years.

Financial Duty	All figures in £000	2010/11	2011/12	2012/13
Remain within Revenue Resource Limit	Performance	429,419	448,380	466,867
	Limit	430,140	449,000	468,020
Remain with Capital Resource Limit	Performance	3,294	5,102	(906)
	Limit	5,244	5,614	262
Remain within Cash Limit	Performance	436,164	452,244	464,345
	Limit	436,164	452,244	464,345

Capital Expenditure

The PCT had a Capital Resource limit of £262k for 2012/13 and spent £1,479k on its Capital Programme. The proceeds of sale of LD properties brought the net position against the CRL to (£906k)

The capital expenditure was on the following developments

Description	£000
GP IT Hardware replacement	255
ESSA IT Projects	655
Works to Healthcare premises	569

Value for Money

Ensuring value for public money is an important principle of the PCT and is outlined in the corporate governance framework adopted by the Board. To ensure value for money is achieved, appropriate procurement procedures are in place, including the tendering of goods and services where necessary. This includes a separate procurement group, with non-executive and executive director membership. Part of the role of the internal audit service that the PCT commissions involves reviewing, appraising and reporting upon value for money within the organisation.

A key priority for the PCT and CCGs looking forward is to ensure that maximum value for money is being achieved through effective commissioning arrangements, as the majority of the PCT's expenditure is spent on commissioning healthcare services. While all healthcare providers, are required to deliver a continuous programme of QIPP, the PCT also must demonstrate that it is properly considering the health needs of the local population and commissioning those services that address those needs.

During 2012/13 the PCT cluster has been working with our NHS and social care colleagues across North Essex in developing system-wide Quality, Improvement, Productivity and Prevention plans setting out how we will respond to the challenging financial climate in which the NHS and the wider public sector will operate over the coming years.

The PCT's overall financial management arrangements were also subject to review by the PCT's external auditors, Ernst & Young LLP (previously the Audit Commission), as part of

their annual review of the PCT's accounts. The PCT received an unqualified value for money opinion in 2011/12 and expect to receive a similar opinion in respect of 2012/13.

Better Payment Practice Code (also in accounts)

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

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

The performance of the PCT against this target is as follows:

	2012-13 Number	**2012-13 £000**
Non-NHS Payables		
Total Non-NHS Trade Invoices Paid in the Year	**13,341**	**61,519**
Total Non-NHS Trade Invoices Paid Within Target	**11,296**	**51,842**
Percentage of NHS Trade Invoices Paid Within Target	84.67%	84.27%
NHS Payables		
Total NHS Trade Invoices Paid in the Year	**3,693**	**346,488**
Total NHS Trade Invoices Paid Within Target	**2,245**	**331,775**
Percentage of NHS Trade Invoices Paid Within Target	60.79%	95.75%

Audit Arrangements

Ernst & Young are our external auditors, appointed by the Audit Commission. The total planned fee for 2012/13 audit was £105k for the PCT. This was £197 in 2011/12.

No other work was carried out by Ernst & Young during 2012/13.

Pension Liabilities

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

2013/14 Financial Plans

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

Balance budgets have been set for 2013/14 across Essex and we are seeking to deliver significant efficiency savings through our Quality, Innovation, Productivity and Prevention programme, which is variable in size across each of the CCGs and Area Team within Essex.

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

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

The Annual Governance Statement can be obtained in full in the Annual Accounts (Appendix B). Statement of the chief executive's responsibilities as the accountable officer of the primary care trust and the Statement of directors' responsibilities in respect of the accounts are in the accounts.

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF NHS WEST ESSEX

Annual Report of the Cluster Audit Committee 2012/3

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

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

3. Integrated Governance, Risk Management and Internal Control
The Committee 'shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives'.

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

4. Internal Audit

'The Cluster Audit Committee shall ensure that there is an effective Internal Audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Cluster Audit Committee, Chief Executive and NHS North Essex Board.'
The internal audit function is currently provided by the Deloitte which operates at arms length from its clients.
The Committee has viewed the developing audit plans for each of the CCGs.
Internal Audit report progress at each meeting of the Committee. Their findings are presented and discussed. Where recommendations have not been implemented on limited assurance reports, these have been monitored by the Cluster Audit Committee who have progressed the action requirements with the relevant manager lead.
The following audits in the Internal Audit Plan were presented to the Cluster Audit Committee during 2012/13:-

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

Information Technology

- IT Procurement
- ITIL Service Desk
- Follow up of Recommendations

- Planning, Liaison, Reporting & Meetings

Where necessary, updates are received at each meeting.

5. External Audit

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

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

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

As with Internal Audit, the External Audit function attends each meeting and contributes to discussions and the Committee's understanding of the issues under consideration.

The Committee received and accepted External Audit reports, including that on the transition.

6. Counter Fraud

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

7. Management

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

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

8. Financial Reporting

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

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

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

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

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

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

9. Audit Committee Development

During the early part of the year, the Committee focused on ensuring that all actions from the three PCT Audit Committee meetings were followed up and any issues picked up appropriately.
Ensuring that governance arrangements and local Audit Committees were established by the CCGs and functioning appropriately at a period of significant change within the NHS was a priority for the committee during the year.
In 2012/13 with significant changes to the NHS commissioning system beginning to take shape the committee will focus on ensuring statutory responsibilities for each PCT are met up to March 2013 and that clinical commissioning groups have effective processes in place from April 2013 onwards for audit and governance.

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

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

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

Jerry Wedge
North Essex Cluster Audit Committee Chair
March 2013

Remuneration report for the period ending 31 March 2013

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

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

Performance Conditions
The performance of all staff (including the Chief Executive, Directors and Senior Managers) is monitored and assessed through the use of a robust appraisal system. A formal appraisal review is undertaken at least annually. With the exception of the Very Senior Manager (VSM) Pay scales there are no performance related pay elements contained in any contracts for 2011/12. Where the payment of bonuses to VSMs are proposed, these are scrutinised by the Remuneration Committee and the Strategic Health Authority.

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

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

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

Senior manager information

Significant Awards

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

Salary and Pension Entitlements

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

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

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

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

Glossaries of terms used in this annual report

Glossary of financial terms

Term	Definition
Accounting Policies	The **Accounting Policies** are the accounting rules that the PCT has followed in preparing its accounts. These policies are based on International Financial Reporting Standards and the Treasury's Financial Reporting Manual. The Department of Health's Manual for Accounts and Capital Accounting Manual detail how these rules should apply to PCTs. One of the main policies is that income and expenditure is recognised on an accruals basis, meaning it is recorded in the period in which services are provided even though cash may or may not have been received or paid out.
Budget	A **Budget** usually refers to a list of all planned and expected future expenses and revenues. A budget is set at the beginning of the financial year.
Capital Expenditure	**Capital Expenditure** is money spent on buying non-current assets (fixed assets) or to add to the value of an existing fixed asset with a useful life that extends beyond a year.

Capital Resource Limit	The **Capital Resource Limit** (CRL) is the amount allocated each year to the PCT for capital expenditure. The PCT must not spend more than the CRL on capital items.
Cash Limit	The **Cash Limit** (CL) is a limit set by the Government on the amount of cash which a PCT may spend during a given financial year. The PCT must ensure that the net amount of cash flowing out of the PCT over the financial accounting period is not more than the CL.
Depreciation	**Depreciation** refers to the fact that assets with finite lives lose value over time. Depreciation involves allocating the cost of the fixed asset (less any residual value) over its useful life to the **Statement of Comprehensive Net Expenditure (SCNE)**. This will cause an expense to be recognised on the SCNE while the net value of the asset will decrease on the Statement of Financial Position.
Impairments	**Impairments** are the losses in the values of non-current assets compared to those values recorded on the Statement of Financial Position. A PCT is required to undertake routinely revaluation reviews of its fixed assets or undertake an impairment review when there is a decline in an asset's value. The impairment (loss) is treated in the same way as depreciation, as a cost in the **Statement of Comprehensive Net Expenditure (SCNE)**, if the change in the value of the asset is permanent.
Intangible Assets [formerly Intangible Fixed Assets]	**Intangible Assets** are invisible or 'soft' assets of an organisation that, nevertheless, have a real current market value and contribute to the (future) operation/income generation of the organisation and may include software licences, trademarks and research development expenditure.
International Financial Reporting Standards	**International Financial Reporting Standards (IFRS)** are the international accounting standards that the Department of Health requires PCTs to follow when they prepare their accounts. 2009-10 was the first year in which PCTs were required to prepare IFRS compliant accounts, having previously used UK reporting standards.
Losses and Special Payments	**Losses and Special Payments** are payments that Parliament would not have foreseen healthcare funds being spent on, for example fraudulent payments, personal injury payments or payments for legal compensation.
NHS Payables (formerly known as NHS Creditors)	An **NHS Payable** is an amount owed to an NHS oganisation for services rendered or goods supplied to the PCT or to patients of the PCT.
Statement of Comprehensive Net Expenditure (formerly known as Operating Cost Statement)	The **Statement of Comprehensive Net Expenditure** (SCNE) records the costs incurred by the PCT during the year, net of miscellaneous

	income (which is income other than the PCT's main funding from the Department of Health which is credited to the general fund on the Statement of Financial Position and not treated as income on the SCNE). It includes non cash expenses such as depreciation. Under government accounting rules the SCNE shows the net resources used by the PCT in commissioning and providing healthcare rather than the surplus or deficit for the year as shown in the income and expenditure account by NHS trusts. The comprehensive net expenditure is debited to the general fund on the Statement of taxpayers equity.
Over Spend	**Over Spend** occurs when more money is spent than was allowed within the cash limit, revenue resource limit or capital limit, or that was planned in the budget.
Pooled budget	A **Pooled Budget** is a joint arrangement with other bodies, such as local authorities and other PCT's, to pool funds for a specific purpose. Each body has to account for its own contribution to the pool within their accounts. Contributions would generally include the resources normally used for the identified services, together with partnership and other grants specific to the services. The host partner will manage the financial affairs of the pooled fund. The pooled budget manager is responsible for managing the pooled fund on behalf of the host authority, and for providing information to enable the partners to monitor the effectiveness of the pooled fund arrangements.
Procurement	**Procurement** is the acquisition of goods and/or services, generally through a contract, at the best possible total cost, in the right quantity and quality, at the right time and in the right place for the direct benefit of the PCT and its patients.
Property, plant & equipment (formerly Tangible Fixed Assets)	**Property, plant and equipment** are assets that individually (or with integrally linked other items) cost more than £5,000 and are held for longer than one year and include: land, buildings, transport equipment, IT and furniture and fittings.
Provisions	A **Provision** is a liability arising from a past event where it is probable the PCT will have to settle and a reliable estimate can be made of the amount to be paid.
Revenue Resource Limit	The **Revenue Resource Limit** (RRL) is the total amount that the PCT may spend on the services that it commissions. This limit is set for the PCT at the start of the financial year by the Department of Health and may change on a monthly basis depending on changes to allocations to the PCT from the Strategic Health Authority for either commissioning or provider functions. Each PCT has a statutory duty not to spend more than its RRL. The RRL takes into account all accrued income and expenditure irrespective of whether

	income has been received or bills paid.
Statement of Cash Flows	The **Statement of Cash Flows** (SCF) shows the effect of the PCT's operating activities on its cash position.
Statement of Changes in Taxpayers' Equity (formerly Statement of Recognised Gains and Losses)	The purpose of the **Statement of Changes in Taxpayers' Equity** is to highlight financial transactions that may not be reflected in the Statement of Comprehensive Net Expenditure, but which affect the PCT's reserves as shown in the "Financed by" section on the Statement of Financial Position. For example, "(Reduction)/Additions in the General Fund due to the transfer of assets to/from NHS bodies and the Department of Health".
Statement of Financial Position (formerly Balance Sheet)	The **Statement of Financial Position** provides a view of the PCT's financial position at a specific moment in time – usually the end of the financial year. It shows assets (everything the PCT owns that has monetary value), liabilities (money owed to external parties) and taxpayers' equity (public funds invested in the PCT).
Tendering	**Tendering** is the process by which one can seek prices and terms for a particular service/project to be carried out under a contract.
Trade and other Payables (Non-NHS) (formerly known as Non-NHS Creditors)	**Trade and other Payables Creditors** are non-NHS organisations owed money by the PCT for goods and services provided to the PCT, e.g. for utilities, equipment, etc.
Trade and other receivables (formerly Debtors)	**Trade and other receivables** represent money owed to the PCT at the Statement of Financial Position date for services rendered or goods supplied by the PCT to the receiver.
Under Spend	**Under Spend** occurs when less money is spent than was allowed within the cash limit or that was planned in the budget.

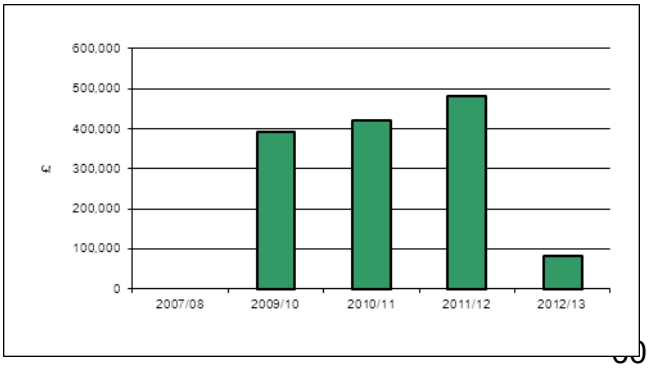
Glossary of non-financial terms

Term	**Definition**
Care pathway	The route that a patient will take from their first point of contact with an NHS or Social Services member of staff (usually their GP), through referral, to the completion of their treatment.
Choice	Giving patients more choice about how, when and where they access health services.
Civil Contingencies Act 2004	Provides a single framework for UK civil protection against any challenges to society – it focuses on local arrangements and emergency powers.

Commissioning	The review, planning and purchasing of health and social services.
Community services	Health or social care and services provided outside hospitals. They can be provided in a variety of settings including clinics and in people's homes. Community services include a wide range of services such as district nursing, health visiting services and specialist nursing services.
Commissioning Support Unit (CSU)	Will provide capacity to clinical commissioners as an extension of their local team to ensure that commissioning decisions are informed and processes structured. This approach will help achieve economies of scale and allow clinical commissioning groups to focus on direct commissioning of services for their patients.
Diabetic retinopathy	One of the most common causes of blindness in the UK. Retinopathy means damage to the tiny blood vessels (capillaries) that nourish the retina, the tissues in the back of the eye that deal with light.
Enhanced services	i) essential or additional services delivered to a higher specified standard, for example, extended minor surgery ii) services not provided through essential or additional services They are services provided by GPs, over and above the core (essential and additional) services to their patients.
Palliative Care	The total care of patients whose disease is incurable. Control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families.
Primary Care Trust (PCT)	Responsible for the planning and securing of health services and improving the health of the local population.
Professional Executive Committee (PEC)	An important aspect of clinical leadership in primary care. The PEC must have a majority of members whose professional work reflects the function of the PCT. For example, members can include GPs, nurses, social workers, pharmacists, dentists, opticians, amongst others. PECs are able to provide a professional viewpoint on the strategy and operations of the PCT.

Sustainability Report

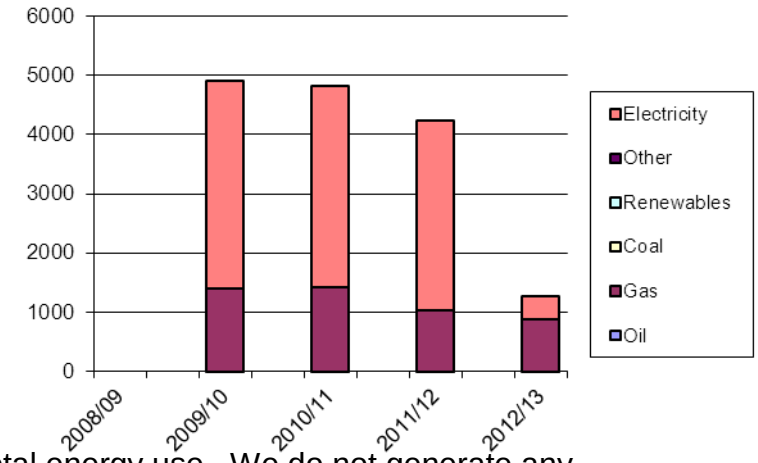
83%



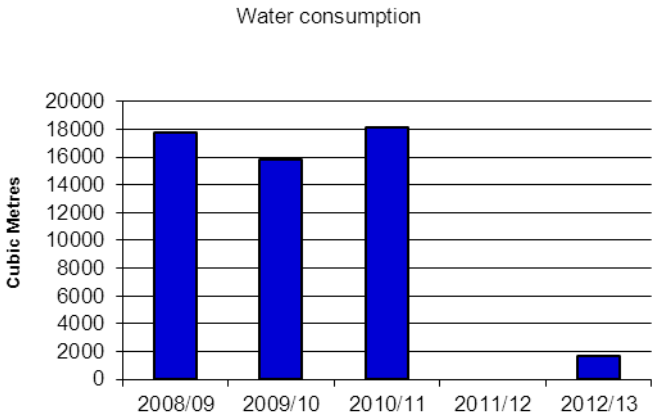
Due to a change in the reporting process a number of properties are now excluded from this return which accounts for the reduction in measured values. The NHS aims to reduce its carbon footprint by 10% between 2009 and 2015. Reducing the amount of energy used in our organisation contributes to this goal. There is also a financial benefit which comes from reducing our energy bill.

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

Our total energy consumption has fallen during the year, from 004,240 to 001,260 MWh



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



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

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

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

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

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

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

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

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

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

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

Dawn Scrafield is the Board Level Lead for Sustainability.

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

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

A sustainable NHS can only be delivered through the efforts of all staff.

Staff awareness campaigns have been shown to deliver cost savings and associated reductions in carbon emissions.

Our organisation does not have a Sustainable Transport Plan.

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

Appendix A

Name of Organisation West Essex PCT

Organisation Code 5PV

Annual Governance Statement

1. Scope of Responsibility

As Accountable Officer and Chief Executive of the NHS North Essex Board[1] from 1 October 2012 I had responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also had responsibility for safeguarding the public funds and the organisation's assets for which I was personally responsible as set out in the Accountable Officer Memorandum. Prior to 1 October 2012, Sheila Bremner was the Accountable Officer and Chief Executive of the NHS North Essex Board and held these responsibilities from 1 April 2012 to 30 September 2012.

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

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

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

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

2. The Governance Framework of the Organisation

Governance Framework Context

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

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

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

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

Key components of the transitional governance systems were:-

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

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

3. Board Committee Structure

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

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

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

- A shadow CCG Board which included a NED from the Board. A supporting committee structure included a CCG Quality, Finance and Performance Committee thus negating the need for the Board to continue with a Quality and Delivery committee
- A CCG Performance Committee to provide oversight and scrutiny of the CCG and which held the CCG to account. This was chaired by a NED with NEDs and PCT executive directors as members
- a public health and future NCB performance committee, again chaired by a NED and with NED and PCT Executive Directors as members to provide oversight, scrutiny and to hold the public health and commissioning leads of the future NCB commissioned services to account
- a Commissioning Support Committee which provided oversight of the development of commissioning support and included a NED and PCT Executive Directors as members
- a PCT Executive Committee for all executive matters which were not within the CCG's remit and which only consisted of the PCT executive members

- a PCT Transition Committee with PCT executive and CCG leads
- A combined Remuneration and Terms of Service Committee with a separate agenda for the PCT/CCG locality and with membership attendance from the CCGs. This Committee was chaired by a NED and made up of NEDs
- Cluster Audit Committee which was chaired by a Board NED with separate agenda items for the PCT/CCG locality and with membership attendance from each of the CCGs. During the course of 2012/13 the designated CCG Audit Committee chair attended in preparation for when the CCG Audit Committee was established.

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

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

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

The Board's assessment of its performance has been informed by:-

- The Annual Accountability Review letter from the SHA in 2012/2013 on the outcome of the 2011/12 Annual Accountability Review. In addition to confirming the outcome of performance for 2011/12, it confirmed the following as key issues to focus on in 2012/13:-

NHS North Essex	**Concern**	**Improvements required**
HCAI (Healthcare Associated Infections)	The PCT Cluster, Colchester Hospital University Foundation Trust (CHUFT) and Princess Alexandra Hospital (PAH) breached their ceilings for C.*difficile* in 2011/12.	Improvements are necessary such that monthly C*. difficile* performance for the commissioner and both providers is below ceiling. This should be sustained for a minimum of three consecutive months to demonstrate real improvements have been embedded.

18 weeks performance	The PCT and all three providers have reported periods of underperformance against both admitted and non-admitted standards in 2011/12, at both aggregated and specialty level.	Performance across the Cluster is to be improved such that all required 18 week metrics are met on a monthly basis. Referral to Treatment performance should be delivered consistently on a specialty level basis from Quarter 2.
A&E	PAH failed to deliver the A&E standard for the full year and recovery of performance has been slow. Mid Essex Hospitals Trust (MEHT) also failed to deliver the standard in Q1 2011/12. Ambulance handover times at MEHT have also been an issue during 2011/12 with long waits regularly reported during the winter period.	Performance at all providers to be above 95% YTD on a consistent basis with evidence of sustainability during periods of peak demand. A reduction in ambulance handover times at MEHT during 2012/13 including during the winter period.

The outcome positions for 2012/13 on the above improvement requirements were:-

- HCAI - the PCT and Princess Alexandra Hospital breached their ceilings for C.difficile.
- 18 weeks performance - the PCT and Princess Alexandra Hospital met the aggregate standards for admitted and non-admitted but did not meet the standards across all specialties.
- A&E - Princess Alexandra Hospital failed to deliver the A&E standard for Quarter 1, 3 and 4. Ambulance handover times remained an issue.

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

5.1. Board Committee reports

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

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

5.2. Audit Committee highlights

The Audit Committee carried out its functions in accordance with its Terms of Reference. It discussed external audit reviews on e.g. demand management and Payment by Results assurance programme, followed up on internal audit recommendations and approved the internal audit programme, reviewed specific policies such as the Hospital and Interest Policy, discussed the Local Counter Fraud Reports, reviewed the assurance frameworks for the cluster and the CCG for the strategic objectives, regularly received the risk register reports, sought assurance in relation to the transition programme and handover arrangements and

received the development of the Schemes of Delegation for the new CCG in readiness for the 1st April 2013.

6. Account of Corporate Governance

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

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

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

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

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

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

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

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

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

- **Public Health Board Lead**
  Dr. Mike Gogarty or Alison Cowie Director of Public Health

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

- **Senior Information Responsible Officer**
  Sarah Jane Relf, Director of Transition and Governance (up to October 2012) with Margaret Hathaway – Director of Commercial Services from October to end March 2013

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

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

- **Security Management Board Lead**
  Adrian Marr – Director of Resources (up to October 2012) and from then on, Dawn Scrafield – Director of Finance, Performance and Operations

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

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

- **Equality and Diversity Champion**
  Qadir Bakhsh – Non-Executive Director (up to end November 2012)

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

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

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

Accounts Process
As part of its review of the PCT's transition governance arrangements, the Audit Committee agreed the financial transition arrangements for the preparation and approval of the 2012/13 accounts and the transfer of outstanding audit recommendations. The plan for the financial accounts was based on the letter setting out roles for financial closedown of PCTs (Gateway ref 18561) and arrangements were assessed as green. The financial services of the Central Eastern Commissioning Support Unit have been utilised to close down the accounts as the majority of PCT financial services staff have transferred into the CSU.

A sub-committee of the Department of Health's Audit Committee has been established to meet on 3 June 2013 to sign off the accounts and discharge the statutory responsibilities of the PCT, checking for any irregularities and ensuring that all reporting is legally compliant.

The PCT operated within the Corporate Governance Manual and there were no known departures from the Corporate Governance Code.

Reports from Internal and External Audit provide the outcomes of the reviews and the Internal Audit Governance report has confirmed that there were no irregularities and that the PCT were legally compliant

7. Risk Assessment

The PCT has a risk assessment framework for carrying out risk assessments within the organisation. Guidance includes policy, procedures and tools which lay out how to undertake risk assessment and the control measures that can be introduced to manage those risks. This extends to information asset risk assessment and guidance which forms part of the information governance and risk assessment process.

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

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

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

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

8. Risk Profile

Close Down Plan

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

The close down plan was monitored by the Transition Board. The last meeting was held on the 7th March 2013 with a resultant report provided to the last Board meeting in which was noted the following red risk:-

- PALS signposting - assurance that a service will be up and running by 1st April.

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

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

The high risks for the CCG are:-

- potential breach of MRSA ceiling and DH set HCAI C difficile reduction targets
- achievement of QIPP for planned care, urgent care and primary care
- Percentage of staff who have undertaken children's safeguarding training is not of a level to ensure those working predominantly with children are adequately trained.
- PAH Non-compliance with targets around stroke care, A&E, cancer waits, SHMI / HSMR, HCAIs. Regulatory moderate concerns as well as non-compliance of targets and poor performance from external audits specifically Failsafe Maternity audit.
- Unfilled shifts at TEDS, these are critical front line staff which could lead to patient safety risks.
- Trust's financial position and risk of an overspend by year end - March 2013.

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

Information governance ensures necessary safeguards for, and appropriate use of, patient and personal information. We reported 1 serious untoward incident relating to information governance at NHS West Essex

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

Date of incident (month)	Nature of incident	Nature of data involved	Number of people potentially affected	Notification steps
April 2012	Facebook	Comment regarding Patient Name & town	1	SHA, ICO and Patient Notified. Member of staff dismissed

Summary of other personal data related incidents in 2012/13

Category	Nature of incident	Total
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises.	0
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises.	0
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents.	0
IV	Unauthorised disclosure	0
V	Other	1

10. The Risk and Control Framework

The North Essex Cluster's risk and control framework described the structure and accountabilities for risk management and it defined the method used for quantifying, reporting and monitoring risk. It enabled the systematic identification, assessment, treatment and monitoring of risks. It minimised the possibility of recurrence of risks and their associated consequences. Risk management was incorporated into the Cluster's strategic aims and objectives and was embedded in the culture. Risks were entered onto the risk register, an assessed risk rating was provided using a standardised risk assessment matrix and each risk had a risk owner. The Corporate Management Team determined the red risks that were to be highlighted to the Board.

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

10.1 Prevention of risks

Examples of how the PCT prevents risks include:-.

- the Code of Conduct for Managers affirms the responsibilities and accountabilities of the role of Managers

- Through guidance published by the National Quality Board all PCTs were charged with producing a Cluster Legacy Document. The Board approved a suite of handover documents including a general, quality and public health document to capture and safeguard the organisational knowledge and corporate memory for the PCT's successor organisations

- Through contracts which clearly state the responsibilities of contracted personnel with regard to risk limitation, identification and reporting. Managers ensured contractors were aware of local instructions and procedures concerning risk reporting and encourage an open and proactive approach.

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

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

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

10.3 Management of Both Manifest and Potential risks.

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

- risk reports were provided to the CCG Board, Executive Committee (to October 2012) and thereafter to the Corporate Management Team, Board and Cluster Audit Committee and CCG risks were reported to the CCG's Audit Committee.
- a grip was maintained on performance, including quality, safety, delivery of QIPP and financial control while the changes for the new system took place. A Transition Plan provided a road map the on the identified key work streams and deliverables.
- A Transition Committee approved an Information Governance Transition Action Plan which provided a framework to identify key risks and mitigating actions to manage these risks during the transition.
- Good practice gained from risk resolution and incident management was disseminated through team and management briefings. The CCG's clinical quality team analysed incidents and risks in order to identify improvements and best practice using Root Cause Analysis.
- The Clinical Quality Review Group monitored contracts.
- The Assurance Framework helped to ensure that the cluster was focusing on and tackling its strategic responsibilities by identifying the risks associated with the achievement of the PCT's strategic objectives. The CCG developed its own Assurance Framework during the year - on which reports were made to the CCG Board. The controls and assurances were detailed and mitigating actions to tackle risk were listed, along with the risk rating and risk owners and reported using the Board Assurance Framework.
- The principal systems and processes that were in place to ensure that certain key operational and risk activity areas had sufficient clinical perspective and control and the Director of Nursing had significant input to these functions. These included complaints, incident management, risk assessment, serious incident management and independent contractor performance investigations.

Other Risk Management Controls:-

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

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

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

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

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

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

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

11.1. Internal Audit

The Head of Internal Audit Opinion has provided Significant Assurance that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk.

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

The Head of Internal Audit reported that 'it has not been possible to assess how the

control environment has changed year on year, as separate audits of the individual PCTs that make up the North Essex PCT Cluster were undertaken in 2011-12 …However, during 2011-12 the audits of Assurance Framework and Risk Management received limited assurance, whereas this year the PCT Cluster received an Adequate Assurance Opinion. This demonstrates a significant improvement in the risk management processes within the PCT Cluster'.

'During the year good progress has been made in reviewing and following up outstanding audit recommendations and a significant number of recommendations from previous years have now been confirmed as completed. All outstanding recommendations were noted by the cluster Audit Committee which endorsed a formal communication by the Director of Finance and Performance to all the new organisations on which recommendations were relevant for them to be aware of in relation to the delivery of their services.

Good Assurance was given for:-

- Governance, Assurance Framework and Risk Management (including Clinical Commissioning Groups)

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

- Payroll – no priority 1 recommendations were made. Seven priority 2 recommendations were made which related predominantly to the processing of new starters, leavers and changes of circumstances.

- Information Technology Procurement – one priority 1, three priority 2 and one priority 3 recommendations were made. The priority 1 recommendation was that 'the PCT Cluster should restrict the ability of staff to install hardware and software linked to the Network. This should be only carried out by suitably authorised members of ICT'.

12. Handover to New Organisations - Transition Board

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

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

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

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

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

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

Accountable Officer : Andrew Pike
Organisation: West Essex PCT
Signature:
Date:

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

Department of Health

NHS

West Essex Primary Care Trust

2012-13 Accounts

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West Essex Primary Care Trust

2012-13 Accounts

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

We have audited the financial statements of West Essex Primary Care Trust for the year ended 31 March 2013 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 40. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

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

- the table of salaries and allowances of senior managers and related narrative notes in Appendix B of the Annual Report
- the table of pension benefits of senior managers and related narrative notes in Appendix B of the Annual Report; and
- the table of pay multiples and related narrative notes in Appendix B of the Annual Report.

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

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

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

Scope of the audit of the financial statements

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

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

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

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

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

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

Opinion on other matters

In our opinion:

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

Matters on which we report by exception

We report to you if:

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

We have nothing to report in these respects

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

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

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

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

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

Certificate

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

Debbie Hanson
for and on behalf of Ernst & Young LLP
Luton
6 June

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

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

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

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

Andrew Pike
Essex Area Director

4 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;

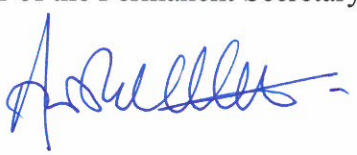
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

- 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.



Andrew Pike
Essex Area Director

4 June 2013

Dawn Scrafield
Director of Finance

4 June 2013

Name of Organisation West Essex PCT

Organisation Code 5PV

Annual Governance Statement

1. Scope of Responsibility

As Accountable Officer and Chief Executive of the NHS North Essex Board[1] from 1 October 2012 I had responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also had responsibility for safeguarding the public funds and the organisation's assets for which I was personally responsible as set out in the Accountable Officer Memorandum. Prior to 1 October 2012, Sheila Bremner was the Accountable Officer and Chief Executive of the NHS North Essex Board and held these responsibilities from 1 April 2012 to 30 September 2012.

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

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

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

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

2. The Governance Framework of the Organisation

Governance Framework Context

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

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

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

The Board approved in March 2012 the dual running of the old and the new governance system to enable all parts of the new system to become established and to test effectiveness

of arrangements that successor/future organisations had put in place. This also gave the performance teams time to test and refine the new reporting regimes. Overall accountability remained with the NHS North Essex Board.

Key components of the transitional governance systems were:-

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

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

3. Board Committee Structure

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

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

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

- A shadow CCG Board which included a NED from the Board. A supporting committee structure included a CCG Quality, Finance and Performance Committee thus negating the need for the Board to continue with a Quality and Delivery committee
- A CCG Performance Committee to provide oversight and scrutiny of the CCG and which held the CCG to account. This was chaired by a NED with NEDs and PCT executive directors as members
- a public health and future NCB performance committee, again chaired by a NED and with NED and PCT Executive Directors as members to provide oversight, scrutiny and to hold the public health and commissioning leads of the future NCB commissioned services to account
- a Commissioning Support Committee which provided oversight of the development of commissioning support and included a NED and PCT Executive Directors as members
- a PCT Executive Committee for all executive matters which were not within the CCG's remit and which only consisted of the PCT executive members
- a PCT Transition Committee with PCT executive and CCG leads

- A combined Remuneration and Terms of Service Committee with a separate agenda for the PCT/CCG locality and with membership attendance from the CCGs. This Committee was chaired by a NED and made up of NEDs
- Cluster Audit Committee which was chaired by a Board NED with separate agenda items for the PCT/CCG locality and with membership attendance from each of the CCGs. During the course of 2012/13 the designated CCG Audit Committee chair attended in preparation for when the CCG Audit Committee was established.

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

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

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

4. Board Performance and Assessment of its Own Effectiveness

The Board's assessment of its performance has been informed by:-

- The Annual Accountability Review letter from the SHA in 2012/2013 on the outcome of the 2011/12 Annual Accountability Review. In addition to confirming the outcome of performance for 2011/12, it confirmed the following as key issues to focus on in 2012/13:-

NHS North Essex	Concern	Improvements required
HCAI (Healthcare Associated Infections)	The PCT Cluster, Colchester Hospital University Foundation Trust (CHUFT) and Princess Alexandra Hospital (PAH) breached their ceilings for C.*difficile* in 2011/12.	Improvements are necessary such that monthly C. *difficile* performance for the commissioner and both providers is below ceiling. This should be sustained for a minimum of three consecutive months to demonstrate real improvements have been embedded.

18 weeks performance	The PCT and all three providers have reported periods of underperformance against both admitted and non-admitted standards in 2011/12, at both aggregated and specialty level.	Performance across the Cluster is to be improved such that all required 18 week metrics are met on a monthly basis. Referral to Treatment performance should be delivered consistently on a specialty level basis from Quarter 2.
A&E	PAH failed to deliver the A&E standard for the full year and recovery of performance has been slow. Mid Essex Hospitals Trust (MEHT) also failed to deliver the standard in Q1 2011/12. Ambulance handover times at MEHT have also been an issue during 2011/12 with long waits regularly reported during the winter period.	Performance at all providers to be above 95% YTD on a consistent basis with evidence of sustainability during periods of peak demand. A reduction in ambulance handover times at MEHT during 2012/13 including during the winter period.

The outcome positions for 2012/13 on the above improvement requirements were:-

- HCAI - the PCT and Princess Alexandra Hospital breached their ceilings for C.difficile.
- 18 weeks performance - the PCT and Princess Alexandra Hospital met the aggregate standards for admitted and non-admitted but did not meet the standards across all specialties.
- A&E - Princess Alexandra Hospital failed to deliver the A&E standard for Quarter 1, 3 and 4. Ambulance handover times remained an issue.

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

5.1. Board Committee reports

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

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

5.2. Audit Committee highlights

The Audit Committee carried out its functions in accordance with its Terms of Reference. It discussed external audit reviews on e.g. demand management and Payment by Results assurance programme, followed up on internal audit recommendations and approved the internal audit programme, reviewed specific policies such as the Hospital and Interest Policy, discussed the Local Counter Fraud Reports, reviewed the assurance frameworks for the cluster and the CCG for the strategic objectives, regularly received the risk register reports, sought assurance in relation to the transition programme and handover arrangements and

received the development of the Schemes of Delegation for the new CCG in readiness for the 1st April 2013.

6. Account of Corporate Governance

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

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

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

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

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

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

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

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

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

- **Public Health Board Lead**
  Dr. Mike Gogarty or Alison Cowie Director of Public Health

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

- **Senior Information Responsible Officer**
  Sarah Jane Relf, Director of Transition and Governance (up to October 2012) with Margaret Hathaway – Director of Commercial Services from October to end March 2013

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

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

- **Security Management Board Lead**
  Adrian Marr – Director of Resources (up to October 2012) and from then on, Dawn Scrafield – Director of Finance, Performance and Operations

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

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

- **Equality and Diversity Champion**
  Qadir Bakhsh – Non-Executive Director (up to end November 2012)

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

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

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

Accounts Process
As part of its review of the PCT's transition governance arrangements, the Audit Committee agreed the financial transition arrangements for the preparation and approval of the 2012/13 accounts and the transfer of outstanding audit recommendations. The plan for the financial accounts was based on the letter setting out roles for financial closedown of PCTs (Gateway ref 18561) and arrangements were assessed as green. The financial services of the Central Eastern Commissioning Support Unit have been utilised to close down the accounts as the majority of PCT financial services staff have transferred into the CSU.

A sub-committee of the Department of Health's Audit Committee has been established to meet on 3 June 2013 to sign off the accounts and discharge the statutory responsibilities of the PCT, checking for any irregularities and ensuring that all reporting is legally compliant.

The PCT operated within the Corporate Governance Manual and there were no known departures from the Corporate Governance Code.

Reports from Internal and External Audit provide the outcomes of the reviews and the Internal Audit Governance report has confirmed that there were no irregularities and that the PCT were legally compliant

7. Risk Assessment

The PCT has a risk assessment framework for carrying out risk assessments within the organisation. Guidance includes policy, procedures and tools which lay out how to undertake risk assessment and the control measures that can be introduced to manage those risks. This extends to information asset risk assessment and guidance which forms part of the information governance and risk assessment process.

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

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

A Corporate Risk Register was in place to help ensure that risks to the achievement of organisational objectives were identified and to allow for the identification of any gaps or

weaknesses in the system of internal control. The risks were rated and had an assigned owner responsible for the management of that risk.

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

8. Risk Profile

Close Down Plan

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

The close down plan was monitored by the Transition Board. The last meeting was held on the 7th March 2013 with a resultant report provided to the last Board meeting in which was noted the following red risk:-

- PALS signposting - assurance that a service will be up and running by 1st April.

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

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

The high risks for the CCG are:-

- potential breach of MRSA ceiling and DH set HCAI C difficile reduction targets
- achievement of QIPP for planned care, urgent care and primary care
- Percentage of staff who have undertaken children's safeguarding training is not of a level to ensure those working predominantly with children are adequately trained.
- PAH Non-compliance with targets around stroke care, A&E, cancer waits, SHMI / HSMR, HCAIs. Regulatory moderate concerns as well as non-compliance of targets and poor performance from external audits specifically Failsafe Maternity audit.
- Unfilled shifts at TEDS, these are critical front line staff which could lead to patient safety risks.
- Trust's financial position and risk of an overspend by year end - March 2013.

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

Information governance ensures necessary safeguards for, and appropriate use of, patient and personal information. We reported 1 serious untoward incident relating to information governance at NHS West Essex

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

Date of incident (month)	Nature of incident	Nature of data involved	Number of people potentially affected	Notification steps
April 2012	Facebook	Comment regarding Patient Name & town	1	SHA, ICO and Patient Notified. Member of staff dismissed

Summary of other personal data related incidents in 2012/13

Category	Nature of incident	Total
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises.	0
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises.	0
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents.	0
IV	Unauthorised disclosure	0
V	Other	1

10. The Risk and Control Framework

The North Essex Cluster's risk and control framework described the structure and accountabilities for risk management and it defined the method used for quantifying, reporting and monitoring risk. It enabled the systematic identification, assessment, treatment and monitoring of risks. It minimised the possibility of recurrence of risks and their associated consequences. Risk management was incorporated into the Cluster's strategic aims and objectives and was embedded in the culture. Risks were entered onto the risk register, an assessed risk rating was provided using a standardised risk assessment matrix and each risk had a risk owner. The Corporate Management Team determined the red risks that were to be highlighted to the Board.

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

10.1 Prevention of risks

Examples of how the PCT prevents risks include:-.

- the Code of Conduct for Managers affirms the responsibilities and accountabilities of the role of Managers

- Through guidance published by the National Quality Board all PCTs were charged with producing a Cluster Legacy Document. The Board approved a suite of handover documents including a general, quality and public health document to capture and safeguard the organisational knowledge and corporate memory for the PCT's successor organisations

- Through contracts which clearly state the responsibilities of contracted personnel with regard to risk limitation, identification and reporting. Managers ensured contractors were aware of local instructions and procedures concerning risk reporting and encourage an open and proactive approach.

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

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

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

10.3 Management of Both Manifest and Potential risks.

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

- risk reports were provided to the CCG Board, Executive Committee (to October 2012) and thereafter to the Corporate Management Team, Board and Cluster Audit Committee and CCG risks were reported to the CCG's Audit Committee.
- a grip was maintained on performance, including quality, safety, delivery of QIPP and financial control while the changes for the new system took place. A Transition Plan provided a road map the on the identified key work streams and deliverables.
- A Transition Committee approved an Information Governance Transition Action Plan which provided a framework to identify key risks and mitigating actions to manage these risks during the transition.
- Good practice gained from risk resolution and incident management was disseminated through team and management briefings. The CCG's clinical quality team analysed incidents and risks in order to identify improvements and best practice using Root Cause Analysis.
- The Clinical Quality Review Group monitored contracts.
- The Assurance Framework helped to ensure that the cluster was focusing on and tackling its strategic responsibilities by identifying the risks associated with the achievement of the PCT's strategic objectives. The CCG developed its own Assurance Framework during the year - on which reports were made to the CCG Board. The controls and assurances were detailed and mitigating actions to tackle risk were listed, along with the risk rating and risk owners and reported using the Board Assurance Framework.
- The principal systems and processes that were in place to ensure that certain key operational and risk activity areas had sufficient clinical perspective and control and the Director of Nursing had significant input to these functions. These included complaints, incident management, risk assessment, serious incident management and independent contractor performance investigations.

Other Risk Management Controls:-

- NHS Pension Scheme arrangements: as an employer with staff entitled to membership of the NHS Pension Scheme, control measures were in place to ensure all employer obligations contained within the Scheme regulations are complied with. This included ensuring that deductions from salary, employer's

contributions and payments into the Scheme were in accordance with the Scheme rules, and that member Pension Scheme records were accurately updated in accordance with the timescales detailed in the Regulations.

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

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

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

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

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

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

11.1. Internal Audit

The Head of Internal Audit Opinion has provided Significant Assurance that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk.

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

The Head of Internal Audit reported that 'it has not been possible to assess how the control environment has changed year on year, as separate audits of the individual PCTs that make up the North Essex PCT Cluster were undertaken in 2011-12 ...However, during 2011-12 the audits of Assurance Framework and Risk Management received limited assurance, whereas this year the PCT Cluster received an Adequate Assurance

Opinion. This demonstrates a significant improvement in the risk management processes within the PCT Cluster'.

'During the year good progress has been made in reviewing and following up outstanding audit recommendations and a significant number of recommendations from previous years have now been confirmed as completed. All outstanding recommendations were noted by the cluster Audit Committee which endorsed a formal communication by the Director of Finance and Performance to all the new organisations on which recommendations were relevant for them to be aware of in relation to the delivery of their services.

Good Assurance was given for:-

- Governance, Assurance Framework and Risk Management (including Clinical Commissioning Groups)

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

- Payroll – no priority 1 recommendations were made. Seven priority 2 recommendations were made which related predominantly to the processing of new starters, leavers and changes of circumstances.

- Information Technology Procurement – one priority 1, three priority 2 and one priority 3 recommendations were made. The priority 1 recommendation was that 'the PCT Cluster should restrict the ability of staff to install hardware and software linked to the Network. This should be only carried out by suitably authorised members of ICT'.

-

12. Handover to New Organisations - Transition Board

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

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

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

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

The Audit Committee approved a series of reports, including the financial transition arrangements for the accounts and the transfer of outstanding audit weaknesses and recommendations. The plan for the financial accounts was based on the letter setting out roles for financial closedown of PCTs (Gateway ref 18561) and arrangements were

assessed as green. The financial services teams of the Greater Eastern Commissioning Support Unit have been utilised to close down the accounts as the majority of the staff relating to financial services have transferred from the PCTs into the CSU.

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

Accountable Officer: Andrew Pike

Organisation: West Essex PCT

Signature: 

Date: 4 June 2013

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

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	**16,574**	15,079
Other costs		5.1	**490,930**	478,728
Income	**NOTE 1**	4	**(41,893)**	(46,712)
Net operating costs before interest			**465,611**	447,095
Investment income		9	**0**	0
Other (Gains)/Losses		10	**0**	35
Finance costs		11	**1,256**	1,250
Net operating costs for the financial year			**466,867**	448,380
Of which:				
Administration Costs				
Gross employee benefits		7.1	**11,535**	10,718
Other costs		5.1	**7,702**	6,623
Income		4	**(7,870)**	(8,381)
Net administration costs before interest			**11,367**	**8,960**
Investment income		9	**0**	0
Other (Gains)/Losses		10	**0**	0
Finance costs		11	**0**	16
Net administration costs for the financial year			**11,367**	**8,976**
Programme Expenditure				
Gross employee benefits		7.1	**5,039**	4,361
Other costs		5.1	**483,228**	472,105
Income		4	**(34,023)**	(38,331)
Net programme expenditure before interest			**454,244**	**438,135**
Investment income		9	**0**	0
Other (Gains)/Losses		10	**0**	35
Finance costs		11	**1,256**	1,234
Net programme expenditure for the financial year			**455,500**	**439,404**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**244**	159
Net (gain) on revaluation of property, plant & equipment	**0**	(568)
Net (gain) on revaluation of intangibles	**0**	0
Net (gain) /loss on Assets Held for Sale	**0**	0
Total comprehensive net expenditure for the year*	**467,111**	**447,971**

NOTE 1 Income has reduced due to the transfer of hosted mental health services.

*This is the sum of the rows above plus net operating costs for the financial year
The notes on pages 1 to 43 form part of this account.

Statement of Financial Position at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	12	**55,976**	61,518
Intangible assets	13	**173**	250
investment property	15	**0**	0
Other financial assets	21	**0**	0
Trade and other receivables	19	**1,054**	1,120
Total non-current assets		**57,203**	62,888
Current assets:			
Inventories	18	**0**	0
Trade and other receivables	19	**6,465**	7,430
Other financial assets	36	**0**	0
Other current assets	22	**0**	0
Cash and cash equivalents	23	**1,970**	7
Total current assets		**8,435**	7,437
Non-current assets held for sale	24	**0**	0
Total current assets		**8,435**	7,437
Total assets		**65,638**	70,325
Current liabilities			
Trade and other payables	25	**(27,053)**	(27,476)
Other liabilities	26,28	**0**	0
Provisions	32	**(1,398)**	(1,162)
Borrowings	27	**(881)**	(1,003)
Other financial liabilities	36.2	**0**	0
Total current liabilities		**(29,332)**	(29,641)
Non-current assets plus/less net current assets/liabilities		**36,306**	40,684
Non-current liabilities			
Trade and other payables	25	**0**	0
Other Liabilities	28	**0**	0
Provisions	32	**(176)**	(1,578)
Borrowings	27	**(17,048)**	(17,258)
Other financial liabilities	36.2	**0**	0
Total non-current liabilities		**(17,224)**	(18,836)
Total Assets Employed:		**19,082**	21,848
Financed by taxpayers' equity:			
General fund		**10,649**	12,356
Revaluation reserve		**8,433**	9,492
Other reserves		**0**	0
Total taxpayers' equity:		**19,082**	21,848

Notes 1 to 40 form part of this account.

The financial statements on pages 1 to 4 were approved by the Department of Health audit sub committee on 3 June 2013 and signed on its behalf by

Andrew Pike
Essex Area Director
4th June 2013

Statement of Changes In Taxpayers Equity for the year ended 31 March 2013

	General fund	Revaluation reserve	Other reserves	Total reserves
	£000	£000	£000	£000
Balance at 1 April 2012	**12,356**	**9,492**	**0**	**21,848**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(466,867)	0	0	**(466,867)**
Net gain on revaluation of property, plant, equipment	0	0	0	**0**
Net gain on revaluation of intangible assets	0	0	0	**0**
Impairments and reversals	0	(244)	0	**(244)**
Movements in other reserves	0		0	**0**
Transfers between reserves*	815	(815)	0	**0**
Release of Reserves to Statement of Comprehensive Net Expenditure	0	0	0	**0**
Reclassification Adjustments	0	0	0	**0**
Total recognised income and expense for 2012-13	**(466,052)**	**(1,059)**	**0**	**(467,111)**
Net Parliamentary funding	464,345	0	0	**464,345**
Balance at 31 March 2013	**10,649**	**8,433**	**0**	**19,082**
Balance at 1 April 2011	**8434**	**9141**	**0**	**17,575**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(448,380)	0	0	**(448,380)**
Net Gain / (loss) on Revaluation of Property, Plant and Equipment	0	568	0	**568**
Net Gain / (loss) on Revaluation of Intangible Assets	0	0	0	**0**
Impairments and Reversals	0	(159)	0	**(159)**
Movements in other reserves	0	0	0	**0**
Transfers between reserves*	58	(58)	0	**0**
Release of Reserves to Statement of Comprehensive Net Expenditure	0	0	0	**0**
Reclassification Adjustments	0	0		**0**
Total recognised income and expense for 2011-12	(448,322)	351	0	**(447,971)**
Net Parliamentary funding	452,244	0	0	**452,244**
Balance at 31 March 2012	**12,356**	**9,492**	**0**	**21,848**

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		**(465,611)**	(447,095)
Depreciation and Amortisation		**1,870**	1,720
Impairments and Reversals		**2,599**	(288)
Interest Paid		**(1,248)**	(1,234)
Release of PFI/deferred credit		**0**	0
Decrease in Inventories		**0**	379
Decrease in Trade and Other Receivables		**1,031**	3,750
(Increase)/Decrease in Other Current Assets		**0**	0
Decrease in Trade and Other Payables		**187**	(3,674)
(Increase)/Decrease in Other Current Liabilities		**0**	0
Provisions Utilised		**(1,227)**	(148)
Decrease in Provisions		**53**	2,015
Net cash outflow from operating activities		**(462,346)**	(444,575)
Cash flows from investing activities			
Interest Received		**0**	0
Payments for Property, Plant and Equipment		**(2,089)**	(5,356)
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)		**2,385**	148
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 from Investing Activities		**296**	(5,208)
Net cash outflow before financing		**(462,050)**	(449,783)
Cash flows from financing activities			
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI		**(332)**	(575)
Net Parliamentary Funding		**464,345**	452,244
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		**464,013**	451,669
Net increase/(decrease) in cash and cash equivalents		**1,963**	1,886
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**7**	(1,879)
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		**1,970**	7

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

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

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

1.1 Accounting Conventions

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

Transforming Community Services (TCS) transactions

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

Acquisitions and Discontinued Operations

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

Critical accounting judgements and key sources of estimation uncertainty

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

Critical judgements in applying accounting policies

The PCT has applied accounting policies in accordance with the Department of Health Manual for Accounts without deviation

Key sources of estimation uncertainty

Continuing healthcare claims provision - During 2012/13 a significant number of claims were received for retrospective Continuing Healthcare services from members of the public and agents acting on their behalf. The volume of claims is such that it will take a considerable period of time to complete the processing of these claims, reflecting the work involved to retrospectively assess each claims eligibility. In order to complete the accounts a thorough process has been undertaken to draw together the information that was available for each of the claims and make provision where there is sufficient information. The number of such claims received in West Essex was 289.

The provision in the accounts of £1.262m covers these 289 retrospective claims as well as 20 cases raised in the previous Year. A provision has been made based on claims where there is sufficient information available to enable a reasonable estimate of the PCTs obligation. The value of this provision has been calculated on the basis of the success rate of previous claims multiplied by the historic cost of previous claims. The key sources of estimation uncertainty within the calculated provision are therefore the historic success rate applied to each claim and the average cost per claim. No adjustment has been made to reflect the percentage of Days claimed that have been paid for settled claims

1. Accounting policies (continued)

There are a number of individual claims where there is insufficient information available to enable the PCT to make a reasonable estimate of its likely liability and this brings about some uncertainty in the provision estimate. Until all the claims have been formally assessed and concluded on it is not possible to be certain that individual claims are not eligible. If those claims that have currently been assessed and classified as unlikely to succeed and therefore not provided for were to be successful, the value of the additional liability could be up to £5.9m, Based on the assessment undertaken by the PCT this is unlikely. This estimation uncertainty is based on historic success rate and average historic cost per claim. There are 266 claims that have not been provided for as adequate information has not been received to support the claim. These cannot be valued but it should be recognised that should any further information become available for these cases, this may result in a future liability that has not been provided for within the accounts.

1.2 Revenue and Funding

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

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

1.3 Taxation

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

1.4 Administration and Programme Costs

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

The broad definition of running costs includes any cost incurred that is not a direct payment for the provision of healthcare or healthcare related services.
Expense incurred under NHS transition redundancy programmes is however classed as "programme" under Treasury

1. Accounting policies (continued)

1.5 Property, Plant & Equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation

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

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

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

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

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

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

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

Subsequent expenditure

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

1. Accounting policies (continued)

1.6 Intangible Assets

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.

1.7 Depreciation, amortisation and impairments

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

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

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

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

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

1. Accounting policies (continued)

1.8 Donated assets

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.

This accounting policy change has been applied retrospectively and consequently the 2010-11 results have been restated.

1.9 Government grants

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

This accounting policy change has been applied retrospectively and consequently the 2010-11 results have been restated.

1.10 Non-current assets held for sale

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

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

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

1.11 Inventories

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

1.12 Cash and cash equivalents

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

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

1.13 Losses and Special Payments

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

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

1.14 Clinical Negligence Costs

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

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

1. Accounting policies (continued)

1.15 Employee benefits

Short-term employee benefits

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

Retirement benefit costs

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

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

1.16 Research and Development

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

1.17 Other expenses

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

1.18 Grant making

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

1. Accounting policies (continued)

1.19 Contingencies

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

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

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

1.20 Leases

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

The PCT as lessee

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

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

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

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

The PCT as lessor

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

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

1.21 Foreign exchange

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

1. Accounting policies (continued)

1.22 Provisions

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

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

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

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

1.23 Financial Instruments

Financial assets

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

Financial assets are initially recognised at fair value.

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

Financial assets at fair value through profit and loss

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

Loans and receivables

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

1. Accounting policies (continued)

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.

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

1.24 Private Finance Initiative (PFI) and NHS LIFT transactions

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.

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.

2 Operating segments

West Essex PCT reports its financial position to the Board based on the operational segments shown below. The assets and liabilities of the PCT are not segmented and are reported to the Board as a whole.

Operational Segment Expenditure	2012-13 £000	2011-12 £000
Princess Alexandra Hospital	**112,218**	113,343
Addenbrookes	**24,389**	22,633
Whipps Cross	**17,100**	16,081
Mid Essex	**11,069**	11,725
Barts	**7,647**	7,452
Barking & Havering	**4,234**	4,305
Colchester University Hospital	**307**	678
Other Acute NHS Contracts	**9,625**	8,835
Ramsay Healthcare	**5,746**	3,719
Other Acute Non NHS Contracts	**4,917**	2,910
Non Contracted Activity	**3,441**	3,191
Ambulance & Other Patient Transport	**9,845**	9,357
Mental Health (Including IAPT)	**34,755**	35,245
Learning Disabilities	**6,231**	3,732
Community Services Provider Contracts	**40,341**	36,998
Continuing/Funded Nursing Care	**13,069**	13,018
Other Commissioning	**1,602**	1,720
Out of Hours Contracts	**2,162**	2,007
GP Prescribing	**39,665**	41,862
Non Tariff High Cost Drugs	**539**	1,494
Other Prescribing	**394**	560
GP Commissioning Management Costs	**854**	442
Specialist Commissioning	**45,820**	39,391
GP Contracts	**34,379**	33,342
Dental Services	**8,660**	9,092
Ophthalmic Services	**2,232**	2,267
Pharmacy Services	**7,486**	7,730
Other Primary Care	**637**	576
Reablement/Joint Working	**3,838**	4,497
Hosted Services	**394**	270
Corporate Management	**11,736**	8,507
Corporate Overheads	**1,535**	1,401
Total	**466,868**	**448,380**
Total Assets	**19,082**	**19,989**

There was a general increase in the cost of services provided, a general growth in demand due to demographics and additional services commissioned by the PCT

3. Financial Performance Targets

3.1 Revenue Resource Limit

The PCTs' performance for the year ended 2012-13 is as follows:	2012-13 £000	2011-12 £000
Total Net Operating Cost for the Financial Year	**(466,867)**	(448,380)
Adjusted for prior period adjustments in respect of errors	**0**	0
Revenue Resource Limit	**468,020**	449,000
Underspend Against Revenue Resource Limit (RRL)	**1,153**	620

3.2 Capital Resource Limit

The PCT is required to keep within its Capital Resource Limit.	2012-13 £000	2011-12 £000
Capital Resource Limit	**262**	5,614
Charge to Capital Resource Limit	**906**	(5,102)
(Over)/Underspend Against CRL	**1,168**	512

3.3 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**(464,345)**	(452,244)
Cash Limit	**464,345**	452,244
Under/(Over)spend Against Cash Limit	**0**	0

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

	2012-13 £000
Total cash received from DH (Gross)	**415,179**
Less: Trade Income from DH	**0**
Less/(Plus): movement in DH working balances	**0**
Sub total: net advances	**415,179**
(Less)/plus: transfers (to)/from other resource account bodies (free text note required)	**0**
Plus: cost of Dentistry Schemes (central charge to cash limits)	**8,590**
Plus: drugs reimbursement (central charge to cash limits)	**40,576**
Parliamentary funding credited to General Fund	**464,345**

4 Miscellaneous Revenue

		2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
		£000	£000	£000	£000
Fees and Charges		**229**	98	131	393
Dental Charge income from Contractor-Led GDS & PDS		**3,204**	0	3,204	3,161
Dental Charge income from Trust-Led GDS & PDS		**0**	0	0	0
Prescription Charge income		**2,485**	0	2,485	2,439
Strategic Health Authorities		**574**	52	522	335
NHS Trusts		**970**	499	471	1,249
NHS Foundation Trusts		**6,837**	1,028	5,809	6,482
Primary Care Trusts Contributions to DATs		**0**	0	0	0
Primary Care Trusts - Other	**Note 1**	**5,650**	5,397	253	3,139
Primary Care Trusts - Lead Commissioning	**Note 2**	**20,409**	0	20,409	28,333
English RAB Special Health Authorities		**0**	0	0	0
NDPBs and Others (CGA)		**33**	33	0	14
Department of Health - SMPTB		**0**	0	0	0
Department of Health - Other		**52**	52	0	37
Recoveries in respect of employee benefits		**0**	0	0	0
Local Authorities		**344**	51	293	104
Patient Transport Services		**0**	0	0	0
Education, Training and Research		**0**	0	0	0
Non-NHS: Private Patients		**0**	0	0	0
Non-NHS: Overseas Patients (Non-Reciprocal)		**0**	0	0	0
NHS Injury Costs Recovery		**0**	0	0	0
Other Non-NHS Patient Care Services		**0**	0	0	0
Charitable and Other Contributions to Expenditure		**0**	0	0	0
Receipt of donated assets		**0**	0	0	0
Receipt of Government granted assets		**0**	0	0	0
Rental revenue from finance leases		**0**	0	0	0
Rental revenue from operating leases		**0**	0	0	0
Other revenue		**1,106**	660	446	1,026
Total miscellaneous revenue		**41,893**	**7,870**	**34,023**	46,712

Note 1 Income from Primary Care Trusts increased due to an increase in the number of PCTs purchasing services from IM&T Services which are hosted by West Essex PCT

Note 2 Lead commissioning income dropped due to the transfer of Mental Health hosted services to South East Essex PCT

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	Note 1	71,294	0	71,294	65,061
Non-Healthcare		839	839	0	865
Total		72,133	839	71,294	65,926
Goods and Services from Other NHS Bodies other than FTs					
Goods and services from NHS Trusts		171,716	72	171,644	170,037
Goods and services (other, excl Trusts, FT and PCT))		8	8	0	282
Total		171,724	80	171,644	170,319
Goods and Services from Foundation Trusts		92,920	1,417	91,503	94,909
Purchase of Healthcare from Non-NHS bodies		29,128	0	29,128	27,062
Social Care from Independent Providers		0	0	0	0
Expenditure on Drugs Action Teams		6,355	0	6,355	5,976
Non-GMS Services from GPs		0	0	0	0
Contractor Led GDS & PDS (excluding employee benefits)		12,391	0	12,391	12,446
Salaried Trust-Led PDS & PCT DS (excluding employee benefits)		0	0	0	0
Chair, Non-executive Directors & PEC remuneration		53	53	0	63
Executive committee members costs		803	803	0	432
Consultancy Services		35	35	0	170
Prescribing Costs		38,065	0	38,065	40,509
G/PMS, APMS and PCTMS (excluding employee benefits)		35,976	0	35,976	34,745
Pharmaceutical Services		1,765	0	1,765	1,569
Local Pharmaceutical Services Pilots		0	0	0	0
New Pharmacy Contract		9,141	0	9,141	9,687
General Ophthalmic Services		2,232	0	2,232	2,267
Supplies and Services - Clinical		340	0	340	385
Supplies and Services - General		21	21	0	9
Establishment		432	421	11	260
Transport		252	241	11	222
Premises		4,293	1,731	2,562	3,677
Impairments & Reversals of Property, plant and equipment		2,594	0	2,594	(288)
Impairments and Reversals of non-current assets held for sale		0	0	0	0
Depreciation		1,792	458	1,334	1,720
Amortisation		78	78	0	0
Impairment & Reversals Intangible non-current assets		5	0	5	0
Impairment and Reversals of Financial Assets		0	0	0	0
Impairment of Receivables		75	0	75	0
Inventory write offs		0	0	0	0
Research and Development Expenditure		0	0	0	0
Audit Fees		105	105	0	197
Other Auditors Remuneration		0	0	0	0
Clinical Negligence Costs		90	0	90	109
Education and Training		120	120	0	47
Grants for capital purposes	Note 2	2,517	0	2,517	0
Grants for revenue purposes		3,828	0	3,828	4,392
Impairments and reversals for investment properties		0	0	0	0
Other		1,667	1,300	367	1,918
Total Operating costs charged to Statement of Comprehensive Net Expenditure		490,930	7,702	483,228	478,728
Employee Benefits (excluding capitalised costs)					
Employee Benefits associated with PCTMS		0	0	0	148
PCT Officer Board Members		395	395	0	590
Other Employee Benefits	Note 3	16,179	11,141	5,038	14,341
Total Employee Benefits charged to SOCNE		16,574	11,536	5,038	15,079
Total Operating Costs		507,504	19,238	488,266	493,807
Analysis of grants reported in total operating costs					
For capital purposes					
Grants to fund Capital Projects - GMS		0	0	0	0
Grants to Local Authorities to Fund Capital Projects		0	0	0	0
Grants to Private Sector to Fund Capital Projects		2,517	0	2,517	0
Grants to Fund Capital Projects - Dental		0	0	0	0
Grants to Fund Capital Projects - Other		0	0	0	0
Total Capital Grants		2,517	0	2,517	0
Grants to fund revenue expenditure					
To Local Authorities		3,828	0	3,828	4,392
To Private Sector		0	0	0	0
To Other		0	0	0	0
Total Revenue Grants		3,828	0	3,828	4,392
Total Grants		6,345	0	6,345	4,392

		Total	Commissioning Services	Public Health
PCT Running Costs 2012-13				
Running costs (£000s)		11,368	11,367	1
Weighted population (number in units)*		254,027	254,027	254,027
Running costs per head of population (£ per head)	Note 4	45	45	0
PCT Running Costs 2011-12				
Running costs (£000s)		8,976	8,486	490
Weighted population (number in units)		254,027	254,027	254,027
Running costs per head of population (£ per head)		35	33	2

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

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

Note 1 Increase in PCT spend is due to transfer of Mental Health Services to specialist commissioning which is hosted by South East Essex PCT.
Note 2 Grants for Capital purposes relates to £2.34m grants for transfer of Learning Disability properties to registeresd social landlords and £169k for improvements to primary care properties.
Note 3 Increase in other employee benefits due to clustering of PCT's, transition and increase in hosted IM&T services
Note 4 Increase in running costs due to clustering of PCT's and transition.

5.2 Analysis of operating expenditure by expenditure classification	2012-13 £000	2011-12 £000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	**35,976**	34,745
Prescribing costs	**38,065**	40,509
Contractor led GDS & PDS	**12,391**	12,446
Trust led GDS & PDS	**0**	0
General Ophthalmic Services	**2,232**	2,267
Department of Health Initiative Funding	**0**	0
Pharmaceutical services	**1,765**	1,569
Local Pharmaceutical Services Pilots	**0**	0
New Pharmacy Contract	**9,141**	9,687
Non-GMS Services from GPs	**0**	0
Other	**0**	0
Total Primary Healthcare purchased	**99,570**	101,223
Purchase of Secondary Healthcare		
Learning Difficulties	**3,846**	3,732
Mental Illness	**40,764**	40,066
Maternity	**14,345**	13,018
General and Acute	**229,548**	224,723
Accident and emergency	**8,814**	8,453
Community Health Services	**42,431**	38,451
Other Contractual	**4,404**	3,332
Total Secondary Healthcare Purchased	**344,152**	331,775
Grant Funding		
Grants for capital purposes	**2,517**	0
Grants for revenue purposes	**3,828**	4,392
Total Healthcare Purchased by PCT	**450,067**	437,390
PCT self-provided secondary healthcare included above	**0**	0
Social Care from Independent Providers	**0**	0
Healthcare from NHS FTs included above	**91,495**	93,683

6. Operating Leases

6.1 PCT as lessee

	Land £000	Buildings £000	Other £000	2012-13 Total £000	2011-12 £000
Payments recognised as an expense					
Minimum lease payments	0	771	0	771	975
Contingent rents	0	0	0	0	0
Sub-lease payments	0	0	0	0	0
Total	0	771	0	771	975
Payable:					
No later than one year	0	753	0	753	753
Between one and five years	0	2,717	0	2,717	2,827
After five years	0	5,247	0	5,247	5,689
Total	0	8,717	0	8,717	9,269

Total future sublease payments expected to be received	0	0

The PCT has 16 operating leases in place as at the 1st April 2013 with an annual contract value ranging from £2.5k to £247k. The expiry dates of these leases range from April 2013 to November 2063. None of these leases have terms in place that warrants the calculation of a contingent rent. There are no rights to purchase these properties on any of the leases although most leases contain the right to an extension under the Landlord and Tenant Act 1954. There are no significant restrictions imposed by any of the lease arrangements which would compromise the PCT in carrying out its day to day operational responsibilities.

6.2 PCT as lessor

The PCT does not act as lessor for any operating leases.

7. Employee benefits and staff numbers

7.1 Employee benefits

	2012-13								
				Permanently employed			Other		
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Employee Benefits - Gross Expenditure									
Salaries and wages	13,940	9,760	4,180	7,034	6,092	942	6,906	3,668	3,238
Social security costs	961	774	187	961	774	187	0	0	0
Employer Contributions to NHS BSA - Pensions Division	764	615	149	764	615	149	0	0	0
Other pension costs	480	386	94	480	386	94	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	429	0	429	429	0	429	0	0	0
Total employee benefits	16,574	11,535	5,039	9,668	7,867	1,801	6,906	3,668	3,238
Less recoveries in respect of employee benefits (table below)	0	0	0	0	0	0	0	0	0
Total - Net Employee Benefits including capitalised costs	16,574	11,535	5,039	9,668	7,867	1,801	6,906	3,668	3,238
Employee costs capitalised	0	0	0	0	0	0	0	0	0
Gross Employee Benefits excluding capitalised costs	16,574	11,535	5,039	9,668	7,867	1,801	6,906	3,668	3,238
Recognised as:									
Commissioning employee benefits	16,574			9,668			6,906		
Provider employee benefits	0			0			0		
Gross Employee Benefits excluding capitalised costs	16,574			9,668			6,906		

	Total £000	Permanently employed £000	Other £000
Net expenditure - 2011-12			
Salaries and wages	12624	8830	3794
Social security costs	778	544	234
Employer contributions to NHS Pensions scheme	1108	775	333
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	569	569	0
Total employee benefits	15079	10718	4361
Employee costs capitalised	0		
Net Employee Benefits excluding capitalised costs	15079		

7.2 Staff Numbers

	2012-13			2011-12		
	Total Number	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number
Average Staff Numbers						
Medical and dental	3	3	0	3	3	0
Ambulance staff	0	0	0	0	0	0
Administration and estates	220	158	62	193	171	22
Healthcare assistants and other support staff	3	3	0	0	0	0
Nursing, midwifery and health visiting staff	93	12	81	6	3	3
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	7	7	0	3	3	0
Social Care Staff	0	0	0	0	0	0
Other	0	0	0	0	0	0
TOTAL	326	183	143	205	180	25
Of the above - staff engaged on capital projects	0	0	0	0	0	0

7.3 Staff Sickness absence and ill health retirements

	2012-13 Number	2011-12 Number
Total Days Lost	3,671	8,875
Total Staff Years	458	970
Average working Days Lost	8.02	9.15

There were no retirements on ill health grounds (2011/12 nil). Figures given for staff sickness are calendar Year.

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	**3**	**0**	**3**	5	3	8
£10,001-£25,000	**3**	**0**	**3**	2	3	5
£25,001-£50,000	**5**	**1**	**6**	1	3	4
£50,001-£100,000	**6**	**1**	**7**	1	2	3
£100,001 - £150,000	**1**	**0**	**1**	1	0	1
£150,001 - £200,000	**2**	**0**	**2**	0	0	0
>£200,000	**0**	**0**	**0**	0	0	0
Total number of exit packages by type (total cost	**20**	**2**	**22**	10	11	21
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Total resource cost	**1,229**	**108**	**1,337**	202	281	483

This note provides an analysis of Exit Packages agreed during the year.

Redundancy and other departure costs have been paid in accordance with the provisions under the terms & conditions of Agenda for Change. Where the PCT has agreed early retirements, the additional costs are met by the PCT and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

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

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

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

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

7.5 Pension costs

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

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2011, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data.

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

c) Scheme provisions

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

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

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

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

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

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

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

8. Better Payment Practice Code

8.1 Measure of compliance

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**13,341**	**61,519**	12,638	59,860
Total Non-NHS Trade Invoices Paid Within Target	**11,296**	**51,842**	10,270	50,121
Percentage of NHS Trade Invoices Paid Within Target	**84.67%**	**84.27%**	81.26%	83.73%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3,693**	**346,488**	3,454	330,860
Total NHS Trade Invoices Paid Within Target	**2,245**	**331,775**	1,736	310,777
Percentage of NHS Trade Invoices Paid Within Target	**60.79%**	**95.75%**	50.26%	93.93%

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

In 2012/13 no interest payments were made in respect of the late payment of commercial debts under the above act (2011/12 nil)

9. Investment Income

The PCT has no investment income

10. Other Gains and Losses

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Gain/(Loss) on disposal of assets other than by sale (PPE)	0	0	0	(35)
Gain/(Loss) on disposal of assets other than by sale (intangibles)	0	0	0	0
Gain/(Loss) on disposal of Financial Assets - other than held for sale	0	0	0	0
Gain (Loss) on disposal of assets held for sale	0	0	0	0
Gain/(loss) on foreign exchange	0	0	0	0
Change in fair value of financial assets carried at fair value through the SoCNE	0	0	0	0
Change in fair value of financial liabilities carried at fair value through the SoCNE	0	0	0	0
Change in fair value of investment property	0	0	0	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	0	0	0	0
Total	0	0	0	(35)

11. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest				
Interest on obligations under finance leases	492	0	492	479
Interest on obligations under PFI contracts:				
- main finance cost	672	0	672	688
- contingent finance cost	84	0	84	67
Interest on obligations under LIFT contracts:				
- main finance cost	0	0	0	0
- contingent finance cost	0	0	0	0
Interest on late payment of commercial debt	0	0	0	0
Other interest expense	0	0	0	0
Total interest expense	1,248	0	1,248	1,234
Other finance costs	0	0	0	0
Provisions - unwinding of discount	8	0	8	16
Total	1,256	0	1,256	1,250

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	9,805	43,174	1,102	7,204	46	0	3,506	105	64,942
Additions of Assets Under Construction	0	0	0	774	0	0	0	0	774
Additions Purchased	0	418	0	0	0	0	258	23	699
Additions Donated	0	0	0	0	0	0	0	0	0
Additions Government Granted	0	0	0	0	0	0	0	0	0
Additions Leased	0	0	0	0	0	0	0	0	0
Reclassifications	0	5,319	0	(7,859)	0	0	2,540	0	0
Reclassifications as Held for Sale	0	0	0	0	0	0	0	0	0
Disposals other than for sale	(835)	(836)	(714)	0	0	0	0	0	(2,385)
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	0
Impairments/negative indexation	0	(244)	0	0	0	0	0	0	(244)
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	0
At 31 March 2013	8,970	47,831	388	119	46	0	6,304	128	63,786
Depreciation									
At 1 April 2012	(439)	1,327	52	0	21	0	2,386	77	3,424
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassifications as Held for Sale	0	0	0	0	0	0	0	0	0
Disposals other than for sale	0	0	0	0	0	0	0	0	0
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	0
Impairments	15	346	0	0	0	0	2,219	14	2,594
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Charged During the Year	0	1,301	12	0	7	0	457	15	1,792
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	0
At 31 March 2013	(424)	2,974	64	0	28	0	5,062	106	7,810
Net Book Value at 31 March 2013	9,394	44,857	324	119	18	0	1,242	22	55,976
Purchased	9,394	44,857	324	119	18	0	1,242	22	55,976
Donated	0	0	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	9,394	44,857	324	119	18	0	1,242	22	55,976
Asset financing:									
Owned	9,394	26,563	324	119	18	0	1,242	22	37,682
Held on finance lease	0	4,450	0	0	0	0	0	0	4,450
On-SOFP PFI contracts	0	13,844	0	0	0	0	0	0	13,844
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	9,394	44,857	324	119	18	0	1,242	22	55,976

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	1,070	8,103	308	0	0	0	0	11	9,492
Movements (specify)	(91)	(842)	(126)	0	0	0	0	0	(1,059)
At 31 March 2013	979	7,261	182	0	0	0	0	11	8,433

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	9,704	42,546	1,077	2,630	271	0	3,390	403	60,021
Additions - purchased	0	80	0	4,839	0	0	116	0	5,035
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	265	0	(265)	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	(225)	0	0	(298)	(523)
Revaluation & indexation gains	101	442	25	0	0	0	0	0	568
Impairments	0	(159)	0	0	0	0	0	0	(159)
Reversals of impairments	0	0	0	0	0	0	0	0	0
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	0
Cumulative dep netted off cost following revaluatic	0	0	0	0	0	0	0	0	0
At 31 March 2012	9,805	43,174	1,102	7,204	46	0	3,506	105	64,942
Depreciation									
At 1 April 2011	(290)	244	26	0	235	0	1,944	356	2,515
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassifications as Held for Sale	0	0	0	0	0	0	0	0	0
Disposals other than for sale	0	0	0	0	(225)	0	0	(298)	(523)
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	0
Impairments	0	5	0	0	2	0	0	4	11
Reversal of Impairments	(149)	(148)	(2)	0	0	0	0	0	(299)
Charged During the Year	0	1,226	28	0	9	0	442	15	1,720
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	0
Cumulative dep netted off cost following revaluatic	0	0	0	0	0	0	0	0	0
At 31 March 2012	(439)	1,327	52	0	21	0	2,386	77	3,424
Net Book Value at 31 March 2012	10,244	41,847	1,050	7,204	25	0	1,120	28	61,518
Purchased	10,244	41,847	1,050	7,204	25	0	1,120	28	61,518
Donated	0	0	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0	0	0
At 31 March 2012	10,244	41,847	1,050	7,204	25	0	1,120	28	61,518
Asset financing:									
Owned	10,244	23,158	1,050	7,204	25	0	1,120	28	42,829
Held on finance lease	0	4,627	0	0	0	0	0	0	4,627
On-SOFP PFI contracts	0	14,062	0	0	0	0	0	0	14,062
PFI residual: interests	0	0	0	0	0	0	0	0	0
At 31 March 2012	10,244	41,847	1,050	7,204	25	0	1,120	28	61,518

12.3 Property, plant and equipment

A revaluation of Land and buildings was undertaken using Building and Construction industry current indeces. The impact of this revaluation was a charge of £586k, of this amount £244k was charged to revaluation reserve and £346k was charge to SoCNE.

For each class of asset the following life years apply:

	Minimum Years	Maximum Years
Buildings	2	64
Dwellings	23	62
Plant & Machinery	0	8
Information Technology	1	4
Furniture and Fittings	1	8

Within the total Land value of the PCT's assets (£9,394k), the following values are land relating to Dwellings:

River Lea House at St Margaret's Hospital	£25,248
Hawthorn Lodge at St Margaret's Hospital	£104,288
	£129,536

13.1 Intangible non-current assets

2012-13	Software internally generated £000	Software purchased £000	Licences & trademarks £000	Patents £000	Development expenditure £000	Total £000
At 1 April 2012	0	250	0	0	0	250
Additions - purchased	0	6	0	0	0	6
Additions - internally generated	0	0	0	0	0	0
Additions - donated	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0
Additions Leased	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Revaluation & indexation gains	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
In-year transfers to/from NHS bodies	0	0	0	0	0	0
At 31 March 2013	0	256	0	0	0	256
Amortisation						
At 1 April 2012	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Revaluation or indexation gains	0	0	0	0	0	0
Impairments charged to operating expenses	0	5	0	0	0	5
Reversal of impairments charged to operating expense:	0	0	0	0	0	0
Charged during the year	0	78	0	0	0	78
In-year transfers to NHS bodies	0	0	0	0	0	0
At 31 March 2013	0	83	0	0	0	83
Net Book Value at 31 March 2013	0	173	0	0	0	173
Net Book Value at 31 March 2013 comprises						
Purchased	0	173	0	0	0	173
Donated	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0
Total at 31 March 2013	0	173	0	0	0	173

Revaluation reserve balance for intangible non-current assets

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

13.2 Intangible non-current assets

2011-12	Software internally generated £000	Software purchased £000	Licences & trademarks £000	Patents £000	Development expenditure £000	Total £000
At 1 April 2011	**0**	**0**	**0**	**0**	**0**	**0**
Additions - purchased	0	250	0	0	0	**250**
Additions - internally generated	0	0	0	0	0	**0**
Additions - donated	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation & indexation gains	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	**0**
In-year transfers to/from NHS bodies	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluation	0	0	0	0	0	0
At 31 March 2012	0	250	0	0	0	250
Amortisation						
At 1 April 2011	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Revaluation or indexation gains	0	0	0	0	0	0
Impairments charged to operating expenses	0	0	0	0	0	0
Reversal of impairments charged to operating expenses	0	0	0	0	0	0
Charged during the year	0	0	0	0	0	0
In-year transfers to NHS bodies	0	0	0	0	0	0
Less cumulative dep written down on revaluation	0	0	0	0	0	0
At 31 March 2012	0	0	0	0	0	0
Net Book Value at 31 March 2012	0	250	0	0	0	250
Net Book Value at 31 March 2012 comprises						
Purchased	0	250	0	0	0	250
Donated	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0
Total at 31 March 2012	0	250	0	0	0	250

13.3 Intangible non-current assets

The PCT's accounting policies in respect of intangible non-current assets are set out in notes 1.6

All intangible non-current assets held by the PCT are software licenses, which are capitalised at cost and depreciated over an estimate of the finite lives (three years)

The PCT has one intangible asset, the current net book value of that asset is £173k

13.4 Economic Lives of non-Current Assets

Economic Lives of Non-Current Assets

	Min Life Years	Max Life Years
Intangible Assets		
Software Licences	2	4
Licences and Trademarks	0	0
Patents	0	0
Development Expenditure	0	0
Property, Plant and Equipment		
Buildings exc Dwellings	7	61
Dwellings	18	59
Plant & Machinery	1	8
Transport Equipment	0	0
Information Technology	1	4
Furniture and Fittings	1	10

Open Market Value of Assets at balance sheet date	Land	Buildings excl. dwellings	Dwellings	Total
	£000s	£000s	£000s	£000s
Open Market Value at 31 March 2013	9,394	44,857	324	54,575
Open Market Value at 31 March 2012	10,244	41,847	1,050	53,141

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

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000
Property, Plant and Equipment impairments and reversals taken to SoCNE			
Loss or damage resulting from normal operations	0	0	0
Over-specification of assets	0	0	0
Abandonment of assets in the course of construction	0	0	0
Total charged to Departmental Expenditure Limit	0	0	0
Unforeseen obsolescence	2,233	0	2,233
Loss as a result of catastrophe	0	0	0
Other	0	0	0
Changes in market price	361	0	361
Total charged to Annually Managed Expenditure	2,594	0	2,594
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Loss or damage resulting from normal operations	0	0	0
Over Specification of Assets	0	0	0
Abandonment of assets in the course of construction	0	0	0
Unforeseen obsolescence	0	0	0
Loss as a result of catastrophe	0	0	0
Other	0	0	0
Changes in market price	244	244	0
Total impairments for PPE charged to reserves	244	244	0
Total Impairments of Property, Plant and Equipment	2,838	244	2,594
Intangible assets impairments and reversals charged to SoCNE			
Loss or damage resulting from normal operations	0	0	0
Over-specification of assets	0	0	0
Abandonment of assets in the course of construction	0	0	0
Total charged to Departmental Expenditure Limit	0	0	0
Unforeseen obsolescence	5	0	5
Loss as a result of catastrophe	0	0	0
Other	0	0	0
Changes in market price	0	0	0
Total charged to Annually Managed Expenditure	5	0	5
Intangible Assets impairments and reversals charged to the Revaluation Reserve			
Loss or damage resulting from normal operations	0	0	0
Over-specification of assets	0	0	0
Abandonment of assets in the course of construction	0	0	0
Unforeseen obsolescence	0	0	0
Loss as a result of catastrophe	0	0	0
Other	0	0	0
Changes in market price	0	0	0
Total impairments for Intangible Assets charged to Reserves	0	0	0
Total Impairments of Intangibles	5	0	5

A review of non-current assets was undertaken dring the period and as a result a number of assets were impaired.

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 £000	31 March 2012 £000
Property, plant and equipment	**0**	569
Intangible assets	**0**	0
Total	**0**	569

16.2 Other financial commitments

The PCT has no other financial commitments

17 Intra-Government and other balances

	Current receivables £000s	**Non-current receivables £000s**	**Current payables £000s**	**Non-current payables £000s**
Balances with other Central Government Bodies	1,967	0	1,719	0
Balances with Local Authorities	137	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	2,572	0	8,295	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	1,789	1,054	17,039	0
At 31 March 2013	**6,465**	**1,054**	**27,053**	**0**
prior period:				
Balances with other Central Government Bodies	818	0	5,484	0
Balances with Local Authorities	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	4,864	0	5,926	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	1,748	1,120	16,066	0
At 31 March 2012	**7,430**	**1,120**	**27,476**	**0**

18 Inventories

The PCT has no inventories

19.1 Trade and other receivables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
NHS receivables - revenue	**4,328**	5,503	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**0**	0	**0**	0
Non-NHS receivables - revenue	**758**	686	**1,054**	1,120
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**1,243**	1,072	**0**	0
Provision for the impairment of receivables	**(75)**	0	**0**	0
VAT	**211**	169	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	**0**	0	**0**	0
Interest receivables	**0**	0	**0**	0
Finance lease receivables	**0**	0	**0**	0
Operating lease receivables	**0**	0	**0**	0
Other receivables	**0**	0	**0**	0
Total	**6,465**	7,430	**1,054**	1,120
Total current and non current	**7,519**	8,550		
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

19.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	**2,702**	2,197
By three to six months	**930**	(90)
By more than six months	**1,980**	1,440
Total	**5,612**	3,547

19.3 Provision for impairment of receivables

	2012-13 £000	**2011-12 £000**
Balance at 1 April 2012	**0**	0
Amount written off during the year	**0**	0
Amount recovered during the year	**0**	0
(Increase)/decrease in receivables impaired	**(75)**	0
Balance at 31 March 2013	**(75)**	0

Impairment of receivables relates to items which were raised in prior years and for which settlement is now considered unlikely

20 NHS LIFT investments

The PCT has no LIFT investments (2011/12 nil)

21 Other financial assets

The PCT has no other financial assets

22 Other current assets

The PCT has no other current assets

23 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**7**	15
Net change in year	**1,963**	(8)
Closing balance	**1,970**	7
Made up of		
Cash with Government Banking Service	**1,970**	6
Commercial banks	**0**	1
Cash in hand	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**1,970**	7
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**1,970**	7
Patients' money held by the PCT, not included above	**0**	0

24 Non-current assets held for sale

	Land	Buildings, excl. dwellings	Dwellings	Asset Under Construction and Payments on Account	Plant and Machinery	Transport and Equipment	Information Technology	Furniture and Fittings	Intangible Assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Balance at 1 April 2012	0	0	0	0	0	0	0	0	0	0
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	0	0
Less assets sold in the year	0	0	0	0	0	0	0	0	0	0
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	0
Transfers (to)/from other public sector bodies	0	0	0	0	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2013	0	0	0	0	0	0	0	0	0	0
Liabilities associated with assets held for sale at 31 March 2013	0	0	0	0	0	0	0	0	0	0
Balance at 1 April 2011	60	123	0	0	0	0	0	0	0	183
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	0	0
Less assets sold in the year	(60)	(123)	0	0	0	0	0	0	0	(183)
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2012	0	0	0	0	0	0	0	0	0	0
Liabilities associated with assets held for sale at 31 March 2012	0	0	0	0	0	0	0	0	0	0

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

At 31 March 2012	0
At 31 March 2013	0

25 Trade and other payables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Interest payable	**0**	0	**0**	0
NHS payables - revenue	**9,842**	11,377	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**0**	0	**0**	0
Family Health Services (FHS) payables	**7,439**	8,567	0	0
Non-NHS payables - revenue	**1,038**	1,476	**0**	0
Non-NHS payables - capital	**104**	714	**0**	0
Non_NHS accruals and deferred income	**5,519**	4,861	**0**	0
Social security costs	**2**	16	**0**	0
VAT	**0**	0	**0**	0
Tax	**148**	17	**0**	0
Payments received on account	**0**	0	**0**	0
Other	2,961	448	0	0
Total	**27,053**	27,476	**0**	0
Total payables (current and non-current)	**27,053**	27,476		

26 Other liabilities

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

27 Borrowings

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Bank overdraft - Government Banking Service	**0**	0	**0**	0
Bank overdraft - commercial banks	**0**	0	**0**	0
PFI liabilities:				
Main liability	**397**	519	**12,498**	12,659
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	**484**	484	**4,550**	4,599
Other (describe)	**0**	0	**0**	0
Total	**881**	1,003	**17,048**	17,258
Total other liabilities (current and non-current)	**17,929**	**18,261**		

Borrowings/Loans - Payment of Principal Falling Due in:

	DH £000s	**#N/A £000s**	**Total £000s**
0 - 1 Years	0	882	**882**
1 - 2 Years	0	843	**843**
2 - 5 Years	0	2,588	**2,588**
Over 5 Years	0	13,616	**13,616**
TOTAL	**0**	**17,929**	**17,929**

28 Other financial liabilities

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Embedded Derivatives at Fair Value through SoCNE	**0**	0	**0**	0
Financial liabilities carried at fair value through SoCNE	**0**	0	**0**	0
Amortised Cost	**0**	0	**0**	0
Total	**0**	0	**0**	0
Total other liabilities (current and non-current)	**0**	**0**		

29 Deferred income

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Opening balance at1 April 2012	**97**	213	**0**	0
Deferred income addition	**(97)**	(116)	**0**	0
Transfer of deferred income	**0**	0	**0**	0
Current deferred Income at 31 March 2013	**0**	97	**0**	0
Total other liabilities (current and non-current)	**0**	**97**		

30 Finance lease obligations

The PCT has two finance lease arrangements: Sydenham House and Nazeing Health Centre

The Sydenham House finance lease was entered into in April 2003 for a period of 35 years. The current lease rent is £414k per annum.
The Sydenham House lease does not allow the PCT to assign, underlet or charge part of or the whole of the premises to another party without the Landlords consent which shouldn't be unreasonably withheld. That permission has been granted to the PCT for the ground floor of Sydenham house for which the PCT charges a reasonable rent.
There is one break date which is the 25th anniversary of the rent Commencement Date (April 2028) and the PCT have to give at least six months notice of intention to break the lease on this date.
The use of the premises is limited to the provision of healthcare and/or a nursing home and ancillary healthcare and for no other purpose whatsoever.

The Nazeing Health Centre finance lease was entered into at the beginning of the financial year 2009/10 for a period of 30 years.
Its current lease rental is £97k per annum.
The Nazeing lease does not allow the PCT to assign or underlet without the permission of the landlord (not to be reasonably withheld). Prior written consent is not required where the proposed assignee is either two NHS general medical practitioners in receipt of NHS funding, or is a Health Service Body.
There is no break clause in the lease and the use is limited to: a surgery, clinic or primary health care centre for the provision of medical services under the NHS and other ancillary primary community health and social care purposes and any other primary and community health care purpose within the meaning of use class D1 of the schedule to the Town and Country Planning (Use Classes) Order 1987 as originally enacted.

Amounts payable under finance leases (Buildings)	**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	**540**	530	**484**	484
Between one and five years	**1,747**	2,121	**1,554**	1,554
After five years	**11,056**	11,250	**2,996**	3,045
Less future finance charges	**(8,309)**	(8,818)	**0**	0
Present value of minimum lease payments	**5,034**	5,083	**5,034**	5,083
Included in:				
Current borrowings			**484**	484
Non-current borrowings			**4,550**	4,599
			5,034	5,083

31 Finance lease receivables as lessor

The PCT has no finance lease receivables and holds no finance lease as the lessor

32 Provisions

		Comprising:								
	Total £000s	Pensions to Former Directors £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Restructuring £000s	Continuing Care £000s	Equal Pay £000s	Agenda for Change £000s	Other £000s	Redundancy £000s
Balance at 1 April 2012	2,740	0	347	36	0	1,760	0	0	143	454
Arising During the Year	128	0	0	0	0	0	0	0	128	0
Utilised During the Year	(1,227)	0	(279)	0	0	(499)	0	0	(40)	(409)
Reversed Unused	(75)	0	(7)	(14)	0	0	0	0	(9)	(45)
Unwinding of Discount	8	0	7	0	0	0	0	0	1	0
Change in Discount Rate	0	0	0	0	0	0	0	0	0	0
Transferred (to)/from otherPublic Sector bodies	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2013	1,574	0	68	22	0	1,261	0	0	223	0
Expected Timing of Cash Flows:										
No Later than One Year	1,398	0	19	22	0	1,261	0	0	96	0
Later than One Year and not later than Five Years	86	0	49	0	0	0	0	0	37	0
Later than Five Years	90	0	0	0	0	0	0	0	90	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at 31 March 2013	388
As at 31 March 2012	78

Amount arising for redundancies relates to reorganisation following implementation of the Health and Social Care Act.
Utilised during the Year relates to continuing health care retrospective payments, redundancies and pensions.

33 Contingencies

Continuing Health Care

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

34 PFI and LIFT - additional information

	31 March 2013 £000	31 March 2012 £000
34.1 Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI		
Total charge to operating expenses in year - OFF SOFP PFI	**0**	0
Service element of on SOFP PFI charged to operating expenses in year	**514**	456
Total	**514**	456
Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI		
No Later than One Year	**597**	451
Later than One Year, No Later than Five Years	**2,405**	2,253
Later than Five Years	**13,165**	17,250
Total	**16,167**	19,954

34.2 Imputed "finance lease" obligations for on SOFP PFI contracts due Analysed by when PFI payments are due	31 March 2013 £000	31 March 2012 £000
No Later than One Year	**1,060**	1,183
Later than One Year, No Later than Five Years	**4,311**	4,253
Later than Five Years	**15,812**	15,939
Subtotal	**21,183**	21,375
Less: Interest Element	**(8,288)**	(8,197)
Total	**12,895**	13,178

The PCT has no LIFT schemes.
The PCT has a Private Finance Initiative (PFI) contract for the Epping Forest Unit (community hospital building) situated at St Margaret's hospital at Epping. The PFI Provider also provides the hard facilities management to the building. The contract has a term of 30 years and is adjusted annually to RPI. The Provider can refinance the scheme but only with the permission of the PCT (which cannot be unreasonably withheld) and the PCT will receive 50% of any benefit derived from any refinancing.
The PCT has no right to require the Provider to refinance.

The Provider was obligated under the contract to build the hospital building together with all plant and fixed equipment. The Provider is also obliged to hand the building to the PCT at the end of the contract term in Estate B condition.

The PCT can retender the contract for Services provided at the end of the contract period. Termination and renewal of the contract would be as covered in the relevant schedule of the project Agreement (available on request)

Under International Financial Reporting Interpretations Committee (IFRIC) guidance 4 the PCT is treating the PFI scheme as an asset of the PCT, the substance of the contract being that the PCT has a finance lease whose
payments comprise of three elements - imputed finance lease charges, service charges and lifecycle repayment charges

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	**434**	0	434
Interest Expense	**688**	0	688
Impairment charge - AME	**0**	0	0
Impairment charge - DEL	**0**	0	0
Other Expenditure	**852**	0	852
Revenue Receivable from subleasing	**(2,037)**	0	(2,037)
Total IFRS Expenditure (IFRIC12)	**(63)**	**0**	(63)
Revenue consequences of LIFT/PFI schemes under UK GAAP / ESA95 (net of any sublease income)	**0**	0	0
Net IFRS change (IFRIC12)	**(63)**	**0**	(63)

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

36 Financial Instruments

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

Currency risk

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

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

Credit Risk

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

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

36.1 Financial Assets	At 'fair value through profit and loss' £000	Loans and receivables £000	Available for sale £000	Total £000
Embedded derivatives	0	0	0	**0**
Receivables - NHS	0	4,328	0	**4,328**
Receivables - non-NHS	0	758	0	**758**
Cash at bank and in hand	0	1,970	0	**1,970**
Other financial assets	1,054	0	0	**1,054**
Total at 31 March 2013	**1,054**	**7,056**	**0**	**8,110**
Embedded derivatives	0	0	0	0
Receivables - NHS	0	5,503	0	5,503
Receivables - non-NHS	0	1,927	0	1,927
Cash at bank and in hand	0	7	0	7
Other financial assets	1,120	0	0	1,120
Total at 31 March 2012	1,120	7,437	0	8,557

36.2 Financial Liabilities	At 'fair value through profit and loss' £000	Other £000	Total £000
Embedded derivatives	0	0	**0**
NHS payables	0	9,842	**9,842**
Non-NHS payables	0	17,211	**17,211**
Other borrowings	0	0	**0**
PFI & finance lease obligations	0	17,929	**17,929**
Other financial liabilities	0	1,574	**1,574**
Total at 31 March 2013	**0**	**46,556**	**46,556**
Embedded derivatives	0	0	0
NHS payables	0	11,309	11,309
Non-NHS payables	0	18,026	18,026
Other borrowings	0	0	0
PFI & finance lease obligations	0	18,261	18,261
Other financial liabilities	0	2,740	2,740
Total at 31 March 2012	**0**	50,336	50,336

37 Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£	£	£	£
The Ross Practice (R Gerlis)	1,092,582	0	72,073	0
Chigwell Medical Centre (Kamai Bishai)	867,798	0	56,639	0
Stephen King	846	0	0	0

Details of related party transactions with organisations are as follows:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000s	£000s	£000s	£000s
Mid Essex PCT	25,830	7,253	735	93
North East Essex PCT	121	11,228	167	485
South East Essex PCT	45,928	3,778	549	854
South West Essex PCT	87	3,547	60	126

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

The Department of Health is regarded as a related party. During the year West Essex Primary Care Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below;

Barking, Havering And Redbridge University Hospitals NHS Trust
Barnet And Chase Farm Hospitals NHS Trust
Barts And The London NHS Trust
Cambridge Univ Hosp NHS Foundation Trust
East Of England Ambulance Service NHS Trust
Hertfordshire Community NHS Trust
Hertfordshire Partnership NHS Foundation Trust
Mid Essex Hospital Services NHS Trust
Mid Essex PCT
North Essex Partnership NHS Foundation Trust
North Middlesex University Hospital NHS Trust
Princess Alexandra Hospital NHS Trust
Royal Free Hampstead NHS Trust
South East Essex PCT
South Essex Partnership NHS Foundation Trust

In addition, the Primary Care Trust has had a significant number of material transactions with other Government Departments and other central and local Government bodies. Most of these transactions have been with Harlow District Council, Epping Forest District Council, Uttlesford Council, Essex County Council and Herts County Council

38 Losses and special payments

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

	Total Value of Cases £s	Total Number of Cases
Losses - PCT management costs	7	4
Special payments - PCT management costs	63	3
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	7	4
Total special payments	63	3
Total losses and special payments	70	7

The total number of losses cases in 2011-12 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses - PCT management costs	0	0
Special payments - PCT management costs	92	11
Losses in respect of the provision of family practitioner services	0	0
Special payments in respect of he provision of family practitioner services	0	0
Total losses	0	0
Total special payments	92	11
Total losses and special payments	92	11

39 Third party assets

The PCT has no third party assets

40 Events after the end of the reporting period

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

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

Future Body	£0
Department of Health	-18,618
Clinical Commissioning Groups	-1,532
NHS England	1394
NHS Trusts	0
Special Health Authorities, NDPBs & Other	0
NHS Foundation Trusts	0
NHS Property Services	37,838
Community Health Partnerships	0
Other	0
Balances held by PCT as 31st March 2013	19,082

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

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

Future Body	Responsibilities
Clinical Commissioning Groups	Acute Care, Mental Health, Community Services, GP Prescribing
NHS England	Primary Care, Specialised Services, Offender Health, Military Health
Central Eastern Commissioning Support Unit	Management Services
NHS Property Services	Ownership and management of all premises
Local Authorities (Essex)	Public Health Services

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

As indicated above a number of assets have transferred to NHS Property Services and other entities on 1st April 2013. These were considered operational at the year end, and so have not been impaired in the PCT books. It is for the successor body to consider whether, in 2013-14, it is necessary

Appendix B

Remuneration Report

Salaries and Allowances

			2012-13				2011-2012			
Name and Title			**Salary (bands of £5,000)**	**Other Remun-eration (bands of £5000)**	**Bonus Payments (bands of £5000)**	**Benefits in kind (Rounded to nearest £00)**	**Salary (bands of £5,000)**	**Other Remun-eration (bands of £5000)**	**Bonus Payments (bands of £5000)**	**Benefits in kind (Rounded to nearest £00)**
		Note	**£,000**	**£,000**	**£,000**	**£00**	**£,000**	**£,000**	**£,000**	**£00**
Alan Tobias	Chairman until 30.11.11		-	-	-	-	20 - 25	0	-	-
Kirsty Boettcher	Director of Strategic Commissioning - (to 6.7.11)		-	-	-	-	25 - 30	0	-	3
Jenny Minihane	Director of Nursing and Modernisation (to 31.05.11)		-	-	-	-	10 - 15	0	-	5
Toni Coles	Locality Director (to 31.05.11)		-	-	-	-	10 - 15	0	-	-

Dr Rory McCrea	Special Medical Advisor (to 31.05.11)		-	-	-	-	10 - 15	0	-	-
Dr Christine Moss	Medical Director (to 31.05.11)		-	-	-	-	5-10	0	-	
Jackie Sully	Non Executive Director (to 30.11.11)		-	-	-	-	5-10	0	-	1
Dr Qadir Bakhsh	Non Executive Director (from 1.4.12-30.11.12)	11	0-5	0-5	-	1	5-10	0	-	1
Stephen King	Non Executive Director/Cluster Chair (from 1.4.12-31.3.13)	12	0-5	0-5	-	-	10 - 15	0-5	-	1
Michael Smith	Non Executive Director (to 31.10.11)		-	-	-	-	0-5	0	-	-
Andrew Pike	Chief Executive and NCB LAT Director (from 1.10.12-31.3.13)		10-15	-	-	-	-	-	-	-
Dawn Scrafield	Deputy CEO/Director of Finance & Performance (from 1.10.12-31.3.13)		10-15	-	-	-	-	-	-	-
Ian Stidson	Director of Commissioning (from 1.10.12-31.3.13)		5-10	-	-	-	-	-	-	-
Pol Toner	Director of Nursing (from 1.10.12-31.3.13)		5-10	-	-	-	-	-	-	-

Alison Cowie	Director of Public Health, (from 01.10.12 to 31.03.13)	15	10-15	0-5	-	0	-	-	-	-
Renata Drinkwater	Non Executive Director (from 1.4.12-31.12.12)	13	0-5	0-5	-	-	5-10	0	-	1
Sheila Bremner	Chief Executive from 1.4.12-30.09.2012 seconded to National Commissioning Board East Anglia from 01.10.12 -31.3.13	1	20-25	0-5	-	1	45-50	0	-	1
Clare Morris	Director of Development (Started 1/6/11 and finished 31/1/12)	6	-	-	-	-	25-30	0-5	-	1
Adrian Marr	Director of Resources (from 1.4.12-30.9.12) seconded to National Commissioning Board East Anglia from 01.10.12 -31.3.13	2	15-20	0-5	-	1	35-40	0-5	-	1
Sallie Mills Lewis	Director of Delivery (from 1.4.12-30.9.12) seconded to National Commissioning Board East	5	15-20	0-5	-	1	25-30	0-5	-	1

	Anglia from 01.10.12 -31.3.13									
Sarah Jane Relf	Director of Transformation and Governance (from 1.4.12-30.9.12) seconded to National Commissioning Board East Anglia from 01.10.12 -31.3.13	4	10-15	0-5	-	0	25-30	0	-	1
Dr Donald McGeachy	Medical Director (from 1.4.12-31.3.13)		15-20	10-15	-	-	10-15	0	-	1
Denise Hagel	Interim Director of nursing (from 1.4.12 to 30.9.12)		-	10-15	-	-	25-30	0	-	-
Rob Gerlis	Clinical Commissioning Lead West Essex (from 1.10.12-31.3.13)		-	70-75	-	-			-	
Kamal Bishai	Deputy Clinical Commissioning Lead West Essex (from 1.10.12-31.3.13)		-	35-40	-	-			-	
Chris Paveley	chairman (from 1.4.12-31.12.12)	7	5-10	0-5	-	2	0-5	0	-	-
Tim Young	Non Executive Director (from 1.4.12-30.11.12)	8	0-5	-	-	-	0-5	0	-	-

Jerry Wedge	Non Executive Director and Chair of Audit Committee (from 1.4.12-31.3.13)	9	0-5	0-5	-	1	0-5	0	-	-
Pam Donnelly	Non Executive Director (from 1.4.12-31.3.13)	10	0-5	0-5	-	1	0-5	0	-	-
Alan Hubbard	Non Executive Director (from 1.4.12-31.3.13)	14	0-5	0-5	-	-	0-5	0	-	-
Dr Mike Gogarty	Director of Public Health (from 1.4.12-30.9.12)	3	10-15	0-5	-	-	0-15	0	-	-

Details of other remuneration are provided in the notes below.

For staff that are shared with other NHS organisations within the North Essex Cluster the salary entitlement included above is based on the actual charge to NHS North Essex. All charges have been made on a weighted capitation basis. The full salary cost including bonus and other remuneration of shared individuals is also provided where applicable for information.pro rata to PCT weighted populations (35% Mid Essex PCT, 37% North East Essex PCT and 28% West Essex PCT respectively. Four Senior Managers worked for National commissioning Board (East Anglia) from 01/10/2013 to 31/03/13.

Note 1 – Sheila Bremner – Appointed 1.11.10 as Joint PCT CEO for NHS North East Essex, NHS Mid Essex and NHS West Essex. employing organisation is NHS Mid Essex, seconded to National Commissioning Board (East Anglia) from 01/10/2013 to 31/03/13 full salary band £75k - £80k.

Note 2 – Adrian Marr started 1.6.11 (shared resource across North Essex, - employing organisation is NHS Mid Essex. Seconded to National Commissioning Board (East Anglia) from 01/10/2013 to 31/03/13 full salary band £60k - £65k.

Note 3 - Dr M Gogarty Director of Public Health full salary band £75k - £80k.

Note 4 – Sarah Jane Relf – interim from 1/04/11 and then established from 1.6.11 shared resource across North Essex - employing organisation is NHS Mid Essex, seconded to National Commissioning Board (East Anglia) from 01/10/2013 to 31/03/13 full salary band £45k-£50k.

Note 5 – Sallie Mills Lewis – started 1/4/11 shared resource across North Essex, Dep CEO for North East Essex until 31.5.11 - employing organisation is NHS Mid Essex, seconded to National Commissioning Board (East Anglia) from 01/10/2013 to 31/03/13 full salary band £55k - £60k.

Note 6 – Clare Morris – Started 1/6/11 and finished 1/2/12 (Deputy CEO for NHS West Essex, shared resource across North Essex - employing organisation was NHS Mid Essex, comparator information only).

Note 7 – Chris Paveley – From 1 December 2011 (shared resource across North Essex – employing organisation is NHS North East Essex, full salary band £25k - £30k).

Note 8 – Tim Young – From 1 December 2011 (shared resource across North Essex – employing organisation is NHS North East Essex, full salary band £5k - £10k).

Note 9 – Jerry Wedge - From 1 December 2011 (shared resource across North Essex – employing organisation is NHS North East Essex, full salary band £10k - £15k).

Note 10 – Pam Donnelly - From 1 December 2011 (shared resource across North Essex – employing organisation is NHS North East Essex, full salary band is £10k - £15k).

Note 11 - Dr Qadir Bakhsh - From 1 December 2011 (shared resource across North Essex – employing organisation is West Essex, full salary band £5k - £10k)

Note 12 - Stephen King - From 1 December 2011 (shared resource across North Essex – employing organisation is West Essex, full salary band £5k - £10k)

Note 13 - Renata Drinkwater - From 1 December 2011 (shared resource across North Essex – employing organisation is West Essex, full salary band £5k - £10k)

Note 14 – Alan Hubbard - From 1 December 2011 (shared resource across North Essex – employing organisation is Mid Essex, full salary band £5k - £10k)

Note 15 - Alison Cowie is seconded to South Essex Cluster is recognised as a director for West Essex PCT in the Annual Report full cost of salary (£95k-£100k).

Pension Benefits

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

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

Staff with more than one position within the NHS (note 1)

Some staff also work for all Essex PCTs, as part of clustering arrangements. These staff are either on the payroll of West Essex, South West Essex or South East Essex PCT and their full pension entitlements have been included in the remuneration report of all organisations. Readers should be aware of this in order to avoid any 'double-count' of these entitlements.

Staff with negative pension information (note 2)

Please note that Luella Dixon has a decrease in pension at age 60 for the period ending 31/03/2013. She is seconded from West Essex PCT to South East Essex and South West Essex PCT's, therefore she does not appear within the West Essex Payroll cost disclosure.

Cash Equivalent Transfer Values

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

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

Real Increase in CETV

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

Pay multiples disclosure

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

The banded remuneration of the highest paid director in The West Essex PCT in the financial year 2012-13 was £40,000-45,000 (2011-12, £45,000-50,000). This was 1.29 times (2011-12, 1.99 times) the median remuneration of the workforce, which was £34,189 (2011-12, £22.7K).

The actual full cost of the highest paid Director across the North Essex Cluster was £155,000-160,000.

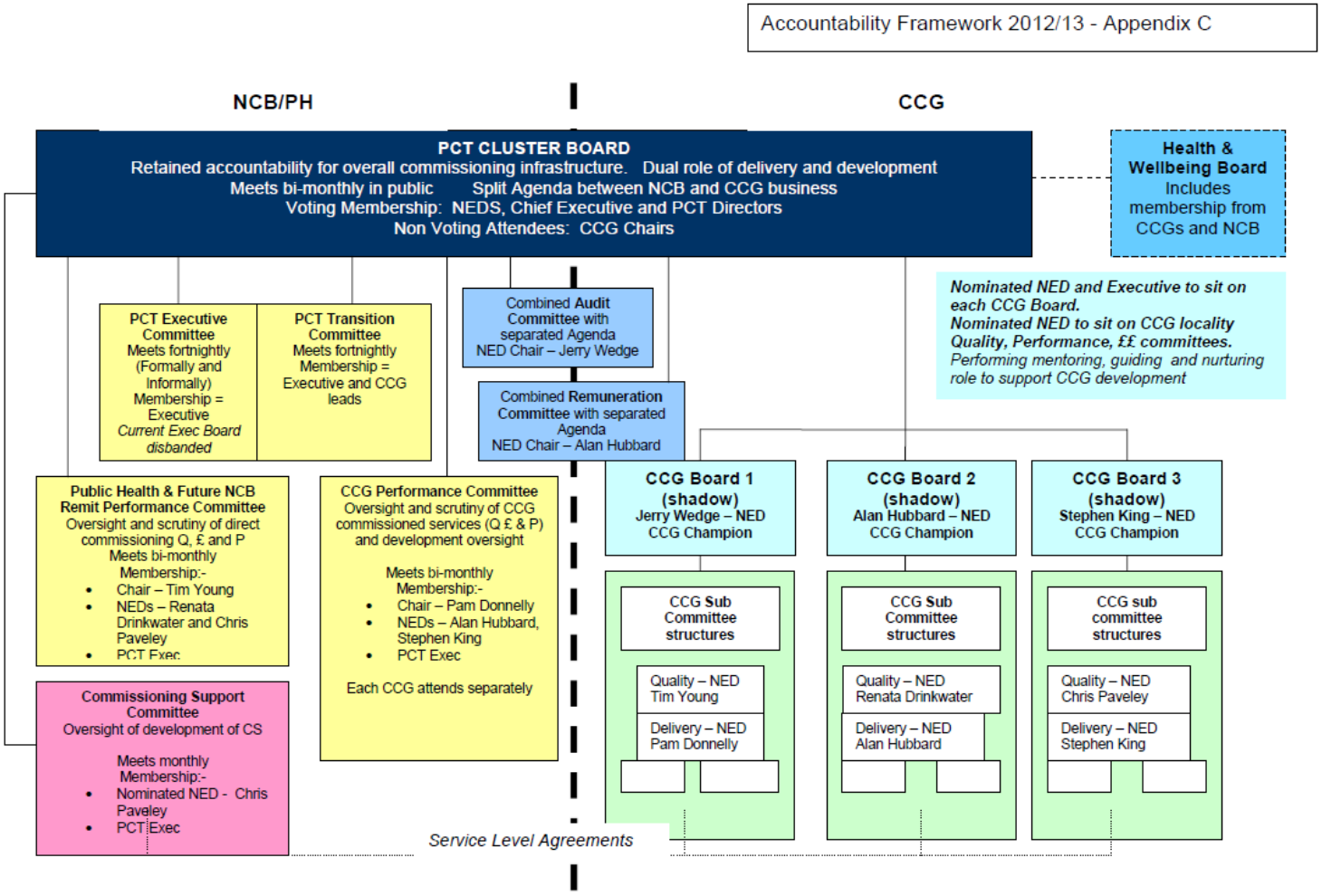
In 2012-13, 44 (2011-12, 47) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £45.25k to £83.83 (2011-12 £0.1k-£114.6k)

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.

There has been a change from the Prior year highest paid director due to eligible senior management seconded National Commissioning Board from October 2012 to 31 March 2013. The prior year's highest paid director has been eliminated from the calculation as that director worked part year with NCB therefore only half salary was applicable and did not qualify as highest paid director.

Although there has been a decrease in the highest paid director the median for this year has also increased resulting in a reduced ratio. The reorganisation of the clusters could have resulted in less lower paid staff in at the time of calculation, this would have pushed up the median value.

APPENDIX C



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