Department of Health

NHS

Southwark Primary Care Trust

2012-13 Annual Report and Accounts

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Southwark Primary Care Trust

2012-13 Annual Report

NHS Southwark

SOUTHWARK PCT

ANNUAL REPORT AND ACCOUNTS

2012/2013

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1. WELCOME

Welcome to NHS Southwark's annual report for 2012/13. This is the final annual report to be published by the PCT, which along with all other PCTs in England ceases to exist after 31 March 2013. This change is a result of the reforms set out in the Health and Social Care Act 2012. From 1 April 2013, commissioning for health services and health improvement in Southwark is taken on by NHS Southwark Clinical Commissioning Group, the NHS Commissioning Board and Southwark Council.

Throughout 2012/13 we have moved towards establishing NHS Southwark Clinical Commissioning Group (CCG) as the statutory body for health service commissioning in the borough from 1 April 2013. Early in the year we saw the CCG receive delegated responsibility for its future areas of responsibility – hospital and emergency care, community health and mental health services. This was followed in January 2013 when NHS Southwark CCG was one of 67 emerging CCGs authorised by the NHS Commissioning Board in the second wave of the national process. However until April 2013, Southwark Primary Care Trust remains the statutory body responsible for commissioning and our full board membership is listed on page 36.

This has been an exciting and challenging year and we are proud of the work we have undertaken in Southwark to improve health and health services throughout a year of significant transition. Having clinical leaders at the helm of commissioning in Southwark is enabling us to focus on clinical outcomes for local people and to make decisions that are genuinely informed by local people and the clinicians that understand their needs so we can achieve the best possible health outcomes for Southwark people. As this annual report shows, we are already seeing some significant success and hope to build on these in the year ahead.

We continue to develop our joint working with other boroughs and their Clinical Commissioning Groups. NHS Southwark CCG has led major programmes of service redesign in urgent and planned care in partnership with Lambeth CCG, local NHS Foundation Trusts and local authority partners.

Highlights of the year in Southwark included the opening the Urgent Care Centre on the Guy's Hospital site with GPs and hospital Emergency Nurse Practitioners working alongside each other providing urgent care to patients 8am – 8pm seven days a week and the CCG carried out a three month engagement exercise with local people on our ideas and plans for health services in the Dulwich and surrounding areas. Critically all cancer waiting times have been met throughout the year, ambulance response times have improved this year and we are on track to achieve our target for the number of people stopping smoking.

During the year, GPs, practice managers and key clinicians in Southwark got together regularly with relevant partners to discuss important issues focusing on how to work more efficiently and better integrate healthcare. In Southwark we have held eight learning events for GPs and other clinicians on a range of subjects including clinical commissioning, planned and unplanned care, community services and safeguarding.

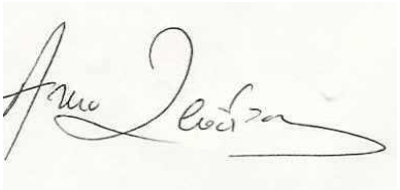
Financially, it has been a challenging year and the CCG has worked hard to ensure the statutory duties of the PCT are forecast to be met including a surplus of £6m. We continue to address the challenges of the Quality, Innovation, Productivity and Prevention (QIPP) agenda and providing a

continued focus on this important area will be vital in maintaining a viable financial environment across healthcare in south east London.

Against a challenging backdrop our staff have worked effectively with clinical leaders right across the borough to achieve better outcomes for patients within the financial resources available to us. We believe this hard work and well established partnership has left the future clinical commissioning group well placed to deliver its vision for improved outcomes for Southwark people.

Andrew Kenworthy Chief Executive, NHS South East London (including Southwark PCT)

Caroline Hewitt, Chair, NHS South East London (including Southwark PCT)



Dr Amr Zeineldine, Chair, NHS Southwark Clinical Commissioning Group

2. OUR VISION FOR HEALTH

In this year's Annual Report you will find a summary of our performance from April 2012 to February 2013 and our annual statement of accounts. This review will also look at some of our key achievements over the last year.

The last year has been one of continued change within the NHS and it is the last year of operation of Southwark Primary Care Trust. However, firm foundations are in place for NHS Southwark Clinical Commissioning Group statutory functions from April 2013 as illustrated by its vision and mission below.

Our Mission

To commission high quality services that improve the physical and mental health and wellbeing of Southwark residents and result in a reduction in health inequalities.

Commissioning for our population will be:

- evidence based
- focused on clinical outcomes and high quality standards of care
- led by local frontline healthcare professionals
- determined by local need
- informed by genuine patient and public engagement, and
- result in more information and choice for patients

Our Vision

NHS Southwark CCG will work to achieve the best possible health outcomes for Southwark people. The vision for services commissioned on behalf of Southwark's population is that they function to ensure:

- People live longer, healthier, happier lives no matter what their situation in life
- The gap in life expectancy between the richest and the poorest in our population continues to narrow
- The care local people receive is high quality, safe and accessible
- The services we commission are responsive and comprehensive, integrated and innovative, and delivered in a thriving and financially viable local health economy
- We make effective use of the resources available to us and always act to secure the best deal for Southwark

Our Values

- We continue to be guided by the founding principle of the NHS - that good healthcare should be available to all, free at the point of delivery.
- We place patients, health improvement and quality at the heart of everything we do
- We are honest and open about the actions and decisions we take

- We are accountable to the public and recognise our responsibility to act in the best interests of the population we serve
- Our decisions are evidence based, fair and make best use of the resources we have available to us
- We act responsibly as a public sector organisation and are committed to working in partnership with local government, voluntary organisations and the wider community to ensure a united approach to tackling the wider determinants of poor health in Southwark.

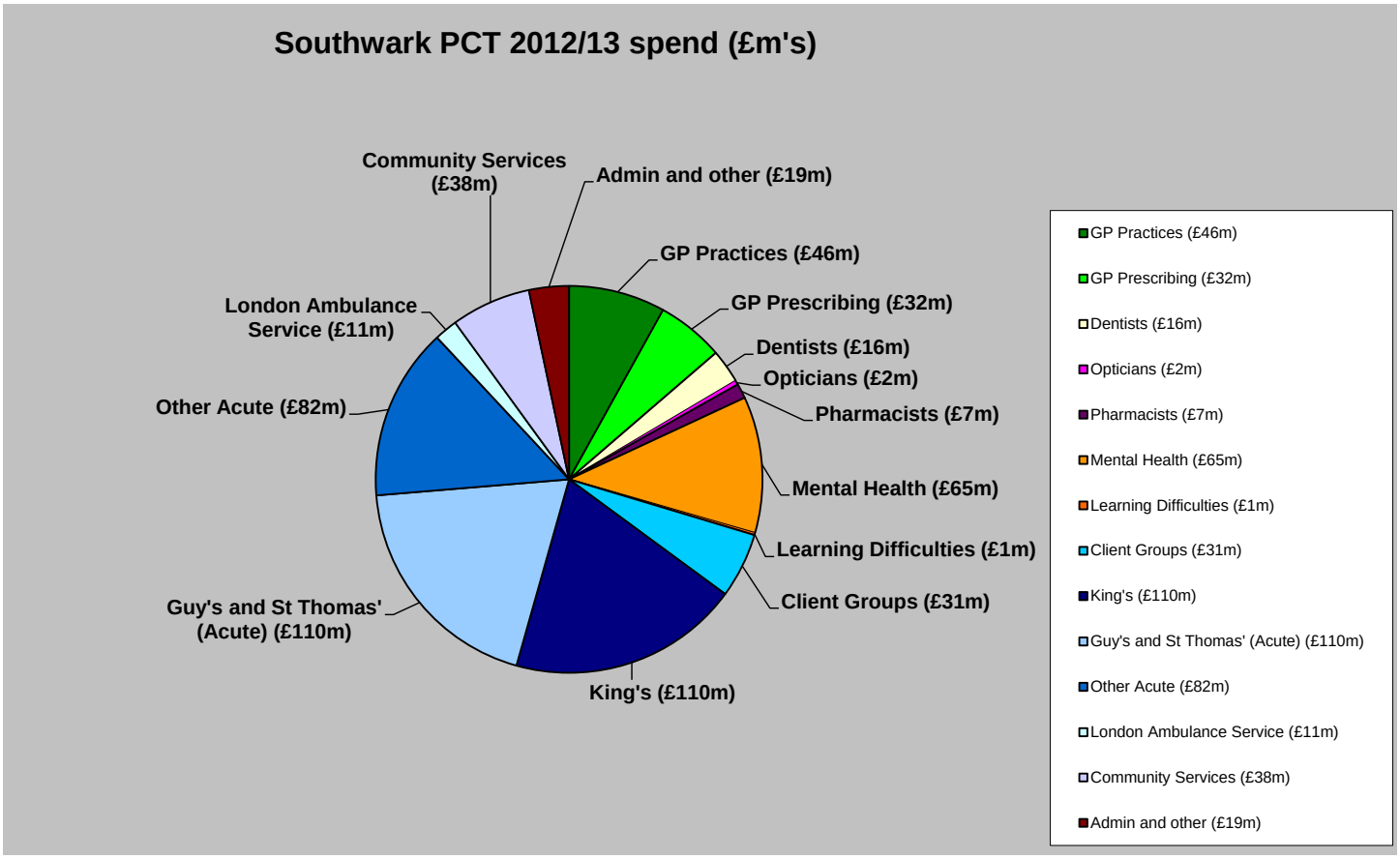
3. WHAT WE DO

Southwark PCT has responsibility for health services for the people who live in, work in or visit Southwark. Working closely with Southwark Clinical Commissioning Group we commission health services for local people

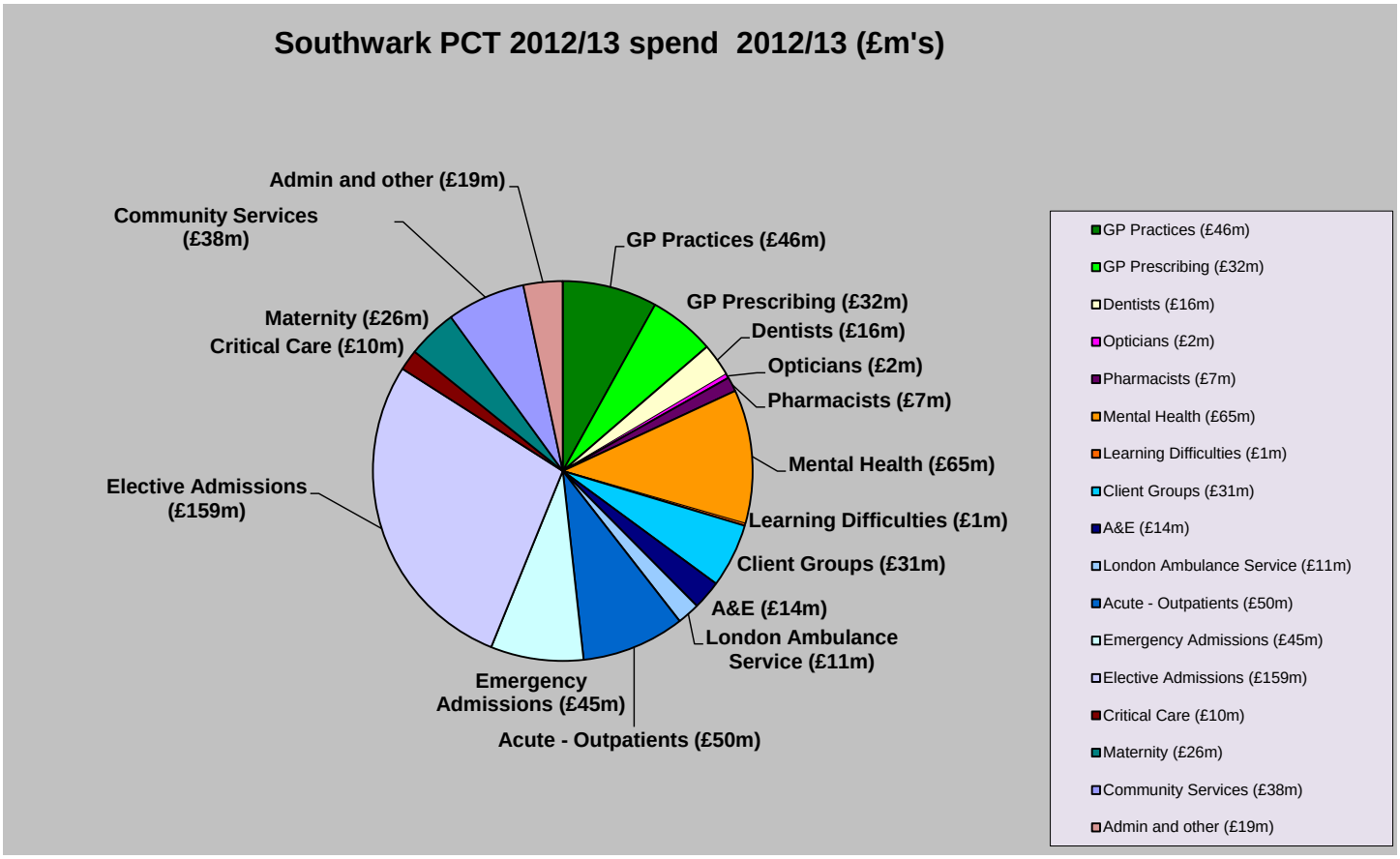
As leaders of the NHS in the borough, we work closely with our local NHS partners including GPs, pharmacists and hospitals and other partners in the borough such as Southwark Council and voluntary and community groups. We aim to promote improved health, reduce health inequalities and ensure people have easy access to high quality health services across the borough.

Our role is to assess the healthcare needs of the borough and co-ordinate and pay for health and care services to meet these needs (what we call commissioning). In 2012/13 we spent £556 million to commission services, using funds we received from the Department of Health. The PCT has experienced significant growth in hospital activity, and has had to use its reserves in order to stay within budget.

The chart below outlines what we spent last year.



The chart overleaf further breaks down the acute spend into areas of care:



The vast majority of people using the NHS in Southwark use primary and community health services. We commission these services from:

- dentists, family doctors (GPs), pharmacists and opticians
- Guy's and St Thomas' Community Health Services, providing services in the community such as district and school nursing, health visiting, specialist child health, therapy services and care for older people.

We have:

- 46 GP practices
- 42 dental practices
- 61 community pharmacies
- 20 opticians.

When people need more specialist care, we also commission:

- King's College Hospital and Guy's and St Thomas' NHS Foundation Trust to provide inpatient, outpatient, day and emergency care

- South London and Maudsley NHS Foundation Trust to provide mental health and substance misuse services.

4. HEALTH AND WELLBEING IN SOUTHWARK

About Southwark

Southwark is a diverse, inner London borough with a population of just under 290,000 with a third of the population from a Black and Minority Ethnic background. The borough's population is young compared to the rest of the country and compared to London as a whole.

Over the last 10 years, life expectancy in Southwark has been improving. On average, men in Southwark can now expect to live to 78 years and women to 83 years. For women this life expectancy is now longer than the national average of 82.3 years. However, there still remain significant causes of ill health leading to premature deaths (deaths under the age of 75 years).

For some health conditions people in Southwark have a higher premature early death rate than the England average. Men in particular have a significantly higher death rate from heart attack, stroke and COPD (chronic lung disease). Women in Southwark also have a higher premature death rate for COPD than England.

We know that there are many people in Southwark living with long term conditions, such as high blood pressure, diabetes and heart disease, but there are also many people whose long term conditions remain undiagnosed.

Poverty and health and wellbeing are closely linked, those individuals living in the most deprived environments often having much poorer health outcomes. Recent data in 2010 indicates that Southwark is the 41st most deprived local authority in England compared with 26th most deprived local authority in England in 2007. As a borough, Southwark is becoming relatively less deprived; at the same time there are also great inequalities within and between different parts of Southwark. For example, despite the overall improvements in life expectancy, the difference in life expectancy between the worst off and best off parts of the borough is some 10 years for men and nearly seven years for women. Trends over time suggest that, for both men and women, this inequality gap is not narrowing.

Addressing inequalities

Tackling health inequalities, therefore, remains a priority for Southwark. Key domains of work where evidence suggests the most impact can be made include diabetes and heart disease, infant mortality/early years, cancer, lifestyles and life chances.

We have high rates of child obesity in Southwark. We have worked with primary care to promote the weighing and identification of unhealthy weight children and the provision of brief advice. We have also worked with school nurses to follow up families of children identified as obese through the childhood measurement programme, including telephone brief interventions and signposts to weight management (MEND), We have worked with MEND so that referrals can now be taken from age 5 onwards (previously age 7 – 13 only); we have worked with a local Food School to train 30 school governors to better understand how they can influence the quality of school meals, and we have supported faith groups and community groups to identify community kitchen facilities to support community led cooking workshops and support families to improve knowledge in healthy eating/cooking through culturally appropriate resources.

We have continued to commission the exercise on referral programme, making the programme more effective with improved completion rates. The programme also works with people with mental health problems to improve their physical health and to measure the impact of exercise on their mental wellbeing. We are also working with Southwark Psychological Therapies, libraries and community support services to improve access to psychological therapies by black and minority ethnic communities. The Books on Prescription scheme has been expanded; early indications are that it is well received, providing valuable and culturally relevant health and wellbeing resources and guided self-help in different languages.

Partnerships with the council have been central in progressing work on inequalities by addressing the wider influences on health. We have continued our work with planning colleagues to enforce restrictions on new take-aways in areas where there are already many. Work continues with children's services to support the roll-out of free healthy school meals, taking a whole school approach to a healthier environment. The 2012 London Olympics saw much joint working with Southwark Council to promote more physical activity across the population including active travel, sports, gardening and dance, and have been one of only three London Boroughs to achieve a significant increase in population activity levels across a five year period.

Long term conditions usually include diabetes, heart disease and respiratory diseases such as asthma and chronic obstructive pulmonary disease (COPD – chronic lung disease). Caring for people with long term conditions is a large element of the NHS. We are, therefore, exploring and planning how we can better support more patients to self manage their conditions and continue to live independently.

The NHS Health Check Programme is a five year rolling programme covering 20% of the population year on year. Those eligible are people aged between 40-75 years with no previous diagnoses of heart disease, stroke, diabetes and kidney disease. Over 4,500 people received a health check in the last year. These are offered via the programme's Outreach Team, GP practices and some pharmacies.

The Health Check Programme provides early identification of people at high risk of developing a stroke, heart attack, diabetes or kidney disease. From April 2013 dementia awareness will be added to the Health Check for people over 65 years old.

During the last year the programme has found

- 797 people with high blood pressure
- 1729 people with high cholesterol
- 218 people with pre diabetes
- 2063 people who are obese
- 310 people with a high risk of cardio vascular disease

For people found to be at high risk of developing these conditions, people are offered a variety of support services for weight management, increasing physical activity, stopping smoking and reducing alcohol intake. To encourage people to choose healthier food options the Outreach Team offers a 10% discount card to clients who complete a Health Check. The card enables them to get 10% off the cost of fruit, vegetables and fish from ten of Southwark's local participating businesses. The client can use the card as many times as they like.

"I've lost 10kg in the six months since attending the Walking Away workshop in June. I'm really happy with the Health Checks Programme and all the support I've received. I've been trying to lose weight for ten years and have never succeeded until now. I'm happy, have lost weight and also managed to get a job ass I'm feeling much more confident in myself. I get my exercise by walking to and from work every day."

"I was overweight with high blood sugar and at risk of developing diabetes and heart disease. Since having the health check, I've changed my diet by reducing portion sizes and also get more physical activity including dancing and aquarobics. I also walk 10,000 steps a day using my pedometer and have lost three stone. The health check was an absolute positive experience which has turned my life around!"

In Southwark 22% of the population aged over 16 regularly drink more alcohol than the Government advises. The harm alcohol has on an individual's own health is supplemented by other costs to public services relating to crime, violence, ill health, worklessness and unplanned pregnancies, and for this reason we worked with the community safety team in the development of a partnership strategy for alcohol.

A number of initiatives address the issue of problematic alcohol use. One example being Identification and Brief Advice (IBA) training which has been rolled out to over 100 probation officers and midwives over the past few months. Sexual health workers have been prioritised as the next group for this training. Work is also being undertaken to improve the alcohol pathway, including developing the roles of the Primary Care Alcohol Worker and King's College Hospital's Alcohol Nurse to ensure greater client support.

Health and Wellbeing Board

Health and Wellbeing Boards are one of a number of new health structures resulting from the Health and Social Care Act 2012. They are being set up to improve health and care services, and the health and wellbeing of local people. They will bring together the key commissioners of public services in an area, including representatives of the new clinical commissioning groups, directors of public health, children's services, and adult social services, with at least one democratically elected councillor and a representative of Healthwatch (the new patient champion group).

Southwark established a shadow Health and Wellbeing Board in April 2012, in anticipation of the full Board that the council will have a duty to institute by April 2013. Key health priorities for the board to address in 2012/13 include early intervention and families; healthy weight and physical activity; mental wellbeing, coping and resilience; and alcohol. The shadow Health and Wellbeing Board have established a process for developing action on these areas within the wider Joint Health and Wellbeing Strategy which is supported by the joint strategic needs assessment (JSNA).

The JSNA identifies the health and wellbeing needs of Southwark's population to inform the commissioning and development of local services. This process brings together a wide range of information and data to help us better understand the needs of our population. The Southwark JSNA is accessible to all online at www.southwarkjsna.com.

Public Health Transition

From April 2013, the responsibility for public health is transferring to the local authority. The Lambeth and Southwark Public Health Teams are coming together to form a joint department hosted by

Southwark Council. The joint team will continue to provide services across the two boroughs, supporting Southwark and Lambeth CCGs with the best possible level of public health expertise and advice and to enable effective partnership working across organisations.

This shift also brings great opportunities in influencing the design of future council services including regeneration, housing, planning, children's services, leisure, adult social care and the wider environment and economy. Together, we will be working hand in hand with communities, commissioners and providers to make real and sustained improvements to health outcomes and reductions in health inequalities.

5. COMMISSIONING HEALTHCARE

Southwark Clinical Commissioning Committee

Southwark has a strong basis for the development of clinical commissioning. GPs in Southwark came together as the Southwark Clinical Commissioning Group and were one of the first groups of GPs to have been granted pathfinder status in December 2010. This application was made following many years of clinically-led commissioning in the borough with a well established clinical leadership team and a strong locality based system of practice involvement. All GP practices in Southwark are members of the Southwark Clinical Commissioning Group.

Early in 2012/13 the CCG receive delegated responsibility for its future areas of responsibility – hospital and emergency care, community health and mental health services.

Southwark undertook a selection / election process for its clinical leads during May and June 2012.

The clinical leads in Southwark for 2012/13 are enlisted below:

- Dr Amr Zeineldine, The Aylesbury Partnership (Chair)
- Dr Adam Bradford, East Street Surgery
- Dr Jane Cliffe, The Gardens Surgery (till June 2012)
- Dr Jonty Heaversedge, Manor Place Surgery
- Dr Mark Ashworth, The Hambledon Clinic (till June 2012)
- Dr Patrick Holden, Surrey Docks Medical Centre
- Dr Roger Durston, Camberwell Green Surgery
- Dr Simon Fradd, Parkside Surgery
- Dr Sian Howell, Bermondsey & Lansdowne Medical Mission (from July 2012)
- Dr Anu Bhatia, Old Kent Road Surgery (July – December 2012)
- Linda Drake, Elm Lodge Surgery (from July 2012)

Clinical commissioning has undergone a process of authorisation during 2012 to ensure that the NHS Southwark Clinical Commissioning Group are ready to take on their statutory role of commissioning health services for patients in their local communities from April 2013. In January 2013 NHS Southwark CCG was one of 67 emerging CCGs authorised by the NHS Commissioning Board in the second wave of the national process. Southwark CCG was particularly commended on partnership working with patients and integrated working with the Local Authority and collaborative arrangements with other CCGs.

Southwark clinical leadership team worked with officers, the NHS South East London colleagues and major providers to develop a QIPP programme in 2012/13. QIPP stands for quality, innovation, productivity and prevention and is a programme of improvement, led by NHS Southwark, with the broad aim of enhancing the quality of commissioned services and patient pathways of care. The purpose of implementing QIPP is to deliver the transformative change set out as part of our strategic plans. We structured our key programmes of QIPP delivery to see that we responded effectively to the opportunity of more integrated care, that we acted to improve the quality of commissioned services and that our programmes of pathway improvement supported a reduction in the variation in the quality of services.

The sections below set out in further detail the key areas of QIPP delivery in 2012/13.

Commissioning for Urgent Care

Southwark CCG has commissioned a new Urgent Care Centre (UCC) at Guy's Hospital, on the site of the former Minor Injuries Unit. The old Minor Injuries Unit was redeveloped to provide a modern, accessible space for urgent care. The new UCC opened in July 2012, just in time for the Olympics, and offers a GP and nurse-led service for minor illness and minor injury, open 7 days a week 8am to 8pm. The service also houses a base for GP Out of Hours visits at weekends. The service includes x-ray facilities and provides a convenient alternative to A&E for patients who are less critically ill.

Southwark has also worked closely with Kings College Hospital to contract for a primary care service which will operate within Kings A&E department from March 2013.

Southwark has continued to work with local health partners on communications with the public on how to appropriately access unplanned care, and re-issued the Choose Well campaign, providing information for local residents on which health services to use for different kinds of illnesses.

Integrated Care and Preventing Admissions

Over the last year we continued to work together with local partners (including Kings Health Partners, Lambeth CCG and Southwark Local Authority) as part of the Integrated Care Programme (ICP). This work aims to develop more joined-up care for people, improving patient outcomes and providing better value across health and social care. This work has included a range of new services for frail elderly people, including community based services aimed at avoiding admission to hospital, such as Enhanced Rapid Response and the Homeward. 2012/2013 saw the introduction of Community Multi-Disciplinary Teams, where a range of health and social care professionals come together to discuss the needs of older people with higher risk of admission or adverse outcomes, and co-ordinate their care.

The next phase of our work, begun this year, is to look at better joined-up services for people with Long Term Conditions (such as diabetes or heart failure). We are also working with the ICP to look at how we can use Information Technology to identify people with higher levels of risk of ill health, and how health and social care professionals can share information to support better patient care.

Case study

Mrs D is 93 years of age. She has high blood pressure and high cholesterol. She lives alone in a council flat and does not have any relatives nearby; she reports feeling isolated.
Mrs D was referred to the Enhanced Rapid Response Team because of unsteadiness in her legs, and she had gone to A&E following a fall at home.

When she was assessed by the Rapid Response Team, they identified severe osteoarthritis in one knee, asthma, reduced balance, loss of lower limb muscle strength and decreased confidence.
The rehabilitation support worker helped Mrs D increase her balance and lower limb muscle strength, and also to improve her confidence and mobility. A physiotherapist visited Mrs D once a week to give her exercises to do. She was given a walking frame to assist her indoor mobility, and a three wheel walker to support her when outside. Other interventions included installing new railing inside her flat to help her when stepping out to the balcony. The housing association added another step to the main entrance to her building and made the threshold into her flat even.

As a result of this, Mrs D's balance improved, she had no further episodes of unsteadiness in her legs, and she increased her confidence about going out. She still needed to build up confidence to go out by herself and was referred to a community physiotherapist to help her achieve her goal of going out shopping.

Planned Care

This year, we have reviewed a number of our community based outpatient services, including ENT, Dermatology, Physiotherapy and Headache services. Our aim remains to ensure that patients get the right care for their condition in the right place, in a timely manner, including community clinics as an alternative to hospital.

We are looking at care pathways and redesigning services to improve the way services are accessed by patients and to provide better support for general practitioners in referring patients who need specialist care or advice. Over the last year, we have worked closely with our patient groups to develop better referral pathways, including specialist support and review of GP referrals, and easier booking when patients need hospital care.

Over the last year, we have widened the level of choice for patients in two areas: audiology (hearing services) and continence services. This means that patients needing these services can now choose from a wide range of different providers and locations. We will be reviewing how well these new arrangements work and may extend choice in other services in future.

We have worked hard on improving care for people with long term health problems. This had involved setting up new community-based clinics for diabetes and heart failure, which offer Southwark patients convenient, specialist support for their health problems without needing to go to hospital. We have also begun working on community based care for people with respiratory disease, including support to remain at home through a period of acute illness, rather than admission to hospital. Key to developing community services is linking them well to local practices. We have developed a programme of support for local GP practices in better identifying, diagnosing and supporting people with health problems, and ensuring that they get the best, evidence based health care.

Community Based Care

NHS Southwark recognises the need to work with colleagues beyond Southwark if we are to ensure a health system best able to deliver best quality healthcare in our area. We have, therefore, worked in collaboration with neighbouring PCTs and other NHS colleagues across a wide range of responsibility. A recent and important example is the future of services provided by South London Healthcare Trust (SLHT). In January 2013 the Secretary of State published his decision on the future of SLHT following the recommendations of the Trust Special Administrator. This decision will affect health service configuration and provision across the whole of South East London. The recommendations notably include the dissolution of SLHT and changes to emergency services at Lewisham Hospital. NHS Southwark CCG NHS and Lambeth CCG and will be working with King's Health Partners and others across the system to ensure continuity of care and improved services across the whole of South East London, including for Southwark patients. In particular NHS Southwark CCG, working with other CCGs in South East London will be taking forward the implementation of the three year Community Based Care Strategy which seeks to ensure:

- support to help people manage their own health
- earlier intervention to prevent disease and better manage ill health and
- Community based services to support people at home

Client Group Commissioning

The NHS in Southwark and Southwark Council work closely together to provide a range of services for residents. These services are provided within local communities or in other settings such as care homes. Working together means that we are able to provide services that people need at a time they need them and in the right environment. It also means that work is not duplicated and that people, often those that are at risk or vulnerable, like older people, get the care they need quickly and efficiently.

Commissioning Mental Health Services

This year we have focussed on addressing key issues and improvements to deliver high quality care and improved efficiencies in Mental Health, both in and out of hospital. We have been focussing on prevention, promotion and early intervention. In January 2012 we held a highly successful, well evaluated, MH training event attended by over 125 GPs, practice nurses and affiliated clinical staff from Southwark.

Together with Southwark Council our model of care for patients with mental health problems, ensures easier and more equal access to mental health services, with greater consistency in the way services are provided and a wider range of options. This work is continuing to be developed with users, carers, local GPs, local clinicians and voluntary sector organisations.

Our focus is on the 'recovery model' of mental health care, which emphasises the importance of supporting people back into education, training and work so that they maintain their sense of self-esteem and live their lives to the full and we have commissioned specific projects to continue do this in the next year.

Implementing this model has required specialist mental health hospitals to apply new and innovative ways of working, including engaging people in self-management strategies relating to their condition and moving away from the traditional medical model.

As with adults, the mental health and wellbeing of children and young people is everyone's business. We have worked jointly with Southwark Council and the South London and Maudsley Foundation Trust to redesign services into targeted and specialist provision to improve the mental and emotional health of children and young people aged 0-19 years in Southwark. This includes improving planning across services and agencies to ensure that young people with additional needs have access to the information, support and opportunities needed as they move into adulthood.

Commissioning Substance Misuse

A key outcome of the Substance Misuse Team's work in 2012-13 has been the significant strengthening of partnership working across a range of partners.

Patterns of substance misuse continue to change due to a number of factors including changing demographics and the regular emergence of new drugs. Services for cannabis users are well established and a cross-agency and cross-borough approach is now being developed for so-called 'party drugs' and 'legal highs' such as crystal meth and ketamine.

The Southwark Treatment and Recovery Partnership (STARP) is a clinical network comprised of the Substance Misuse Commissioner and senior managers and clinicians of local providers of drug and alcohol services. Developed over the past twelve months, its main functions include driving local strategy, service provision and improvement, innovation and governance. It is a non-contractual body

that works to a mutually agreed model of service delivery and development that extends across Primary Care, specialist clinical services and in-patient and residential rehabilitation services.

A number of joint initiatives have already emerged from this model including a STARP website, cross-agency training and clinical supervision, the multi-agency aftercare service SARIS (Southwark Aftercare and Re-Integration Service) and a more responsive and inclusive Day Programme pathway.

To ensure that the broader health needs of service users are met linkages have been established with providers of other specialist health services like Sexual Health and TB and lung health. For example, an in-reach sexual health worker provides regular sessions at Blackfriars Community Drug and Alcohol Team and a Mobile TB screening bus visits the service once a month.

Support to GPs continues with on-going provision and uptake of training in substance misuse. Primary Care services were further supported with the delivery of a Substance Misuse training day for Pharmacists and GPs in September 2012. Topics included blood-borne viruses, TB and pre and post test counselling for Hepatitis C and further such training days are planned.

Services to steroid users have also been expanded. This includes greater promotion of needle exchange facilities to groups like body-builders and signposting those experiencing problematic steroid use to Turning Point's 'Smart Muscle' project.

A number of initiatives are addressing the issue of problematic alcohol use. For example, Identification and Brief Advice (IBA) training has been rolled out to probation officers and midwives over the past few months and sexual health workers have been prioritised as the next group for this training. Work is also being undertaken on the improvement of the alcohol pathway from Primary Care to hospital. This includes developing the roles of the Primary Care Alcohol Worker and King's College Hospital's Alcohol Nurse to ensure greater client support.

Maintaining a strong recovery focus remains a priority within the borough and staff from all local services have undertaken training in recovery principles and practices. Other staff training initiatives have covered pre and post-test Hepatitis C counselling, party drugs and the management of clients who are at high risk of reoffending, which was delivered with support from Southwark Probation.

The crucial role of carers and partners in an individual's recovery has long been recognised and services for those groups continue to be developed. All services now offer support to families and carers of service users and psychologists from CDAT also offer a number of borough-wide support groups such as those for families where one partner has recently completed a detoxification programme.

Access to residential rehabilitation beds at Cranstoun's City Roads project has been extended to a broader group of clients following a review of eligibility criteria. Some of the groups who will benefit from this change include those who are relatively new to drug treatment, have shorter drug histories or whose rehabilitation needs can be met through relatively shorter stays. The introduction of a self-referral option has also extended client choices in this area.

Commissioning Services for Older People, Carers and Learning Disabilities

We are continuing to work jointly with Southwark Council and other partners to ensure that we improve the health and social care outcomes for adults and older people in Southwark making best use of joint resources and shaping our services to meet the challenges that a growing older population affords.

We are working in partnership with Southwark Council and the Learning Disability Partnership Board to ensure that the recommendations from the Department of Health Winterbourne View are implemented. In particular we continue to jointly consider our commissioning arrangements for people with learning disabilities in order to ensure that health and social care outcomes are met and that there is equality in access to health care services for this client group.

We are committed to person centred planning for adults and older people and, in order to ensure that this is achieved, we have started to introduce Personal Health Budgets for clients meeting the criteria for NHS Fully Funded Healthcare living in their own homes. We have developed our processes for the introduction of personal health budgets in line with Southwark Council in order to ensure seamless care for clients whose care funding responsibility transfers across organisation boundaries. In line with the Department of Health Evaluation of Personal Health Budgets we will be considering how we can widen access to personal health budgets to other client groups.

We continue to work in partnership with Southwark Council to raise the standard and quality of nursing care within care homes. We are jointly funding St Christopher's Hospice to improve end of life care within these homes. We are also working with the Council to support a project designed to improve the quality of the experience of clients within care homes called 'My Home Life'.

For people who have advanced, progressive and incurable illness it is important to support them to live as well as possible until their death. Our goal is to ensure that all patients at the end of their life have effective, high quality services and are given more choice in the decisions about care and preferred place of death. We are currently focussing on the transfer of clients from out local Gold Patient Register for end of life clients to the new London wide Co-ordinate My Care Register which is part of the new 111 system. We continue to work with staff to ensure the development of end of life skills including advance care planning to support end of life choices.

There has been significant joint work during 2012/13 around carers, including the research by Carers UK to support the Southwark health and social care review for carers in Southwark, which has identified a number of key priority areas for development and investment during 2013/14. This focus will help to reduce the number of hidden carers in Southwark and improve access to carer services, improving health and social care outcomes. We are working with Southwark Council through a joint steering group to refresh the Carers Strategy for 2013 onwards.

Safeguarding Adults and Children

Integrated multi-agency working is the key to our robust joint approach to key safeguarding issues and keeping adults and children safe is a key priority for us and is an integral part of all our planning, commissioning, contracting and monitoring of delivery of services. We are members of the Southwark Safeguarding Adults Partnership Board and the Southwark Safeguarding Children Board (SSCB) which ensure best practice safety and that any lessons learned from internal management reviews and serious case reviews are embedded in practice at the earliest opportunity. The designated nurse and doctor for safeguarding children also attend the SEL meetings with the Director of Nursing and the Medical Director and the NHS London Designate Meetings. From the outset we have involved clinicians in this area of work and have a named clinical leads for safeguarding children and adults.

All GP Practices are signed up to ‘My Learning Source’, a website providing free safeguarding children and adult training.

This year we have developed our Safeguarding Adults Commissioning Strategy which sets out our safeguarding expectations for commissioners of services for adults and older people. We are working in partnership with the Southwark Adult Safeguarding and the Learning Disability Partnership Boards to ensure that all the recommendations from the Winterbourne Review are implemented locally.

Training was undertaken with the safeguarding lead from each Southwark GP Practice in November 2012 and February 2013. The facilitation is by the designated nurse for child protection and variously the SSCB Development Manager and the commissioned provider for response to domestic abuse in Southwark, Solace.

Attendees were updated on the latest trends in safeguarding children both nationally and within Southwark, emphasising the issues of responding in a timely way to neglect .The vulnerability of older children above the age of 14 years, in particular regarding child sexual exploitation and youth violence was highlighted and how early attachment difficulties can leave children more vulnerable to these areas of abuse.

The Royal College of General Practitioner’s safeguarding children audit tool and the job description for the safeguarding lead from the GP Toolkit was introduced and discussed as a way of GP Practices focusing on what is required as assurance to the commissioners in 2013 that they are discharging their safeguarding responses adequately. The designated nurse continues to offer Level 2 training in child protection to all GP Practices in Southwark.

A very successful training event on safeguarding children from serious youth and gang violence was held in February 2013 aimed at the GP Practices, attended by approximately 150 GPs, practice nurses and affiliated clinical staff in Southwark. There were a wide range of speakers from different agencies in Southwark including Community Safety and Children’s Services.

Quality

Finally the future of health service commissioning in Southwark will need to take account of the report on Mid-Staffordshire NHST Trust published on February 2013 by Roberts Francis QC. This report challenges all parties involved in the provision, commissioning and scrutiny of health services. The main thrust of the report is a call to improve awareness of poor continuity of care in the NHS where it exists, as well as to encourage a culture which naturally challenges all instances of poor care. NHS Southwark CCG has developed its approach to commissioning for quality and this was agreed at a meeting of the Clinical Commissioning Committee in public in March 2013. This includes setting out the process for identifying early warnings and bringing together different sources of information. The approach will be iterative in nature with further reviews to ensure the framework takes account of the Francis recommendations as well as being aligned with the final Department of Health response to the document.

6. IMPROVING PERFORMANCE

In 2012/13 Southwark PCT has continued to improve performance and achieved target levels in most key areas (based on November 2012 'year-to-date' positions unless otherwise stated).

Highlights of the year include the following:

- Incidence of healthcare acquired infections (MRSA and *c.difficile*) are lower than last year and better than targeted performance
- All cancer waiting time targets achieved consistently through the current year
- Ambulance response times have improved this year compared to last year's reported performance
- standards for A&E access and RTT achieved in 2012/13
- having supported a record number of people to quit smoking last year, Southwark is on track to again achieve its target in 2012/13
- NHS Southwark is achieving its target for the number of people receiving and benefiting from psychological therapy services

Performance data

Table: Performance on Vital Signs Existing Commitments 2012-2013

Southwark PCT performance against the National Performance Measures included in *The Operating Framework for the NHS in England 2012/13*. The below performance reflect the PCT's position against the indicators listed as of November 2012 unless otherwise stated.

National Priorities		Year End Position 11/12	Target 12/13	M8 YTD 12/13	Traffic Light
Clostridium difficile (C. *diff*.) cases		96	68 (12/13)	34	
MRSA bacteraemia		6	7(12/13)	2	
18 weeks - referral to treatment	% of admitted patients treated in 18 weeks	86.4%	90%	88.1%	
	% of non-admitted patients treated in 18 weeks	97.8%	95%	98.0%	
	% incomplete pathways within 18 weeks	88.8%	92%	92.4%	
Diagnostics - % patients waiting 6 weeks or more		2.87%	1%	2.99%	
The number of breaches of mixed-sex accommodation (MSA) sleeping accommodation, per 1,000 finished consultant episodes.		0	0	1.59	
A&E – % patients who spend 4 hours or less in A&E		95.8% (KCH A&E)	95%	95.8% (KCH A&E)	
Ambulance Response Times (South East London)	Cat. A (Red 1) calls response within 8 mins	75.6%	75%	75.8%	
	Cat. A (Red 2) calls response within 8 mins	75.6%	75%	74.6%	
	Cat A response within 19 mins	99.1%	95%	98.0%	
Cancer 2 week waits (all urgent GP referrals)		97.6%	93%	96.6%	
Cancer 2 week wait (for all breast symptom referrals)		97.0%	93%	97.6%	
Cancer 31 day wait from diagnosis to (first definitive) treatment		97.9%	94%	98.4%	
Cancer 31 day wait from diagnosis to (subsequent surgical) treatment		97.5%	96%	100.0%	
Cancer 31 day wait from diagnosis to (subsequent anti-cancer drug regime) treatment		99.1%	98%	99.6%	
Cancer 31 day wait from diagnosis to (subsequent radiotherapy) treatment		95.9%	94%	97.6%	
Cancer 62 day wait from urgent GP referral to treatment		89.5%	85%	85.4%	

National Priorities		Year End Position 11/12	Target 12/13	M8 YTD 12/13	Traffic Light
Cancer 62 day wait from urgent referral from national screening services to treatment		97.1%	85%	95.7%	
Cancer 62 day wait from consultant (upgrade) referral to treatment		92.3%	90%	94.7%	
Smoking quitters		1685	445 (Q2)	693 (Q2)	
NHS Health Checks	% people ages 40-74 who have been offered a health check	9.4%	6.3% (Q2)	14.7% (Q2)	
	% people ages 40-74 who have received a health check	1.8%	2.5% (Q2)	4.9% (Q2)	
The number of new cases of psychosis served by early intervention teams year to date		92	Trajectory	50	
Proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care		96.4%	95%	92.3%	
IAPT	Proportion of people with depression referred for psychological therapy	6.2%	4.4% (Q2)	4.9% (Q2)	
	Proportion who complete therapy who are moving to recovery	37.3%	40.8% (Q2)	40.5%	

7. WORKING IN PARTNERSHIP

Engaging patients and the public

We have continued to develop our patient engagement structures throughout the last year. Nearly all GP practices in Southwark are members of the National Association of Patient Participation which provides a range of resources and tools to help practices develop a range of engagement mechanisms to help strengthen our engagement structure. Each practice based Patient Participation Group (PPG) has one or two patient representatives who attend one of four locality PPGs to enable patients to have a say and contribute to commissioning health services on a locality basis. In turn, the locality PPGs have two patient representatives that attend the borough wide Engagement and Patient Experience Sub Group (EPEG) of the Clinical Commissioning Group in Southwark and which is chaired by one of the clinical leads who sits on the Clinical Commissioning Group. The Local Involvement Network (LINk), Community Action Southwark and the Forum for Equality and Human Rights in Southwark are also members of EPEG. The LINk also has a place on the Clinical Commissioning Group, which meets monthly in public.

EPEG set up a number of short term working groups during the last year to enable patients to take part in the review of Ear, Nose and Throat (ENT) and Dermatology services and development of proposals. Patients have also worked with us in developing our proposals for better supporting general practitioners in referring patients who need specialist care and developing our patient survey and leaflets about this.

We are also working with Membership Engagement Services (MES) to explore how we can extend our participation to other local people and they ran a workshop in September 2012 with local people to explore why people do engage in local health services and what prevents them. A write up of the workshop with recommendations was written to inform the development of our work in this area.

Developing health services in Dulwich and the surrounding areas

In August 2011, the Southwark Clinical Commissioning Group decided that it would develop health services in the Dulwich area in the south of the borough, following on from the borough wide consultation in 2009 on the vision for primary and community health services. Since then this has been the work of the Dulwich Project Board, a sub-group of the Southwark Clinical Commissioning Group. This group has two GPs on it providing the clinical leadership and representatives from the key partner organisations: the NHS South East London, King's College Hospital NHS Foundation Trust and Guy's and St Thomas' NHS Foundation Trust as well a representative from the local LINk, and two representatives from our Engagement and Patient Experience Sub Group.

The first part of the project was to engage with local people and get their views for health services in the Dulwich area. We focussed on services which address the increasing birth rate in East Dulwich, and the more widespread increase in people with long term conditions and people who are older and need short term or longer term support to be able to stay at home. Our ideas

were set out in a document ‘Developing Health Services in the Dulwich Area’ and people were able give their views through a paper based or electronic survey.

During this three month engagement period we discussed our ideas with over 50 different groups and over 300 at people including patient participation groups based at general practices, children’s centres, baby clinics, older people’s groups, carer’s groups, specific groups for people living with particular conditions, faith groups, a drop in session at Dulwich library and the local community councils. By the end of the engagement we had over 1000 comments and views which we fed back to local people at a public meeting in July 2012.

Since then we have continued our discussions with local clinicians working in primary and community health services and at King’s College Hospital asking for their views and ideas about how community based health care can be improved.

We then drew all this information together, and also looked at the demographic information and how people currently use health services and developed a proposed ‘service model’ – the combination of services we want to see in the community. We have also considered how this model might be delivered on the ground. Both our proposals include developing a health centre ’hub’ on the Dulwich Hospital site.

The pre consultation business case was agreed at the Southwark Clinical Commissioning Committee and the Joint PCT Board meeting in January 2013. A three month consultation runs until May 2013 on the service model and the options for delivery. The results of the consultation will be independently analysed and a report presented to the NHS Southwark Clinical Commissioning Group to inform their decision and the development of the next stages of the project.

Stakeholder reference groups

In April 2011 the NHS South East London Clinical Strategy Group and South East London Joint Boards established three stakeholder reference groups (SRGs). One for Lambeth, Southwark and Lewisham (LSL), one for Bexley, Bromley and Greenwich (BBG) and a South East London (SEL) wide group attended by members of both the LSL and BBG groups.

The SRGs report into the Clinical Strategy Group and have two main objectives:

- to improve the engagement plans of the local NHS and identify opportunities for strengthening engagement
- to review the impact of any plans on patient choice.

The SRGs aim to improve relationships with stakeholders and ensure they are kept informed of changes in the local NHS. They are made up of representatives from LINks, the voluntary sector, council overview and scrutiny chairs and officers, clinical commissioners, non executive directors and other representatives across NHS South East London. Local provider organisations are also invited.

Achievements over the last year include:

- reviewing of a range of engagement plans relating to different service improvements and developments

- co-ordinating responses to national developments and processes, including the engagement requirements for Any Qualified Provider and the Trust Special Administrator's report on South London Hospitals Trust (SLHT) and the NHS in South East London
- improving relationships between clinical specialities and organisations.

Local Involvement Network

LINk Southwark is a statutory body set up to enable local people to become involved in their health and care services. LINk Southwark appointed a new leadership group at the beginning of the year and we have been working with LINk on a number of areas. We have LINk representatives on a number of committees and sub groups: the Southwark Clinical Commissioning Group, the Engagement and Patient Experience Sub Group, the Dulwich Project Board, the Integrated Governance and Performance Sub Group, the Lambeth, Southwark and Lewisham Stakeholder Reference Group, and the South East London Stakeholder Reference Group.

Overview and Scrutiny Committee

NHS Southwark Clinical Commissioning Group has worked closely with the democratically elected members of the Southwark Health, Adult Social Care, Communities and Citizenship Scrutiny Committee as they reviewed the development of clinical commissioning in Southwark. We regularly updated the committee on our developments and our progress through authorisation. We also worked with the scrutiny sub committee on a number of mental health redesign projects and led a round table workshop with key local players which the Chair of the sub committee attended. In January 2013 we discussed our plans for consultation for developing health services in the Dulwich and surrounding areas and received some useful suggestions for incorporation.

Complaints and Patient Advice and Liaison Service (PALS)

PALS provide a free phone telephone service Monday to Friday, five hours a day as well as answering queries received via email or post.

Local people contact the PALS service when they are experiencing difficulties relating to GPs, dentists, pharmacists and opticians or have more general enquiries about health entitlements. Common reasons for contacting the helpline include wanting to register with a GP, difficulties getting an appointment, or queries about dental charges. PALS helps by resolving any issues within 48 working hours and this can often help prevent issues becoming formal complaints.

Between 1 April 2012 and 31 December 2012 PALS received a total of 1,432 enquires, of which, 1,242 were calls to the free phone helpline. PALS were able to signpost or provide more detailed information to patients to resolve the majority of these enquiries. However, 335 enquiries required more detailed casework: 148 of these cases were about GPs and 34 were about dentists and six were about pharmacies. Examples of the case work involve patients requesting immunisation records, individual funding requests or treatment abroad. PALS also received one compliment about the care the patient received at a GP surgery.

From 1 April 2012 to 30 September 2012 PALS also provided a face to face service for patients in King's Emergency Department (ED) Monday to Friday to support people who have visited the

ED with a health need that could best be treated at a GP practice. During this period PALS provided information or support to 1,380 patients and redirected 338 of these patients to other services. From 1 October the ED PALS service transferred back to King's College Hospital.

Our approach to complaints handling reflects the six principles representing good practice as set out in the Parliamentary and Health Service Ombudsman's "Principles for Remedy" (May 2010) and we encourage these principles to be followed by all staff investigating complaints. In line with the "Principles for Remedy" we seek continuous improvement in our handling of complaints. Our approach is also reflected in our Complaints Policy and the Being Open Policy, which ensures a patient focused and transparent process for addressing complaints.

From April 2012 -31 December 2012 we received 90 complaints about GPs, 11 about dentists, three about pharmacists and one about SELDOC. Common reasons for making a complaint include staff attitude, communication issues and difficulty getting convenient appointments.

Quarterly and annual Complaints and PALS reports are presented to our Engagement and Patient Experience Sub Group and the Integrated Governance and Performance Sub Group.

From 1 April 2013 enquiries relating to GPs, pharmacies, dentists and opticians will be answered by a call centre in the NHS Commissioning Board in Leeds 0113 825 2525.

8. MAKING IT HAPPEN

NHS South East London staff

NHS South East London currently employs 753.45 full time equivalent (FTE) staff across five PCTs and one care trust. Following the last organisational change process in March 2011 which led to the creation of NHS South East London, a new human resources (HR) team was formed. Staff in Southwark receive HR expertise, advice and support from this central team together with workforce transformation support as we continue to develop our services towards delivering GP commissioning.

As a result of the Health Act 2012, it was agreed that PCTs would not be subject to a Staff Survey in 2012. However, staff views are valuable and an action plan was developed after the 2011 staff survey and a series of development actions with our staff have taken place including a series of developmental days in addition to personal training and development.

Sickness absence

Monthly sickness absence reports include individual sickness absence trends. These are discussed with appropriate managers to ensure that the right support is provided to staff who are absent due to sickness to enable appropriate and timely returns to work. The sickness absence rate for the NHS in England for the period July to September 2012 was 4.06 per cent.

The following sickness information relating to Southwark PCT has been provided by Department of Health ESR system:

	2012-13 Number	2011-12 Number
Total Days Lost	**511**	**1,342**
Total Staff Years	**75**	**253**
Average working Days Lost	6.80	5.30

Training and development

The NHS South East London Staff Development Programme was launched in September 2011 based on the training needs identified in personal development plans. This programme offers a range of learning and development opportunities for staff such as project management with the aim of supporting knowledge, skills and personal development particularly during a period of organisational change. The programme also ensures that all staff work in a safe and effective way and are up to date with their statutory and mandatory training. Staff can also apply for external training that is not covered by the programme.

- 6 different training courses were offered to staff up to March 2013, arranged in 7 course sessions with a total of 85 places available
- 47 staff have had individual training fund requests approved.

Additionally, in March 2012, NHS South East London launched the “Piecing Together Change” programme designed specifically to help support staff during transition. The programme was comprised 85 workshops with a total of 1020 places available. The second part of the programme comprised of a series of one to one clinics providing additional support to staff affected by change. 126 slots of 1h 15 minutes were made available to staff.

Communicating with our staff and our member practices

In Southwark, communicating with our staff and member practices has always been a priority, particularly during periods of change and uncertainty. It is well recognised that good communication is vital to the effective implementation of organisational change and a number of systems have been put in place to provide clear and consistent information to staff and enable them to contribute and engage in developments.

These include:

- weekly e-bulletins to GP practices and development of a dedicated GP intranet
- regular staff communication through weekly updates and e-bulletins and special transition bulletins
- monthly staff briefings with the opportunity for questions and feedback
- interactive staff road shows organised to update on key organisational change such as the development of a commissioning support service
- confidential comment box and email addresses for questions raised and responded to.

As part of our commitment to effective and productive conduct of employee relations we are part of a cluster wide joint partnership forum with staff side representatives. The purpose of the forum is to identify and facilitate workforce and employment business. This involves negotiation and consultation on policies and impending organisational changes. The forum meets on a bi-monthly basis and is committed to continuously improving the working lives, health and wellbeing of its staff.

During the last year, we have also worked collaboratively across London on communication campaigns and initiatives. This has enabled us to benefit from shared expertise and consistent public messaging around key organisational priorities. This includes a:

- London wide flu campaign encouraging people at risk to get vaccinated
- South East London Choose Well campaign based on patient insight and evaluation
- Waste Medicines Campaign

Effective communications will remain an important component of successfully moving to the new commissioning healthcare system in April 2013.

Equalities for staff

As part of the development of the PCTs Equality objectives for 2012/2013, we have developed equality objectives for our staff and leadership. The purpose of setting these objectives is to strengthen our performance under the Public Sector Equality Duty (PSED) of the Equality Act 2010. The development of the equality objectives has been aligned to the outcome of our Equality Delivery System (EDS) grading for staff and leadership, the EDS goals and outcomes, as well as the priorities of the organisation in regards to people transition. The EDS grading for

staff and the leadership of NHS South East London was carried out at the beginning of March 2012.

In order to comply with our statutory duty to publish workforce information in relation to the nine protected characteristics listed in the Equality Act 2010, we have recently carried out a process of data cleansing of personal information currently held on our HR Electronic Staff Record (ESR) system.

This process has enabled us to collect non-personalised data to provide an initial equality and diversity baseline. This indicates the coverage of information collection across the protected characteristics: Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Race, Religion and Belief, Sexual Orientation, Ethnicity and Pregnancy and Maternity. The data collection process will be done again in early 2012/13 to improve the accuracy and completeness of personal information held on the HR Information System. This will be used to form the baseline for equality impact assessments to ensure a fair and consistent transition processes for all staff.

Equality, Diversity and Human Rights

After adopting the Equality Delivery System (EDS) in 2011, in 2012 we built upon our achievements made during the previous year.

The EDS aims to achieve positive cultural change in the NHS by creating an environment where services for patients and workplaces for staff that are more equitable, diverse and which fairly represent the wider community. The Corporate Equalities Group, set up to implement the EDS across NHS organisations in south east London, continued the work of embedding equality into mainstream business activity.

The EDS enabled us to meet the aims of the Equality Act 2010 which is a legal requirement of all public organisations to take the necessary actions to achieve:

- Elimination of unlawful discrimination.
- Advancement of equality of opportunity.
- Fostering of good relations between individuals and communities.

Adoption of the EDS was an essential requirement in order for the new Clinical Commissioning Groups (CCGs) to become authorised.

Achievements during 2012/13 include:

- Equality embedded into the new CCG organisations
- Joint Strategic Needs Assessments cover all the protected characteristics and key disadvantaged groups.
- Cluster-wide performance in the Learning Disability – Self Assessment Framework (LD-SAF) 2012 improved significantly, with central co-ordination and monitoring.
- All local NHS organisations complied with the Public Sector Equality Duty (PSED).
- CCGs have Equality Leads at Non Executive and Executive Levels and/or they have purchased an Equality and Diversity Service from the South London Commissioning Support Unit.

The efforts of staff at many levels within the NHS organisations, in implementing the EDS have played a part in improving health outcomes for all and reducing health inequalities across South East London.

We are committed to promoting equality, diversity and human rights and we have made equality and human rights "everyone's business" to integrate equality and human rights into everything we do. Moreover, we have ensured that our commissioning processes are grounded in the human rights principles known as "the FREDA Principles". This means that commissioning decisions about care pathways for Southwark people will be based on:

- Fairness
- Respect
- Equality
- Dignity
- Autonomy

Last year, as part of our response to the Public Sector Equality Duty, we set ourselves some challenging four year Equality Objectives, particularly in the present economic and budgetary constraints. With the help of our dedicated workforce, stakeholders, providers, partners and local community organisations, we have made good progress on these objectives. In addition, our adoption of the Equality Delivery System (EDS) NHS outcomes framework provides a comprehensive picture on how we are doing as a new organisation in integrating equality and human rights, eliminating discrimination, advance equality of opportunity, and foster good relations between different people and addressing health inequalities in everything we do.

Achievements during 2012/13 include:

- Launched our Equality and Diversity Strategy
- Developed an annual equality and human rights Action Plan
- Developed the consultation plan for developing health services in Dulwich and the surrounding areas, which included conducting an Equality Impact Assessment across the 9 protected groups and developing this as Best Practice for Southwark people

We have made further positive achievements for meeting the needs of people with Learning Disabilities (LD). At the NHS London ratification meeting, NHS Southwark was congratulated on the quality of the submission and evidence provided for its Learning Disability Self Assessment Framework. We have ensured that a resource pack to go out to all GP practise in Southwark. The pack includes:

- Easy read appointment letters
- Invitations for annual health checks
- Top tips for recognising learning disabilities
- Easy read complaints & PALS leaflets
- Information on the Community Learning Disability Team
- Tips around making reasonable adjustments i.e. offering longer appointments
- Easy read booklets around bowel, breast and cervical screening.

We have continued integration of equality and human rights outcomes in mental health for Southwark people by redesigning a number of services to enhance outcomes through our

Quality, Innovation, Productivity and Prevention (QIPP) transformational programme for the NHS. There are some good examples of how we are integrating a right to life and safeguarding for Southwark people. These include:

- The Community Pharmacy Medicines Information Exchange pilot – the aim of the service is to identify clients with mental health conditions who do not collect their prescribed medication and thereby enable GPs and Community Mental Health Teams (CMHT) to manage clients appropriately and reduce the risk of harm for clients not taking their prescribed oral medicines regularly.

- A single point of access - as part of the Improving Access to Psychological Therapies (IAPT) programme a Single Point of Access (SPoA) has been developed within each locality, which will triage referrals to the relevant intervention as part of the stepped care model for mental health services.

- Older people services - create a community based model which will be a multidisciplinary team approach offered to people at high risk of unplanned hospital admission

- Community Services - reconfigure the Community Teams to enhance the assessment team and provide better support for people in crisis in the community.

Preparing for emergencies

With the formation of the NHS South East London, emergency planning and response has been coordinated across south east London level with participation of PCT emergency planning leads through a combined steering group. This group formed policies and plans and ensured that the PCTs remained resilient through transition and this was evidenced in an assurance process conducted by NHS London in 2012.

The highlight of 2012 was, of course, the London Olympic and Paralympic Games. One third of the games time events took place within Greenwich, with many visitors enjoying passing through Southwark, and considerable time and effort went into ensuring that south east London's health service was games-ready. A high-level senior coordinating committee planned and coordinated all providers, from the major acute trusts to small community pharmacies and nursing homes, to ensure everyone was prepared. NHS South East London also worked closely with local authorities and Transport for London to ensure that staff and service users were aware of the possible impacts of the games and that disruption was kept to a minimum.

As we look to the future, the emergency planning, responsiveness and resilience (EPRR) functions of the PCTs will transfer to either the NHS Commissioning Board (who will undertake the majority of emergency planning and response functions for London) or Public Health England (who will be responsible for the local and regional health protection) in liaison with Directors of Public Health who will be integrated with their local authority.

NHS Southwark CCG will continue to play an important role in EPRR with responsibilities under the Civil Contingencies Act and a focus on ensuring that Southwark's health service remains robust in planning for, and managing surges in demand. We will also be required to assist the Commissioning Board in the event of a major incident.

CCGs will additionally be represented on their local Borough Resilience Forum and the strategic body, the London Local Health Resilience Partnership.

A transition process has been underway since 2012 to ensure that these functions are handed over safely with assurance exercises conducted in 2013 prior to the handover culminating in Exercise Sentinel which took place in early February. The NHS Commissioning Boards South Area EPRR team will continue to work with all CCGs, providers and stakeholders in south east London to ensure that the NHS remains resilient in planning and response in the years to come.

ICT services

ICT services for Southwark are provided by a South East London ICT Services, which formed by joining our local team with a shared ICT infrastructure service. This new service is responsible for providing co-ordinated, consistent and value for money services across a range of NHS organisations in south east London. The shared service has prioritised a number of key areas for investment and improvement in 2012/13, including:

- The **Primary Care ICT Improvement Programme**, including
    - Implementing a standard three year rolling equipment refresh
    - Upgrading the N3 network for the majority of practices in south east London
    - Continuing and/or completing the rollout of mandated national systems such as the Summary Care Record and the Electronic Prescription Service
    - Upgrading 138 practices across south east London to the latest, hosted version of their GP clinical information system.

- A **core infrastructure upgrade**, including:
    - Upgrading the core data centre at Lower Marsh
    - Upgrading the infrastructure at Southwark's Tooley Street
    - Rationalising core infrastructure where this is the right thing to do, is cost effective, and improves the resilience and availability of the core network, and leads to a greener ICT infrastructure.

- Ensuring that the requirements associated with the **Handover and Closure** programme are delivered, including ensuring that:
    - staff can continue to access their emails by migrating their accounts to their new host body
    - smartcards controls are in place
    - all staff leavers system access rights are managed and/or deleted.

The ICT service will be provided by the South London Commissioning Support Unit in 2013/14. The CSU has developed a suite of strategies that further sets out improvements to the ICT service for NHS and other organisations in South East London, including:

- **Primary Care ICT Strategy:** to complete the rollout of mandated national systems such as the Summary Care Record, and to set out the deployment plan to meet requirements set out in the 2013/14 Operating Plan, including giving patients improved access to their medical records

- **Infrastructure Strategy**: to drive and deliver further improvements in the core infrastructure in South East London, including working with estates leads in Propco to deliver a fit for purpose network, and to further rollout secure remote working solutions for GPs, CCG and other staff, and

- **Capital programme:** a bid for funding has been submitted that will build on these two strategies, as well as focus on looking at the feasibility of introducing new ways of working such as exploiting the telehealth/telemedicine markets.

The CSU will continue to work with its partners to manage and deliver a portfolio of projects in 2013/14 and beyond, including the delivery of a number of estates projects such as the Lambeth and Southwark Integrated Care Programme.

Protecting your information

To provide the best possible healthcare services, NHS organisations collect sensitive and/or confidential information, often called Personal Identifiable Data (PID). The key elements of Information Governance set the standards to ensure that this information is dealt with legally, securely, efficiently and effectively. Throughout this year we have focused on the management and preparation of change in the NHS to ensure continuity of service and appropriate controls around patient information. All our staff have to undertake Information Governance training and we continue to be committed to the standards set out by the Care Record Guarantee and the Information Governance Toolkit.

We continue to work hard to ensure the security of patient information and maintain appropriate access. We are reviewing current ways of working as well as support new innovations to ensure that appropriate controls and security are in place. Along with these changes we are keeping local patients informed about how their information is being used to deliver their healthcare and manage the NHS.

Areas of focus during 2011/12 and 2012/13 include:

- Records management in response to Department of Health guidance published in October 2011.
- Information security – ensuring that patient information continues to be handled safely and securely.
- Registration Authority – ensuring there is an appropriate framework in place that meets NHS and legal requirements to provide, monitor and manage access to NHS Care Record Service systems such as GP clinical systems.

We have put in place arrangements for investigating if there is any potential breach of our procedures or policies. As part of this process, we consider whether we need to report breaches to NHS London and the independent Information Commissioner's Office.

Statement on public information

NHS Southwark complies with HM Treasury's guidance on setting charges for information in 'Managing Public Money' which can be found at
http://www.hm-treasury.gov.uk/psr_mpm_index.htm

Managing our risks

Our approach to risk management and board assurance is in accordance with legislation and national and local guidance. It seeks to embed recognised and developed best practice through a process of on-going review and improvement whilst underpinning the production of the annual governance statement.

We believe that we have in place a sound governance structure to serve our local population. As part of this we use effective risk management to ensure that our corporate and key objectives are met.

Full details of the NHS South East London approach to risk management can be found in the Final Accounts and Annual Governance Statement.

Between April 2012 and January 2013 King's College Hospital Foundation NHS Trust reported 56 Serious Incidents, three of which were Never Events. These were under the category of retained foreign objects.

Southwark revised its Risk Management Strategy in summer 2012 to reflect the emerging health landscape and define accountability at all levels for good risk management. We continue to work closely with internal and external partners to promote best practice risk management and to ensure compliance with all relevant local and national requirements as part of good governance. In January 2013 NHS Southwark CCG achieved authorisation to become a statutory body. This followed a rigorous assessment of its capability and capacity across all domains. NHS Southwark CCG was declared a safe and robust organisation, capable of undertaking its duties.

Southwark developed its Board Assurance Framework for 2012/13, based on objectives for the year with input from the SEL PCT cluster – our parent organisation. Our Corporate Risk Register captures key risk issues drawn from local directorate risk registers to enable direct monitoring of risk performance over time. These are formally reviewed at least monthly and presented to each meeting of the Integrated Governance and Performance Group, a sub-committee of the CCG Governing Body, and to the Governing Body on a quarterly basis.

Our Estate and sustainability

Transfer of Estates and staff to NHS Property Services Ltd.

NHS Property Services Ltd has been set up to maintain, manage and develop around 3,600 NHS facilities, from GP Practices to administrative buildings. The NHS SEL Estates team are preparing for the transfer of existing roles to NHS PS prior to the launch of the new organisation in April 2013. The team will remain at Lower Marsh and will initially continue to undertake the current range of services provided.

Southwark Estates

2012/13 has been a year of further significant investment in the Southwark community estate, with investment to reduce backlog maintenance being the main priority. Funding has also been

secured and approved to address statutory, contractual and CQC identified priorities across Southwark GP sites.

The new Urgent Care Centre in Guy's Hospital opened to patients in July 2012, and was officially opened in September 2012 by Simon Hughes MP.

Estates support has continued to be provided to the Dulwich project and Project Board.

Considerable time has been given to DoH completing due diligence returns in support of the transfer of the estate planned for 31st March 2013 to community service providers, Community Health Partnerships (LIFT) or to NHS Property Services Ltd. Additional resources have been made available to progress where possible, outstanding TCS and other tenant leases prior to transfer.

Sustainability

Environmental sustainability is an important NHS priority. New developments brought into use in the year have conformed to the latest requirements providing better quality patient and staff environments as well as more efficient infrastructure. Capital has been invested in energy efficiency measures such as boiler replacement and new windows.

NHS Southwark shares office accommodation with Southwark Council which was designed to the highest environmental standards including a biomass boiler and rainwater harvesting.

9. GOVERNANCE

The Board

On 1 April 2011, NHS South East London was established as a transitional organisation to take us through to 2013 and the implementation of the new healthcare system. NHS South East London consists of a single shared corporate management team and six borough based business support units (BSUs). There is a single accountable officer (the Chief Executive), an executive team made up of the Chief Executive and four other directors (3 from 1 June 2012), a chief nurse and a medical director who work with the managing directors of the six BSUs and the Chairs of the Local Clinical Commissioning Committees.

The joint boards are six individual PCT/care trust boards that work together as one entity, undertaking the duties that are enshrined in law relating to the governance of primary care trusts and care trusts, but fulfilling them in a slightly different way. Certain mandatory positions on the boards, such as the chair and chief executive, are fulfilled by the same individual across all of the boards, while other positions are taken by local BSU managing directors and locally focused non executive directors. Fulfilling the same legal duties as trust boards have always had, the boards focus on developing strategies and priorities for the entirety of South East London, ensuring that the shadow clinical commissioning groups are fulfilling their duties, in accordance with what is delegated to them.

Throughout 2012/13 the boards met every two months, in public. All meetings were quorate for all boards. During 2012/13, the Southwark PCT Board members were as follows:

Name	**Position**
Caroline Hewitt	Chair, NHS South East London
Steven Corbishley	Non Executive Director
Andrew Kenworthy	Chief Executive NHS South East London (until 4/9/12)[1]
Christine Craig	Interim Chief Executive NHS South East London (from 3/9/12)
Richard Chapman	Acting Director of Finance[2]
Malcolm Dennett	Interim Director of Finance (from 14/11/12)
Alison Tonge	Interim Director of Finance (from 6/8/12 to 15/11/12)
Jane Schofield	Director of Operations and Joint Deputy Chief Executive

Gill Galliano	Director of Development and Joint Deputy Chief Executive (until 30/7/12)
Donna Kinnair	Director of Nursing (until 1/10/12)
Jane Clegg	Interim Director of Nursing (1/10/12)
Sue Gallagher	Non Executive Director
Richard Gibbs	Non Executive Director
Graham Laylee	Non Executive Director
Rona Nicholson	Non Executive Director
Robert Park	Non Executive Director
David Whiting	Non Executive Director
Dr Ruth Wallis	Director of Public Health (from September 2012)
Dr Amr Zeineldine	Chair, Southwark Clinical Commissioning Group
Andrew Bland	Managing Director, Southwark Business Support Unit
Dr Ann Marie Connolly	Director of Public Health (until September 2012)

[1] Mr Kenworthy retained Accountable Officer status for the whole of 2012/13

[2] Mr Chapman retained Director of Finance Accountable Officer status for the whole of 2012/13

The declared interests of the Board members are in the following table:

Declaration of Board members personal and financial interests – 2012/2013

NAME	Company/ Organisation	Position/ Shareholding/ remuneration	Directorships and or other significant interests
Steven Corbishley	BT	A small number of shares of insignificant value	Nil
Susan Gallagher	Guy's and St Thomas' Charity	Trustee No remuneration paid	Self employed executive coach, facilitator and development consultant Husband a consultant oncologist at the Barts Health NHS Trust
	Guy's and St Thomas' Foundation Trust	Stakeholder governor	
Richard Gibbs	PHAST, a provider of public health consultancy to NHS bodies	Associate Consultant Value: None Materiality: Negligible since I avoid involvement with PHAST work in SE London	Nil
	Pembroke House, a charity helping deprived children in Walworth	Trustee No remuneration paid	
Caroline Hewitt	Withers LLP	Husband is partner in law firm whose clients include some NHS organisations. Remuneration: benefits from profit share	Nil
	VSO UK/VSO International	Member of Audit Committee No remuneration paid	
	King's College Hospital Charity	Trustee No remuneration paid	
Graham Laylee	ECT Venues Ltd – from time to time provides conference rooms for NHS organisations.	Non Executive Director and small shareholder. Remuneration paid	Nil
Rona Nicholson	None	None	I am an Executive Director of Hanover Housing Association which operates in South East London and holds supporting people contracts with a number of Local Authorities
Robert Park	Cambridge House	Trustee No remuneration paid	Nil
David Whiting	Whiting & Birch Ltd	Director & Co Owner 50% shareholding Remuneration paid	Occasional sales of books and journals to NHS bodies which are largely indirect and through agencies. Working relationship with academics and others who may be employed in the NHS, or undertake research in the NHS. Publishing activities on behalf of professional organisations

NAME	Company/ Organisation	Position/ Shareholding/ remuneration	Directorships and or other significant interests
			and academic bodies (non in the UK).
Richard Chapman	None	None	Nil
Ann-Marie Connolly (left)	None	None	Nil
Gill Galliano (left)	PCC CIC (Social Enterprise)	Trustee	Nil
Andrew Kenworthy	Diabetes UK Alzheimer's Society British Heart Foundation	Fund-raising for these organisations Wife – Consultancy business, training health professionals on cardio-vascular health and stroke for health communities/organisations across the UK	Nil
Christina Craig	None	None	Nil
Donna Kinnair	Royal College of Nursing Publications	Consultant Editor Expenses paid	Nil
	CWfI (Mouchell)	Board Member No remuneration paid	
	Walworth Academy	School Governor No remuneration paid	
Jane Clegg			
Jane Schofield	None	None	Nil
Malcolm Dennett			
Amr Zeineldine	Aylesbury Partnership General Practice Membership of SELDOC	Partner (GP Principal) 20% shareholder Remuneration paid	Director of Aylesbury Medical Services Ltd providing Community Dermatology in Southwark
Andrew Bland	None	None	Nil
Ruth Wallis	Lambeth Local Authority Southwark Local Authority Lambeth CCG Southwark CCG	Joint Director	Nil

Board committees:

Southwark Clinical Commissioning Committee

Southwark Clinical Commissioning Committee

The local clinical commissioning committees (LCCCs) are forerunners to the clinical commissioning groups (CCGs) replacing PCTs and care trusts as the commissioners of local health services on 1 April 2013. These clinically led bodies are supported to identify local healthcare needs and prioritise commissioning accordingly, providing a local focus to cluster wide strategies. They also undertake the duties of the professional executive committees (PECs) and provide oversight of local performance.

The Southwark Clinical Commissioning Committee is chaired by Dr Amr Zeineldine. It meets monthly in public. The full membership is listed below:

Name	Position
Dr Amr Zeineldine	Chair
Dr Jonty Heaversedge	Clinical Lead
Dr Adam Bradford	Clinical Lead
Dr Patrick Holden	Clinical Lead
Dr Simon Fradd	Clinical Lead
Dr Mark Ashworth	Clinical Lead (until June 2012)
Dr Jane Cliffe	Clinical Lead (until June 2012)
Dr Roger Durston	Clinical Lead
Dr Sian Howell	Clinical Lead (from June 2012)
Dr Anu Bhatia	Clinical Lead (June to December 2012)
Andrew Bland	Managing Director, Southwark BSU and Chief Officer NHS Southwark CCG
Malcolm Hines	Chief Financial Officer, Southwark BSU and NHS Southwark CCG
Tamsin Hooton	Director of Service Redesign
Gwen Kennedy	Director, Client Group Commissioning
Dr Ann Marie Connolly	Director of Public Health (until September 2012)
Dr Ruth Wallis	Director of Public Health (from September 2012)
Richard Gibbs	Non Executive Director (Southwark PCT) Lay Member
Robert Park	Non Executive Director (Southwark PCT) Lay Member
Diane French	Lay Member

Dr Stewart Kay	Local Medical Committee Representative (to June 2012)
Dr Catherine McAdam-Freud Dr Claire Lloyd	Local Medical Committee Representative (job share) (from July 2012)
Sarah McClinton	Director of Adult Social Care, Southwark Council
Dr John Moxham	King's Health Partners
Linda Drake	Practice Nurse Member
Dr Suparna Das	Secondary care doctor representative (from January 2013)
Professor Ami David	External nurse representative (from November 2013)
Martin Saunders	LINk Representative (until April 2012)
Barry Silverman	LINk Representative (from May 2012)

There are four sub groups of the NHS Southwark Clinical Commissioning Committee:

- the Engagement and Patient Experience Group
- the Commissioning Strategy Group
- the Integrated Governance and Performance Group
- the Dulwich Project Board.

Joint Audit Committee

The Joint Audit Committee fulfils the statutory audit functions required of PCTs and care trusts, ensuring that the governance and machinery of the cluster and the BSUs is functioning as it should. Its work programme includes reviewing governance arrangements (including information governance), assurance mechanisms including the work of internal and external audit, local counter fraud services, debt and waiver management, and reviewing the board assurance framework to make sure that corporate objectives and organisational risks are properly addressed. The Committee meets four times a year and all meetings in 2012/13 were quorate.

Chair: Steven Corbishley
Executive members: Richard Chapman, Acting Director of Finance, Malcolm Dennett, Interim Director of Finance and Jane Schofield, Deputy Chief Executive
Non executive members: Keith Wood, Harvey Guntrip, Graham Laylee, Rona Nicholson, Robert Park and Jeremy Fraser

Integrated Governance Committee (IGC)

The IGC has the following roles and responsibilities:-

- To oversee the integrated governance of the shadow CCGs and give the Joint Boards assurance that actions and plans put in place by the CCGs are appropriate, adequate and followed through as they work towards Authorisation.
- To give a forum for the shadow CCGs to operate at scale to manage the performance and quality of the major acute, community and mental health providers

- To help enable the Cluster Chief Executive to exercise his role as Accountable Officer through consideration and review of the aggregate Cluster position with respect to performance, finance, quality and emergency planning
- To review and consider the quality and performance of Primary Care, Prison Health and Specialist Services prior to full establishment of the National Commissioning Board
- To oversee the procedures for identifying, investigating and learning for serious incidents and for safeguarding children and vulnerable adults.

The Committee meets monthly and all meetings were quorate during 2012/13. Meetings are not held in public but a summary report detailing issues discussed and actions proposed is provided at each Joint Boards meeting. Meetings rotate on a three monthly cycle:

- Lambeth, Southwark and Lewisham (LSL)
- Bexley, Bromley and Greenwich (BBG)
- NHS South East London Cluster (SEL)

Joint Chairs (rotation): Jim Gunner (BBG), Robert Park (LSL), Caroline Hewitt (SEL)
Executive members: Andrew Kenworthy/ Christina Craig, Chief/Interim Chief Executive; Jane Schofield, Deputy Chief Executive; Richard Chapman, Acting Director of Finance; Malcolm Dennett, Interim Director of Finance; Donna Kinnair/ Jane Clegg, Director/ Interim Director of Nursing
Non executive members: Keith Wood, Susan Free, Rona Nicholson and Sue Gallagher

Handover and Closure Committee
The Handover and Closure Committee oversees all aspects of the Handover and Closure programme in the NHS in South East London leading up to the new NHS commissioning arrangements that come into force on the 1 April 2013. The Committee meets in private but provides its minutes to the Joint Boards. All meetings in 2012/13 were quorate.

Chair: Steven Corbishley
Executive members: Christina Craig, Interim Chief Executive; Jane Schofield, Deputy Chief Executive; Malcolm Dennett, Interim Director of Finance
Non executive members: All non-executive directors are members of this Committee. At least three must be present (including one from LSL and one from BBG) for the meeting to be quorate.

Capital Strategy Group
The Capital Strategy Group oversees all aspects of Capital Strategy, planning and progress in the NHS in South East London. The Group meets in private but considers issues prior to their decision at public meetings of LCCCs or the Joint Boards. All meetings in 2012/13 were quorate.

Chair: Caroline Hewitt
Executive members: Malcolm Dennett, Interim Director of Finance, Richard Chapman, Director of Finance. All BSU Managing Directors are members of this Committee; at least two must be present for the meeting to be quorate.

Non executive members: Richard Gibbs, Keith Wood

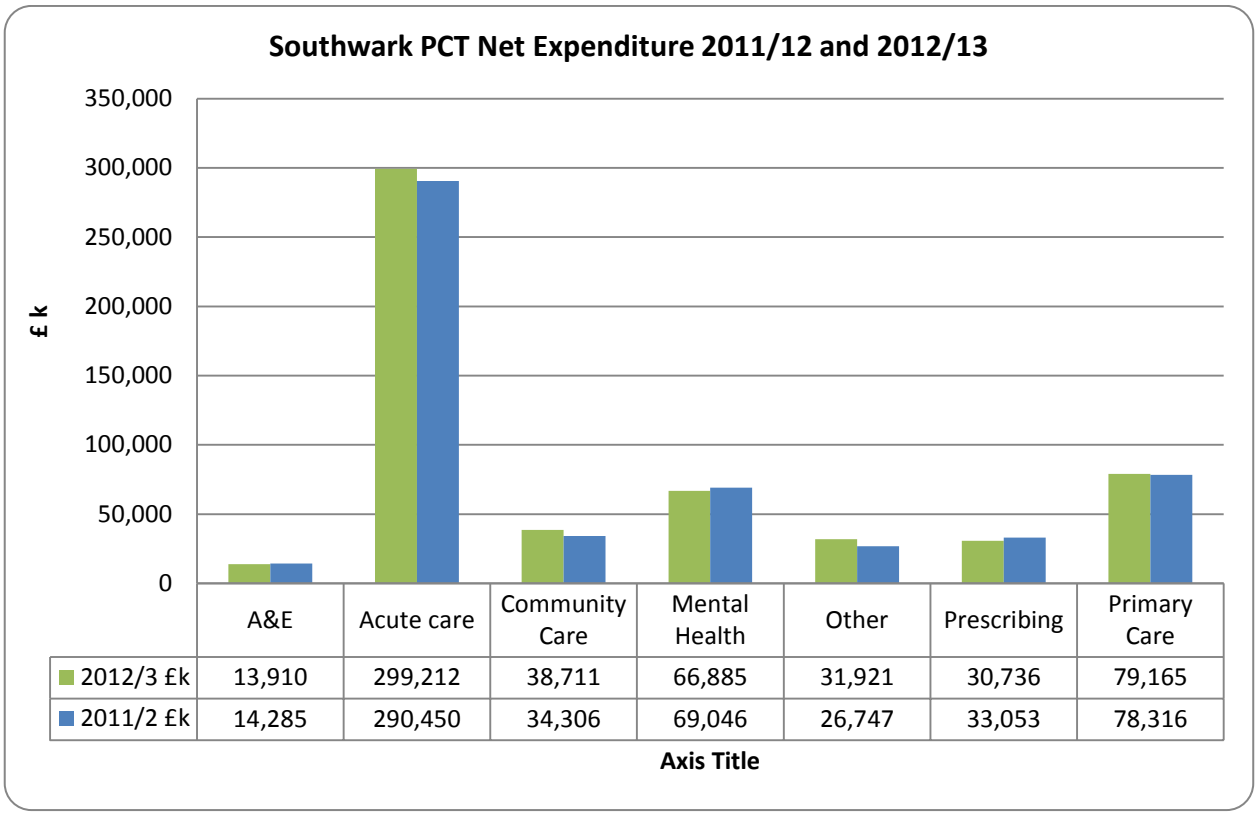
Employment and Remuneration Committee
The Employment and Remuneration Committee meets to consider the employment packages for those employees of the cluster whose remuneration falls outside the scope of Agenda for Change.

Chair: Caroline Hewitt
Executive members: Una Dalton, Director of Human Resources
Non executive members: Sue Gallagher, Graham Laylee, Richard Gibbs, Robert Park, Rona Nicholson, David Whiting, Keith Wood, Paul Cutler, Harvey Guntrip, James Gunner, Susan Free and Jeremy Fraser

10. HOW WE SPENT YOUR MONEY

During 2012/13 we spent:

- **£451m on secondary and community healthcare** of which mental health £67m; general & acute £299m, accident & emergency £14m, community £39m, learning difficulties, Reablement, Continuing Care and other contractual £32m.
- **£109m on primary healthcare** of which, primary medical services £49m; prescribing £31m; dental services £18m; new pharmacy contract £9m and ophthalmic contracts £2m.



	A&E	Acute care	Community Care	Mental Health	Other	Prescribing	Primary Care
2012/3 £k	13,910	299,212	38,711	66,885	31,921	30,736	79,165
2011/2 £k	14,285	290,450	34,306	69,046	26,747	33,053	78,316

11. REMUNERATION REPORT

11.1 Unaudited

The Employment and Remuneration committee of Cluster PCT's meets to consider the employment arrangements for those employees across NHS South East London whose remuneration falls outside the scope of agenda for Change.

The following information relates to the employment of Cluster executive directors and non-executive directors and Chair, Managing Director and Director of Public Health for the PCT.

11.2 Contract details

As a consequence of implementing Health and Social Care Act 2012, all the PCTs and SHAs were abolished on 31st March 2013. Contractual arrangements for officer Board members and Non-executive members, therefore, also terminate on the same date.

Name	Title	Start Date	End Date
Andrew Kenworthy * (to 4/9/2012)	Chief Executive, NHS SEL Cluster	03/10/2011	31/03/2013
Christina Craig *	Interim Chief Executive, NHS SEL Cluster	03/09/2012	31/03/2013
Gill Galliano	Director of Development and Joint Deputy Chief Executive, NHS SEL Cluster	01/04/2011	30/06/2012
Richard Chapman *	Director of Finance, NHS SEL Cluster	01/11/2011	31/03/2013
Alison Tonge *	Interim Director of Finance, NHS SEL Cluster	06/08/2012	15/11/2012
Malcolm Dennett *	Interim Director of Finance, NHS SEL Cluster	14/11/2012	31/03/2013
Jane Schofield	Director of Operations, NHS SEL Cluster	01/04/2011	31/03/2013
Donna Kinnair	Director of Nursing, NHS SEL Cluster	12/02/2011	01/10/2012
Jane Clegg	Director of Nursing, NHS SEL Cluster	09/11/2012	31/03/2013
Caroline Hewitt	Chair, NHS SEL Cluster	01/04/2011	31/03/2013
Steven Corbishley	Non Executive Director, NHS SEL Cluster	14/04/2011	31/03/2013
Susan Gallagher	Non Executive Director, NHS SEL Cluster	01/04/2011	31/03/2013
Richard Gibbs	Non Executive Director, NHS SEL Cluster	01/04/2007	31/03/2013
Graham Laylee	Non Executive Director, NHS SEL Cluster	01/04/2011	31/03/2013
Rona Nicholson	Non Executive Director, NHS SEL Cluster	01/04/2011	31/03/2013
Robert Park	Non Executive Director, NHS SEL Cluster	01/04/2005	31/03/2013

David Whiting	Non Executive Director, NHS SEL Cluster	01/04/2011	31/03/2013
Dr Amr Zeineldine	Local Clinical Commissioning Committee Chair	01/04/2011	31/03/2013
Andrew Bland	Managing Director	01/04/2011	31/03/2013
Dr Ann Marie Connolly	Director of Public Health	11/08/2008	31/03/2013

* During 2012-13 both the Accountable Officer and the Statutory Director of Finance moved to new roles within the NHS. However, for the purposes of these statutory roles they continued to assume this accountability through to the 31 March 2013 and they attended both Joint Boards and Audit Committees. To recognise the requirement for leadership, as a result of these moves, an interim Chief Executive was appointed through to the 31 March and an Interim Finance Director. The Interim Finance Director appointment changed during the course of the year.

11.3 Senior Management cost sharing arrangements

The PCT senior management comprises cluster posts of Chair, Chief Executive and Directors of Finance, Corporate Development, Operations and Nursing shared equally across the five PCTs and the Care Trust in the Cluster. The Non-Executive directors appointed to the Cluster Board are shared equally across their representation of separate health economies of LSL (Lambeth, Southwark and Lewisham PCTs) and BBG (Bexley Care Trust, Bromley and Greenwich PCTs). The rest of the PCT Board consists of local Managing Director, Director of Public Health and GP lead Chair of the PCT's Clinical Commissioning Committee.

11.4 The costs of the Executive and Non-Executive members reported below are the PCT's share of costs, where relevant, in the line with the arrangements described above.
Audited

Cluster Board Executive and Non-Executive members (*PCT's share of costs*)

Salaries and allowances

		2012/13				2011/12			
Name	**Title**	**Salary (bands of £5,000)**	**Other Remuneration (bands of £5,000)**	**Bonus Payments (bands of £5,000)**	**Benefits in kind (rounded to the nearest £00)**	**Salary (bands of £5,000)**	**Other Remuneration (bands of £5,000)**	**Bonus Payments (bands of £5,000)**	**Benefits in kind (rounded to the nearest £00)**
Andrew Kenworthy (to 4/9/2012)	Chief Executive, NHS SEL Cluster	5-10				10-15			
Simon Robbins (to 31/08/2011)	Chief Executive, NHS SSEL Cluster					10-15			
Christina Craig (from 3/9/2012)	Interim Chief Executive, NHS SEL	25-30							
Gill Galliano (to 30/6/2012)	Director of Development and Joint Deputy Chief Executive, NHS SEL Cluster	5-10				20-25			
Richard Chapman	Director of Finance, NHS SEL Cluster	15-20				10-15			
Alison Tonge (from 6/8/2012 to 15/11/2012)	Interim Director of Finance, NHS SEL	10-15							
Malcolm Dennett (from 14/11/2012)	Interim Director of Finance, NHS SEL Cluster	10-15							
Jane Schofield	Director of Operations, NHS SEL Cluster	20-25	40-45			20-25			
Donna Kinnair (to 1/10/2012)	Director of Nursing, NHS SEL Cluster	15-20	15-20			10-15			
Jane Clegg (from 9/11/2012)	Director of Nursing, NHS SEL Cluster	5-10							
Caroline Hewitt	Chair, NHS SEL Cluster	5-10				5-10			
Steven Corbishley (No remuneration paid)	Non Executive Director, NHS SEL	0				0			
Susan Gallagher	Non Executive Director, NHS SEL	1-5				1-5			
Richard Gibbs	Non Executive Director, NHS SEL	1-5				1-5			
Graham Laylee	Non Executive Director, NHS SEL	1-5				1-5			
Rona Nicholson (No remuneration paid)	Non Executive Director, NHS SEL	0				0			
Robert Park	Non Executive Director, NHS SEL	1-5				1-5			
David Whiting	Non Executive Director, NHS SEL Cluster	1-5				1-5			

Other remuneration relates to PCT's share of redundancy payments made to Executive Board members.

Southwark PCT senior staff – these staff represent Southwark PCT on Cluster Board.
Salaries and allowances

		2012/13				2011/12			
		Salary (bands of £5,000)	**Other Remuneration (bands of £5,000)**	**Bonus Payments (bands of £5,000)**	**Benefits in kind (rounded to the nearest £00)**	**Salary (bands of £5,000)**	**Other Remuneration (bands of £5,000)**	**Bonus Payments (bands of £5,000)**	**Benefits in kind (rounded to the nearest £00)**
Dr Amr Zeineldine	Local Clinical Commissioning Committee Chair	55-60				35-40			
Andrew Bland	Managing Director	90-95				90-95			
Dr Ann Marie-Connolly	Director of Public Health	105-110				50-55			

Pension Benefits (*PCT's share of Pension entitlement costs*)

Non-Executive directors on the Board and General Practitioners on Clinical Commissioning Collaborative Committee are not employed by the PCT and are not members of the NHS pension scheme. Their pension benefits are, therefore, not required to be reported in the remuneration report.

In line with the guidance in the Manual of Accounts, it is not possible to apportion the cash equivalent transfer value (CETV) across the PCTs and Care Trust in the Cluster on any systematic basis. This has been, therefore, reported below in full.

Name	Title	Real increase in pension at age 60	Real increase in pension lump sum at aged 60	Total accrued pension at age 60 at 31 March 2013	Lump Sum at age 60 related to accrued pension at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2012	Real increase in Cash Equivalent Transfer Value	Employer contribution to stakeholder pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£'000	£'000	£'000	£'000
Andrew Kenworthy	Chief Executive, NHS SEL Cluster	0-2.5	0-2.5	5-10	25-30	896	872	24	
Gill Galliano (to 30/6/2012)	Director of Development and Joint Deputy Chief Executive, NHS SEL Cluster	0-2.5	0-2.5	5-10	20-25	0	912	-912	
Richard Chapman	Director of Finance, NHS SEL Cluster	0-2.5	2.5-5	2.5-5	10-15	287	202	84	
Jane Schofield (Left Pension scheme 2011-12 restated)	Director of Operations, NHS SEL Cluster	0-2.5	0-2.5	5-10	25-30	1157	1217	-60	
Donna Kinnair (to 1/10/2012)	Director of Nursing, NHS SEL Cluster	0-2.5	2.5-5	5-10	10-15	565	500	65	
Andrew Bland	Managing Director	0-2.5	0-2.5	10-15	40-45	161	152	9	
Dr Ann Marie-Connolly	Director of Public Health	0-2.5	0-2.5	30-35	90-95	582	599	-17	

11.5 The costs of Cluster Board executive and Non-Executive members, reported below are the total remuneration and pension entitlement of the individual. These costs are shared across the six PCTs and Care Trust in South East London.

Cluster Board Executive and Non-Executive members *(Total remuneration)*

Salaries and allowances

		2012/13				2011/12			
Name	Title	Salary (bands of £5,000	Other Remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (rounded to the nearest £00)	Salary (bands of £5,000	Other Remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (rounded to the nearest £00)
		£000	£000	£000	£00	£000	£000	£000	£00
Andrew Kenworthy (to 4.9.2012)	Chief Executive, NHS SEL Cluster	45-50				85-90			
Simon Robbins (to 31/08/2011)	Chief Executive, NHS SSEL Cluster					60-65			
Christina Craig (from 3.9.2012)	Interim Chief Executive, NHS SEL Cluster	150-155							
Gill Galliano (to 30.6.2012)	Director of Development, NHS SEL Cluster	30-35				125-130			
Jane Schofield	Director of Operations, NHS SEL Cluster	130-135	260-265			130-135			
Richard Chapman	Director of Finance, NHS SEL Cluster	110-115				65-70			
Alison Tonge (from 6.8.12 to 15.11.2012)	Interim Director of Finance, NHS SEL Cluster	80-85							
Malcolm Dennett (from 14.11.2012)	Interim Director of Finance, NHS SEL Cluster	70-75							
Donna Kinnair (to 1.10.2012)	Director of Nursing, NHS SEL Cluster	95-100	105-110			95-100			
Jane Clegg (from 9.11.2012)	Director of Nursing, NHS SEL Cluster	50-55							
Caroline Hewitt	Chair, NHS SEL Cluster	40-45				40-45			
Steven Corbishley	Non Executive Director, NHS SEL Cluster	Nil Remuneration				Nil Remuneration			
Susan Gallagher	Non Executive Director, NHS SEL Cluster	10-15				10-15			
Richard Gibbs	Non Executive Director, NHS SEL Cluster	10-15				10-15			
Graham Laylee	Non Executive Director, NHS SEL Cluster	10-15				10-15			
Rona Nicholson	Non Executive Director, NHS SEL Cluster	Nil Remuneration				Nil Remuneration			
Robert Park	Non Executive Director, NHS SEL Cluster	5-10				5-10			
David Whiting	Non Executive Director, NHS SEL Cluster	10-15				10-15			

Other remuneration relates to total redundancy payments made to Executive Board members.

Southwark PCT senior staff – these staff represent Southwark PCT on Cluster Board.

Salaries and allowances

		2012/13				2011/12			
		Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (rounded to the nearest £00)	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (rounded to the nearest £00)
Dr Amr Zeineldine	Local Clinical Commissioning Committee Chair	55-60				35-40			
Andrew Bland	Managing Director	90-95				90-95			
Dr Ann Marie-Connolly	Director of Public Health	105-110				105-110			

Pension Benefits *(Total Pension entitlement)*

Name	Title	Real increase in pension at age 60	Real increase in pension lump sum at aged 60	Total accrued pension at age 60 at 31 March 2013	Lump Sum at age 60 related to accrued pension at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2012	Real increase in Cash Equivalent Transfer Value	Employer contribution to stakeholder pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£'000	£'000	£'000	£'000
Andrew Kenworthy	Chief Executive, NHS SEL Cluster	0-2.5	0-2.5	50-55	155-160	896	872	24	
Gill Galliano (to 30/6/2012)	Director of Development and Joint Deputy Chief Executive, NHS SEL Cluster	0-2.5	0-2.5	45-50	145-150	0	912	-912	
Richard Chapman	Director of Finance, NHS SEL Cluster	5-7.5	17.5-20	20-25	60-65	287	202	84	
Jane Schofield (Left Pension scheme 2011-12 restated)	Director of Operations, NHS SEL Cluster	0-2.5	0-2.5	55-60	165-170	1157	1217	-60	
Donna Kinnair (to 1/10/2012)	Director of Nursing, NHS SEL Cluster	0-2.5	2.5-5	25-30	85-90	565	500	65	
Andrew Bland	Managing Director	0-2.5	0-2.5	10-15	40-45	161	152	9	
Dr Ann Marie-Connolly	Director of Public Health	0-2.5	0-2.5	30-35	90-95	582	599	-17	

* The information for the increase in real pension and lump sum cannot be calculated for new members of staff as the information reported in the previous year is not available.

11.6 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 benefits 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 the period.

11.7 Pay Multiples

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 Southwark PCT in the financial year 2012-13 was £112,500 (2011-12, £92,500). This was 2.76 times (2011-12 2.07 times) the median remuneration of the workforce, which was £40,750 (2011-12 £44,616)

In 2012-13, no (2011-12, one) employee received remuneration in excess of the highest paid director. Remuneration ranged from £7,882 to £112,500 (2011-12 £1,858 to £109,727).
Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind excluding severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The increase in the multiple between 2011-12 and 2012-13 is due to the increase in the salary of the highest paid director from £92,500 to £112,500 as well as the decrease in the median salary from £44,616 to £40,750.

11.8 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	**0**	**0**	**0**	0	0	**0**
£10,001-£25,000	**2**	**0**	**2**	0	0	**0**
£25,001-£50,000	**3**	**0**	**3**	0	0	**0**
£50,001-£100,000	**1**	**0**	**1**	0	0	**0**
£100,001 - £150,000	**0**	**0**	**0**	0	0	**0**
£150,001 - £200,000	**1**	**0**	**1**	0	0	**0**
>£200,000	**0**	**0**	**0**	0	0	**0**
Total number of exit packages by type (total cost	**7**	**0**	**7**	**0**	**0**	**0**
	£s	**£s**	**£s**	**£s**	**£s**	**£s**
Total resource cost	426,706	0	**426,706**	0	0	**0**

11.9 Off Payroll Engagements – *(unaudited)*

Table 1: For off-payroll engagements at a cost of over £58,200 per annum that were in place as of 31 January 2012	Southwark PCT
	No.
No. in place on 31 January 2012	**33**
of which	
No that have since come onto the organisation's payroll	0
of which	
No. that have since been re-negotiated/re-engaged, 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 (**31st March 2013**)	32
Total	**33**

Table 2: For all off-payroll engagements between 23 August 2012 and 31 March 2013, for more than £220 per day and more than 6 months.	
	Southwark PCT
No. of new engagements	5
of which	
No of new engagements which include contractual clauses giving the department the right to request assurance in relation to income tax and National Insurance Obligations	5
of which	
No. for whom assurance has been requested and received	1
No. for whom assurance has been requested but not received (See Below)	4
No. that have been terminated as a result of assurance not being received	
No. for whom assurance was not required due to	
Left the organisation	4
Joined an agency	0
Enetered substantive employment	0
Request not made	0

11.10 Related Party Transactions

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

During the year the following Board Members and members of Clinical Commissioning Collaborative Committee and parties related to them have undertaken material transactions with Southwark Primary Care Trust as follows:

	Services Received from Organisation	Payments to Related Party
		£
Dr Adam Bradford-East Street Surgery	Primary Care	953,311
Dr Jane Cliffe-Gardens Surgery	Primary Care	856,999
Simon Fradd-Concordia Health Parkside	Primary Care	862,632
Simon Fradd-Concordia Melbourne Grove	Primary Care	961,669
Patrick Holden-Surrey Docks Health Centre	Primary Care	1,236,523
Roger Durston-Camberwell Green Practice	Primary Care	1,573,922
Aylesbury Partnership - Stewart Kay (Principal GP), Dr Amir Zeineldine (partner)	Primary Care	3,229,740

The Department of Health, as Southwark PCT's parent department, is regarded as a related party. During the year 2012/13, Southwark 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;

		£000
Croydon PCT	Commissioning of Healthcare	43,294
Lambeth PCT	Commissioning of Healthcare	4,530
Barts And The London NHS Trust	Provision of acute healthcare services	2,282
Imperial College Healthcare NHS Trust	Provision of acute healthcare services	1,237
London Ambulance Service NHS Trust	Provision of acute healthcare services	10,766
St Georges Healthcare NHS Trust	Provision of acute healthcare services	838
The Lewisham Healthcare NHS Trust	Provision of acute healthcare services	4,190
Chelsea And Westminster Hospital NHS Foundation Trust	Provision of acute and community healthcare services	1,713
Guys And St Thomas NHS Foundation Trust	Provision of acute and community healthcare services	148,352
Kings College Hospital NHS Foundation Trust	Provision of acute and community healthcare services	128,284
South London And Maudsley NHS Foundation Trust	Provision of mental healthcare services	64,696
University College London NHS Foundation Trust	Provision of acute and community healthcare services	3,137

12. HOW WE SPENT YOUR MONEY

SOUTHWARK PCT SUMMARY FINANCIAL STATEMENTS 2012/13

These summary financial statements are a summary of the information in the PCT's full annual accounts for 2012/13. The summary financial statements might not contain sufficient information for a full understanding of the PCT's financial position and performance.

IFRSs are accounting standards issued by the International Accounting Standards Board (IASB). The term IFRS refers to the international equivalent to UK GAAP, the set of Generally Accepted Accounting Principles that includes accounting standards, interpretations, the IASB's framework and established accounting practice. The Chancellor's 2007 Budget announced that the accounts of central government departments and entities in the wider public sector will be produced using IFRS, as interpreted for the public sector in the IFRS-based Financial Reporting Manual (FReM). Central government, NHS Trusts, Primary Care Trusts and NHS Foundation Trusts all need to adopt IFRS and the annual accounts for government organisations and the NHS are to be prepared using IFRS standards.

12.1 PCT FINANCIAL PERFORMANCE 2012/2013

Statutory and other financial duties

The PCT is required by statute to meet certain financial duties in order to ensure that public funds are used appropriately. These duties are:

- not to exceed the PCT's revenue resource limit;
- not to exceed the PCT's capital resource limit;
- not to exceed the (combined) revenue and capital cash limits

Southwark PCT met all of its statutory duties in full in 2012/13.

Financial balance

PCTs have a statutory duty to keep expenditure within the resource limits set by the Department of Health for revenue and capital separately. The PCT's audited annual accounts show a surplus of £6,066m on revenue and £0.222m on capital.

	2012/13 Revenue £000	**2012/13 Capital £000**	**2012/13 Total £000**
Resource Limit	575,091	2,458	577,549
Net Operating Costs	569,026	2,236	571,262
Surplus / (Deficit)	**6,065**	**222**	**6,287**

All the Primary Care Trusts and Strategic Health Authorities were abolished from 1 April 2013. Under Department of Health year-end carry forward arrangements and guidance around financial planning for 2013/14, Southwark PCT has been advised by DH to assume 65% (£3.857m) as a carry forward resource in 2013/14 plans. Underspends against Capital Resource Limits are not carried forward. PCTs bid for capital resources on an annual basis.

Cash performance

The PCT has a statutory duty to remain within its set cash limit. There is a single cash limit covering both revenue and capital. The PCT returned £7.5 million of its cash limit as agreed with NHS London. The Department of Health also sets a maximum year-end cash balance for PCTs of £250k. The PCT's cash balance as at 31st March 2012 was £44k.

	£000
Opening Cash balance 1 April 2012	44
Cash drawings including cash top sliced by DH	560,402
Cash Outgoings	(552,846)
Cash returned to DH	(7,500)
Closing cash balance 31 March 2013	**100**

Capital charges

Capital charges were introduced in the NHS in 1991 to increase awareness of the cost of owning assets. The amount payable is based on the actual opening and closing Balance Sheets for the year. There are two elements to this: depreciation of fixed assets and a charge of 3.5 per cent on net relevant assets. The Department of Health has revised the mechanism for charging capital charges interest since 2011/12. The PCT revenue resources for 2012/13 were adjusted by £551k for capital charges interest. Capital charges for Southwark PCT for 2012/13 were as follows:

	£000
Depreciation	3,575
3.5% cost of capital charge on net relevant assets	552
Total	**4,127**

Public sector payment targets

In addition to the PCT's statutory targets, the Department of Health requires that NHS bodies pay their creditors in accordance with the Prompt Payment Code (PPC) and government accounting rules. The target is to pay 95 per cent of all creditors within 30 days of receipt of the goods or a valid invoice (whichever is later) unless other payment terms have been agreed with the supplier. Southawrk PCT is not an approved signatory to the Prompt Payment Code. The PCT's performance against this target is reported below:

Non-NHS creditors	**2012/13 Number**	**2012/13 £000**	**2011/12 Number**	**2011/12 £000**	**2010/11 Number**	**2010/11 £000**
Total bills paid in the year	10,435	59,225	9,882	55,702	24,981	72,828
Total bills paid within target	9,675	54,014	9,020	51,783	23,362	67,882
Percentage of bills paid within target	**93%**	**91%**	**91%**	**93%**	**93%**	**93%**

NHS creditors	**2012/13 Number**	**2012/13 £000**	**2011/12 Number**	**2011/12 £000**	**2010/11 Number**	**2010/11 £000**
Total bills paid in the year	**4,054**	**464,499**	**3,691**	**423,460**	**3,612**	**335,746**
Total bills paid within target	**3,738**	**448,084**	**3,387**	**397,306**	**3,288**	**334,819**
Percentage of bills paid within target	**92%**	**96%**	**92%**	**94%**	**91%**	**99%**

Comparisons of 2012/13 annual accounts with previous years

1 Net operating costs

Costs decreased slightly in 2012/13, after taking into account reduced income and a significant QIPP programme.

	2008/09	2009/10	2010/11	2011/12	2012/13	Change from 2011/12	
	£m	£m	£m	£m	£m	£m	%
Gross Operating Costs	520	604	622	580	597	17	2.93%
Including income of	32	40	39	29	28	(1)	(3.45%)
Net Operating Costs	**488**	**564**	**583**	**552**	**569**	**17**	**3.08%**

2 Non-Current Assets

Southwark PCT's land and buildings have been revalued by the District Valuer as at 31 March 2013 by carrying out a full valuation exercise. This resulted in a net decrease in asset values of £2m. During the year the PCT incurred capital spend of £2.2m. The net reduction in non current assets of £2.9m reflects these transactions as well as the depreciation charges.

2006/07	Restated 2007/08	Restated 2008/09	2009/10	2010/11	2011/12	2012/13	Change
£m	£m	£m	£m	£m	£m	£m	£m
37.6	52.1	51.6	49.0	51.4	51.9	49.0	2.9

3 Net liabilities

	2006/07 £m	Restated 2007/08 £m	Restated 2008/09 £m	2009/10 £m	2010/11 £m	2011/12 £m	2012/13 £m	Change £m
Current Assets	14.3	17.3	12.6	9.6	8.0	9.1	5.3	(3.8)
Current Liabilities	(33.7)	(37.2)	(30.7)	(37.2)	(32.0)	(31.4)	(31.8)	(0.4)
Net Current Liabilities	**(19.4)**	**(19.9)**	**(18.1)**	**(27.6)**	**(24.0)**	**(22.3)**	**(26.5)**	**(4.2)**

4 Taxpayers' equity

	2009/10 £m	2010/11 £m	2011/12 £m	2012/13 £m	Change £m
General Fund	12	12.5	7	(1.7)	(8.7)
Revaluation Reserve	13.9	10.3	13.7	12.7	1.1
Total	**25.9**	**22.8**	**20.6**	**11.0**	**(9.6)**

5 Pensions

Past and present employees are covered by the provisions of the NHS Pensions Scheme. For full details of how pension liabilities are treated please see Note 1.24 Accounting Policies in the Annual Accounts. For details of senior manager's pension entitlements please see the PCT's remuneration report.

Statement of cash flows for the year ended 31 March 2013

	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities		
Net Operating Cost Before Interest	**(568,263)**	(551,741)
Depreciation and Amortisation	**3,575**	3,509
Impairments and Reversals	**635**	538
Other Gains / (Losses) on foreign exchange	**0**	0
Donated Assets received credited to revenue but non-cash	**0**	0
Government Granted Assets received credited to revenue but non-cash	**0**	0
Interest Paid	**(789)**	(770)
Release of PFI/deferred credit	**0**	0
(Increase)/Decrease in Inventories	**0**	302
(Increase)/Decrease in Trade and Other Receivables	**2,110**	3,985
(Increase)/Decrease in Other Current Assets	**0**	0
Increase/(Decrease) in Trade and Other Payables	**(454)**	(843)
(Increase)/Decrease in Other Current Liabilities	**0**	0
Provisions Utilised	**(57)**	(2,875)
Increase/(Decrease) in Provisions	**4,275**	831
Net Cash Inflow/(Outflow) from Operating Activities	**(558,968)**	**(547,064)**
Cash flows from investing activities		
Interest Received	**27**	11
(Payments) for Property, Plant and Equipment	**(1,284)**	(1,119)
(Payments) for Intangible Assets	**0**	0
(Payments) for Other Financial Assets	**0**	0
(Payments) for Financial Assets (LIFT)	**0**	0
Proceeds of disposal of assets held for sale (PPE)	**0**	2,310
Proceeds of disposal of assets held for sale (Intangible)	**0**	0
Proceeds from Disposal of Other Financial Assets	**0**	0
Proceeds from the disposal of Financial Assets (LIFT)	**0**	0
Loans Made in Respect of LIFT	**0**	0
Loans Repaid in Respect of LIFT	**0**	0
Rental Revenue	**0**	0
Net Cash Inflow/(Outflow) from Investing Activities	**(1,257)**	**1,202**
Net cash inflow/(outflow) before financing	**(560,225)**	**(545,862)**
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**(121)**	(113)
Net Parliamentary Funding	**560,402**	546,006
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**	2
Net Cash Inflow/(Outflow) from Financing Activities	**560,281**	**545,895**
Net increase/(decrease) in cash and cash equivalents	**56**	**33**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**44**	**11**
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	**100**	**44**

Statement of Financial Position at 31 March 2013

	31 March 2013	31 March 2012
	£000	£000
Non-current assets:		
Property, plant and equipment	**49,041**	51,937
Intangible assets	**0**	0
investment property	**0**	0
Other financial assets	**247**	247
Trade and other receivables	**0**	0
Total non-current assets	**49,288**	52,184
Current assets:		
Inventories	**0**	0
Trade and other receivables	**5,193**	9,103
Other financial assets	**0**	0
Other current assets	**0**	0
Cash and cash equivalents	**100**	44
Total current assets	**5,293**	9,147
Non-current assets held for sale	**0**	0
Total current assets	**5,293**	9,147
Total assets	**54,581**	61,331
Current liabilities		
Trade and other payables	**(29,026)**	(30,280)
Other liabilities	**0**	0
Provisions	**(2,672)**	(1,047)
Borrowings	**(129)**	(121)
Other financial liabilities	**0**	0
Total current liabilities	**(31,827)**	(31,448)
Non-current assets plus/less net current assets/liabilities	**22,754**	29,883
Non-current liabilities		
Trade and other payables	0	(48)
Other Liabilities	0	0
Provisions	(2,593)	0
Borrowings	(9,080)	(9,208)
Other financial liabilities	0	0
Total non-current liabilities	**(11,673)**	(9,256)
Total Assets Employed:	**11,081**	20,627
Financed by taxpayers' equity:		
General fund	(1,656)	6,968
Revaluation reserve	12,737	13,659
Other reserves	0	0
Total taxpayers' equity:	**11,081**	20,627

Statement of Comprehensive Net Expenditure for year ended 31 March 2013

	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure		
Gross employee benefits	**7,996**	6,535
Other costs	**588,594**	574,057
Income	**(28,327)**	(28,851)
Net operating costs before interest	**568,263**	551,741
Investment income	**(27)**	(11)
Other (Gains)/Losses	**0**	(310)
Finance costs	**790**	830
Net operating costs for the financial year	**569,026**	552,250
Transfers by absorption -(gains)	**0**	
Transfers by absorption - losses	**0**	
Net (gain)/loss on transfers by absorption	**0**	
Net operating costs and transfer gains/losses for the financial year	**569,026**	**552,250**
Of which:		
Administration Costs		
Gross employee benefits	**5,269**	3,936
Other costs	**7,646**	8,966
Income	**(1,099)**	(966)
Net administration costs before interest	**11,816**	**11,936**
Investment income	**0**	0
Other (Gains)/Losses	**0**	0
Finance costs	**0**	0
Net administration costs for the financial year	**11,816**	**11,936**
Programme Expenditure		
Gross employee benefits	**2,727**	2,599
Other costs	**580,948**	565,091
Income	**(27,228)**	(27,885)
Net programme expenditure before interest	**556,447**	**539,805**
Investment income	**(27)**	(11)
Other (Gains)/Losses	**0**	(310)
Finance costs	**790**	830
Net programme expenditure for the financial year	**557,210**	**540,314**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**1,428**	100
Net (gain) on revaluation of property, plant & equipment	**(506)**	(4,198)
Net (gain) on revaluation of intangibles	**0**	0
Net (gain) on revaluation of financial assets	**0**	0
Net (gain)/loss on other reserves	**0**	0
Net (gain)/loss on available for sale financial assets	**0**	0
Net (gain) /loss on Assets Held for Sale	**0**	
Release of Reserves to Statement of Comprehensive Net Expenditure	**0**	
Net actuarial (gain)/loss on pension schemes	**0**	0
Reclassification Adjustments		
Reclassification adjustment on disposal of available for sale financial assets	**0**	0
Total comprehensive net expenditure for the year*	**569,948**	**548,152**

10 Post balance sheet events

As disclosed within note 1.1 due to the Health and Social Care Bill as of 1st April 2013 the PCT in its current legal form will be abolished. As a result the PCT's functions will continue with either a Commissioning Support Unit (CSU), Clinical Commissioning Group (CCG), NHS England, NHS Foundation Trusts (FT) or Local Authorities (LA). Estates functions will be transferred to NHS Property Services Limited (NHS PS). Ultimate control will still reside with the Department of Health.

All assets and liabilites contained within the statement of financial position as at 31st March 2013 must be identified and agreed for transfer.

Under this NHS Transition, the PCT's assets and liabilities will be split between different 'Receivers' and, in some cases, multiple 'Receivers' will require access to an asset or be assigned a liability. The principles for the split of residual balances is still subject to Department of Health guidance.

The majority of assets and liabilities (including all land and buildings) will transfer by way of a 'Sender' organisation's Transfer Schemes. A Transfer Scheme is an instrument in writing made by the Secretary of State under sections 300 to 302 of the Act. It can deal with the transfers of staff, property and liabilities between those entities as specified in Schedules 22 and 23 to the Act but unlike Transfer Orders does not need to be laid before Parliament.

Where functions transfer, any claim, liability and financial asset, which relate to that will follow. However NHS England will take historical NHS Litigation Authority (NHSLA) indemnified clinical negligence claims, including those incurred but not reported relating to new functions of CCG's or Local Authorities.

The final year-end aggregate surplus generated by the PCTs in 2012/13 will be carried forward to NHS England in 2013/14. CCGs will not inherit legacy debt, but balances will transfer from PCTs, in line with provisions of the Act, based on the principles set out below, subject to further guidance from the Department of health on the split of financial balances and related financial transactions.

- Liabilities that correspond to an asset which relate to a particular function should transfer with that asset from a sender to a receiver by reference to the destination of the function.

- Liabilities that correspond to a function or policy that is being moved from a sender should transfer to the nominated receiver for that function.

- Discrete, and current assets and liabilities, even if associated with a function continuing in 2013/14 will transfer to the Department of Health.

- Liabilities relating to the PCT as a statutory body in its own right that do not relate to an ongoing function such as VAT or tax liabilities, will transfer to the Department of Health.

- Employer liabilities will transfer to the new employer, where an individual's employment is transferred to a receiver organisation.

- Where employment of staff ceases prior to 1st April 2013, the employer liabilities related to those staff members will transfer to Department of Health.

11 Running costs

PCTs are required to report the proportion of their costs per head of local weighted population that is spent on management. The Department of Health (DH) has issued guidance on the definition of running costs.

	2012/13	2011/12	Change
Running costs (£000s)	12,327	12,208	119
Weighted population (number)	324,522	324,522	-
Management cost per head of weighted population (£)	**38**	**38**	**0%**

The PCT measures its running costs according to the definitions provided by the Department of Health.
The PCT running costs for 2012/13 have increased by £0.119m (0.01%) in the year.

Audit

The PCT's external auditor is Grant Thornton. During the financial year 2012/13 £120k (including VAT) was paid in respect of carrying out the external audit of the PCT in accordance with the Code of Audit Practice.

2012/13 Accounts Certificate of Financial Assurance to the Department of Health Director General, Strategy Finance and NHS

I am aware that as signing officer designated by the Department of Health Accounting Officer, you are required to sign the accounts and supporting certificates of Southwark Primary Care Trust (PCT) in order to comply with the Department's 2012/13 accounts finalisation process.

To assist you in that process, I can confirm that in my role managing the preparation of the annual statutory accounts, the accounts were prepared in the 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. As required 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.

Richard Chapman
Director of Finance SEL Cluster 2012/13

Signature: 

Date: 24 April 2013

2012/13 Accounts Certificate of Assurance to the Department of Health Director General, Strategy Finance and NHS

I am aware that as signing officer designated by the Department of Health Accounting Officer, you are required to sign the accounts and supporting certificates of Southwark Primary Care Trust (PCT) in order to comply with the Department's 2012/13 accounts finalisation process.

To assist you in that process, I can confirm that for the year ended 31 March 2013 based on my own knowledge of internal control matters and through experience in my role as Accountable Officer until 31 March 2013, the PCT:

- had in place effective management systems to safeguard public funds and assets and assist in the implementation of corporate governance;
- kept proper accounting records which disclosed with reasonable accuracy at any time the financial position of the PCT;
- took reasonable steps for the prevention and detection of fraud and other irregularities;
- achieved value for money from the resources available to the PCT;
- applied income and expenditure to the purposes intended by Parliament and conformed to the authorities which governed them; and
- had effective and sound financial management systems in place.

I also confirm that in my role overseeing the preparation of the annual statutory accounts, the accounts were prepared in the 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. As required 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.

Name: Andrew Kenworthy

Signature:

Date: 24 April 2013

STATEMENT OF THE RESPONSIBILITIES OF THE SIGNING OFFICER OF THE PRIMARY CARE TRUST 2012-13 ACCOUNTS

The Department of Health's Accounting Officer has designated the role of signing officer for the final accounts of Southwark Primary Care Trust to discharge the following responsibilities for the Department of Health:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

- value for money is achieved from the resources available to the primary care trust;

- the expenditure and income of the primary care trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;

- effective and sound financial management systems are 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, and from the assurances provided by the PCT Accountable Officer until 31 March 2013, I am assured that the responsibilities have been properly discharged.

Signed.....

Date 31 May 2013

Carl Vincent
Director of Provider Finance and Finance Transition

INDEPENDENT AUDITOR'S REPORT TO THE DEPARTMENT OF HEALTH'S ACCOUNTING OFFICER IN RESPECT OF SOUTHWARK PCT

We have examined the summary financial statements for the year ended 31 March 2013 which comprises the Statement of Cashflows, the Statement of Financial Position and the Statement of Comprehensive Net Expenditure and the related notes.

This report is made solely to the Department of Health's Accounting Officer in respect of Southwark PCT in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Department of Health's accounting officer and the Trust as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of directors and auditor

The Signing Officer is responsible for preparing the Annual Report.

Our responsibility is to report to you our opinion on the consistency of the summary financial statement within the Annual Report with the statutory financial statements.

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

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

Opinion

In our opinion the summary financial statement is consistent with the statutory financial statements of the Southwark Primary Care Trust for the year ended 31 March 2013.

Grant Thornton UK LLP
Grant Thornton House
Melton Street, Euston Square
London
NW1 2EP

The Annual Report including the remuneration report was approved by the DH authorised signatory at the DH sub Audit Committee for South East London on 31 May 2013.

Carl Vincent
Director of Provider Finance and Finance Transition

Further Information

A copy of the 2012/13 audited annual accounts as well as the PCT's Annual Governance Statement is available from:

Malcolm Hines
Chief Financial Officer
Southwark CCG
160 Tooley Street, London, SE1 2QH
Tel 020 7525 0402
malcolm.hines@nhs.net

Department of Health

NHS

Southwark Primary Care Trust

2012-13 Accounts

Published to gov.uk, in PDF format only.

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Southwark Primary Care Trust

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Southwark Primary Care Trust

2012-13 Accounts

Southwark PCT

Annual Accounts

Year Ended 31st March 2013

FOREWORD TO THE ACCOUNTS

SOUTHWARK PRIMARY CARE TRUST

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

STATEMENT OF THE RESPONSIBILITIES OF THE SIGNING OFFICER OF THE PRIMARY CARE TRUST 2012-13 ACCOUNTS

The Department of Health's Accounting Officer has designated the role of signing officer for the final accounts of Southwark Primary Care Trust to discharge the following responsibilities for the Department of Health:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

- value for money is achieved from the resources available to the primary care trust;

- the expenditure and income of the primary care trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;

- effective and sound financial management systems are 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, and from the assurances provided by the PCT Accountable Officer until 31 March 2013, I am assured that the responsibilities have been properly discharged.

Signed.....CV West.....

Date.....31/5/13.....

Carl Vincent
Director of Provider Finance and Finance Transition

2012/13 Accounts Certificate of Assurance to the Department of Health Director General, Strategy Finance and NHS

I am aware that as signing officer designated by the Department of Health Accounting Officer, you are required to sign the accounts and supporting certificates of Southwark Primary Care Trust (PCT) in order to comply with the Department's 2012/13 accounts finalisation process.

To assist you in that process, I can confirm that for the year ended 31 March 2013 based on my own knowledge of internal control matters and through experience in my role as Accountable Officer until 31 March 2013, the PCT:

- had in place effective management systems to safeguard public funds and assets and assist in the implementation of corporate governance;
- kept proper accounting records which disclosed with reasonable accuracy at any time the financial position
- took reasonable steps for the prevention and detection of fraud and other irregularities;
- achieved value for money from the resources available to the PCT;
- applied income and expenditure to the purposes intended by Parliament and conformed to the authorities which governed them; and
- had effective and sound financial management systems in place.

I also confirm that in my role overseeing the preparation of the annual statutory accounts, the accounts were prepared in the 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. As required 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.

Andrew Kenworthy
Accountable Officer 2012/13

Signature: 

Date: 24 April 2013

2012/13 Accounts Certificate of Financial Assurance to the Department of Health Director Strategy Finance and NHS

I am aware that as signing officer designated by the Department of Health Accounting Officer, you are required to sign the accounts and supporting certificates of Southwark Primary Care Trust (PCT) in order to comply with the Department's 2012/13 accounts finalisation process.

To assist you in that process, I can confirm that in my role managing the preparation of the annual statutory accounts, the accounts were prepared in the 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. As required the accounts:

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

Richard Chapman
Director of Finance SEL Cluster 2012/13

Signature: 

Date: 24 April 2013

INDEPENDENT AUDITOR'S REPORT TO THE DEPARTMENT OF HEALTH'S ACCOUNTING OFFICER IN RESPECT OF SOUTHWARK PCT

We have audited the financial statements of Southwark PCT for the year ended 31 March 2013 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. 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 tables of salaries and allowances of senior managers and related narrative notes;
- the tables of pension benefits of senior managers and related narrative notes; and.
- the pay multiples disclosure and related narrative notes.

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

Respective responsibilities of the Signing Officer and auditor

As explained more fully in the Accounts Certificate of Assurance to the Department of Health Director General, Strategy, Finance and NHS, the Signing Officer is 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 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 Southwark PCT as at 31 March 2013 and of its net operating costs for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters

In our opinion:

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

Matters on which we report by exception

We report to you if:

- in our opinion the governance statement does not reflect compliance with the Department of Health's Guidance;
- we refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have a 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.

Other matters on which we are required to conclude

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. We are also required by the Audit Commission's Code of Audit Practice 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 and,

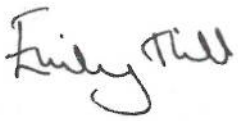
having regard to the guidance issued by the Audit Commission, we have considered the results of the following:

- our review of the annual governance statement;
- the work of other relevant regulatory bodies or inspectorates, to the extent the results of the work have an impact on our responsibilities; and
- our locally determined risk-based work on transition arrangements.

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

Certificate

We certify that we have completed the audit of the financial statements of Southwark PCT in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.



Emily Hill
Senior Statutory Auditor, for and on behalf of Grant Thornton UK LLP

Grant Thornton House
Melton Street
Euston Square
London
NW1 2EP

5 June 2013

Statement of Comprehensive Net Expenditure for year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure			
Gross employee benefits	7.1	**7,996**	6,535
Other costs	5.1	**588,594**	574,057
Income	4	**(28,327)**	(28,851)
Net operating costs before interest		**568,263**	551,741
Investment income	9	**(27)**	(11)
Other (Gains)/Losses	10	**0**	(310)
Finance costs	11	**790**	830
Net operating costs for the financial year		**569,026**	552,250
Transfers by absorption -(gains)		**0**	
Transfers by absorption - losses		**0**	
Net (gain)/loss on transfers by absorption		**0**	
Net operating costs and transfer gains/losses for the financial year		**569,026**	**552,250**
Of which:			
Administration Costs			
Gross employee benefits	7.1	**5,269**	3,936
Other costs	5.1	**7,646**	8,966
Income	4	**(1,099)**	(966)
Net administration costs before interest		**11,816**	**11,936**
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**0**	0
Net administration costs for the financial year		**11,816**	**11,936**
Programme Expenditure			
Gross employee benefits	7.1	**2,727**	2,599
Other costs	5.1	**580,948**	565,091
Income	4	**(27,228)**	(27,885)
Net programme expenditure before interest		**556,447**	**539,805**
Investment income	9	**(27)**	(11)
Other (Gains)/Losses	10	**0**	(310)
Finance costs	11	**790**	830
Net programme expenditure for the financial year		**557,210**	**540,314**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**1,428**	100
Net (gain) on revaluation of property, plant & equipment	**(506)**	(4,198)
Net (gain) on revaluation of intangibles	**0**	0
Net (gain) on revaluation of financial assets	**0**	0
Net (gain)/loss on other reserves	**0**	0
Net (gain)/loss on available for sale financial assets	**0**	0
Net (gain) /loss on Assets Held for Sale	**0**	
Release of Reserves to Statement of Comprehensive Net Expenditure	**0**	
Net actuarial (gain)/loss on pension schemes	**0**	0
Reclassification Adjustments		
Reclassification adjustment on disposal of available for sale financial assets	**0**	0
Total comprehensive net expenditure for the year*	**569,948**	**548,152**

*This is the sum of the rows above plus net operating costs for the financial year after absorption accounting adjustments.
The notes on pages 11 to 51 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	49,041	51,937
Intangible assets	13	0	0
investment property	15	0	0
Other financial assets	21.2	247	247
Trade and other receivables	19	0	0
Total non-current assets		49,288	52,184
Current assets:			
Inventories	18	0	0
Trade and other receivables	19	5,193	9,103
Other financial assets	36	0	0
Other current assets	22	0	0
Cash and cash equivalents	23	100	44
Total current assets		5,293	9,147
Non-current assets held for sale	24	0	0
Total current assets		5,293	9,147
Total assets		54,581	61,331
Current liabilities			
Trade and other payables	25	(29,026)	(30,280)
Other liabilities	26,28	0	0
Provisions	32	(2,672)	(1,047)
Borrowings	27	(129)	(121)
Other financial liabilities	36.2	0	0
Total current liabilities		(31,827)	(31,448)
Non-current assets plus/less net current assets/liabilities		22,754	29,883
Non-current liabilities			
Trade and other payables	25	0	(48)
Other Liabilities	28	0	0
Provisions	32	(2,593)	0
Borrowings	27	(9,080)	(9,208)
Other financial liabilities	36.2	0	0
Total non-current liabilities		(11,673)	(9,256)
Total Assets Employed:		11,081	20,627
Financed by taxpayers' equity:			
General fund		(1,656)	6,968
Revaluation reserve		12,737	13,659
Other reserves		0	0
Total taxpayers' equity:		11,081	20,627

The notes on pages 11 to 51 form part of this account.

The financial statements on pages *7 to 10* were approved by the DH Audit Committee on *31 May 2013* and signed on its behalf by

CVincent

Carl Vincent
Director of Provider Finance and Finance Transition

Date: 31/5/13

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

	General fund	Revaluation reserve	Other reserves	Total reserves
	£000	£000	£000	£000
Balance at 1 April 2012	**6,968**	**13,659**	**0**	**20,627**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(569,026)			**(569,026)**
Net gain on revaluation of property, plant, equipment		506		**506**
Net gain on revaluation of intangible assets		0		**0**
Net gain on revaluation of financial assets		0		**0**
Net Gain / (loss) on Revaluation of Assets Held for Sale		0		**0**
Impairments and reversals		(1,428)		**(1,428)**
Movements in other reserves			0	**0**
Transfers between reserves*	0	0		**0**
Release of Reserves to SOCNE		0		**0**
Reclassification Adjustments				
Transfers between Revaluation Reserve & General Fund in respect of assets transferred under absorption	0	0		**0**
Net actuarial gain/(loss) on pensions	0		0	**0**
Total recognised income and expense for 2012-13	**(569,026)**	**(922)**	**0**	**(569,948)**
Net Parliamentary funding	560,402			**560,402**
Balance at 31 March 2013	**(1,656)**	**12,737**	**0**	**11,081**

Balance at 1 April 2011	**12,765**	**10,299**	**0**	**23,064**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(552,250)			(552,250)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment		4,198		4,198
Net Gain / (loss) on Revaluation of Intangible Assets		0		0
Net Gain / (loss) on Revaluation of Financial Assets		0		0
Net Gain / (loss) on Revaluation of Assets Held for Sale		0		0
Impairments and Reversals		(100)		(100)
Movements in other reserves			0	0
Transfers between reserves*	738	(738)		0
Release of Reserves to Statement of Comprehensive Net Expenditure		0		0
Reclassification Adjustments				
Transfers to/(from) Other Bodies within the Resource Account Boundary	(291)	0	0	(291)
On disposal of available for sale financial assets	0	0	0	0
Net actuarial gain/(loss) on pensions	0		0	0
Total recognised income and expense for 2011-12	(551,803)	3,360	0	(548,443)
Net Parliamentary funding	546,006			546,006
Balance at 31 March 2012	**6,968**	**13,659**	**0**	**20,627**

Statement of cash flows for the year ended 31 March 2013

	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities		
Net Operating Cost Before Interest	**(568,263)**	(551,741)
Depreciation and Amortisation	**3,575**	3,509
Impairments and Reversals	**635**	538
Other Gains / (Losses) on foreign exchange	**0**	0
Donated Assets received credited to revenue but non-cash	**0**	0
Government Granted Assets received credited to revenue but non-cash	**0**	0
Interest Paid	**(789)**	(770)
Release of PFI/deferred credit	**0**	0
(Increase)/Decrease in Inventories	**0**	302
(Increase)/Decrease in Trade and Other Receivables	**2,110**	3,985
(Increase)/Decrease in Other Current Assets	**0**	0
Increase/(Decrease) in Trade and Other Payables	**(454)**	(843)
(Increase)/Decrease in Other Current Liabilities	**0**	0
Provisions Utilised	**(57)**	(2,875)
Increase/(Decrease) in Provisions	**4,275**	831
Net Cash Inflow/(Outflow) from Operating Activities	**(558,968)**	**(547,064)**
Cash flows from investing activities		
Interest Received	**27**	11
(Payments) for Property, Plant and Equipment	**(1,284)**	(1,119)
(Payments) for Intangible Assets	**0**	0
(Payments) for Other Financial Assets	**0**	0
(Payments) for Financial Assets (LIFT)	**0**	0
Proceeds of disposal of assets held for sale (PPE)	**0**	2,310
Proceeds of disposal of assets held for sale (Intangible)	**0**	0
Proceeds from Disposal of Other Financial Assets	**0**	0
Proceeds from the disposal of Financial Assets (LIFT)	**0**	0
Loans Made in Respect of LIFT	**0**	0
Loans Repaid in Respect of LIFT	**0**	0
Rental Revenue	**0**	0
Net Cash Inflow/(Outflow) from Investing Activities	**(1,257)**	**1,202**
Net cash inflow/(outflow) before financing	**(560,225)**	**(545,862)**
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**(121)**	(113)
Net Parliamentary Funding	**560,402**	546,006
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**	2
Net Cash Inflow/(Outflow) from Financing Activities	**560,281**	**545,895**
Net increase/(decrease) in cash and cash equivalents	**56**	**33**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**44**	**11**
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	**100**	**44**

1. Accounting policies

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

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

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

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

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

1.1 Accounting Conventions

The financial statements have been prepared in accordance with EU endorsed International Financial Reporting Standards and IFRIC's as applicable to the NHS under the FReM.

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

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

Critical accounting judgements and key sources of estimation uncertainty

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

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

Revenue recognition
Revenue is accounted for applying the accruals convention. Income is recognised in the period in which services are provided. Where revenue has been received for a specific activity to be delivered in the following financial year, that revenue will be deferred.
Expenditure related to partially completed contracts for patient services are not accounted for as work-in-progress but expenditure is accrued in respect of part-completed treatment episodes at the statement of financial position date.

Classification of property
The PCT owns a number of properties, which are maintained primarily to provide services. The receipt of market-based rental from these properties is incidental to holding these properties. These properties are held for service delivery objectives as part of the PCT's Community Strategy Plan and Strategic Services Development Plan. These properties are accounted for as property, plant and equipment

1. Accounting policies (continued)

PFI and LIFT

The PCT's accounting policies regarding its PFI and LIFT scheme are disclosed in Note 1.26 to these financial statements. The PCT accounts for these assets under IFRIC 12 as a service concession and when the applicable elements of IAS 17 are met these are capitalised.
The PCT initially recognised the PFI and LIFT assets and associated finance lease liability at the assets' fair value. The PCT's PFI asset is being accounted for in two ways, an element as if it was a freehold building and an element as plant and equipment, the accounting judgements and estimation uncertainty for both of which are disclosed below. The PCT has taken the judgement that, due to the uncertainty over the size and structure of the health care economy at the end of the lease, it is unlikely that it will exercise its repurchase option over the LIFT at the end of the lease life. It is therefore depreciating the asset over the life of the lease rather than the asset's useful economic life. The PFI and LIFT finance lease liabilities are being amortised over the lives of the lease using the rate of return required by the assets' operators. This rate has been estimated using the assets' operators' financial models, as agreed with the PCT at the schemes' inception, and is estimated to spread that return over the life of the leases.

As part of the PCT's PFI contract, the PFI operator provides a Managed Equipment Service ('MES'). Through this service the PCT has access to a wide range of equipment within the scheme, and these assets are maintained and replaced at the end of their useful economic life by the PFI operator. This PCT has judged that these assets should be held as plant and equipment and therefore, in line with the PCT's accounting policies, depreciated over 5 years. Deferred income has been set up to smooth tenant's income in relation the MES element of the PFI unitary payment to the MES costs over time.

The PCT recognises the fact that the financial models employed to account for the PFI and LIFT scheme profiles the capital additions and capital lease payments on a changeable basis each year, which causes considerable variations in the rental costs taken to the Statement of Comprehensive Net Expenditure from year to year. Subsequent rental charges for the PFI and LIFT properties to the PCT's tenants are conversely calculated on a basis which allows a more comparable and predictable charge year on year and smoothes the affect of these variations. The difference between the rental charge to tenants and the charge to the income statement relating to that rental charge is a timing difference and is accounted for as either deferred or accrued income in the year.

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term and determining an appropriate discount rate to calculate the present value of the minimum lease payments.

Provisions

The significant critical judgments for the PCT's pension provisions are disclosed in Note 7.5.

Redundancy Payment Accruals and Provisions – PCT Reorganisation : The accounts include accruals for redundancies that incurred during March 2013. Number of payments for these redundancies were made in March 2013 and reported as cash expenditure. Payments for redundancies due and not paid have been accrued in the Accounts.

Property, plant, and equipment

The PCT's accounting judgments around its property, plant, and equipment base are the residual lives and value of the PCT assets, which impact the annual depreciation charge and therefore holding amount of the asset, the methodology used to ensure the assets holding amount reflect current cost, particularly around its land and buildings and the application of indexation, and the timing of when asset are capitalised (brought into use) and derecognised (and moved to assets held for resale and to be disposed off).

The PCT recognises leases when in the judgement of the board the transaction meets the definition of a lease as set down by IAS 17 or transactions where there is no formal lease but where there is a substance of a lease as required by IFRIC 4. The PCT will decide on whether to recognise leases as finance or operating leases using the criteria laid down by IAS 17 with a rebuttable presumption that leases where the net present of future lease payments exceeds 90% of the asset's fair value at the inception of the lease the lease will be capitalised as a finance lease. Where other factors suggest a finance lease category better reflects the substance of the transaction and the transfer of risks and rewards of the leased asset the PCT will capitalise the lease even if the 90% target is not met.

Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant and equipment, whereas for an operating lease no such asset is recognised.

The Primary Care Trust has exercised its judgement on the appropriate classification of building leases and has determined that none are finance leases.

1. Accounting policies (continued)

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

Recoverability of NHS debtors
The PCT does not provide against amounts due from other NHS bodies and believes that these amounts are recoverable in full.

Provisions
The significant estimation uncertainties for the PCT's pension provisions are disclosed in Note 7.5

The PCT has a provision for Continuing Care, details of which are shown under Note 32. The PCT does not believe that it has material estimation uncertainty over the completeness of its provisions. Contingent liabilities are disclosed in Note 1.21.

Property, plant, and equipment
The PCT's estimates regarding property, plant, and equipment used are disclosed in Note 1.7. They are annually reviewed by the PCT, using external specialist advice where appropriate. Where there is indication that the PCT's assets are impaired, the estimation technique used to calculate the level of impairment is to compare the current holding amount of the asset to the assets fair value as derived by a professional valuer and using a valuation basis suitable for the asset (normally open market value for alternative use). The difference is then accounted for in line with the applicable accounting standards.

Other
Prescribing: The prescribing accrual is necessary due to the delay in receiving data from the NHS Business Services Authority (Prescription Services). It is calculated using past trends and the latest information received (see Note 25 re: FHS Payables).
Pharmacist Fees: The process is similar to that of prescribing, the accrual being based on historic patterns of
Quality and Outcome Framework (QoF) and other GP Payments: These payments depend on the achievements on targets given to the GP Practices. The results are often not available until after the accounts are closed so an estimate is made of the success against these targets based on previous year's achievements.

1. Accounting policies (continued)

1.2 Revenue and Funding

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

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

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

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

1.3 Care Trust Status

Southwark PCT is not designated as a Care Trust.

1.4 Pooled budgets

The pooled budgets were transferred to the London Borough of Southwark on 1st April 2011.

1.5 Taxation

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

1.6 Administration and Programme Costs

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

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

1. Accounting policies (continued)

1.7 Property, Plant & Equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation

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

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

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

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

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

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

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

Subsequent expenditure

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

1. Accounting policies (continued)

1.8 Intangible Assets

The PCT had no intangible assets in 2012/13.

1.9 Depreciation, amortisation and impairments

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

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

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

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

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

1. Accounting policies (continued)

1.10 Donated assets

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

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

1.11 Government grants

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

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

1.12 Non-current assets held for sale

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

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

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

1.13 Inventories

The PCT had no inventories in 2012/13.

1.14 Cash and cash equivalents

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

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

1.15 Losses and Special Payments

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

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

1.16 Clinical Negligence Costs

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

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

1. Accounting policies (continued)

1.17 Employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

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

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

1.18 Research and Development

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

1.19 Other expenses

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

1.20 Grant making

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

1. Accounting policies (continued)

1.21 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.

1.22 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.

1.23 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.

1.24 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 rates of: short term minus 1.8%, medium term minus 1% and long term plus 2.2% in real terms. For post employment benefit provisions the rate is 2.35% 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 on-going activities of the entity.

1. Accounting policies (continued)

1.25 Financial Instruments

Financial assets

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

Financial assets are initially recognised at fair value.

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

Financial assets at fair value through profit and loss

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

Held to maturity investments

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

Available for sale financial assets

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

Loans and receivables

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

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

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

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

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

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

1. Accounting policies (continued)

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

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

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

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

1.26 Private Finance Initiative (PFI) and NHS LIFT transactions

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

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

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

b) PFI and LIFT assets, liabilities, and finance costs

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

A LIFT liability is recognised at the same time as the LIFT assets are recognised. It is measured initially at the present value of the minimum lease payments] 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.

1. Accounting policies (continued)

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

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

IAS 27 Separate Financial Statements - subject to consultation
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IFRS 9 Financial Instruments - subject to consultation - subject to consultation
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IPSAS 32 - Service Concession Arrangement - subject to consultation
IAS 19 (Revised 2011) Employee Benefits
IAS 32 Financial Instruments: Presentation
IFRS 7 Financial Instruments: Disclosures

2 Operating segments

Southwark PCT operates as a single segment.

3. Financial Performance Targets

3.1 Revenue Resource Limit

	2012-13 £000	2011-12 £000
The PCTs' performance for the year ended 2012-13 is as follows:		
Total Net Operating Cost for the Financial Year	**569,026**	552,250
Revenue Resource Limit	**575,091**	558,237
Under/(Over)spend Against Revenue Resource Limit (RRL)	6,065	5,987

3.2 Capital Resource Limit

	2012-13 £000	2011-12 £000
The PCT is required to keep within its Capital Resource Limit.		
Capital Resource Limit	**2,458**	(2,019)
Charge to Capital Resource Limit	**2,236**	(2,138)
(Over)/Underspend Against CRL	**222**	**119**

3.3 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**560,402**	546,006
Cash Limit	**567,902**	546,006
Under/(Over)spend Against Cash Limit	**7,500**	**0**

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

	2012-13 £000
Total cash received from DH (Gross)	506,926
Less: Trade Income from DH	0
Less/(Plus): movement in DH working balances	0
Sub total: net advances	**506,926**
(Less)/plus: transfers (to)/from other resource account bodies (free text note required)	0
Plus: cost of Dentistry Schemes (central charge to cash limits)	15,452
Plus: drugs reimbursement (central charge to cash limits)	38,024
Parliamentary funding credited to General Fund	**560,402**

4 Miscellaneous Revenue

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Fees and Charges	**0**	0	0	0
Dental Charge income from Contractor-Led GDS & PDS	**2,369**		2,369	2,438
Dental Charge income from Trust-Led GDS & PDS	**0**		0	0
Prescription Charge income	**1,763**		1,763	1,947
Strategic Health Authorities	**1,399**	0	1,399	864
NHS Trusts	**0**	0	0	0
NHS Foundation Trusts	**1,147**	240	907	3,325
Primary Care Trusts Contributions to DATs	**0**		0	0
Primary Care Trusts - Other	**10,855**	578	10,277	9,440
Primary Care Trusts - Lead Commissioning	**0**	0	0	0
English RAB Special Health Authorities	**0**	0	0	0
NDPBs and Others (CGA)	**0**	0	0	0
Department of Health - SMPTB	**0**	0	0	0
Department of Health - Other	**3**	2	1	0
Recoveries in respect of employee benefits	**0**	0	0	0
Local Authorities*	**5,869**	0	5,869	7,308
Patient Transport Services	**1**		1	1
Education, Training and Research	**176**	0	176	0
Non-NHS: Private Patients	**0**		0	0
Non-NHS: Overseas Patients (Non-Reciprocal)	**0**		0	0
NHS Injury Costs Recovery	**0**		0	0
Other Non-NHS Patient Care Services	**0**	0	0	0
Charitable and Other Contributions to Expenditure	**0**		0	0
Receipt of donated assets	**0**		0	0
Receipt of Government granted assets	**0**		0	0
Rental revenue from finance leases	**0**	0	0	0
Rental revenue from operating leases	**4,745**	279	4,466	3,180
Other revenue	**0**	0	0	348
Total miscellaneous revenue	**28,327**	**1,099**	**27,228**	**28,851**

* From 1st April 2012 part of the allocation for Learning Difficulties was transferred directly to the Local Authority (London Borough of Southwark).

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	**44,066**		44,066	38,486
Non-Healthcare	**2,459**	2,454	5	3,962
Total	**46,525**	**2,454**	**44,071**	**42,448**
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	**22,630**	0	22,630	24,034
Goods and services (other, excl Trusts, FT and PCT))	**572**	(1)	573	680
Total	**23,202**	**(1)**	**23,203**	**24,714**
Goods and Services from Foundation Trusts	**349,293**	0	349,293	338,294
Purchase of Healthcare from Non-NHS bodies	**40,109**		40,109	38,315
Social Care from Independent Providers	**0**		0	0
Expenditure on Drugs Action Teams	**0**		0	0
Non-GMS Services from GPs	**0**	0	0	0
Contractor Led GDS & PDS (excluding employee benefits)	**18,156**		18,156	17,551
Salaried Trust-Led PDS & PCT DS (excluding employee benefits)	**0**		0	0
Chair, Non-executive Directors & PEC remuneration	**25**	25	0	28
Executive committee members costs	**501**	501	0	238
Consultancy Services	**1,467**	1,037	430	689
Prescribing Costs	**30,736**		30,736	33,053
G/PMS, APMS and PCTMS (excluding employee benefits)	**49,706**	305	49,401	49,158
Pharmaceutical Services	**0**		0	4
Local Pharmaceutical Services Pilots	**0**		0	0
New Pharmacy Contract	**8,834**		8,834	9,427
General Ophthalmic Services	**2,469**		2,469	2,176
Supplies and Services - Clinical	**3,495**	190	3,305	2,813
Supplies and Services - General	**1,083**	2	1,081	1,224
Establishment	**951**	625	326	426
Transport	**30**	25	5	43
Premises	**5,733**	1,427	4,306	6,794
Impairments & Reversals of Property, plant and equipment	**635**	0	635	538
Impairments and Reversals of non-current assets held for sale	**0**	0	0	0
Depreciation	**3,575**	0	3,575	3,509
Amortisation	**0**	0	0	0
Impairment & Reversals Intangible non-current assets	**0**	0	0	0
Impairment and Reversals of Financial Assets	**0**	0	0	0
Impairment of Receivables	**277**	0	277	(593)
Inventory write offs	**0**	0	0	0
Research and Development Expenditure	**0**	0	0	0
Audit Fees	**120**	120	0	184
Other Auditors Remuneration	**0**	0	0	176
Clinical Negligence Costs	**0**	0	0	0
Education and Training	**276**	258	18	308
Grants for capital purposes	**576**	0	576	1,800
Grants for revenue purposes	**0**	0	0	0
Impairments and reversals for investment properties	**0**	0	0	0
Other	**820**	678	142	740
Total Operating costs charged to Statement of Comprehensive Net Expenditure	**588,594**	**7,646**	**580,948**	**574,057**
Employee Benefits (excluding capitalised costs)				
Employee Benefits associated with PCTMS	**0**	0	0	0
Trust led PDS and PCT DS	**0**	0	0	0
PCT Officer Board Members	**353**	353	0	344
Other Employee Benefits	**7,643**	4,916	2,727	6,191
Total Employee Benefits charged to SOCNE	**7,996**	**5,269**	**2,727**	**6,535**
Total Operating Costs	**596,590**	**12,915**	**583,675**	**580,592**
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	1,800
Grants to Private Sector to Fund Capital Projects	**576**	0	576	0
Grants to Fund Capital Projects - Dental	**0**	0	0	0
Grants to Fund Capital Projects - Other	**0**	0	0	0
Total Capital Grants	**576**	**0**	**576**	**1,800**
Grants to fund revenue expenditure				
To Local Authorities	**0**	0	0	0
To Private Sector	**0**	0	0	0
To Other	**0**	0	0	0
Total Revenue Grants	**0**	**0**	**0**	**0**
Total Grants	**576**	**0**	**576**	**1,800**

The Capital Grants were made for the improvement of GP premises.

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**12,327**	9,046	3,281
Weighted population (number in units)*	**324,522**	324,522	324,522
Running costs per head of population (£ per head)	**38**	**28**	**10**
PCT Running Costs 2011-12			
Running costs (£000s)	**12,208**	11,336	872
Weighted population (number in units)	**324,522**	324,522	324,522
Running costs per head of population (£ per head)	**38**	**35**	**3**

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

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

5.2 Analysis of operating expenditure by expenditure classification	2012-13 £000	2011-12 £000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	49,706	49,158
Prescribing costs	30,736	33,053
Contractor led GDS & PDS	18,156	17,551
Trust led GDS & PDS	0	0
General Ophthalmic Services	2,469	2,176
Department of Health Initiative Funding	0	0
Pharmaceutical services	0	4
Local Pharmaceutical Services Pilots	0	0
New Pharmacy Contract	8,834	9,427
Non-GMS Services from GPs	0	0
Other	0	0
Total Primary Healthcare purchased	**109,901**	111,369
Purchase of Secondary Healthcare		
Learning Difficulties	1,493	1,085
Mental Illness	66,885	69,046
Maternity	24,147	24,634
General and Acute	275,065	265,816
Accident and emergency	13,910	14,285
Community Health Services	38,711	34,306
Other Contractual	30,428	25,662
Total Secondary Healthcare Purchased	**450,639**	434,834
Grant Funding		
Grants for capital purposes	576	1,800
Grants for revenue purposes	0	0
Total Healthcare Purchased by PCT	**561,116**	**548,003**
PCT self-provided secondary healthcare included above	0	0
Social Care from Independent Providers	0	0
Healthcare from NHS FTs included above	349,293	338,070

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				**1,440**	1,993
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**1,440**	**1,993**
Payable:					
No later than one year	**0**	**1,697**	**7**	**1,704**	1,993
Between one and five years	**0**	**5,085**	**0**	**5,085**	5,148
After five years	**0**	**12,074**	**0**	**12,074**	8,957
Total	**0**	**18,856**	**7**	**18,863**	**16,098**
Total future sublease payments expected to be received:		0		0	0

6.2 PCT as lessor

Southwark PCT has entered into short term leases with Guys and St Thomas's NHS Foundation Trust for the properties providing community services, which transferred under TCS on 1st April 2011. There is nothing shown as receivable later than one year for these properties as they are likely to be transferred to GSTT once a flow of funds has been agreed.

	2012-13 £000	2011-12 £000
Recognised as income		
Rental Revenue	**4,745**	3,180
Contingent rents	**0**	0
Total	**4745**	3,180
Receivable:		
No later than one year	**4,745**	3,180
Between one and five years	**0**	0
After five years	**0**	0
Total	**4,745**	3,180

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	6,582	4,090	2,492	5,261	3,944	1,317	1,321	146	1,175
Social security costs	412	311	101	337	254	83	75	57	18
Employer Contributions to NHS BSA - Pensions Division	547	413	134	547	413	134	0	0	0
Other pension costs	234	234	0	234	234	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	221	221	0	221	221	0	0	0	0
Total employee benefits	7,996	5,269	2,727	6,600	5,066	1,534	1,396	203	1,193
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	7,996	5,269	2,727	6,600	5,066	1,534	1,396	203	1,193
Employee costs capitalised	0	0	0	0	0	0	0	0	0
Gross Employee Benefits excluding capitalised costs	7,996	5,269	2,727	6,600	5,066	1,534	1,396	203	1,193
Recognised as:									
Commissioning employee benefits	7,996			6,600			1,396		
Provider employee benefits	0			0			0		
Gross Employee Benefits excluding capitalised costs	7,996			6,600			1,396		

2012-13				Permanently employed			Other		
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Employee Benefits - Revenue									
Salaries and wages	0	0	0	0	0	0	0	0	0
Social Security costs	0	0	0	0	0	0	0	0	0
Employer Contributions to NHS BSA - Pensions Division	0	0	0	0	0	0	0	0	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other Post Employment Benefits	0	0	0	0	0	0	0	0	0
Other Employment Benefits	0	0	0	0	0	0	0	0	0
Termination Benefits	0	0	0	0	0	0	0	0	0
TOTAL excluding capitalised costs	0	0	0	0	0	0	0	0	0

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	5,572	4,100	1,472
Social security costs	407	407	0
Employer Contributions to NHS BSA - Pensions Division	556	556	0
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Total gross employee benefits	6,535	5,063	1,472
Less recoveries in respect of employee benefits	0	0	0
Total - Net Employee Benefits including capitalised costs	6,535	5,063	1,472
Employee costs capitalised	0	0	0
Gross Employee Benefits excluding capitalised costs	6,535	5,063	1,472
Recognised as:			
Commissioning employee benefits	6,535		
Provider employee benefits	0		
Gross Employee Benefits excluding capitalised costs	6,535		

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	75	61	14	71	63	8
Healthcare assistants and other support staff	0	0	0	1	1	0
Nursing, midwifery and health visiting staff	2	2	0	1	1	0
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	10	9	1	7	7	0
Social Care Staff	0	0	0	0	0	0
Other	0	0	0	7	0	7
TOTAL	89	74	15	90	75	15
Of the above - staff engaged on capital projects	0	0	0	0	0	0

The 2011/12 numbers have been re-stated as they included some Community staff in error.

7.3 Staff Sickness absence and ill health retirements

	2012-13 Number	2011-12 Number
Total Days Lost	511	1,342
Total Staff Years	75	253
Average working Days Lost	6.80	5.30

	2012-13 Number	2011-12 Number
Number of persons retired early on ill health grounds	1	2
	£000s	£000s
Total additional pensions liabilities accrued in the year	66	292

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	**0**	**0**	**0**	0	0	**0**
£10,001-£25,000	**2**	**0**	**2**	0	0	**0**
£25,001-£50,000	**3**	**0**	**3**	0	0	**0**
£50,001-£100,000	**1**	**0**	**1**	0	0	**0**
£100,001 - £150,000	**0**	**0**	**0**	0	0	**0**
£150,001 - £200,000	**1**	**0**	**1**	0	0	**0**
>£200,000	**0**	**0**	**0**	0	0	**0**
Total number of exit packages by type (total cost	**7**	**0**	**7**	**0**	**0**	**0**
	£s	**£s**	**£s**	**£s**	**£s**	**£s**
Total resource cost	426,706	0	**426,706**	0	0	**0**

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

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

7.5 Pension costs

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

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

a) Accounting valuation

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

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

b) Full actuarial (funding) valuation

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

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

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

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

c) Scheme provisions

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

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

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

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

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

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

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

8. Better Payment Practice Code

8.1 Measure of compliance

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**10,435**	**59,225**	9,882	55,702
Total Non-NHS Trade Invoices Paid Within Target	**9,675**	**54,014**	9,020	51,783
Percentage of NHS Trade Invoices Paid Within Target	92.72%	91.20%	91.28%	92.96%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**4,054**	**464,499**	3,691	423,460
Total NHS Trade Invoices Paid Within Target	**3,738**	**448,084**	3,387	397,306
Percentage of NHS Trade Invoices Paid Within Target	92.21%	96.47%	91.76%	93.82%

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

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

	2012-13 £000	2011-12 £000
Amounts included in finance costs from claims made under this legislation	**1**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**1**	0

9. Investment Income

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Rental Income				
PFI finance lease revenue (planned)	0	0	0	0
PFI finance lease revenue (contingent)	0	0	0	0
Other finance lease revenue	0	0	0	0
Subtotal	0	0	0	0
Interest Income				
LIFT: equity dividends receivable	0	0	0	0
LIFT: loan interest receivable	27	0	27	11
Bank interest	0	0	0	0
Other loans and receivables	0	0	0	0
Impaired financial assets	0	0	0	0
Other financial assets	0	0	0	0
Subtotal	27	0	27	11
Total investment income	27	0	27	11

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	310
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	310

11. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest				
Interest on obligations under finance leases	0	0	0	0
Interest on obligations under PFI contracts:				
- main finance cost	0	0	0	0
- contingent finance cost	0	0	0	0
Interest on obligations under LIFT contracts:				
- main finance cost	789	0	789	770
- contingent finance cost	0	0	0	0
Interest on late payment of commercial debt	1	0	1	0
Other interest expense	0	0	0	0
Total interest expense	790	0	790	770
Other finance costs	0	0	0	0
Provisions - unwinding of discount	0		0	60
Total	790	0	790	830

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	28,209	16,643	0	0	804	0	13,599	923	60,178
Additions of Assets Under Construction				0					0
Additions Purchased	0	941	0		5	0	1,257	33	2,236
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
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	202	304	0	0	0	0	0	0	506
Impairments/negative indexation	(1,400)	(28)	0	0	0	0	0	0	(1,428)
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
Cumulative dep netted off cost following revaluation	0	(1,805)	0	0	0	0	0	0	(1,805)
At 31 March 2013	27,011	16,055	0	0	809	0	14,856	956	59,687
Depreciation									
At 1 April 2012	0	0	0	0	595	0	7,232	414	8,241
Reclassifications	0	0	0		0	0	0	0	0
Reclassifications as Held for Sale	0	0	0		0	0	0	0	0
Disposals other than for sale	0	0	0		0	0	0	0	0
Upward revaluation/positive indexation	0	0	0		0	0	0	0	0
Impairments	0	635	0	0	0	0	0	0	635
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Charged During the Year	0	1,170	0		62	0	2,258	85	3,575
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	0
Cumulative dep netted off cost following revaluation	0	(1,805)	0	0	0	0	0	0	(1,805)
At 31 March 2013	0	0	0	0	657	0	9,490	499	10,646
Net Book Value at 31 March 2013	27,011	16,055	0	0	152	0	5,366	457	49,041
Purchased	27,011	16,055	0	0	152	0	5,366	457	49,041
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	27,011	16,055	0	0	152	0	5,366	457	49,041
Asset financing:									
Owned	25,511	9,575	0	0	152	0	5,366	200	40,804
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP LIFT contracts	1,500	6,480	0	0	0	0	0	257	8,237
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	27,011	16,055	0	0	152	0	5,366	457	49,041

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	12,224	1,327	0	0	43	0	0	65	13,659
Movements (specify)	(1,199)	277	0	0	0	0	0	0	(922)
At 31 March 2013	11,025	1,604	0	0	43	0	0	65	12,737

Additions to Assets Under Construction in 2012-13

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

12.2 Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:									
At 1 April 2011	**26,560**	**16,727**	**0**	**0**	**802**	**0**	**12,885**	**852**	**57,826**
Additions - purchased	0	876	0	0	2	0	714	71	**1,663**
Additions - donated	0	0	0	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassified as held for sale	(1,800)	0	0	0	0	0	0	0	**(1,800)**
Disposals other than by sale	0	0	0	0	0	0	0	0	**0**
Revaluation & indexation gains	3,799	400	0	0	0	0	0	0	**4,199**
Impairments	(100)	0	0	0	0	0	0	0	**(100)**
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 revaluation	(250)	(1,360)	0	0	0	0	0	0	**(1,610)**
At 31 March 2012	**28,209**	**16,643**	**0**	**0**	**804**	**0**	**13,599**	**923**	**60,178**
Depreciation									
At 1 April 2011	**0**	**0**	**0**		**476**	**0**	**4,986**	**342**	**5,804**
Reclassifications		0	0		0	0	0	0	**0**
Reclassifications as Held for Sale	0	0	0		0	0	0	0	**0**
Disposals other than for sale	0	0	0		0	0	0	0	**0**
Upward revaluation/positive indexation	0	0	0		0	0	0	0	**0**
Impairments	250	255	0	0	33	0	0	0	**538**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Charged During the Year	0	1,105	0		86	0	2,246	72	**3,509**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluation	(250)	(1,360)	0	0	0	0	0	0	**(1,610)**
At 31 March 2012	**0**	**0**	**0**	**0**	**595**	**0**	**7,232**	**414**	**8,241**
Net Book Value at 31 March 2012	**28,209**	**16,643**	**0**	**0**	**209**	**0**	**6,367**	**509**	**51,937**
Purchased	28,209	16,643	0	0	209	0	6,367	509	**51,937**
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	**28,209**	**16,643**	**0**	**0**	**209**	**0**	**6,367**	**509**	**51,937**
Asset financing:									
Owned	26,709	9,888	0	0	209	0	6,367	509	**43,682**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	1,500	6,755	0	0	0	0	0	0	**8,255**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**28,209**	**16,643**	**0**	**0**	**209**	**0**	**6,367**	**509**	**51,937**

12.3 Property, plant and equipment

The PCT did not receive any donations in respect of property, plant and equipment.

IAS16 has been applied for the valuation of Property, Plant and Equipment. This is defined as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. The fair value of land and buildings is usually determined from market-based evidence and appraisal undertaken by professionally qualified valuers.

An independent valuation was carried out in respect of the 31st March 2013 by Peter Ashby of the 'DVS Property Specialists for the public sector', the BCIS index has been used for the valuation of specialised assets. The age and remaining lives of buildings and their elements have been assessed as at the valuation date. It has been assumed that building elements will continue to be maintained normally over the period from the date of inspection to the valuation date and that there will be no untoward changes. Another independent consultant Howard Williams of BNP Paribas carried out a valuation of two sites where there is surplus land; Dulwich Hospital and St Olaves. The land was valued at market value. The PCT entered into a pre-sale agreement with Barratts Homes to sell Surrey Docks Health Centre for £636k on completion of a new health centre, which Barratts are building, with a 15 year rent free period. The valuation of £636k was carried out by BNP Paribas in November 2012. The new health centre is expected to be completed in late 2014.

The valuation of each property is on the basis of Market Value subject to the following :

The Department of Health has indicated that for NHS assets it requires the above assumption to be applied for operational assets and that approach has been followed by the Valuer.
There has been no changes of asset lives/residual values and thus no effect in the current and/or future years.

The economic lives of non-current assets were:	**Min life Years**	**Max life Years**
Buildings excl. Dwellings	5	55
Plant & Machinery	5	10
Transport Equipment	5	10
Information Technology	3	15
Furniture and Fittings	10	15

13.1 Intangible non-current assets

The PCT did not hold any Intangible non-current assets in 2012/13 (2011/12 Nil).

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

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000
Property, Plant and Equipment impairments and reversals taken to SoCNE			
Loss or damage resulting from normal operations	0	0	0
Over-specification of assets	0	0	0
Abandonment of assets in the course of construction	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen obsolescence	0		0
Loss as a result of catastrophe	0		0
Other	0		0
Changes in market price	635		635
Total charged to Annually Managed Expenditure	**635**		**635**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Loss or damage resulting from normal operations	0		
Over Specification of Assets	0		
Abandonment of assets in the course of construction	0		
Unforeseen obsolescence	0		
Loss as a result of catastrophe	0		
Other	0		
Changes in market price	1,428		
Total impairments for PPE charged to reserves	**1,428**		
Total Impairments of Property, Plant and Equipment	**2,063**	**0**	**635**

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

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000
Total Impairments charged to Revaluation Reserve	1,428		
Total Impairments charged to SoCNE - DEL	0	0	0
Total Impairments charged to SoCNE - AME	635		635
Overall Total Impairments	2,063	0	635

15 Investment property

The PCT held no investment property in 2012/13 (2011/12 Nil).

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**	400
Intangible assets	**0**	0
Total	**0**	400

16.2 Other financial commitments

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

17 Intra-Government and other balances

	Current receivables £000s	**Non-current receivables £000s**	**Current payables £000s**	**Non-current payables £000s**
Balances with other Central Government Bodies	776	0	977	0
Balances with Local Authorities	428	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	2,181	0	6,706	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	1,808	0	21,343	0
At 31 March 2013	**5,193**	**0**	**29,026**	**0**
prior period:				
Balances with other Central Government Bodies	314	0	2,401	0
Balances with Local Authorities	2,184	0	0	0
Balances with NHS Trusts and Foundation Trusts	4,184	0	8,573	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	2,421	0	19,306	48
At 31 March 2012	**9,103**	**0**	**30,280**	**48**

18 Inventories

The PCT held no inventories as at 31th March 2013. (£0 at 31th March 2012).

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	**2,378**	4,498	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**579**	0	**0**	0
Non-NHS receivables - revenue	**1,751**	2,628	**0**	0
Non-NHS receivables - capital	**0**	1,800	**0**	0
Non-NHS prepayments and accrued income	**664**	305	**0**	0
Provision for the impairment of receivables	**(503)**	(421)	**0**	0
VAT	**264**	220	**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	**60**	73	**0**	0
Total	**5,193**	9,103	**0**	0
Total current and non current	**5,193**	9,103		
Included above:				
Prepaid pensions contributions	**0**	0		

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

19.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	**204**	288
By three to six months	**66**	128
By more than six months	**1,085**	539
Total	**1,355**	955

19.3 Provision for impairment of receivables

	2012-13 £000	**2011-12 £000**
Balance at 1 April 2012	**(421)**	(1,233)
Amount written off during the year	**195**	219
Amount recovered during the year	**84**	819
(Increase)/decrease in receivables impaired	**(361)**	(226)
Balance at 31 March 2013	**(503)**	(421)

Southwark PCT accounting policy is to provide for all non NHS debtors older than one year with specific adjustments made for known debts that may or may not be doubtful. The NHS debtors are part of agreement of NHS balances exercise. No bad debt provision is made for NHS debtors. In line with NHS London's guidance to reduce outstanding debtors to less than 90 days, the PCT has made a provision for 2012/13 for all Non NHS debtors older than 90 days.

20 NHS LIFT investments

	Loan £000	Share capital £000	Total £000
Balance at 1 April 2012	**244**	**3**	**247**
Additions	**0**	**0**	**0**
Disposals	**0**	**0**	**0**
Loan repayments	**0**	**0**	**0**
Revaluations	**0**	**0**	**0**
Loans repayable within 12 months	**0**	**0**	**0**
Balance at 31 March 2013	**244**	**3**	**247**
Balance at 1 April 2011	244	3	247
Additions	0	0	0
Disposals	0	0	0
Loan repayments	0	0	0
Revaluations	0	0	0
Loans repayable within 12 months	0	0	0
Balance at 31 March 2012	**244**	**3**	**247**

21.1 Other financial assets - Current

	31 March 2013 £000	31 March 2012 £000
Opening balance 1 April	0	0
Transfers (to)/from Other Public Sector Bodies in year	0	0
Other Movements	0	0
Closing balance 31 March	**0**	0

21.2 Other Financial Assets - Non Current

	31 March 2013 £000	31 March 2012 £000
Opening balance 1 April	**247**	247
Additions	**0**	0
Revaluation	**0**	0
Impairments	**0**	0
Impairment Reversals	**0**	0
Transferred to current financial assets	**0**	0
Disposals	**0**	0
Transfers (to)/from Other Public Sector Bodies in year	0	0
Total Other Financial Assets - Non Current	**247**	247

21.3 Other Financial Assets - Capital Analysis

	31 March 2013 £000	31 March 2012 £000
Capital Expenditure	**0**	0
Capital Income	**0**	0

22 Other current assets

	31 March 2013 £000	31 March 2012 £000
EU Emissions Trading Scheme Allowance	**0**	0
Other Assets	**0**	0
Total	**0**	0

23 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**44**	11
Net change in year	**56**	33
Closing balance	**100**	44
Made up of		
Cash with Government Banking Service	**99**	44
Commercial banks	**0**	0
Cash in hand	**1**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**100**	44
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**100**	44
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**
										0
Balance at 1 April 2011	2,001	0	0	0	0	0	0	0	0	**2,001**
Plus assets classified as held for sale in the year	1,800	0	0	0	0	0	0	0	0	**1,800**
Less assets sold in the year	(3,801)	0	0	0	0	0	0	0	0	**(3,801)**
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		
NHS payables - revenue	**5,539**	6,983	**0**	0
NHS payables - capital	**0**	562	**0**	0
NHS accruals and deferred income	**2,130**	3,295	**0**	0
Family Health Services (FHS) payables*	**11,870**	7,601		
Non-NHS payables - revenue	**3,491**	4,675	**0**	0
Non-NHS payables - capital	**53**	339	**0**	0
Non-NHS accruals and deferred income	**5,473**	5,996	**0**	0
Social security costs	**1**	60		
VAT	**0**	0	0	0
Tax	**13**	74		
Payments received on account	**0**	0	**0**	0
Other	456	695	0	48
Total	**29,026**	30,280	**0**	48
Total payables (current and non-current)	**29,026**	**30,328**		

* FHS Payables - Prescribing costs have been estimated on the basis of the previous year's spend in March. The average was then used to project the March 2013 figures.

Other payables include £0 (2011-12: £0) in respect of payments due in future years under arrangements to buy out the liability for [number] early retirements over 5 instalments; and £0 (2011-12: £0) in respect of outstanding pensions contributions at 31 March 2013 £0 (31 March 2012: £0).

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 *[specify]*	**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		
Bank overdraft - commercial banks	**0**	0		
PFI liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
LIFT liabilities:				
Main liability	**129**	121	**9,080**	9,208
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**0**	0	**0**	0
Other (describe)	**0**	0	**0**	0
Total	**129**	**121**	**9,080**	**9,208**
Total other liabilities (current and non-current)	**9,209**	**9,329**		

Borrowings/Loans - Payment of Principal Falling Due in:

	DH £000s	**Other £000s**	**Total £000s**
0 - 1 Years	0	0	**0**
1 - 2 Years	0	0	**0**
2 - 5 Years	0	0	**0**
Over 5 Years	0	9,209	**9,209**
TOTAL	**0**	**9,209**	**9,209**

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	**32**	265	**0**	0
Deferred income addition	**0**	32	**0**	0
Transfer of deferred income	**0**	(265)	**0**	0
Current deferred Income at 31 March 2013	**32**	32	**0**	0
Total other liabilities (current and non-current)	**32**	**32**		

30 Finance lease obligations

The PCT has no finance leases as the LIFT agreement for Sunshine House is shown under the separate heading of LIFT and Borrowings.

31 Finance lease receivables as lessor

The PCT has no finance lease receivables as Sunshine House is a LIFT agreement and not a finance lease. There is no rental income.

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	**1,047**	0	0	0	0	850	0	0	74	123
Arising During the Year	**4,341**	0	0	0	0	4,336	0	0	5	0
Utilised During the Year	**(57)**	0	0	0	0	0	0	0	0	(57)
Reversed Unused	**(66)**	0	0	0	0	0	0	0	0	(66)
Unwinding of Discount	**0**	0	0	0	0	0	0	0	0	0
Change in Discount Rate	**0**	0	0	0	0	0	0	0	0	0
Transferred (to)/from other Public Sector bodies	**0**	0	0	0	0	0	0	0	0	0
Balance at 31 March 2013	**5,265**	**0**	**0**	**0**	**0**	**5,186**	**0**	**0**	**79**	**0**
Expected Timing of Cash Flows:										
No Later than One Year	**2,672**	**0**	**0**	**0**	**0**	**2,593**	**0**	**0**	**79**	**0**
Later than One Year and not later than Five Years	**2,593**	**0**	**0**	**0**	**0**	**2,593**	**0**	**0**	**0**	**0**
Later than Five Years	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Continuing Care Provisions

In March 2012 the Department of Health announced deadlines for individuals or their representatives to notify the relevant PCT if they believe there was a period of care between 1st April 2004 and 31st March 2012 where there is evidence that the individual should have been assessed for eligibility for NHS continuing healthcare (NHS CHC). This only applies to new cases i.e. where, the individual has not previously been assessed for NHS CHC during the identified period. The first deadline was the 30th September 2012 relating to claims between 1st April 2004 to 31st March 2011. The second deadline was 31st March 2013 relating to the period from 1st April 2011 to 31st March 2012. The PCT received a total of 67 claims representing a significant financial risk to the organisation. The process of assessing the impact of these claims has been on-going through the year and a financial provision has been made based on estimates of the potential financial exposure using the latest information available at the time.

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at 31 March 2013	189
As at 31 March 2012	336

33 Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities		
Equal Pay	**0**	0
Other	**(5,007)**	(6)
Amounts Recoverable Against Contingent Liabilities	**0**	0
Net Value of Contingent Liabilities	**(5,007)**	(6)
Contingent Assets		
Contingent Assets	**0**	0
Net Value of Contingent Assets	**0**	0

34 PFI and LIFT - additional information

The PCT has no PFI schemes.

The PCT's LIFT scheme is not off-Statement of Financial Position - see below.

The PCT has a LIFT lease scheme for the Sunshine House Child Development Centre. This centre provides children's services, and is a fully managed site. The estimated capital value of the land and buildings is £8.3m, as at 31st March 2013. An independent valuation was carried out by the 'DVS Property Specialists for the public sector'.

At the end of the lease period in 2032, the PCT has the option to purchase the site (at below market value), renew the lease (subject to agreement with the landlord) or walk away.

Under IFRIC 12, the PCT has accounted for this asset as a finance lease, and the capital value of circa £8.3m is reflected in the Statement of Financial Position as a finance lease asset with a corresponding finance lease creditor. Payments to the landlord comprise of two elements - imputed finance lease charges and service charges (see below).

	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	**0**	0
Total	**0**	**0**
Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI		
No Later than One Year	**0**	0
Later than One Year, No Later than Five Years	**0**	0
Later than Five Years	**0**	0
Total	**0**	0

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

	31 March 2013 £000	31 March 2012 £000
Estimated Capital Value of Project - off SOFP PFI	**0**	0
Value of Deferred Assets - off SOFP PFI	**0**	0
Value of Reversionary Interest - off SOFP PFI	**0**	0
34.2 Imputed "finance lease" obligations for on SOFP PFI contracts due		
Analysed by when PFI payments are due		
No Later than One Year	**0**	0
Later than One Year, No Later than Five Years	**0**	0
Later than Five Years	**0**	0
Subtotal	**0**	0
Less: Interest Element	**0**	0
Total	**0**	0

Charges to operating expenditure and future commitments in respect of on and off SOFP LIFT	31 March 2013 £000	31 March 2012 £000
Total Charge to Operating Expenses in year - OFF SOFP LIFT	**0**	0
Service element of on SOFP LIFT charged to operating expenses in year	**133**	130
Total	**133**	130

	31 March 2013 £000	31 March 2012 £000
Payments committed to in respect of off SOFP LIFT and the service element of on SOFP LIFT.		
LIFT Scheme Expiry Date:		
No Later than One Year	**136**	133
Later than One Year, No Later than Five Years	**580**	566
Later than Five Years	**2,723**	2,873
Total	**3,439**	3,572

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

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

Imputed "finance lease" obligations for on SOFP LIFT Contracts due	31 March 2013 £000	31 March 2012 £000
No Later than One Year	**799**	818
Later than One Year, No Later than Five Years	**2,820**	3,143
Later than Five Years	**17,286**	17,742
Subtotal	**20,905**	21,703
Less: Interest Element	**(11,696)**	(12,374)
Total	**9,209**	9,329

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	**194**	0	194
Interest Expense	**789**	0	789
Impairment charge - AME	**0**		0
Impairment charge - DEL	**0**	0	0
Other Expenditure	**0**	0	0
Revenue Receivable from subleasing	**0**	0	0
Total IFRS Expenditure (IFRIC12)	**983**	**0**	**983**
Revenue consequences of LIFT/PFI schemes under UK GAAP / ESA95 (net of any sublease income)	**(1,097)**	0	(1,097)
Net IFRS change (IFRIC12)	**(114)**	**0**	**(114)**

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

36 Financial Instruments

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

Currency risk

The PCT 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**
Receivables - NHS		2,771		**2,771**
Receivables - non-NHS		1,248		**1,248**
Cash at bank and in hand		100		**100**
Other financial assets	0	247	0	**247**
Total at 31 March 2013	**0**	**4,366**	**0**	**4,366**
Embedded derivatives	0			0
Receivables - NHS		4,498		4,498
Receivables - non-NHS		4,007		4,007
Cash at bank and in hand		44		44
Other financial assets	0	247	0	247
Total at 31 March 2012	0	8,796	0	8,796

36.2 Financial Liabilities	At 'fair value through profit and loss' £000	Other £000	Total £000
Embedded derivatives	0		**0**
NHS payables		7,995	**7,995**
Non-NHS payables		21,424	**21,424**
Other borrowings		0	**0**
PFI & finance lease obligations		9,209	**9,209**
Other financial liabilities	0	0	**0**
Total at 31 March 2013	**0**	**38,628**	**38,628**
Embedded derivatives	0		0
NHS payables		9,642	9,642
Non-NHS payables		20,472	20,472
Other borrowings		0	0
PFI & finance lease obligations		9,329	9,329
Other financial liabilities	0	0	0
Total at 31 March 2012	**0**	39,443	39,443

37 Related party transactions

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

During the year the following Board Members and members of Clinical Commissioning Collaborative Committee and parties related to them have undertaken material transactions with Southwark Primary Care Trust as follows:

	Services Received from Organisation	Payments to Related Party £
Dr Adam Bradford-East Street Surgery	Primary Care	953,311
Dr Jane Cliffe-Gardens Surgery	Primary Care	856,999
Simon Fradd-Concordia Health Parkside	Primary Care	862,632
Simon Fradd-Concordia Melbourne Grove	Primary Care	961,669
Patrick Holden-Surrey Docks Health Centre	Primary Care	1,236,523
Roger Durston-Camberwell Green Practice	Primary Care	1,573,922
Aylesbury Partnership - Stewart Kay (Principal GP), Dr Amir Zeineldine (partner)	Primary Care	3,229,740

The Department of Health, as Southwark PCT's parent department, is regarded as a related party. During the year 2012/13, Southwark 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;

		£000
Croydon PCT	Commissioning of Healthcare	43,294
Lambeth PCT	Commissioning of Healthcare	4,530
Barts And The London NHS Trust	Provision of acute healthcare services	2,282
Imperial College Healthcare NHS Trust	Provision of acute healthcare services	1,237
London Ambulance Service NHS Trust	Provision of acute healthcare services	10,766
St Georges Healthcare NHS Trust	Provision of acute healthcare services	838
The Lewisham Healthcare NHS Trust	Provision of acute healthcare services	4,190
Chelsea And Westminster Hospital NHS Foundation Trust	Provision of acute and community healthcare services	1,713
Guys And St Thomas NHS Foundation Trust	Provision of acute and community healthcare services	148,352
Kings College Hospital NHS Foundation Trust	Provision of acute and community healthcare services	127,706
South London And Maudsley NHS Foundation Trust	Provision of mental healthcare services	64,696
University College London NHS Foundation Trust	Provision of acute and community healthcare services	3,137

2011/12	Services Received from Organisation	Payments to Related Party £
Dr Mark Ashworth-Hurley Clinic	Primary Care	3,348,734
Dr Adam Bradford-East Street Surgery	Primary Care	918,038
Dr Jane Cliffe-Gardens Surgery	Primary Care	753,782
Simon Fradd-Concordia Health	Primary Care	2,023,957
Jonty Heaversedge-Manor Place Surgery & Sir John Close Surgery	Primary Care	2,204,743
Patrick Holden-Surrey Docks Health Centre	Primary Care	1,014,793
Roger Durston-Camberwell Green Practice	Primary Care	1,350,019
Aylesbury Partnership - Stewart Kay (Principal GP), Dr Amir Zeineldine (partner)	Primary Care	2,929,081

		£000
Croydon PCT	Commissioning of Healthcare	36,668
Lambeth PCT	Commissioning of Healthcare	5,251
Barts And The London NHS Trust	Provision of acute healthcare services	1,808
Imperial College Healthcare NHS Trust	Provision of acute healthcare services	1,427
London Ambulance Service NHS Trust	Provision of acute healthcare services	10,667
St Georges Healthcare NHS Trust	Provision of acute healthcare services	1,011
The Lewisham Healthcare NHS Trust	Provision of acute healthcare services	4,147
Chelsea And Westminster Hospital NHS Foundation Trust	Provision of acute and community healthcare services	1,767
Guys And St Thomas NHS Foundation Trust	Provision of acute and community healthcare services	144,623
Kings College Hospital NHS Foundation Trust	Provision of acute and community healthcare services	119,546
South London And Maudsley NHS Foundation Trust	Provision of mental healthcare services	66,592
University College London NHS Foundation Trust	Provision of acute and community healthcare services	2,871

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	2,643	1
Special payments - PCT management costs	1,973	2
Losses in respect of the provision of family practitioner services	0	0
Special payments in respect of he provision of family practitioner services	0	0
Total losses	2,643	1
Total special payments	1,973	2
Total losses and special payments	4,616	3

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	15,000	1
Special payments - PCT management costs	0	0
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	15,000	1
Total special payments	0	0
Total losses and special payments	15,000	1

Details of cases individually over £250,000	0	None

39 Third party assets

The PCT held £0 cash and cash equivalents at 31 March 2013 on behalf of patients (£0 at 31 March 2012).

40 Pooled budget

The pooled budgets were transferred to the London Borough of Southwark on 1st April 2011.

41 Cashflows relating to exceptional items

There were no exceptional items requiring disclosure.

42.1 Events after the end of the reporting period

As disclosed within note 1.1 due to the Health and Social Care Bill as of 1st April 2013 the PCT in its current legal form will be abolished. As a result the PCT's functions will continue with either a Commissioning Support Unit (CSU), Clinical Commissioning Group (CCG), NHS England, NHS Foundation Trusts (FT) or Local Authorities (LA). Estates functions will be transferred to NHS Property Services Limited (NHS PS). Ultimate control will still reside with the Department of

All assets and liabilities contained within the statement of financial position as at 31st March 2013 must be identified and agreed for transfer.

Under this NHS Transition, the PCT's assets and liabilities will be split between different 'Receivers' and, in some cases, multiple 'Receivers' will require access to an asset or be assigned a liability. The principles for the split of residual balances is still subject to Department of Health guidance.

The majority of assets and liabilities (including all land and buildings) will transfer by way of a 'Sender' organisation's Transfer Schemes. A Transfer Scheme is an instrument in writing made by the Secretary of State under sections 300 to 302 of the Act. It can deal with the transfers of staff, property and liabilities between those entities as specified in Schedules 22 and 23 to the Act but unlike Transfer Orders does not need to be laid before Parliament.

Where functions transfer, any claim, liability and financial asset, which relate to that will follow. However NHS England will take historical NHS Litigation Authority (NHSLA) indemnified clinical negligence claims, including those incurred but not reported relating to new functions of CCG's or Local Authorities.

The final year-end aggregate surplus generated by the PCTs in 2012/13 will be carried forward to NHS England in 2013/14. CCGs will not inherit legacy debt, but balances will transfer from PCTs, in line with provisions of the Act, based on the principles set out below, subject to further guidance from the Department of health on the split of financial balances and related financial transactions.

- Liabilities that correspond to an asset which relate to a particular function should transfer with that asset from a sender to a receiver by reference to the destination of the function.

- Liabilities that correspond to a function or policy that is being moved from a sender should transfer to the nominated receiver for that function.

- Discrete, and current assets and liabilities, even if associated with a function continuing in 2013/14 will transfer to the Department of Health.

- Liabilities relating to the PCT as a statutory body in its own right that do not relate to an on-going function such as VAT or tax liabilities, will transfer to the Department of Health.

- Employer liabilities will transfer to the new employer, where an individual's employment is transferred to a receiver organisation.

- Where employment of staff ceases prior to 1st April 2013, the employer liabilities related to those staff members will transfer to Department of Health.

Southwark Primary Care Trust

Organisation Code: 5LE

1. Scope of responsibility

As signing officer delegated by the Department of Health's Accounting Officer I have taken assurances from the Accountable Officer for 2012-13 that he took responsibility for maintaining a sound system of internal control that supports the achievement of Southwark Primary Care Trust (PCT) policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am responsible. I am also responsible for ensuring that Southwark PCT is administered prudently and economically and that resources are applied efficiently and effectively. These responsibilities are as set out in the Accountable Officer Memorandum.

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Southwark PCT, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Southwark PCT for the year ended 31 March 2013.

NHS South East London was established on 1 April 2011 and is a partnership of Bromley, Greenwich, Lambeth, Lewisham and Southwark Primary Care Trusts and Bexley Care Trust. This change was a first step towards delivering the Governments reforms to the NHS under the provisions of the Health and Social Care Act 2012 and which come into statutory force from 1 April 2013. In this document NHS South East London is sometimes referred to as a "PCT Cluster" or "Cluster".

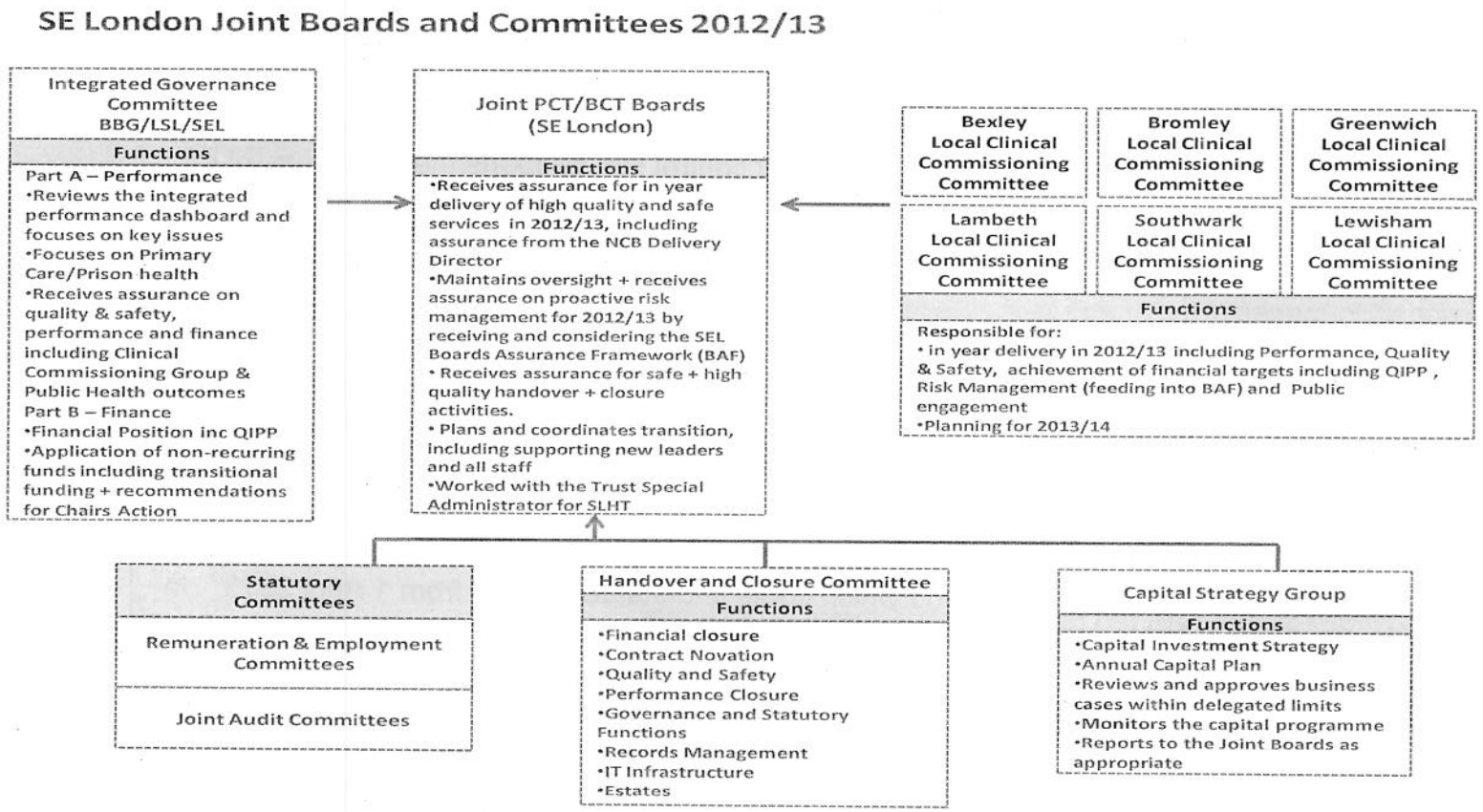
NHS South East London covers a population of 1,568,000. There are four acute hospital trusts, two of which are Foundation Trusts, two mental health Foundation Trusts, and a diverse and active community sector. An Academic Health Sciences Centre consisting of Guy's and St Thomas', King's, South London and Maudsley and King's College London has also been formed. There are 271 GP practices and six community care providers, five of which have integrated with local NHS providers with one becoming a social enterprise.

Southwark has been through the national process to achieve authorisation as a Clinical Commissioning Group from 1st April 2013.

This includes revising our governance processes and committee structures and ensuring that conflicts of interests are dealt with appropriately. Southwark CCG has now been authorised with no conditions.

2. The governance framework of the organisation

The Governance Framework is comprised of the Boards and Boards Committees detailed in the following diagram:



- The Joint Boards are six individual PCT/Care Trust Boards that work together as one entity, undertaking the duties that are enshrined in law relating to the governance of Primary Care Trusts and Care Trusts. Certain mandatory positions on the Boards, such as the Chair and Chief Executive, are fulfilled by the same individual across all of the Boards, while other positions are taken by local Primary Care Trust (PCT) Managing Directors and locally-focused non-executive directors. The Boards focus on developing strategies and priorities for the entirety of NHS South East London (NHS SEL) (including Southwark PCT), ensuring that the clinical commissioning committees are fulfilling their duties, in accordance with what is delegated to them.

- During 2012/13 the Joint Boards:
  - Implemented the revised Governance arrangements agreed on 26 January 2012 reflecting the new shadow Clinical Commissioning Group (CCG) arrangements in place from 1 October 2012
  - Agreed revised arrangements for managing conflicts of interest in NHS SEL
  - Adopted revised Corporate Governance Arrangements enacting the Transition
  - Reviewed and updated the Boards Assurance Framework at every Boards meeting.
  - Considered risk at every meeting and received assurance via an exception reporting arrangement, the format for which was considerably strengthened by the Boards during the year. This approach was supported through the delegation process whereby each borough Local Clinical Commissioning Committee (LCCC) reviewed risks relevant to their populations. The Joint Audit Committees (JAC) tested the system and process of assurance.
  - At each meeting received and considered reports on the following topics:
    - Quality and Performance
    - Finance
    - Integrated Governance
    - Local Clinical Commissioning Committees
    - Transition and Handover & Closure including:
      - Clinical Commissioning Groups
      - The South London Commissioning Support Unit
    - Individual matters reserved to the Joint Boards

- The Joint Boards' Assurance Framework is publicly available on the NHS SEL website.
- In 2012/13 the Boards met every two months, in public. All meetings were quorate for all Boards.

The Boards have assessed their own performance and effectiveness, including their compliance with key elements of the Code of Conduct and Code of Accountability for NHS Boards. Views were obtained via an anonymous online survey designed in keeping with the structure and format of a comparable survey last year. Twenty two returns were received from the Joint Boards membership of thirty four.
In the key areas of governance, there was a 100% satisfaction rating that governance arrangements enable members to identify and, when necessary, declare potential conflicts of interest when conducting Board business. There was also a near unanimous satisfaction rating in the following areas (with one member disagreeing):

- the Joints Boards' ability to support the fulfillment of the statutory duties of the constituent PCTs and Care Trust
- ensuring effective financial control, financial planning and value for money.

Overall, members were also satisfied that:

- the Cluster's governance arrangements support the achievement of the standards and targets set out in the NHS Operating Framework;
- that there is clarity on the role of the Joint Boards and on responsibilities that can be delegated to committees and officers;
- that the Joint Boards and their committees provide clarity on who is to take action following decisions made.

A small number of members did not agree that the Joint Boards have the opportunity to explore all the challenges and opportunities faced by the Cluster, although this was tempered by comment that such a situation was not, perhaps, surprising, given the considerable focus having to be devoted to the transition.

More members (though still a minority) recorded concerns about the amount of information sent to them for meetings, together with the limited time given to digest it. Though fewer members felt that duplication in the business and decision-making between the Joint Boards and their committees had taken place, perhaps, demonstrating the success of our arrangements for delegation and the implementation of revised governance arrangements during spring 2012.
Notwithstanding the reflections detailed above, the Chair and Chief Executive believe that there has been no material departure from the Code of Conduct and Code of Accountability for NHS Boards and none has been suggested by other Board members

Southwark Clinical Commissioning Committee (SCCC)

Southwark SCCC provides oversight, challenge and review of local issues, management response and interaction /

dependencies with cluster activities. The SCCC delegates detailed scrutiny of all risks to the Integrated Governance and Performance Committee, which also reviews locally specific risks and recommends their escalation to the Joint BAF in line with the principles contained within the NHS SEL Assurance Framework.
The Corporate Secretary holds minutes and records for attendance for the Southwark Clinical Commissioning Committee and our committees and sub-committees.
The Integrated Governance and Performance Committee is assured through the Board Assurance Framework and various Director reports on issues that all statutory functions are being discharged satisfactorily and in accordance with legislation e.g. Safeguarding.

Joint Audit Committees

- The Joint Audit Committees (JAC) fulfil the statutory audit functions required of PCTs and Care Trusts, ensuring that the governance and machinery of the cluster and the PCTs/Care Trust is functioning as it should. Their work programme includes reviewing governance arrangements (including Information Governance), assurance mechanisms including the work of internal and external audit, local counter fraud and security management services, debt and waiver management, and reviewing the Board Assurance Framework to make sure that corporate objectives and organisational risks are properly addressed.
- During 2012/13 the JAC considered all residual risks and Assurance Frameworks from the PCTs / Care Trust in SEL. The Committee reviewed the Assurance Framework at every meeting.
- The JAC considered each of the six individual PCTs/Care Trust Annual Accounts, Audit opinions, Annual Reports and Annual Governance Statements for 2011/12 at its meetings on the 9 and 30 May 2012. .
- In September 2012, the Joint Audit Committee received and considered the Annual Audit Letters
- On 13 and 27 March 2013 the JAC considered each of the six individual PCTs/ Care Trust draft Annual Reports and Annual Governance Statements, along with the interim work on the 2012/13 Annual Accounts undertaken by internal and external audit. Year end documents will be finalised and approved post 31 March 2013 through the temporary mechanism being designed by the Department of Health.
- The JAC has increased its engagement with PCT/Care Trust Chief Finance Officers and Chief Officers; both are now routinely invited to meetings.
- The JAC meet at least quarterly. Meetings are not held in public but activities are reported to the Joint Boards. All meetings in 2012/13 were quorate.

Integrated Governance Committee (IGC)

The IGC has the following roles and responsibilities:-

- To oversee the integrated governance of the shadow CCGs and give the Joint Boards assurance that actions and plans put in place by the CCGs are appropriate, adequate and followed through as they work towards Authorisation.
- To give a forum for the shadow CCGs to operate at scale to manage the performance and quality of the major acute, community and mental health providers
- To help enable the Cluster Chief Executive to exercise his role as Accountable Officer through consideration and review of the aggregate Cluster position with respect to performance, finance, quality and emergency planning
- To review and consider the quality and performance of Primary Care, Prison Health and Specialist Services prior to full establishment of the National Commissioning Board
- To oversee the procedures for identifying, investigating and learning for serious incidents and for safeguarding children and vulnerable adults.
- The Committee meets monthly and all meetings were quorate during 2012/13
- Meetings are not held in public but a summary report detailing issues discussed and actions proposed is provided at each Joint Boards meeting.

Handover and Closure Committee

- Oversaw all aspects of the Handover and Closure programme in the NHS in South East London.
- The Committee meets in private but provides its minutes to the Joint Boards. All meetings in 2012/13 were quorate.

Capital Strategy Group

- Oversaw all aspects of Capital Strategy, planning and progress in the NHS in South East London
- The Group meets in private but considers issues prior to their decision at public meetings of LCCCs or the Joint Boards. All meetings in 2012/13 were quorate.

Joint Remuneration and Employment Committee

- The Joint Remuneration and Employment Committee meets to consider the employment packages for those employees of the cluster whose remuneration fall outside the scope of Agenda for Change.
- The Committee meets as required and in private. All meetings in 2012/13 were quorate.

Assurance

In July 2012 Internal Audit carried out a review of CCG Governance and Delegation. While the audit was forward looking it also encompassed aspects of current practice. The audit concluded that for all six NHS SEL organisations the design and operation of governance arrangements for the CCG authorisation process and shadow year were **adequate** (Green RAG rating). A summary of recommendations is given below:

Organisation	Assurance Level	Recommendations by Priority		
		High	Medium	Low*
Lambeth (Made/accepted)	Adequate	0	0	4/4
Southwark (Made/accepted).	Adequate	0	0	3/3
Lewisham (Made/accepted)	Adequate	0	0	4/4
Bexley (Made/accepted)	Adequate	0	0	3/3
Bromley (Made/accepted).	Adequate	0	0	3/3
Greenwich (Made/accepted)	Adequate	0	0	4/4
Summary of Audit	**Adequate**	**0**	**0**	**21/21**

*Low Priority	Recommendations which could improve the efficiency and/or effectiveness of the system or process but which are not vital to achieving strategic aims and objectives. These are generally issues of good practice that the auditors consider would achieve better outcomes.

3. Risk Assessment

3.1. Introduction

The Southwark PCT approach to risk management and board assurance is in accordance with legislation, national and local guidance. It seeks to embed recognised and developed best practice through a process of ongoing review and improvement and underpins the production of the Annual Governance Statement (AGS).

Through adopting the agreed NHS SEL approach to risk management and board assurance, Southwark PCT believes that it has in place a sound governance structure and risk management arrangements to enable it deliver its objectives and thus serve its resident population.

The PCT systematically identifies, at all levels, those risks that could affect these objectives and takes every reasonable step to control risk. This includes a process to monitor, and if necessary improve, how risks are being managed and demonstrate how this is occurring.

Southwark PCT leadership team employs effective techniques for risk management, supported by good information systems, discusses and shares risk information amongst themselves and trains and supports all their staff to an appropriate level of expertise. Southwark PCT also requires that the organisations and people it commissions to provide health services operate demonstrably effective risk management systems.

3.2. Purpose of risk management and board assurance

The establishment of effective risk management systems is recognised as being fundamental in ensuring good governance. Its aim is to continually improve the quality of health service commissioning through the identification, prevention, control and mitigation of risks. To do this, a systematic and consistent approach to risk management is required in Southwark PCT and across NHS SEL commissioning and other activities.

The PCTs in NHS SEL have adopted the principles of the Australia/New Zealand Risk Management Standard (AS/NZS 4360:1999) in their approach to risk management. This is a generic model for identifying, prioritising and dealing with risks in any situation – at local or corporate level. It comprises definition, scope and consequence of risk. It provides an effective means of controlling and mitigating the risks associated with the delivery of commissioned services, the achievement of corporate

objectives and any other aspect of health in NHS SEL.
The Southwark CCG Integrated Risk Framework sets out Southwark CCG's strategy and appetite to risk as we establish ourselves. Its implementation will aim to:

- Demonstrate robust risk management processes with regular reporting to the Governing Body
- Assure the Governing Body through presentation of Board Assurance Framework that systems of risk assessment and review are operating for risks in all workstreams and projects
- Formalise reviewing management of risk, through the IGP committee and Audit committee of the CCG

During the year, Southwark organised a workshop with the Good Governance Institute on determining Risk Appetite for the CCG, which was attended by all GP leads and designated lead officers.

The Joint Boards ensure that they receive robust and independent assurances on the soundness and effectiveness of the systems and processes in place for meeting its objectives and delivering appropriate outcomes. The Joint Boards therefore have overall responsibility for ensuring they have assurance that the process of risk identification, evaluation and control are effective. This is achieved through the management and application of the Joint Boards Assurance Framework. The Joint Boards Assurance Framework (JBAF) enables the NHS SEL Executive Management Team to be assured that the controls applied in the mitigation of risk are operating effectively.

Both the Joint SEL Audit Committees and the shadow CCG Audit Committee have discussed and agreed actions to give them additional assurance, following the auditors reports on adverse events in other PCTs.

3.3 Objectives

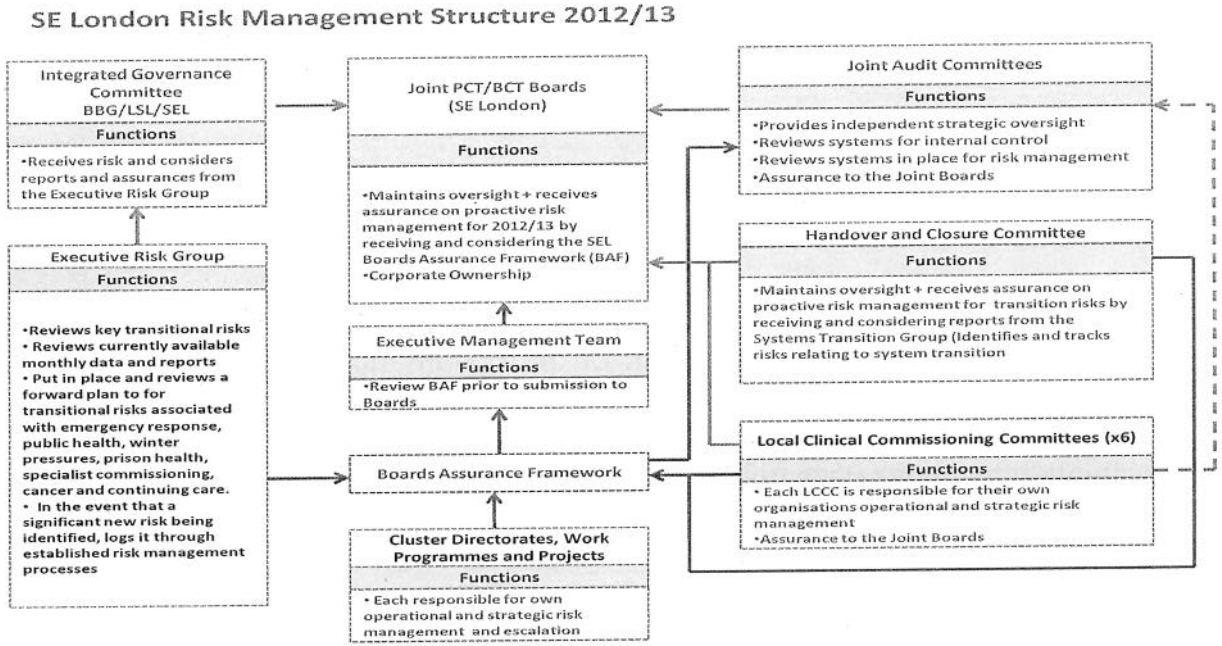
The objectives of the risk management and board assurance approach adopted by NHS SEL are:
1. Ensuring compliance with all standards and regulations that apply to health care for all commissioned services;
2. Ensuring a common and integrated approach to risk management across NHS SEL;
3. Implementation and management of a robust assurance framework that addresses risks at all levels of the organisation with relevant and appropriate escalation.

3.4. Description of terms and definitions

Risk management and assurance uses a number of terms and definitions that are necessary in order to communicate its meaning, interpretations and outcomes in a common way. The description of the terms, definitions and principles that the cluster works to are set out in the joint NHS SEL Risk Management and Assurance Toolkit, a companion document to the JBAF.

3.5. The risk management structure

3.5.1 The risk management and assurance structure allows for risk to be captured, reported and managed in a consistent way across NHS SEL. It enables risks to be considered at an operational level and strategic level depending on the nature and severity of the risk as represented by an assessment of its likelihood of occurring, the potential area impacted by that risk and the consequences resulting from its potential occurrence.



The diagram above shows the high level linkages between operational risks, and NHS SEL strategic risks and the level at which oversight takes place. As with most models of risk management the structure recognises the principle of escalation between the lowest reported level of risk (department / function) to the highest reported level of risk (JBAF). This provides for a transparent, owned and accessible approach with in-built oversight.
Additional information on the above groups follows:

Joint Boards (Corporate Ownership)

The Joint Boards own the organisational objectives, risks to delivery and the assurance framework. It has identified all its key significant risks and they are being managed appropriately. Monitoring of the key risks is done via the Joint Boards Assurance Framework. The Joint Boards need to be satisfied that appropriate policies and strategies are in place and that systems are functioning effectively.

The Joint Boards satisfy themselves that operational responsibility is being discharged and that risks are mitigated to support the delivery of organisational objectives. The Joint Boards are briefed on the challenge and scrutiny exercised by its committees in order to secure additional assurance.

The Joint Boards are briefed by exception on particular local risks or borough specific considerations for an NHS SEL wide risk where this is judged to have potential for local impact at a scored level of 15 or above.

Joint Audit Committees (Assurance)

The Joint Audit Committees provide, collectively and individually, independent oversight of the governance and assurance processes on behalf of the organisations. This includes responsibility for reviewing and providing verification on the systems in place for internal control and risk management. It reviews the adequacy of the Joint Boards Assurance Framework and the structures, processes and responsibilities for identifying and managing key risks facing the Cluster.

Southwark Clinical Commissioning Committees (Assurance)

Southwark CCC provides oversight, challenge and review of local issues, management response and interaction / dependencies with cluster activities. The SCCC also reviews locally specific risks and recommend their escalation to the JBAF in line with the principles contained within the NHS SEL Assurance Framework. The SCCC discusses risk at every meeting and considers, and acts on, its corporate risk register. This is a vital contribution to retaining local ownership and to escalating appropriate risks to the Joint Boards. It gains assurance from the key committees including the Integrated Governance and Performance Committee.

Executive Management Team (Management Adoption)

Fulfils the corporate governance functions of a Risk Committee. It is responsible for co-ordinating and overseeing the development and implementation of the Policy & Strategy across the cluster. It oversees the development of the Joint Boards Assurance Framework and the maintenance of appropriate local risk registers. On an alternate monthly basis it reviews all significant risks on the JBAF prior to oversight by the Joint Boards, and new emerging risks that have escalated from the Directorates. The Committee monitors and ensures that the JBAF reflects all the key risks with particularly high residual scores and that it remains a dynamic document.

Assesses congruence and identification of any cross PCT issues. Ensures all strategic risks have been identified, have been appropriately allocated and are being managed in accordance with NHS SEL policy. Makes recommendations on escalation and commonality including identification of pct specific risks (15 or above).

The Integrated Governance Committee (Management Adoption)

Considers reports from the Executive Risk Group at every meeting. This is at both macro and micro level and the depth of discussion is dependent on the matter being considered.

Executive Risk Group (Transition Risk Oversight)

In acknowledgement of the risks associated with the transitional period to March 31st 2013, the Joint Boards established an Executive Risk Group in November 2012. The Executive Risk Group brings together senior Executive Directors, including the Nursing and Medical Director, from the Cluster and the London office of the NHS Commissioning Board. The Executive Risk Group meets every fortnight and systematically reviews key risks as the transitional arrangements unfold and as functions are handed on to the new shadow bodies. In addition to reviewing currently available monthly data and reports, the Executive Risk Group has put in place a forward plan to review transitional risks associated with emergency response, public health, winter pressures, prison health, specialist commissioning, cancer and continuing care. The Executive Risk Group reports to the Integrated Governance Committee and, in the event that a significant new risk was identified through this process, it would be logged in the normal way on the risk register.

PCT and Directorate Structures (Operational Management)

All directors have in place local risk management structures (in Southwark this includes aspects of capturing LCCC intelligence). All Directors and therefore their managers are responsible for; ensuring that appropriate and effective risk management processes are in place for each department / function within their scope of responsibility; compliance to the NHS SEL approach to risk management and board assurance; bringing to the attention of their director / department lead any significant risks that

have been identified where local control measures are considered to be inadequate.

3.5.2 Risk reporting and management

Risk registers are the mechanism by which identified risks and the details of the associated controls and assurances that are put in place to manage an individual risk to its agreed acceptable level are recorded.

Risk registers are used at each level of risk reporting. A core data set is required (to facilitate escalation to the JBAF which is reviewed by the Joint Boards) with local adaptation of the adopted NHS SEL approach encouraged to facilitate local management. Risks escalated to a corporate level via the JBAF will require completion of an Action Plan, thereby capturing a higher level of detail and providing the required level of additional assurance. Local processes and approaches to secure enhanced assurance are developed under the stewardship of the LCCC.

The level of risk determined to be necessary for escalation from a local or directorate risk register to the JBAF is 15 or above with impact on one of more PCTs. An action plan is completed for all risks rated as 15 or above; such reports are offered to the Boards provided that they do not contain commercially sensitive or confidential information.

At Southwark, directorate risk registers along with Corporate Risk Register are presented to the Integrated Governance and Performance Committee on a monthly basis. The Board Assurance Framework is reviewed by the Southwark LCCC every quarter.

3.5.3 Duties (roles & responsibilities)

A prerequisite for the effective management of risk is the need for all staff, clinicians, boards and committees to be clear on, and to fully undertake, their specific duties in respect to their roles and responsibilities within the risk management structure. These are described below.

- As signing officer delegated by the Department of Health's Accounting Officer I have taken assurance from the Accountable Officer during 2012-13 that he took overall Executive responsibility for ensuring that there is an effective risk management or assurance framework in place within the cluster, for meeting all statutory requirements, adhering to guidance issued by the Department of Health in respect of Governance. I am required to sign the Annual Governance Statement. The Accountable Officer was accountable to the Joint Boards.

- **All Directors and Managers**
  All levels of management must understand and implement the principles of the JBAF and toolkit. All Directors/Directorate managers are responsible for: -

  - Ensuring that appropriate and effective risk management processes are in place within their designated areas and scope of responsibility.
  - Ensuring all staff are made aware of the risks within their work environment and of their personal responsibilities.
  - Preparing specific Directorate/Departmental policies and guidelines to ensure all necessary risk assessments are carried out within their directorate/department in liaison with appropriate identified relevant advisors where necessary.
  - Implementing and monitoring any identified and appropriate risk management control measures within their functions and scope of responsibility.
  - Ensuring situations are addressed where significant risks have been identified and where local control measures are considered to be potentially inadequate, Directors/ Directorate managers are responsible for bringing these risks to the attention of the Executive Management Team
  - Ensuring that all staff are given the necessary information and training to enable them to undertake effective risk management practices.
  - Ensuring that a Risk Register is maintained for their area of responsibility.

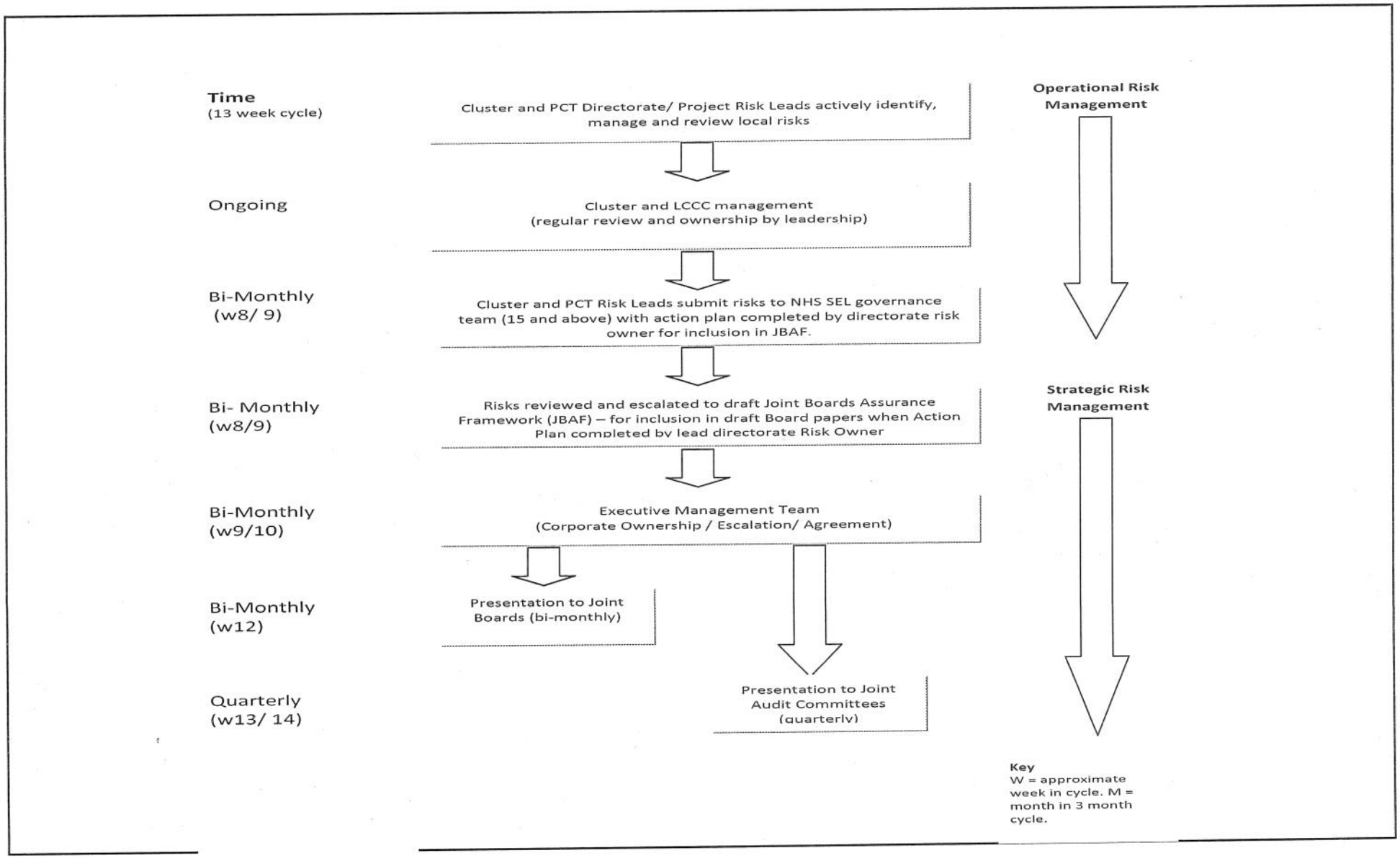
- **All Employees** must understand the nature of risk and accept responsibility for risks associated with their area of authority. They are responsible for:-
  - Reporting incidents/accidents and near misses using the agreed channels.
  - Complying with all cluster Rules, regulations, guidance and instructions to protect the health, safety and welfare of anyone affected by the Cluster's business.
  - Complying with all rules, regulations, guidance and instructions to ensure the cluster carries out its business in a safe and proper manner.

4. Risk reporting and risk ratings

4.1 Risk reporting process flow

Risks are reported and managed as shown in the diagram below. This is aligned to, and is consistent with, the operational and strategic linkages identified above and sets out the applicable timescales of the reporting process.
It illustrates the risk identification, reporting, escalations and actions at each level of risk management process.

The organisational level at which risks are managed within Directorates is set out with local determination as to application of the risk management process and reporting on outcomes. All risks recorded as strategic and those operational risks assessed to be of sufficient severity to be escalated to the JBAF (and scored above 15) require completion of action plans and is managed through the programme management process.


Time
(13 week cycle)
Cluster and PCT Directorate/ Project Risk Leads actively identify, manage and review local risks
Operational Risk Management
Ongoing
Cluster and LCCC management
(regular review and ownership by leadership)
Bi-Monthly
(w8/ 9)
Cluster and PCT Risk Leads submit risks to NHS SEL governance team (15 and above) with action plan completed by directorate risk owner for inclusion in JBAF.
Bi- Monthly
(w8/9)
Risks reviewed and escalated to draft Joint Boards Assurance Framework (JBAF) – for inclusion in draft Board papers when Action Plan completed by lead directorate Risk Owner
Strategic Risk Management
Bi-Monthly
(w9/10)
Executive Management Team
(Corporate Ownership / Escalation/ Agreement)
Bi-Monthly
(w12)
Presentation to Joint Boards (bi-monthly)
Quarterly
(w13/ 14)
Presentation to Joint Audit Committees (quarterly)
Key
W = approximate week in cycle. M = month in 3 month cycle.

4.2 Risk ratings

Every identified risk has a chance of occurring therefore each risk has its own potential likelihood. Similarly if the risk were to occur then it would have its own measure of impact (also known as a consequence). It is important to recognise that risk can never be eliminated with the aim of risk management being to progressively manage risk within acceptable levels. The acceptable level of risk is known as the 'risk appetite' of a particular risk.

The NHS in SEL determines inherent, residual (current) and target risk scores (levels of risk) for every risk and these are reviewed on a regular basis for all risks.

The NHS in SEL has determined the acceptable level of organisational risk to be '9'. That is the scoring at which the PCTs find a risk to be acceptable and less likely to be in need of regular monitoring or reporting. 9 is the preferred maximum, long term, target score for a risk.

Likelihood and impact are allocated a number between 1 and 5. The total risk score is the impact multiplied by the likelihood. Hence the risk score can lie between 1 (1x1) and 25 (5x5). The overall risk score determines the risk rating. This in turn determines the actions that are required to manage the particular risk.

The LCCC reviews risks above the stated tolerance threshold (10 and above). The Joint Boards, having delegated borough oversight to each LCCC, will review risks of 15 and above.

The diagram below illustrates the risk matrix scoring and consequential risk rating methodology.

Risk Matrix	Consequence				
Likelihood	Negligible	Minor	Moderate	Major	Catastrophic
Rare	1	2	3	4	5
Unlikely	2	4	6	8	10
Possible	3	6	9	12	15
Likely	4	8	12	16	20
Almost Certain	5	10	15	20	25

TOLERANCE THRESHOLD

Key Levels of Risk	
1-3	Low Risk
4-6	Moderate Risk
8-12	Significant Risk
15-25	High Risk

4.3 Zero tolerance risks

The risk management and Joint Boards assurance process shows how those risks that are reported through the SEL Joint Boards BAF (JBAF) are determined. These are those high rated risks that impact all of NHS SEL PCTs and Bexley Care Trust and all those risks that are rated as being 'high'.

However there are a number of areas where the boards might benefit from being aware of an existing risk, regardless of risk rating at any particular point in time. These risks are referred to as 'zero tolerance' risks and are noted on the JBAF. Recommendations for classification of zero based risks come from directors and are assessed by the Executive Management Team. NHS SEL has identified five zero tolerance risks, Safeguarding, Emergency planning, Staff Retention; Conflicts of Interest and reputational risk.

Where a borough specific risk is reported by exception to the Boards and this is aligned but scored more highly (15 or above)

than an identified Joint Boards level risk then the latter risk will be reported as a zero tolerance risk in order to ensure that the Boards have sufficient context and access to all relevant information on the issue.

We discuss all our key risks at the Integrated Governance Committee and agree the actions to mitigate these risks with our clinical and lay members on the committee.

5. Independent assurance

5.1 External audit

External audit provides assurance that the JBAF is in place, in collaboration with the processes carried out by Internal Audit.

5. 2 Internal audit

Internal audit reviews the process for the maintenance and delivery of the JBAF and provides the assurance that it meets the requirements of the Department of Health. Internal audit also reviews other risk areas in line with an agreed annual audit plan and reports its findings to the audit committee.

5.3 NHS Litigation Authority (NHSLA)

The NHSLA perform an independent assessment against risk management standards, in order to establish the level of discount the NHS SEL receives in relation to its indemnity contribution schemes. No assessment was carried out during 2012/13.

6. Reviews and updates

The approach Joint Boards adopt to managing risk and gaining assurance is/was reviewed annually by both the Joint Audit Committees who will report to the Joint Boards upon its findings. An additional review relating to areas of best practice and practical application will be undertaken by the Governance team.

7. New risks identified in the year 2012/13

7.1 The risks in the following table scored 15 or above (High or Red rated risks) and appeared for the first time on the Joint Boards Assurance Framework during 2012/13. The risks were accepted by the Joint Boards at their bi-monthly meeting on behalf of the relevant PCT or PCTs.

ID	Work Stream	Date Raised	Risk Category	Risk Description	Initial Risk Score	Still on JBAF @ 31/03/13	Risk Score @ 31/3/13	PCT/ Care Trusts affected by Risk
COM 22	MD	23/04/2012	Clinical	Successful delivery of national deadlines and requirements for Continuing Care retrospective review. Consequences for CCG team capacity, Providers capacity and funding	16	Yes	16	Southwark PCT
ICT18	ICT	27/04/2012	Information Management and Technology	There is a risk that the amount of change to happen in 2012/13 due to changes in the NHS such as the closure of PCTs will lead to an undeliverable ICT workplan, leading to some change requirements not being met	16	No: deescalated from JBAF or closed		All PCTs/ Care Trust
E25	Governance (Approval)	01/05/2012	Governance	There is a risk that lack of clarity about the future of the Capital Strategy Group caused by internal review of corporate governance arrangements will lead to delays in reaching decisions on business cases for capital schemes, disposals etc	15	No: deescalated from JBAF or closed		All PCTs/ Care Trust
ICT25	ICT	18/05/2012	Information Management and Technology	There is a risk that the main data centre for the core ICT network covering LSLG is housed in Lower Marsh, whose lease ends on 28/9/12, leading to a significant clinical and financial risk if the lease is not extended	20	No: deescalated from JBAF or closed		All PCTs/ Care Trust

ICT28 (i)	ICT	02/07/2012	Information Management and Technology	There is a risk that proposed structures for the South London Commissioning Support Service are not fit for purpose and reduce ICT resources and capability at a time when increased resources are needed to meet organisational changes within South London	20	No: deescalated from JBAF or closed		All PCTs/ Care Trust
ICT28 (ii)	ICT	02/07/2012	Information Management and Technology	There is a risk that a number of staff will not have posts within SLCSS as of 01/10/12, leading to low morale, unclear line management and a lack of customer focus, leading to an increased risk of not meeting the needs of the business during the second half of 2012/13	16	No: deescalated from JBAF or closed		All PCTs/ Care Trust
IGR42	IG	19/08/2012	Legal & Compliance	There is a risk that successor organisations (the CSU)will not be set up to deal effectively or efficiently with information governance and information management caused by the levels of resource available and the complexity, pace and lack of clarity around transition leading to a failure to become authorised and embed efficient business processes	16	No: deescalated from JBAF or closed		All PCTs/ Care Trust
IGR50	IG	14/01/2013	Legal & Compliance	The NHS Commissioning Board is a new national organisation and as such it is likely that records management processes are not yet fully developed or embedded. Therefore there is a risk that records transferred to the NHS CB may not be fully managed in keeping with NHS requirements in the short term. Records cannot be transferred until assurances are received.	16	Yes	16	All PCTs/ Care Trust

7.2 For Southwark PCT, one risk from 2011/12 reappeared during 2012/13:

ACC 2	Finance	**01/06/2011**	Financial	Maintaining grip on finance and performance during organisation transition and increasing delegation. Specifically, KCH and GSTFT not meeting Referral to Treatment and A&E 4 hour waiting targets.	**16**	**Yes**	**16**	Southwark PCT

7.3 A summary of the above RED risks on the JBAF at March 2013 by work stream is given below:

Work Stream	**Red**
Continuing Care	1
Finance	1
Information Governance	1
Total	3

In addition to the Zero tolerance risks detailed above, other zero tolerance risks were reported through the JBAF covering the following areas: Adult and Child Safeguarding, Emergency planning, Staff Retention; Conflicts of Interest and reputational risk. These additional zero tolerance risks scored under 15 but were ongoing risks the Board wished to retain sight of irrespective of their current risk score. A summary of the zero tolerance risks on the JBAF at 31 March 2013 is given below

Zero Tolerance Risk	**NHS Cluster**	**Southwark**
Adult Safeguarding		
Child Safeguarding		
Emergency planning	✓	✓
Staff Retention	✓	✓
Conflicts of Interest		✓
Reputational risk	✓	✓

Organisations in South East London are aware of the Secretary of State's decisions based upon the Trust Special Administrator's recommendations related to the South London Healthcare Trust and are actively reviewing the outcome of this process and its impact upon boroughs.

The common risk framework used across South East London evolved over the course of 2012 and 2013. It was informed by analysis and consideration by the Joint Boards, Boards Committees and local Business Support Units. During CCG preparation in 2012 and 2013 the Clinical Commissioning Groups gained greater delegation for managing Board level risks as well as their own local risks.

The risks listed above are managed by the process described in this document.

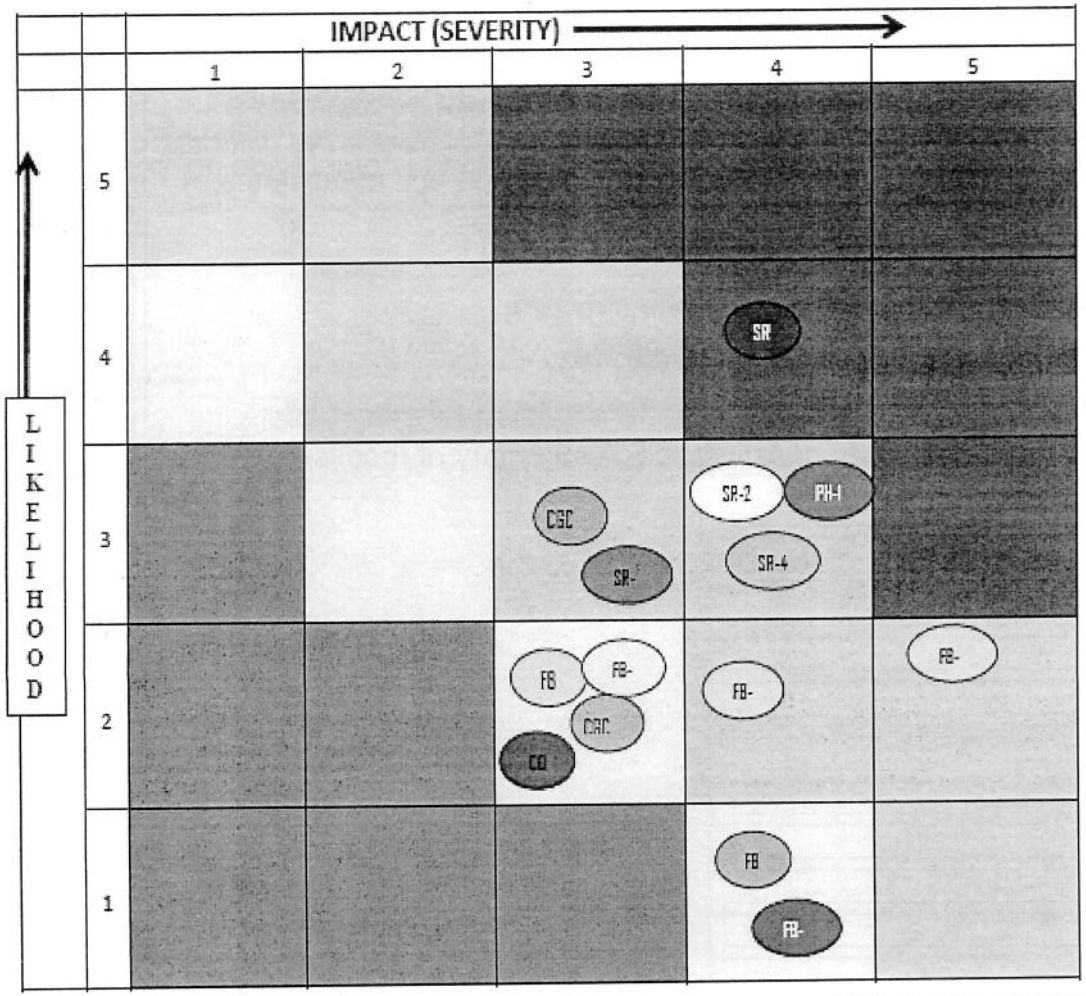
For Southwark PCT, the following risks were identified as could particularly affect the PCTs strategies and development were as below; for all these areas Southwark has a zero tolerance approach:

- Potential conflicts of interest (COI) in commissioning decisions will result in legal challenge to commissioning decisions caused by the potential for clinical commissioners being both providers and commissioners of services. (Conflict of Interest)
- Risk of compromised emergency preparedness and resilience in a period of transition esp. with specific event pressures e.g. 2012 Olympics. (Emergency planning/ Reputational risk)
- Maintaining staff in key positions and ensuring staff capacity to meet Operating Plan requirements e.g. safe services, business intelligence, organisational knowledge. Risk includes maintaining staff morale during uncertainties and following loss of key leads (Staff retention risk).
- Maintaining grip on finance and performance during organisation transition and increasing delegation. Specifically, KCH and GSTFT not meeting Referral to Treatment and A&E 4 hour waiting targets (Reputational risk).
- Ensuring quality of service provision & adequate quality monitoring processes for all acute & community contracted services during transition. (Reputational risk)
- Successful delivery of national deadlines and requirements for Continuing Care retrospective review - consequences for CCG team capacity, Providers capacity and funding (Reputational risk)
- Ensuring Southwark Healthcare Commissioning meets the criteria to pass the Authorisation process in wave 1 or 2 including capacity to upload evidence, and Information Governance requirements

There are other risks that are managed at PCT and Cluster Directorate level but have not warranted escalation to the Joint Boards.

NHS SOUTHWARK - HEAT MAP FOR ASSURANCE FRAMEWORK
Q4 2012 - 2013 (YEAR_END) POSITION

APPENDIX 1 - HEAT MAP FOR BOARD ASSURANCE FRAMEWORK



SR-1		Maintaining grip on finance and performance during organisation transition and increasing delegation.
FB-1		Achieving full delivery of £15.86m (gross) QIPP Programme in 2012/13
CGC-3		Delivering effective commissioning within financial envelope and delivery of QIP
FB-2		Maintaining staff in key positions and ensuring staff capacity to meet Operating Plan requirements
SR-2		Non-delivery of Service Redesign QIPP due to pressure on maintaining 12/13 financial balance target:
PH-1		Robust handover of Public Health department to PHE and Southwark Local Authority
SR-4		Quality of service provision & adequate quality monitoring processes for all acute & community contracted services.
CGC-8		Joint working with LA to support delivery of joint working
FB-3		Establishment of NHS Property Services
SR-7		Quality and Performance in Primary Care
FB-14		Southwark CCG meets authorisation criteria including IG requirements
FB-12		Development of CSU
CO-1		Robust contracting arrangements during handover
FB-7		Handover and Closure of PCT's:

8. Assurance

In October and November 2012 Internal Audit carried out a review of the BAF and Risk Management processes in each of the six Primary Care and Care Trusts in South East London.

Summary of Findings: CCG Risk Management Strategies and Procedures:

Through interviews, review of policy documents and risk registers the auditors checked the adequacy of the risk management approach at each CCG. Detailed findings for each CCG's processes for identifying, monitoring, addressing and escalating risks and how these are collated and reported to the governing body were also provided. Also identified were the design and compliance of the key controls in place covering:

- Whether risk management frameworks reflect an integrated risk management approach;
- The clarity of ownership and responsibilities for risk management within the governance structure;
- The identification of mitigating SMART actions, risk owners and evidence of timely monitoring;
- Sufficiency of risk register scrutiny and the timeliness/appropriateness of escalation of risks to the governing body;

The application of risk appetite in judging risks, mitigating controls and sources of assurance; A summary of results is detailed below.

	Southwark
Integrated risk management approach reflected	✓
Risk appetite determined and reflected in risk management framework	✓
Adequate tracking of risks at directorate level	✓
Evidence of the assignment of risk owners	✓
SMART actions	✓
Evidence of timely monitoring of risks and actions	✓
Evidence of consistent and accurate escalation to the governing body	✓
Effective use of heat maps/risk distribution maps	x
Evidence of timely review by sub-committee with appropriate scrutiny	✓

Evidence of timely review by governing body with appropriate scrutiny	✓

Recommendations raised:
Summarised below is the number of recommendations raised at NHS SEL (Cluster) or PCT level as a result of the review (high priority represents the most urgent and high risk category).

	[illegible]	Medium (2)	Low (3)	Total
SEL Cluster	0	3	8	11
Southwark PCT	0	0	3	3

Risk	Recommendation Area	Southwark	Cluster
(two)	Review of high risks by Sub-committees		Yes
(two)	Risk appetite and tolerance levels		Yes
(three)	Directorate risks escalation to Assurance Framework		Yes
(three)	Review of Directorate risks		Yes
(three)	Risk register design to reflect action taken against appetite for each risk	Yes	Yes
(three)	Heat Maps production for Clinical Commissioning Committee	Yes	Yes

(three)	Zero Tolerance Risks	Yes	Yes

For Southwark PCT, all prior year (2011-12) internal audit recommendations were reported as implemented.

9. Summary of lapses of data security, including any that were reported to the information Commissioner

No significant breaches of data security were reported during the year.

10. Significant Issues -

This section sets out: first, an overview of the major challenges that we expect Southwark Clinical Commissioning Group to face during 2013/14 and how we are managing these at 31 March 2013; and secondly the significant issues which we have identified during 2012/13, and which have or are being addressed.

Challenges during 2013/14

During 2013/14 CCGs face a number of significant challenges as they deliver against the NHS Operating framework. From a governance perspective these challenges fall into three areas: **building on the transition**; **doing things differently**, and **improving quality** of local healthcare services.

1. Delivering the transition

Throughout 2012/13 we have moved towards establishing NHS Southwark Clinical Commissioning Group (CCG) as the statutory body for health service commissioning in the borough from 1 April 2013. Early in the year we saw the CCG receive delegated responsibility for its future areas of responsibility – hospital and emergency care, community health and mental health services. This culminated in January 2013 when NHS Southwark CCG was one of 67 emerging CCGs authorised by the NHS Commissioning Board in the second wave of the national process. The process had required considerable work during 2012 by NHS Southwark CCG to provide an extensive suite of information, in order that the NHS Commissioning Board could be assured that the CCG were ready to take on their statutory responsibilities.

2013/14 will be a challenging year for Southwark CCG, building on the success of its shadow running which commenced on 1 October 2012. We recognise the risks associated with the transition to new commissioning arrangements. We have robust plans in place supported by governance arrangements that will enable us to address the ongoing risks associated with transition whilst continuing to fulfill our statutory duty in 2013/14 of delivering the health and wellbeing needs of our local population.

2. Doing things differently

A significant amount of transformational change is needed across the local health economy in South East London and locally in Southwark. Our commissioners are continuing to deliver service redesign schemes to maximise the benefits of our local community and acute providers, Kings College Hospital NHS Foundation Trust and Guys and St. Thomas' NHS Foundation Trust.

We continue to develop our joint working with other boroughs and their Clinical Commissioning Groups. NHS Southwark CCG has led major programmes of service redesign in urgent and planned care in partnership with Lambeth CCG, local NHS Foundation Trusts and local authority partners.

Highlights of the year in Southwark included the opening the Urgent Care Centre on the Guy's Hospital site with GPs and hospital Emergency Nurse Practitioners working alongside each other providing urgent care to patients 8am – 8pm seven days a week. The CCG also carried out a three month engagement exercise with local people on our ideas and plans for health services in the Dulwich and surrounding areas.

During the year, GPs, practice managers and key clinicians in Southwark got together regularly with relevant partners to discuss important issues focusing on how to work more efficiently and better integrate healthcare. In Southwark we have held eight learning events for GPs and other clinicians on a range of subjects including clinical commissioning, planned and unplanned care, community services and safeguarding.

Southwark is working with other South East London clinical commissioners to deliver 'NHS 111', the national NHS initiative of a single telephone number which will enable patients to be directed to the most appropriate service for their non-urgent health needs. There is a closely managed process in place to deliver the 111 service in South East London, including the mitigation of financial and other risks associated with the Project. A 111 Project Board has been established and meets regularly.

Southwark had a significant QIPP target of £11m to deliver with partners; 98% of the QIPP programme was achieved. This work continues in 2013-14 to improve quality and service redesign. There has been re-investment of savings in acute, community and mental health services.

3. Improving quality

We have set an ambitious productivity improvement targets for our health economy. Through our governance structures and

processes we are monitoring and assuring execution of our plans on an ongoing basis, to ensure that we make savings without compromising the ongoing improvement of care quality, including outcomes across cancer, Referral to Treatment, A&E and waiting times.

The Olympics and Paralympics were a great success in London during the summer of 2012. The local NHS maintained "business as usual" despite the resulting operational pressures.

Specific issues identified during 2012/13

We continue to work with our internal auditors to identify areas where our systems and processes for governance and internal control can be further strengthened. The work of Internal Audit during 2012/13 resulted in twelve high priority recommendations where improvements could be made to internal control systems and processes. These recommendations have been agreed by PCT Management and the resultant actions have been taken, or are in the process of being taken.
These covered:

Topic	NHS SEL Cluster	Southwark
Conflicts of Interest	1	1
HR Staff Records	3	-
General IT Controls	-	-

Southwark has incorporated the high priority internal audit recommendation regarding Appointments to the Governing Body, confirming that final interviews with new appointees to governing body will consider conflicts of interests. Other recommendations are being implemented/ addressed.

The other specific local issues identified as significant by Southwark Primary Care Trust were as follows:

1. Continuing Care Retrospective Claims: Southwark received 69 claims to date – 20 claims have been closed; the remainder are currently under investigation.
2. The implementation of the TSA recommendation has started but details of timescales and short-term costs etc. are still being quantified. Resources have been set aside to manage this issue.
3. Action on Francis report: Southwark PCT have established Quality Group to recommend appropriate actions.

11. Review of the effectiveness of risk management and internal control

The Department of Health's Accounting Officer has designated the role of signing officer for the final accounts and governance statement. In fulfilling this role I have taken assurance from the Accountable Officer on the effectiveness of the system of internal control and risk management. The review of the effectiveness of the system of internal control was informed by the work of the internal auditors, executive managers and clinical leads who had responsibility for the development and maintenance of the internal control framework. This review was also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of the review of the effectiveness of the system of internal control by the Joint Boards, the Joint Audit Committee as well as the Department of Health Audit Sub Committee and the Integrated Governance Committee and action to address weaknesses.

This review was further informed and supported by the work of the Joint Boards, the Joint Audit Committees and the LCCCs. The Joint Boards, Joint Audit Committees and the LCCCs reviewed the Joint Boards Assurance Framework at each meeting during the year.

Executive managers within the organisation who had responsibility for the development and maintenance of the system of internal control provided assurance. The JBAF itself provided evidence that the effectiveness of controls that managed the risks to the organisation achieving its principal objectives had been reviewed. The review was also informed by the final report of external and internal auditors, and internal management reports and other key reports.

The Head of Internal Audit Opinion for 2012/13 is that substantial assurance can be given that there is generally a sound system of internal control on key financial and management processes. These are designed to meet the Primary Care Trust objectives, and controls are generally being applied consistently.

However, internal audit have identified specific areas where high risk recommendations required action to ensure that the Primary Care Trust's strategic objectives were met and the systems of internal control remained sufficiently robust to mitigate critical financial, operational and governance risks.

I have been satisfied that the governance statement incorporates a full description of the board's committee structure and performance together with appropriate reference to performance against national priorities set out in the NHS Operating Framework 2012/13. I have been given assurance that the Governance Statement has taken appropriate account of the guidance issued by the

Department of Health.

I believe that the above, combined with the outputs of the Governance Framework give me substantial assurance that the risk management processes and systems of internal control put in place are operating effectively and that the statement has been prepared in accordance with the Department of Health Guidance.

Department of Health Designated Signing Officer
Carl Vincent – Director of Provider Finance and Finance Transition

Signature: C Vincent **Date :** 31/5/13