Department of Health

NHS

Bromley Primary Care Trust

2012-13 Annual Report and Accounts

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Bromley Primary Care Trust

2012-13 Annual Report

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2. WELCOME

We are pleased to present the annual report of Bromley Primary Care Trust for 2012/13. This is our last annual report as a Primary Care Trust (PCT), as the main responsibility for commissioning health services in Bromley moves to NHS Bromley Clinical Commissioning Group (CCG) from 1 April 2013.

This report presents our main achievements in the last year. It sets out how we are continuing to work towards the aims of reducing health inequalities in the borough and improving the health and wellbeing of our population.

Much of the year was spent with the CCG operating in shadow form, overseen by the NHS Commissioning Board. Following many months of hard work putting together the constitution, governance and operational management arrangements for the new, GP led CCG, we received authorisation from the NHS Commissioning Board in January 2013. This means that on 1 April we will be fully authorised as the new NHS statutory authority for commissioning services in Bromley. From April 2013 Bromley CCG will take up its full range of responsibilities as set out in the Health and Social Care Act 2012.

Authorisation and the complex transitional and handover arrangements from the former PCT have been completed. We also introduced a very full programme of improvements in health care, led by Bromley GPs, of quality improvements in acute services, such as venous thromboembolism assessments in hospital, developing new care pathways that reduce waiting times, improving access and quality for local people, and implementing

innovative ways of delivering care through our providers, resulting in a significant reduction in average healing time for leg ulcers.

One of the most significant development is our innovative Proactive Management and Integrated Services for the Elderly programme (ProMISE). This programme has been developed to improve the health of older people, particularly those with long term conditions, with the aim of ensuring that patients are able to stay in their own homes rather than in hospital or nursing and residential care homes.

Other service improvements included developing community cardiology, dermatology, gynaecology, physiotherapy, IVF, minor oral surgery, ophthalmology and urgent care services. You will find more detail on all these later in this report.

As well as reducing waiting times and improving accessibility and quality, these new developments in the community decrease the use of hospital services, and helped us to achieve good value for money.

Much progress was made on the Orpington Health Services Project during the year. With a full programme of public involvement that included a three month formal public consultation exercise and public meetings, we developed and agreed proposals to develop a new Health and Wellbeing Centre in the Orpington area.

In so doing, we had to respond to and accommodate the strongly articulated views of local people in a way that provided the maximum benefit for Orpington residents as a whole and the wider Bromley population. The implementation of this project will continue through 2013/14 and the following year, eventually producing some very real long term healthcare improvements.

Our focus in recent years has been very much on the quality of services provided by the South London Healthcare NHS Trust (SLHT), our main acute services provider, which has been beset with financial problems.

On the announcement from the Secretary of State that SLHT would be the first NHS Trust to be subject to the Unsustainable Provider Regime arrangements provided for in recent legislation, we took the opportunity to work closely with the Trust Special Administrator (TSA) to achieve the best possible solution for the people of Bromley.

The Secretary of State's decision published in February 2013 included arrangements for King's College Hospital NHS Foundation Trust to take over the management of our local Princess Royal University Hospital. We welcome that decision and are now working with King's to sustain high quality hospital services in the borough.

We are also taking the opportunity provided by the eventual withdrawal of SLHT services at Beckenham Beacon to reassess the healthcare needs of the population in the north of the borough and develop a comprehensive range of community and primary care services provided at Beckenham Beacon. Implementation of the TSA decisions will be a major focus for us in 2013/14, and we will take every available opportunity to bring long term improvements to health services in Bromley.

2012/13 was the 11th and final year of Bromley PCT, and, as in every preceding year, we once again achieved all our statutory financial duties by staying within the revenue resource, cash and capital resource limits. We also achieved the public sector target for timely invoice payments.

We owe a huge debt of gratitude to Bromley GPs and the staff of the shadow CCG and transitional PCT, as well as our key partners, for all that they have achieved together in 2012/13. This has included a further restructuring to ensure that the new statutory

organisation is fit for purpose as it embarks on its first year. Our thanks go out equally to those staff who have remained with us during this period of change, those who have more recently joined us to bring the new skills and knowledge the new organisation needs, and especially to those who gave years of sterling service to the PCT and are now pursuing their interests elsewhere in the NHS and beyond.

Caroline Hewitt
Chair
Bromley Primary Care Trust

Dr Angela Bhan
Chief Officer
Bromley Clinical Commissioning Group

Andrew Kenworthy
Chief Executive
Bromley Primary Care Trust

Dr Andrew Parson
Clinical Chair
Bromley Clinical Commissioning Group

3. WHAT WE DO

Until 1 April 2013, Bromley PCT is responsible for improving the health and well-being services for the people who live and work in or visit the borough. Working with our partners in the local NHS - GPs, pharmacists, dentists, hospitals and mental health providers – and other borough partners (such as the London Borough of Bromley and local voluntary and community groups) we seek to protect and improve health and well-being and reduce health inequalities, ensuring everyone has equal access to healthcare services. We are responsible for assessing the healthcare needs of the borough and then for arranging and paying for health and care services to meet those needs (commissioning).

In 2012/13, we spent over £500m to commission health services, using funds we receive from the Department of Health. In this report we show how we spent this money on behalf of Bromley's communities.

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

- GPs, pharmacists, opticians and dentists;
- community services, provided through Bromley Healthcare, such as district and school nursing, health visiting, specialist child health, therapy services and care for older people.
- GP Practices (47 in Bromley)
- Dental practices (52 in Bromley)
- Community pharmacies (59 in Bromley)
- Opticians (33 in Bromley)

For people who require secondary or more specialist care, we also commission:

- South London Healthcare NHS Trust (a hospital trust) to provide inpatient,
- outpatient, day and emergency care; and
- Oxleas NHS Foundation Trust (a mental health trust) to provide mental health services.
- Specialist services from a range of teaching hospitals.

Historically, learning disabilities services were also provided by the PCT. However, over the past five years Bromley PCT has been working with the London Borough of Bromley to re-design the commissioning and provision arrangements for learning disabilities clients, and this transition is due for completion in the coming year.

4. HEALTH AND WELL-BEING IN BROMLEY

4.1 The Bromley population

Bromley has a population of 316,647 (2012 estimate). It has the lowest average population density in London, with 60% of the borough being protected Green Belt or Metropolitan Open Land.

The borough's population is generally affluent, although there are wide geographical variations in health and wellbeing, with pockets of low income populations and high levels of unemployment. Inequalities across these wards are manifest in outcomes such as lower life expectancy and self-reported levels of poor health. The population is projected to rise.

The birth rate within the borough has been rising since 2006, and is predicted to continue to rise. The number of nought to four year olds has gradually been increasing since 2004 and it is estimated that it will peak in 2016. The proportion of older people in

Bromley is expected to remain fairly stable at 15.6% over the next 10 years.

The pattern of population change in the different age groups is variable between wards, with some wards such as Bromley Town experiencing a large rise in the proportion of young people and Biggin Hill experiencing a large rise in the over 75s.

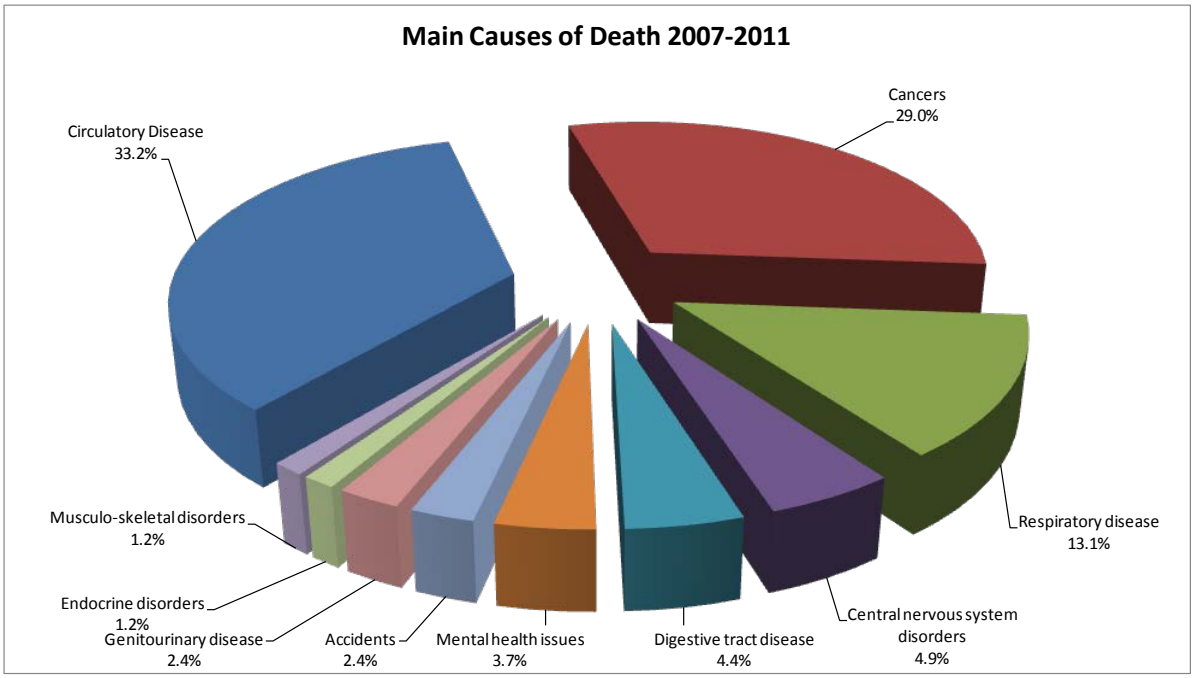
The 2011 census shows a rise in the ethnic minority population in Bromley to 22.6% (from 13.5% in the 2001 Census).

4.2 Health inequalities

Life expectancy at birth in Bromley has been rising steadily over the last 20 years, and the latest figures (2007 - 2009) report a life expectancy of 79.9 years for men and 83.8 years for women. Whilst these figures are significantly better than the national average, there are areas of Bromley with lower life expectancy. The gap in years of life expectancy between the least and most deprived areas within the local authority (based on mortality data for the five year period 2006 to 2010) is 7.8 years for men and 6.2 years for women.

Bromley has lower ‘all cause’ mortality rates and infant mortality rates than the national average. The key causes of mortality in Bromley are circulatory disease, cancer and respiratory disease, driven by a variety of factors such as obesity, unhealthy lifestyle and deprivation. Figure 1 below sets out the main causes of death in the period from 2007-2011.

Figure 1: Main Causes of Death 2007-2011



4.3 Improving health and wellbeing

4.3.1 Health and Wellbeing Strategy

The Bromley Health and Wellbeing Board has been established as a vehicle to help the borough achieve a sustainable high quality health and social care system for local people. It also aims to ensure the maximum benefits are delivered arising out of the new NHS Reforms.

A Health and Wellbeing Strategy has been developed to address the priorities identified in the Joint Strategic Needs Assessment. These are:

- Diabetes
- Hypertension
- Obesity

- Moderate mental illness
- Children with complex needs and disabilities
- Children with mental health and emotional problems
- Children referred to children's social care
- Dementia and social care
- Support for carers

Each of the priorities in the Health and Wellbeing Strategy is being tackled through a series of interventions and monitored by a partnership group.

4.3.2 Improving health

There are a number of public health programmes in place to improve the health of the population and the PCT has worked closely with the Public Health Department on these. These are set out below.

4.3.3 Healthy Weight Strategy

A Healthy Weight Strategy has been developed and services have been reviewed in the light of emerging evidence of increased levels of obesity and diabetes in Bromley.
The new adult weight management programme has received over 1000 referrals in the last seven months with 83% of 'completers' achieving a weight loss of 5% or more.

The National Child Measurement Programme has engaged with over 90% of local schools this year and is providing good information to inform the management of childhood obesity. The HENRY (Health Exercise Nutrition for the Really Young) programme is now well established and delivering good outcomes.

The Healthy Weight Programme Group is supporting the development and delivery of Pro-Active Bromley, which is a strategic, independent alliance of partners who are

active in sustaining and increasing participation in sport and physical activity in the London Borough of Bromley.

4.3.4 Tobacco Control Programme

The Tobacco Control Programme aims to reduce the prevalence of smoking in the borough. Estimates suggest that the prevalence is rising; the prevalence estimate was 18.1% in 2011/12, as compared with 16.5% in 2010/11. Smoking prevalence does remain lower than for England as a whole (20%).

During 2012/13, the Tobacco Control Group has continued to work closely with partners in the local authority to identify and reduce smuggled and illicit tobacco. Work with Bromley Healthcare has focused on the delivery of smoking cessation services. Across the south east London sector the Bromley Tobacco Control Group has been instrumental in developing a smoking Commissioning Quality and Innovation (CQUIN) measure for South London Healthcare NHS Trust.

4.3.5 Substance Misuse Services

Substance Misuse Services are jointly commissioned by the PCT and Local Authority. A new integrated Drug and Alcohol service has been in place from December 2011 providing an integrated drug and alcohol service, The National Treatment Agency has placed Bromley as a nudge partnership meaning that improvement in performance is required.

The overall number of people in treatment has reduced from last year, and there is an increase in the number of those successfully completing their treatment, Work continues to increase the numbers accessing the service, Bromley's Drug Intervention Programme performance continues to be good across all areas.

4.3.6 Sexual Health Network

Bromley has an active Sexual Health Network which meets regularly to address the three key areas in the Bromley Sexual Health Strategy: HIV (reducing late diagnosis), reducing Chlamydia and other sexually transmitted infections, and reducing teenage conceptions.

The prevalence of HIV in Bromley has been increasing and a pilot project of HIV point of care testing has been running in eight GP practices in the north west of the borough since early 2012.

This project will be evaluated to assess whether rates of testing and HIV diagnosis increase. Early findings suggest that this style of testing is acceptable to patients.

The Chlamydia screening programme is operating well, with 21% of 15 to 24-year-olds tested for Chlamydia in 2011/12. This rate is significantly higher than the rate for London and England. Bromley continues to deliver this screening programme through GP practices, pharmacies and outreach projects.

4.3.7 Teenage pregnancy

In the area of teenage pregnancy, we continue to focus our efforts on awareness raising and education as part of our prevention strategy. Based on evidence that shows the importance of including schools, colleges and youth settings in reducing teenage pregnancy and a comprehensive programme of Sex and Relationships Education programme (SRE) in these settings can build knowledge and confidence so young people can make well informed choices.

A new incentive scheme has been set up to pilot in the Orpington Campus at Bromley Further Education College, a peer-led Sex and Relationship Education programme using mobile web technologies that will also promote the use of condoms, provide

information about the Long-Acting Reversible Contraceptive (LARC) methods and on how to access Emergency Hormone Contraception (EHC). Its effectiveness will ultimately be evaluated against the level of reduction on STIs and unwanted pregnancies.

4.3.8 The Immunisation and Vaccination Programme

The Immunisation and Vaccination Programme includes both the childhood immunisation programme and the influenza immunisation programme for over 65s and people deemed at risk. The key aims of these programmes are to improve uptake and to ensure that all those eligible are given the opportunity to access vaccination.

For childhood immunisations there has been a steady increase in uptake in all age groups as compared with last year, with the World Health Organization (WHO) recommended level of 95% reached for immunisation by age 1 year. Uptake of the second dose of Measles, Mumps, and Rubella (MMR) and of the preschool booster is now above 85 per cent.

4.3.9 The NHS Health Check programme for vascular risk assessment

The programme has now been running for three years. There are currently 43 GP surgeries across the borough carrying out health checks. Five pharmacies are also running health checks (the pharmacists have all been through the same training programme as the practice nurses and health care assistants).

Bromley Healthcare, Mytime Health and Heart Smart have been commissioned to run health checks in the community (in the case of Bromley Healthcare working within the surgery).

We expect to achieve our target of 20,007 by the end of December 2012, 5,475 health checks were completed.

4.3.10 The Breastfeeding Support Initiative

The initiative is a pilot project hosted by the Public Health Department until March 2013. Its aim is to evaluate whether the development of a targeted breastfeeding support service can increase the prevalence of breastfeeding women at six to eight weeks in a designated area within Bromley.

Over the last year the initiative has continued to run six breastfeeding support groups across Bromley, maintained a breastfeeding support line for all Bromley residents, and finalised a clear process for referral to King's College Hospital NHS Foundation Trust for tongue-tie. Monthly antenatal classes on breastfeeding awareness have been running. In addition, two groups of peer supporters have been trained and assist at the breastfeeding support groups. The initial improvement in the proportion of women breastfeeding at six to eight weeks in Bromley has been sustained, and a further 1.5% increase seen up to the end of December 2012.

5. COMMISSIONING HEALTHCARE

Bromley PCT is still the accountable commissioning organisation in Bromley. It has established a Quality Working Group to provide it with assurance on the quality of the services being commissioned.

Looking to the future, clinical commissioning in shadow form in Bromley has been led by the emerging CCG engaging all 47 Bromley practices. In January 2013, the emerging CCG received notification from the NHS Commissioning Board that it had been authorised as a CCG from 1 April 2013. The process of becoming a statutory organisation is known as 'authorisation' and involves a rigorous assessment of the CCG's competencies and capabilities.

In this period of transition, we have continued working closely with NHS London, the

Department of Health and the emerging NHS Commissioning Board to demonstrate that it has the competencies necessary for full authorisation from 1 April 2013.

There has also been a delivery strategy in place. This is part of our Commissioning Support Plan. This delivery strategy has directed the healthcare commissioning work of the outgoing PCT and the emerging CCG. We will look again at this strategy plan and refresh it where necessary so that it is fit for purpose after 1 April 2013, when the Bromley CCG becomes the authorised, accountable commissioning organisation.

Practices in Bromley are grouped together into three clusters. The Local Clinical Commissioning Committee (the shadow CCG governing body in place until authorisation) took delegated responsibility during 2011 from the PCT Board for a wide range of commissioning budgets, including community services, mental health and acute commissioning budgets.

Clinical leadership for the shadow organisation comes from six GPs who were appointed through a selection and an election process held in September 2011. Two non-executive PCT Board members, executive leads and co-opted board members from the London Borough of Bromley and a Bromley LINk also sit on the current shadow governing body (the Bromley Clinical Commissioning Committee). Shadow organisation Board meetings are held in public every month. Details and agenda papers are archived on the NHS South East London website at www.selondon.nhs.uk, and will continue to be available after 1 April 2013.

The year 2012/13 was a crucial transitional period for Bromley CCG. The robust meeting and governance structures now in place will be further developed, reflecting the increasing responsibilities. NHS Bromley has continued to work closely with NHS South East London during the transitional year to transfer remaining responsibilities prior to full authorisation in April 2013.

6. IMPROVING QUALITY AND PERFORMANCE

6.1 Quality, Innovation, Productivity and Prevention (QIPP)

The Quality, Innovation, Productivity and Prevention (QIPP) programme is all about ensuring that each pound spent is used to bring maximum benefit and quality of care to patients.

QIPP is a large scale transformational programme for the NHS, involving all NHS staff, clinicians, patients and the voluntary sector. It will improve the quality of care the NHS delivers whilst making up to £20 billion of efficiency savings by 2014/15, which will be reinvested in frontline care. Bromley PCT had a QIPP plan to save £9.2m in 2012/13. Details of the plan including; schemes, descriptions and values are show below.

Scheme	Description	Planned Savings £	Actual Savings £
Anti-Coagulant	Procurement of new anti-coagulant service	383,000	255,334
2% Efficiency - SLHT	Efficiency savings on the South London Healthcare NHS Trust contract	2,371,000	2,371,000
Bereavement Counselling	Procurement of new bereavement service	100,000	50,000
Cardiology	Contractual adjustment for cardiology pathway for patients being treated by multiple providers	250,000	0
Dermatology	Implementation of new out of hospital Dermatology service	527,000	163,779
Estates Rationalisation	Management of PCT owned properties	888,000	888,000
Extend MSK	Provision of direct access to diagnostics for the out of hospital		107,000

	Musculoskeletal service provider	107,000	
Gynaecology	Implementation of new out of hospital Gynaecology service	801,000	102,281
Integrated Care Elderly IP	Proactive case management of the elderly with one or more long term conditions	427,000	427,000
IVF	Contractual saving post IVF backlog clearance	200,000	200,000
Minor Oral Surgery	Implementation of new out of hospital Minor Oral Surgery service	670,000	670,000
Ophthalmology (PEARS)	Community Ophthalmology referral and assessment service	28,000	28,000
Prescribing efficiency	Various prescribing initiatives	1,118,000	1,907,606
Substance Misuse	Provision of new service for Substance Misuse	200,000	200,000
UCC Front End of A&E - Enhanced Savings	Increase the percentage of patients being seen in the urgent care centre	1,050,000	525,000
Urgent Care Centre	More efficient management of the Princess Royal Urgent Care Centre pilot	125,000	125,000
Intermediate Care	Savings on Intermediate Care Management	0	375,000
Admission Avoidance	Working with Primary Care and Community Services to keep people out of hospital	0	500,000
Continuing Care	Review of cases funded for continuing care	0	250,000
Oxygen Contract Review	Review of existing Oxygen provision contract	0	100,000
		9,245,000	**9,245,000**

The PCT reviews each of the QIPP schemes monthly and if a scheme is thought not to be delivering, a review is undertaken and new validated initiatives are introduced to the schedule.

It has been a challenging year for the PCT and good progress has been made in delivering the QIPP savings this year.

The CCG will now continue with work started by the PCT to ensure that the member practices are fully engaged with the newly established services such as dermatology and gynaecology.

The implementation of the some of the PCT's schemes has been delayed this year so only a part year saving has been achieved e.g. Bereavement and anti-coagulant services. In these cases the remainder of the full year savings will be rolled over into next year's QIPP plan.

The PCT rolled out the use of a risk stratification tool across all practices with the aim of helping practices to identify their patients most at risk of being admitted to hospital. A number of Bromley practices are now actively using the tool to manage their patients. Others are using the tool to log care plans and review dates. This work is helping to reduce the number of inappropriate admissions and A&E attendances.

The PCT has exceeded the expected level of savings from prescribing efficiencies in 2012/13. A large proportion of the savings relate to the savings on the cost of drugs when they are no longer under patent conditions. A number of drugs have come in at a much lower cost than expected. Also, the uptake of some newer drugs, such as the new oral anti-coagulants, has been lower than expected.

6.2 Performance

The following table summarises performance against the selected key indicators in 2012/13:

	Target	2012-13 Performance
RTT admitted	90%	91.1%
RTT non admitted	95%	94.8%
RTT incomplete Pathways	92%	94.7%
MRSA	3	2
C Diff	75	94
Cancer 2 wk	93%	92.8%
Cancer 62 Days	86%	84.6%
Cancer 31 day	94%	97.2%
Amb. Resp 8 min	75%	76.0%
Smoking Quit #	1400	1352
% offered Health Checks	15%	17.5%
% Depression (referred)	4.20%	4.9%
Diag.wait > 6w	Minimal breaches	0.85%

Note: All performance figures are estimates for 2012-13 performance as final year end data was not available at the time of producing this report

The PCT breached its annual target for the number of cases of Clostridium Difficile (C-Diff) attributable to Bromley registered patients. This breach occurred, in part, due to the changes made to the way that acute Trusts record C-Diff cases. All acute Trusts implemented a new testing regime in April 2012. In addition to a more sensitive test, it is now the case that when an acute Trust identifies a patient with a positive C-Diff result, provided the test has been carried out within three days of admission to hospital, the case is not attributable to the Trust but still counted against the responsible PCT.

The PCT is working with acute and community clinicians to ensure that all patients are appropriately tested whether in hospital or in the community. This has led to an increase in the number of cases detected. Bromley are leading a Bexley, Bromley and

Greenwich wide ‘Health Protection Committee’. This committee work through all issues relating to C-Diff and initiate work streams to improve performance in this area.

Bromley PCT has narrowly missed two of the cancer wait targets, two week and 62 days. The PCT has worked with acute Trusts and Commissioning Support Unit (CSU) colleagues to understand the reasons behind each breach. Although the number of breaches in each category is small, our vision is that no patient should breach these wait times. There have been ongoing problems throughout the year with provider to provider referrals. These issues have now been addressed and the PCT are expecting to see these targets being met in the next financial year.

A clinical lead has been assigned to the Cancer work stream; they will be responsible along with a named manager for ensuring that we understand any breaches that occur and that the PCT take appropriate action to ensure that breaches are minimal.

The CCG will continue to work with the Cancer Network (or its replacement) to ensure cancer pathways are adhered to and that Bromley patients continue to receive the best care possible.

The number of smoking quitters was not achieved this year despite continued efforts from the PCT’s community provider, Bromley Healthcare. Performance in this area is much improved on last year.

Public Health commissioned a private provider, Solutions4Health, to deliver 400 quitters in 2012/13. They over achieved on their target of 400.

7. WORKING IN PARTNERSHIP

7.1 Bromley has a strong history of partnership working. We believe that health in the borough can only be improved through effective working with local partners and by fully engaging clinicians to work with local communities and patients to design services for the future. Our key partners include local people and patients, Bromley GP practices, independent contractors, SLHT, Bromley Healthcare, Oxleas NHS Foundation Trust, the London Borough of Bromley and Bromley Local Involvement Network (LINk).

7.2 Local partners

Bromley PCT listens to feedback from local people and uses what they tell us to ensure that decisions we make about healthcare are underpinned by a clear understanding of public views, concerns and aspirations. Knowing what people think about existing health services in Bromley is also vital to helping us improve patient experience in the future.

We work closely with the local authority Overview and Scrutiny Committee, the Bromley Local Involvement Network (LINk) and voluntary groups to actively encourage members of the public to help us plan and commission the best high quality services possible.

Views of the public and patients are essential to us, so that we know whether the services we commission meet local needs.

7.3 Working with Bromley LINk

Until 1 April 2013, we continued to work closely with Bromley LINk, a network of people, organisations and groups from across the borough who want to improve health and care services. From 1 April 2013, Bromley LINk will be replaced by Bromley Healthwatch.

7.4 Overview and Scrutiny Committee

We regularly attend and make submissions to the Bromley Adult and Community Policy

Development and Scrutiny Committee, engaging Bromley's democratically elected members in the local implementation of national NHS reforms and in plans and proposals for service change. We have presented papers at this committee and responded to questions on a range of topics including improvements to stroke services and the implications of the new NHS reforms.

7.5 Patient satisfaction

We gather information on patient satisfaction from a huge range of sources including the NHS patient survey programme, surveys carried out by our local NHS providers, our quality and complaints monitoring systems.

7.6 Engaging with patients and the public

We use a range of methods to engage with Bromley patients and the public to make the Government's call for 'no decision about me without me' a reality for Bromley's populations.

For example, in October 2010 NHS Bromley took part in a 'health show' at Bromley College's campus. The aim was engage directly with the students and to give them healthy living advice across a range of areas including healthy eating, sexual health, smoking and drug use. The event was very popular with students, and views, questionnaire responses and workshop ideas were then used by Bromley clinical commissioners to prepare a report for NHS Bromley on how to improve health services for children and young people.

7.7 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.

7.8 Patient Advice and Liaison and Complaints Service

Anyone can express a view or find out more about their local NHS through our Patient Advice and Liaison Service (PALs). The majority of these enquiries are handled through the PALs helpline. Of those handled directly by Bromley PCT during the year, the

majority of enquiries concerned treatment and care. Anyone who is unhappy about the quality of service they receive can complain through the NHS complaints process. Bromley PCT takes all complaints seriously, investigating them thoroughly and making it clear that a complaint will not adversely affect the quality of care provided.

The total number of complaints received in 2012/13 was 92 compared with 103 in 2011/12 and 139 in 2010/11. The following table shows the breakdown of these complaints across the main service areas:

Complaints	2012/13	2011/12	2010/11
Community Provider Unit	0	3	40
Primary care	55	70	59
Others (including PCT commissioning and other providers, hospitals, etc)	37	30	40
Total	92	103	139

Bromley Healthcare, which was established on 1 April 2011 as a social enterprise organisation providing community health services in Bromley, manages its own complaints, in common with other providers.

During the year 5 cases were referred to the Parliamentary and Health Services Ombudsman by complainants; three with regards to GP diagnosis and treatment and two regarding a funding decision. One case is still being assessed the other cases were not upheld.

The Parliamentary and Health Service Ombudsman has set out “Principles for Remedy” that describe best practice for dealing with any injustice or hardship caused by maladministration or service failure. These principles have been fully adopted by the PCT and are set out in Appendix E of the PCT’s Complaints and PALS Policy and Procedure. During 2012/13 the PCT did not make any payment under these arrangements.

8. MAKING IT HAPPEN

8.1 Bromley PCT currently employs 66 staff. 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 Bromley 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.

8.2 NHS staff survey

Although we value the views of our staff, it was agreed that PCTs would not be subject to a Staff Survey in 2012 due to its abolishment on 31 March 2013 as a result of Health & Social Care Act.

8.3 London 2012 Olympic and Paralympic Games

Several employees took advantage of the provisions for volunteering as part of co-ordinated HR guidance for staff and employers in the NHS. This covered a range of areas from annual leave and volunteering, to areas for people to consider reducing the impact of travel disruption, as well as picking up core business and business as usual.

8.4 Sickness absence

Monthly sickness absence reports are produced which report on 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 following sickness information relating to Bromley PCT has been provided by Department of Health ESR system:

	2012-13 Number	2011-12 Number
Total Days Lost	**1,701**	**6,225**
Total Staff Years	**339**	**735**
Average working Days Lost	5.02	8.47

8.5 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 whilst at the same time ensuring that everyone is safe, effective and up to date with their statutory and mandatory training. Staff can also apply for external training that is not covered by the programme. These include

- More than 20 different training courses were offered to staff up to March 2013, arranged in over 80 course sessions with a total of over 500 places available
- Two staff in NHS Bromley made requests for individual training funding in 2012/13 and both were approved.

The Piecing Together Change development programme was launched at the end of March 2012. This programme has been designed based on input from seven staff focus groups and consists of a range of optional modules so that staff can 'pick and mix' what training they require.

8.6 Communicating with our staff

This last year has been one of huge change and uncertainty for our staff. The clustering of five primary care trusts and one care trust in April 2011 resulted in a reduced workforce with staff working either within a borough based Business Support Unit or within one of the main cluster wide departments of NHS South East London.

In Bromley, communicating with our staff has always been a priority, particularly during periods of 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:

- Regular staff communication through the staff fortnightly update and monthly management brief.
- 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.
- Updated databases to ensure all staff are included in regular communications.
- Establishment of a NHS South East London intranet and website.

- Video messages from the Chief Executive on key policy areas uploaded onto the staff intranet.
- Confidential comment box and email addresses for questions to 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 well-being 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:

- London wide flu campaign encouraging people at risk to get vaccinated.
- South East London Choose Well campaign based on patient insight and evaluation.
- Bowel Cancer awareness campaign.

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

8.7 Equalities action plan for NHS South East London staff and leadership

As part of the development of the NHS South East London equality objectives for 2012/13, the HR team has developed equality objectives for the staff and leadership

of NHS South East London. 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, and our priorities for people transition. The EDS grading for the staff and leadership of NHS South East London was carried out at the beginning of March 2012.

To comply with our statutory duty to publish workforce information on the nine protected characteristics in the Equality Act 2010, NHS South East London recently carried out a process of data cleansing of personal information held on the HR Electronic Staff Record (ESR) system.

This process has enabled us to collect non-personalised data to provide an initial equality and diversity baseline across the six PCTs. 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 was 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 process for all staff.

8.8 Bromley Single Equality Scheme

The below Single Equality Scheme with action plan sets out how Bromley Clinical Commissioning intends to lead and further develop a systems wide approach to promote equality and prevent discrimination in all its functions, policies and strategies.

The Single Equality Scheme was developed following a full consultation across Bromley

which included the Voluntary Sector, other statutory agencies and involved people from all protected populations. The consultation was COMPACT compliant and was carried out by an external consultant. This consultation was followed up by a further consultation on Equality Objectives for the NHS at Bromley Diversity Day which was held locally and attended by over 800 participants from both the protected populations and other vulnerable groups such as gypsies and travellers.

These consultation findings were discussed at the Equality and Diversity Steering Group, where agreement was reached to further stretch the organisation with the addition of a further four objectives. These further objectives were:

(1) Improving the health and well being of older people, particularly those with Dementia. The recommendations from a detailed needs assessment on dementia will be implemented, including expansion of the memory service, improved training for health and social care staff and improvements in written and verbal information. Further work will be carried out on reducing the use of antipsychotics with older people. This work will be coordinated by the Bromley Older Peoples' Partnership.

(2) Improving the health and well being of carers. A detailed health needs assessment of carers of all ages will be carried out to build up the local evidence base. The Carers' Strategy 2012-2015 will be refreshed and there will be a focus on improving information and guidance. Increasing referrals from GPs to Carers Bromley with improved communication and education about carers' issues with GP practices is also a priority. The Bromley Carers Partnership will coordinate and lead on this approach.

(3) Improving outcomes for people with Learning Disabilities will be measured by using the Learning Disabilities Self Assessment Framework review.

(4) Improving access for people with Physical Disabilities and Sensory Impairment is a shared objective developed with Bromley Local Authority. We will concentrate on implementing recommendations from the Physical Disability and Sensory Impairment needs assessment. This will be coordinated through the Physical Disability and Sensory Impairment Partnership Group. The achievement and progress of implementation of the these plans and objectives will demonstrate how Bromley Clinical Commissioning will assess performance and take action to lead on reducing inequalities and identifying the key equality issues for Healthcare.

These Equality Objectives were reviewed by Bromley LINK and the Equality and Diversity Steering Group, the chart below summarises developments in 2012-2013 and highlights plans for 2013-2014.

Objective	**Planned Action 2012/2013**	**Achievements 2012/2013**	**Future Plans 2013/2014**
Health and Wellbeing of Older People	Implement recommendations from Public Health Needs Assessment on Dementia, namely: • Set up Psychiatric Liaison Team set up. • Investment in Memory Services • Review Antipsychotic use in people with Dementia.	Public Health Dementia Needs Assessment dissemination and actions. Psychiatric Liaison team set up at the PRUH. Significant increased investment in Bromley Memory Services. Use of antipsychotics medications in patients with Dementia audit completed with good reported outcomes for Bromley.	CQUIN developed on Dementia across Oxleas and PRUH acute services. PRoMISE Programme plan for Bromley CCG. Development of early diagnosis of Dementia care pathway.

Health and Wellbeing of Carers	Improving the Health and wellbeing of Carers through: • Develop GP Carers project. • Refresh Bromley Carers Strategy. • Scope Carers Needs Assessment. • Develop Carers approach in Bromley through the Carers Partnership Group.	GP Carers Project completed. Bromley Carers Strategy Refreshed. Initial plans on a carer's needs assessment for Bromley have been scoped. Carers Partnership now chaired by Assistant Director Integrated Commissioning	Implement refreshed Carers Strategy with Local Authority. Develop partnership approach to carers through the Carers partnership Group.

Improving Outcomes for People with Learning Disabilities	Improve outcomes for people with Learning Disabilities demonstrated through the Learning Disabilities SAF process.	Good Practices and positive upward trends in improvements for both commissioning and providing services for people with Learning Disabilities as measured by the Learning Disability SAF process.	Development in approaches in disease prevention and screening for people with Learning Disabilities ensuring reasonable adjustments are built into current systems. Improve accurate data capture for health services for people with Learning Disabilities in both mainstream and specialist health services. Improve scoring for LDSAF for 2013 and develop integrated approach for the new Health and Social Care Assessment. .
Improving Access with People with Physical Disabilities and Sensory Impairment	Continue implementation of Physical Disability and Sensory Impairment Needs assessment recommendations.	Experts by Experience Training programme developed and implemented on Physical Disabilities and sensory Impairment. New Bromley Vision Strategy developed. Counselling Service developed for people with newly diagnosed sight loss. Named projects in all directorates with Bromley Local Authority on improving access to services.	Implement Bromley Vision Strategy. Continued development of joint approaches between health and Local Authority to improve access for people with both Physical Disability and sensory impairment.

8.9 Review of quality objectives for 2012/13

One of the underlying pillars of the vision for Bromley CCG was achieving a significant positive impact on the health and well-being of those who live and work in Bromley. In line with the requirements of the Equality Act 2010, we aspire to eliminate discrimination and promote equality in partnership with local communities, the voluntary sector and other statutory partner organisations. Throughout 2012 NHS Bromley has demonstrated further positive developments in its approach to the Health and Wellbeing of those who live in Bromley and its approach to Equality and Diversity has helped it achieve CCG Authorisation.

Bromley Commissioning Services have forged new paths in taking a system wide approach to embed the principles of Equality and Diversity into all corners of Healthcare policy and practice. This has included setting up a new Equality and Diversity Steering Group which will report to the Governing Board of Bromley CCG. The Steering Group has voluntary sector representation alongside clinical commissioning colleagues, Public Health and the Local Authority. The approach to Equality and Diversity continues to be led by the Accountable Officer and Public Health leading to a continued significant impact on Equality and Diversity in the following areas:

- Service development based on needs assessments: Mental Health Needs Assessment 2012.
- Equality Impact Assessment of all new Policies, Strategies and Developments; Orpington Hospital Development, Equality Impact Assessment 2012.
- Engagement of patient representatives for all major care pathway and service redesign work streams and systems; Promise Programme
- Inclusion of appropriate contractual terms and conditions to comply with the Equality Act 2010; See Contracts.

- Development of a clinical engagement strategy-Clinical Engagement Strategy Developed.

- The JSNA has been informed by both Equality and Needs Assessments; JSNA 2012-2013

- Annual Public Health Reports have led and been informed by the focus on reducing inequalities in health across Bromley: A Good Life for Young People, APHR 2012 and Bromley Health and Wellbeing Strategy.

There has also been a focus across the organisation on targeting known inequalities which have been detailed in the JSNA for both 2012 and 2013. This approach is also evident in Bromley's Health and Wellbeing Strategy (attach link here). Further developments have been continued for people with Learning Disabilities and those with Mental Health problems.

8.10 Informatics

ICT services for Bromley 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 coordinated, 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 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 new Health and Wellbeing Centre in the Orpington area, and the development of services at Beckenham Beacon.

8.11 Our estate

8.11.1 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.

8.11.2 Bromley estate

2012/13 has been a year of capital investment in the Bromley community estate in order to reduce backlog maintenance and improve the patient experience. Work has included significant refurbishment of Global House in readiness for Bromley Healthcare's relocation from Bassetts House and other community sites. Financial and technical

support has provided in support of improvements to GP practices prior to their registration with the Care Quality Commission (CQC) by 1 April 2013.

Changes to a number of sites are planned or have been completed. 118 Widmore Road has transferred to Bromley Council under the learning disabilities programme. Summit house has been vacated following expiry of the lease. Beckenham Clinic and Hawes Down Clinic will be vacated following planned occupation of Global House by Bromley Healthcare.

Support has been provided to Primary Care including ongoing rent reviews and the development of a number of new Primary Care facilities including re-provision on the Penge Clinic site and reviewing Business Cases for a number of other potential new GP developments.

A Business Case is being developed for the disposal of the Bassets site which is gradually being run down as services relocate. Negotiations are progressing with the preferred bidder.

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

8.12 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 Bromley complies with HM Treasury's guidance on setting charges for information in 'Managing Public Money'**.**

8.13 Serious incidents in relation to information governance

Staff are encouraged to report incidents and 'near miss' events so they can be investigated and so that we can reduce the risk of such incidents in future. We are also legally required to assess whether any incident constitutes a serious incident.

A serious incident is something out of the ordinary or unexpected, with the potential to cause serious harm, and/or likely to attract public and media interest that occurs on NHS premises or in the provision of an NHS or a commissioned service.

In the context of information governance, a serious incident is defined as any incident involving the actual or potential loss of personal information that could lead to identity fraud or have other significant impact on individuals. Incidents of this type must be reported to the Department of Health and the Information Commissioner's Office. During 2012/13 no incidents of this type were reported

8.14 Risk Management - how we are managing risk across NHS south east London

The NHS South East London 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 ongoing review and improvement whilst underpinning the production of the annual governance statement.

We have 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 is in the Final Accounts and Annual Governance Statement.

8.15 Serious Incidents and Never Events

Serious Incidents are out of the ordinary and unexpected incidents or events with serious or likely to be serious consequences. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measure has been implemented by healthcare providers.

We recognise that high reporting organisations are high performing organisations, with a stronger safety culture. Provider reports on all incidents are reviewed through our Quality meetings. Additionally, National Patient Safety Agency guidance on serious incident management defines the responsibilities of Primary Care Trusts in monitoring serious incidents reported by their providers. We have established robust processes for the management of serious incidents which are in line with the national guidance and an agreed NHS South East London Cluster policy. Serious incident requirements are included within provider contracts. Processes which have continued in the last year include:

- Regular provider serious incident monitoring meetings chaired by clinical commissioners
- Individual provider meetings to review and streamline serious incident processes
- Evaluation templates developed and implemented for reviewing the quality of serious incident reports
- Serious Incident report evaluation training provided to key staff within Bromley PCT
- Analysis of serious incidents and outcomes provided to the Board
- Regular feedback to providers on serious incidents.

During the year we were notified of 141 Serious Incidents by South London Healthcare NHS Trust, three of which were Never Events; Oxleas Foundation NHS Trust reported 60 Serious Incidents, none of which were Never Events; and Bromley Healthcare, the social enterprise which provides community services in Bromley, notified of 110 Serious Incidents and no Never Events.

8.16 Sustainability report (statement)

Environmental sustainability is an important NHS priority. During 2011/12 NHS South East London PCTs have concluded a number of property disposals for sites which did not meet healthcare requirements. This has seen older, less energy efficient stock sold. New buildings opened in the year have conformed to the BREEAM requirements, providing better quality patient and staff environments as well as more efficient infrastructure.

PCTs and shadow CCGs also have an important contribution to make to the NHS's commitment to environmental sustainability. Bromley CCG consolidated onto one site during 12/13 with concomitant reduction in heating and other office costs and reduced car travel to the office headquarters, Bassetts House, is also a direct result.

As a commissioner of NHS services, the CCG has a crucial role to play in commissioning environmentally sound services. The shadow CCG has developed a Procurement Policy which clearly states our expectations of any providers from whom we commission. Adherence to our policy will be through our regular contract monitoring meetings.

In 2013/14, the CCG will work with IT support to ensure appropriate and effective use of our technology including PCs, printers and photocopiers to reduce energy use.

8.17 Emergency preparedness

With the formation of the PCT Cluster, emergency planning and response has been coordinated at the Cluster 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 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. The Cluster 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 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.

CCGs will continue to play an important role in EPRR with responsibilities under the Civil Contingencies Act and a focus on ensuring that South East London's health service remains robust in planning for, and managing surges in demand. They 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 CB 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.

9. GOVERNANCE

9.1 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 (three 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 Bromley CCG 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 (undertook a secondment from 4 September 2011)[1]
Christina Craig	Interim Chief Executive NHS South East London (from 3 September 2012)
Richard Chapman	Acting Director of Finance[2]
Malcolm Dennett	Interim Director of Finance (from 14 November 2012)
Alison Tonge	Interim Director of Finance (from 6 August 2012 – 15 November 2012)
Jane Schofield	Director of Operations and Joint Deputy Chief Executive
Gill Galliano	Director of Development and Joint Deputy Chief Executive (until 30 July 2013/7/12
Dame Donna Kinnair	Director of Nursing (undertook a secondment from 1 October 2012)

Jane Clegg	Interim Director of Nursing (from 1 October 2012)
Susan Free	Non Executive Director
Harvey Guntrip	Non Executive Director
Keith Wood	Non Executive Director
Paul Cutler	Non Executive Director
Dr Andrew Parson	Chair, Bromley Clinical Commissioning Group
Dr Angela Bhan	Managing Director, Bromley Business Support Unit
Dr Nada Lemic	Director of Public Health
Jeremy Fraser	Non Executive Director
Jim Gunner	Non Executive Director

[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

9.2 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
Paul Cutler	None	None	• Trustee UK Charity Interaction • Associate for the National Children's Bureau, the Centre for Public Scrutiny and the Health Foundation
	Erith School	Trustee Governor No remuneration paid	
	Orbit South Housing Association	Service Board Member No remuneration paid	
Susan Free	Nil	Nil	Nil
Jeremy Fraser	Four Communications	Managing director of public affairs division Shareholder and Non-Executive Director Holds shares Remuneration paid	• Vicar, Church of England – stipend paid • Member of the Labour Party – no pay
	London Transport Museum	Trustee and Board member No remuneration paid	
	Globe Academy	Advisor No remuneration paid	
	St Michael and All Angel School	Governor No remuneration paid	
	Guys and St Thomas Foundation Trust	Stakeholder governor	
	Pembroke House, a charity helping deprived children in Walworth	Trustee No remuneration paid	

NAME	Company/ Organisation	Position/ Shareholding/ remuneration	Directorships and or other significant interests
James Gunner	London Specialised Commissioning Group	Non Executive Director No remuneration paid	All of my other business interests have no impact on my NHS responsibilities. They are completely separate and no conflict of interest arises.
	Bromley Healthcare	Governor No remuneration paid	
Harvey Guntrip	Hadlow College, Kent	Chairman No remuneration paid	Nil
	SDM Biomass Limited	Director 50% shareholding No remuneration paid	
	Berties Wood Fuel Ltd	Partner 1/3 shareholder 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	
	Kings College Hospital Charity	Trustee No remuneration paid	
Keith Wood	(a) Greenwich & Bexley Community Hospice Ltd (b) Different Strokes (Trustees) Ltd	I hold no office in either company nor do I receive any remuneration	Each company is limited by guarantee & I am a member of each company, each member guarantees its liabilities up to a maximum of £1; there are approximately 20 members of (a) & 12 members of (b). (a) has material Service level agreements with Bexley Care Trust & Greenwich TPCT. (b) has no such financial relationships but has a representative on the Bexley stroke round table & is in a position to provide community services in SEL I am a long term user of hospital services in Bromley.
Richard Chapman	None	None	Nil

NAME	Company/ Organisation	Position/ Shareholding/ remuneration	Directorships and or other significant interests
Malcolm Dennett			
Alison Tonge (left)	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
Andrew Parson	Chislehust medical practice (PMS) Practice is opted in to	Partner – 14% share	My wife and daughter are employees of Bromley Y; Wife - child and adolescent counsellor; Daughter is administrator

NAME	Company/ Organisation	Position/ Shareholding/ remuneration	Directorships and or other significant interests
	EMDOC		
	Bexley Health Limited – clock Tower company	Practice has a share in this company - No remuneration paid	
	Next Step Fostering Agency	Medical Adviser Remuneration paid	
Hany Wahba	GP partner at St Mark's Medical Centre.	Member of GRABADOC; Currently work out of hours (OOH) paid sessions at GRABADOC.	Special interest in surgery, currently provide minor surgery services paid by NHS Greenwich.
Angela Bhan	None	None	Nil
Nada Lemic	None	None	Nil

9.3 Board committees

9.3.1 Bromley Clinical Commissioning Committee

Bromley Clinical Commissioning Committee is a committee of Bromley PCT Board. It has also acted as the Shadow Governing Body of Bromley Clinical Commissioning Group since 1 October 2012. Its role during 2012/13 has been to take on full delegated responsibility from the Joint PCT Board for commissioning those areas for which the Bromley Clinical Commissioning Group will be statutorily responsible from 1 April 2013. These include prescribing, community services, jointly commissioned services, mental health services and acute services. It has also successfully overseen the arrangements and process for achieving authorisation from the NHS Commissioning Board for the establishment of NHS Bromley Clinical Commissioning Group from 1 April 2013. During 2012/13 the Local Clinical Commissioning Collaborative Committee also undertook the duties of the Professional Executive Committee (PEC), and provided oversight of local performance, including quality.

The Bromley Local Clinical Commissioning Committee is chaired by Dr Andrew Parson. It meets monthly in public. The full membership is listed below:

Name	Position
Dr Andrew Parson	Clinical Chair
Jim Gunner	Non Executive Director, Lay Member, Deputy Chair
Dr Ruchira Paranjape	Principal Clinical Lead
Dr Jon Doyle	Clinical Lead
Dr Atul Arora	Clinical Lead
Dr Mandy Selby	Clinical Lead
Dr Mark Essop	Clinical Lead
Harvey Guntrip	Non Executive Director, Lay Member
Martin Lee	Lay Member
Dr Tan Vandal	Secondary Care Doctor
Sara Nelson	Registered Nurse Member
Dr Angela Bhan	Chief/Accountable Officer
Mark Cheung	Chief Finance Officer
Sonia Colwill	Director of Quality, Governance and Patient Safety

Meredith Collins	Director of Healthcare System Reform
Dr Nada Lemic	Director of Public Health
Terry Parkin	Executive Director, Education & Care Services, London Borough of Bromley

Bromley Clinical Commissioning Committee established two sub groups

- the Integrated Governance Committee
- the Quality Assurance Sub Committee

These two groups were also operating as shadow CCG committees. The shadow CCG Audit Committee and Remuneration Committee were also established by the Clinical Commissioning Committee in its role as Shadow CCG Governing Body during 2012/13.

9.3.2 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. 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

9.3.3 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. 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 between:

- 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

9.3.4 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.

9.3.5 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

9.3.6 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

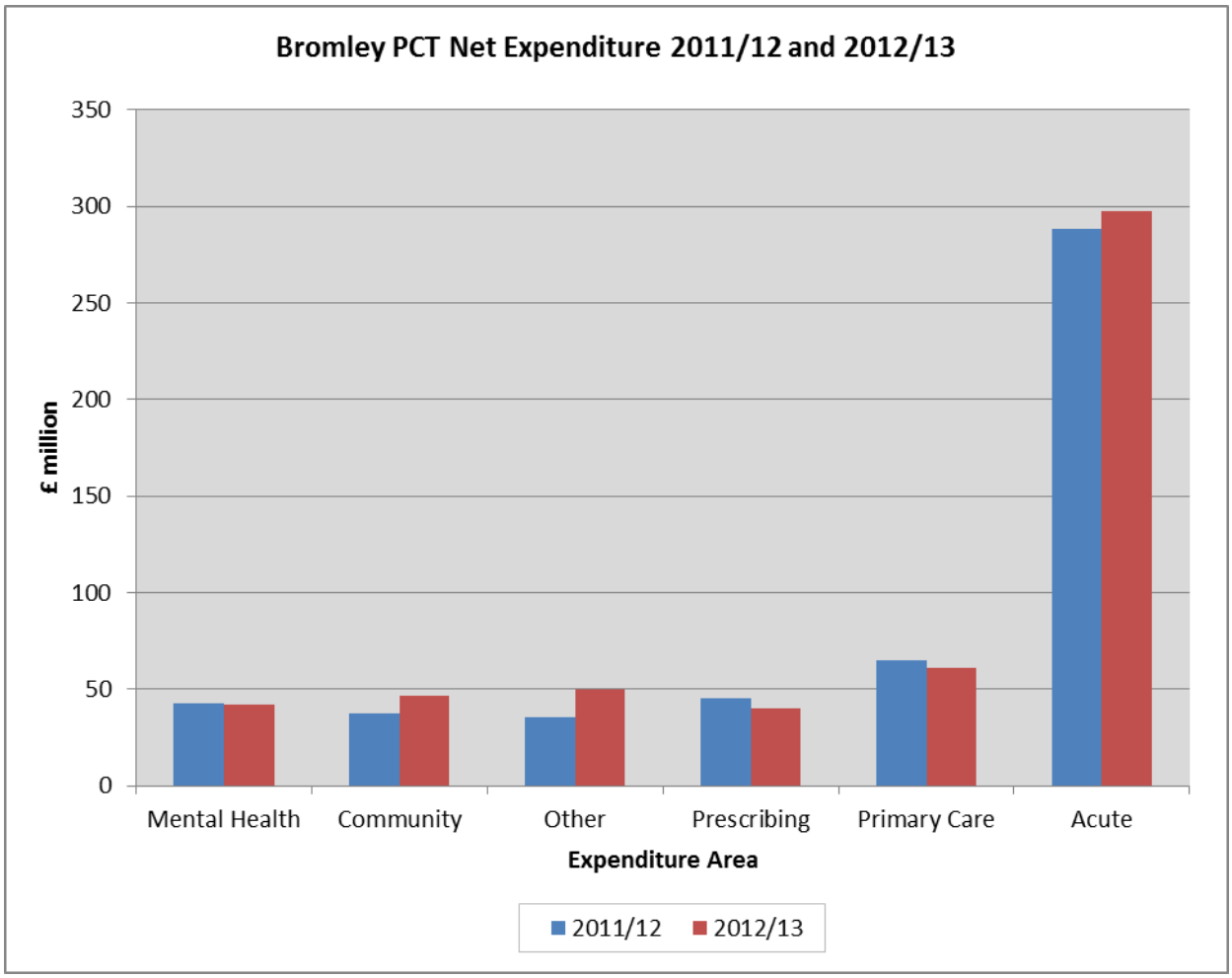
Executive members: Una Dalton, Director of Human Resources

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:

- **£415m on secondary and community healthcare** of which mental health £42m; general & acute & maternity £276m, accident & emergency £22m, community £46m, learning difficulties and other contractual £29m.
- **£104m on primary healthcare** of which, primary medical services £40m; prescribing £42m; dental services £11m; new pharmacy contract £8m and ophthalmic contracts £3m.



11. REMUNERATION REPORT

11.1 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	01/04/2011	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
Paul Cutler	Non Executive Director, NHS SEL Cluster	01/04/2011	31/03/2013
Susan Free	Non Executive Director, NHS SEL Cluster	01/04/2011	31/03/2013
Jeremy Fraser	Non Executive Director, NHS SEL Cluster	01/04/2011	31/03/2013
James Gunner	Non Executive Director, NHS SEL Cluster	01/03/2008	31/03/2013
Harvey Guntrip	Non Executive Director, NHS SEL Cluster	01/04/2007	31/03/2013

Keith Wood	Non Executive Director, NHS SEL Cluster	14/04/2011	31/03/2013
Dr Andrew Parson	Local Clinical Commissioning Committee Chair	01/10/2011	31/03/2013
Dr Angela Bhan	Managing Director and Joint Director of Public Health	01/04/2001	31/03/2013
Dr Nada Lemic	Joint Director of Public Health	01/04/2002	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 Cluster	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 Cluster	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			15-20			
Jane Clegg (from 1/10/2012)	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 Cluster	0				0			
Paul Cutler	Non Executive Director, NHS SEL Cluster	1-5				1-5			
Susan Free	Non Executive Director, NHS SEL Cluster	1-5				1-5			
Jeremy Fraser	Non Executive Director, NHS SEL Cluster	1-5				1-5			
James Gunner	Non Executive Director, NHS SEL Cluster	1-5				5-10			
Harvey Guntrip	Non Executive Director, NHS SEL Cluster	1-5				1-5			
Keith Wood	Non Executive Director, NHS SEL Cluster	1-5				1-5			

Bromley PCT senior staff – these staff represent Bromley 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 Andrew Parson	Local Clinical Commissioning Committee Chair	0-5				20-25			
Dr Angela Bhan	Managing Director	135-140		35-40		135-140		35-40	
Dr Nadia Lemic	Director of Public Health	125-130		15-20		120-125		15-20	

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	829	67	
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	867	-867	
Richard Chapman	Director of Finance, NHS SEL Cluster	0-2.5	2.5-5	2.5-5	10-15	287	192	95	
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	1157	0	
Donna Kinnair (to 1/10/2012)	Director of Nursing, NHS SEL Cluster	0-2.5	0-2.5	0-5	10-15	565	475	90	
Dr Angela Bhan	Managing Director and Joint Director of Public Health	0-2.5	0-2.5	55-60	170-175	1105	1016	89	
Dr Nadia Lemic	Joint Director of Public Health	0-2.5	2.5-5	45-50	140-145	912	738	174	

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

Name	Title	2012/13 Salary (bands of £5,000	2012/13 Other Remuneration (bands of £5,000)	2012/13 Bonus Payments (bands of £5,000)	2012/13 Benefits in kind (rounded to the nearest £00)	2011/12 Salary (bands of £5,000	2011/12 Other Remuneration (bands of £5,000)	2011/12 Bonus Payments (bands of £5,000)	2011/12 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	155-160							
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			
Paul Cutler	Non Executive Director, NHS SEL Cluster	5-10				5-10			
Susan Free	Non Executive Director, NHS SEL Cluster	5-10				5-10			
Jeremy Fraser	Non Executive Director, NHS SEL Cluster	5-10				5-10			
James Gunner	Non Executive Director, NHS SEL Cluster	10-15				15-20			
Harvey Guntrip	Non Executive Director, NHS SEL Cluster	10-15				5-10			
Keith Wood	Non Executive Director, NHS SEL Cluster	10-15				10-15			

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

		2012/13 Salary (bands of £5,000)	2012/13 Other Remuneration (bands of £5,000)	2012/13 Bonus Payments (bands of £5,000)	2012/13 Benefits in kind (rounded to the nearest £00)	2011/12 Salary (bands of £5,000)	2011/12 Other Remuneration (bands of £5,000)	2011/12 Bonus Payments (bands of £5,000)	2011/12 Benefits in kind (rounded to the nearest £00)
Dr Andrew Parson	Local Clinical Commissioning Committee Chair	0-5				20-25			
Dr Angela Bhan	Managing Director	135-140		35-40		135-140		35-40	
Dr Nadia Lemic	Director of Public Health	125-130		15-20		120-125		15-20	

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	
Dr Angela Bhan	Managing Director and Joint Director of Public Health	0-2.5	0-2.5	55-60	170-175	1105	1068	37	
Dr Nadia Lemic	Joint Director of Public Health	0-2.5	2.5-5	45-50	140-145	912	776	136	

* 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 Bromley PCT in the financial year 2012-13 was £172,500 (2011-12, £171,834). This was 4.99 times (2011-12 6.99 times) the median remuneration of the workforce, which was £34,537 (2011-12 £24,554).

In 2012-13, no (2011-12, none) employee received remuneration in excess of the highest paid director. Remuneration ranged from £5,571 to £173,430 (2011-12 £3,911to £171,676).
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 decrease in the multiple between 2011-12 and 2012-13 is due to increase in the median salary from £24,554 to £34,537. The median salary across the PCTs increased due to the commissioning arm of the PCT which mainly consists of staff at higher bandings due to the specialist nature of the services it manages.

11.8 Exit Packages

	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	**2**	**0**	**2**	0	0	**0**
£10,001-£25,000	**0**	**0**	**0**	0	0	**0**
£25,001-£50,000	**3**	**0**	**3**	0	0	**0**
£50,001-£100,000	**3**	**0**	**3**	0	0	**0**
£100,001 - £150,000	**1**	**0**	**1**	0	0	**0**
£150,001 - £200,000	**0**	**0**	**0**	0	0	**0**
>£200,000	**0**	**0**	**0**	0	0	**0**
Total number of exit packages by type (total cost	**9**	**0**	**9**	**0**	**0**	**0**
	£s	**£s**	**£s**	**£s**	**£s**	**£s**
Total resource cost	446,419	0	**446,419**	0	0	**0**

11.9 Off Payroll Engagements

Table 1: For off-payroll engagements at a cost of over £58,200 per annum that were in place as of 31 January 2012	Bromley PCT
	No.
No. in place on 31 January 2012	**18**
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	0
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	7
No. that have come to an end (**31st March 2013**)	11
Total	**18**

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.	
	Bromley PCT
No. of new engagements	2
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	2
of which	
No. for whom assurance has been requested and received	1
No. for whom assurance has been requested but not received (See Below)	0
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	1
Joined an agency	0
Enetered substantive employment	0
Request not made	0

11.10 Related Party Transactions

Bromley 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 Bromley Primary Care Trust as follows:

	Services Received from Organisation	Payments to Related Party
		£
Dr Andrew Parson-Chislehurst Medical Practice	Primary Care	1,700,132
Dr Jon Doyle - Southview lodge practice	Primary Care	637,858
Dr Atul Arora-Sundridge Medical Practice	Primary Care	571,957
Dr Ruchira Paranjape-Knoll Rise Surgery	Primary Care	814,811
Dr Mark Essop - Summercroft Surgery	Primary Care	1,452,007
Meredith Collins - Mereditch Collins Ltd	Consultancy	195,891

The Department of Health, as Bromley PCT's parent department, is regarded as a related party. During the year 2012/13, Bromley 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
South London Healthcare Trust	161,673
Guys And St Thomas NHS Foundation Trust	37,536
Kings College Hospital NHS Foundation Trust	31,776
Oxleas NHS Foundation Trust	35,651

12. 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.

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

Bromley 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 £5.110m on revenue and £0.027m on capital.

	2012/13 Revenue £000	2012/13 Capital £000	2012/13 Total £000
Resource Limit	541,269	1,405	542,674
Net Operating Costs	536,159	1,378	537,537
Surplus / (Deficit)	**5,110**	**27**	**5,137**

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, Bromley PCT has been advised by DH to assume 68.9% 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 under drew its cash limit 2012/13 of £532.567m by £9m. The Department of Health also sets a maximum year-end cash balance for PCTs of £50k. The PCT's cash balance as at 31st March 2013 was £9k.

	£000
Opening Cash balance 1 April 2012	6
Cash drawings including cash top sliced by DH	532,567
Cash Outgoings	(523,564)
Cash returned to DH	(9,000)
Closing cash balance 31 March 2013	**9**

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 reduced by £157k for capital charges interest. Capital charges for Bromley PCT for 2012/13 were as follows:

	£000
Depreciation	1,818
3.5% cost of capital charge on net relevant assets	157
Total	**1,975**

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. . Bromley PCT is an approved signatory to the Prompt Payment Code. The PCT's performance against this target is reported below:

12.2 Better Payment Practice Code

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**10,969**	**49,987**	11,626	48,178
Total Non-NHS Trade Invoices Paid Within Target	**10,823**	**49,000**	11,338	47,465
Percentage of NHS Trade Invoices Paid Within Target	98.67%	98.03%	97.52%	98.52%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**4,006**	**368,159**	3,604	372,378
Total NHS Trade Invoices Paid Within Target	**3,926**	**365,952**	3,551	368,815
Percentage of NHS Trade Invoices Paid Within Target	98.00%	99.40%	98.53%	99.04%

Comparisons of 2012/13 annual accounts with previous years

1 Net operating costs

The overall growth in net operating costs of £22m (4.2%) since 2011/12 reflects the funding growth received by the PCT during 2012/13.

	2009/10	2010/11	2011/12	2012/13	Change from 2011/12	
	£m	£m	£m	£m	£m	%
Gross Operating Costs	489	518	528	549	22	4.2%
Including income of	9	12	13	13	-	0%
Net Operating Costs	480	506	514	536	22	4.2%

2 Non-Current Assets

Bromley PCT's land and buildings have been revalued by the District Valuer as at 31 March 2013 by carrying out a full valuation exercise. The net reduction in Property, Plant & Equipment assets of £2.807m reflects the impact of revaluation, depreciation charges as well as capital expenditure incurred during the year.

2009/10 £m	2010/11 £m	2011/12 £m	2012/13 £m	Change £m
58.6	55.4	58.7	55.9	2.8

3 Net liabilities

	2009/10 £m	2010/11 £m	2011/12 £m	2012/13 £m	Change £m
Debtors	7.0	11.0	8.2.	3.3	(4.9)
Creditors within one year	(34.0)	(31.4)	(34.2)	(36.0)	(1.8)
Net current liabilities	(27.0)	(20.4)	(26.0)	(32.7)	(6.7)

4 Taxpayers' equity

	2009/10 £m	2010/11 £m	2011/12 £m	2012/13 £m	Change £m
General Fund	(3.9)	0.3	(3.6)	(16.2)	(12.6)
Revaluation Reserve	9.3	8.1	14.8	14.0	(0.8)
Donated Asset Reserve	0.2	0.0	0.0	0.0	0.0
Total	5.6	8.5	11.1	(2.2)	(13.4)

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	**(534,471)**	(512,720)
Depreciation and Amortisation	**1,818**	1,975
Impairments and Reversals	**1,168**	605
Interest Paid	**(2,745)**	(2,713)
Decrease in Trade and Other Receivables	**5,318**	1,101
Increase/(Decrease) in Trade and Other Payables	**(2,501)**	695
Provisions Utilised	**(321)**	(2,758)
Increase/(Decrease) in Provisions	**9,450**	(67)
Net Cash Inflow/(Outflow) from Operating Activities	**(522,284)**	**(513,882)**
Cash flows from investing activities		
Interest Received	**1,057**	1,119
(Payments) for Property, Plant and Equipment	**(1,623)**	(181)
(Payments) for Other Financial Assets	**(124)**	0
Proceeds of disposal of assets held for sale (PPE)	**0**	2,578
Loans Repaid in Respect of LIFT	**7**	27
Net Cash Inflow/(Outflow) from Investing Activities	**(683)**	**3,543**
Net Cash Inflow/(Outflow) before financing	**(522,967)**	**(510,339)**
Cash flows from Financing Activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**(597)**	(382)
Net Parliamentary Funding	**523,567**	508,908
Capital grants and other capital receipts	**0**	1,771
Cash Transferred (to)/from Other NHS Bodies (free text note required)	**0**	0
Net Cash Inflow/(Outflow) from Financing Activities	**522,970**	**510,297**
Net increase/(decrease) in cash and cash equivalents	**3**	**(42)**
Cash and Cash Equivalents at Beginning of the Period	**6**	**48**
Cash and Cash Equivalents at year end	**9**	**6**

Statement of Financial Position at 31 March 2013

	31 March 2013	31 March 2012
	£000	£000
Non-current assets:		
Property, plant and equipment	**55,937**	58,744
Intangible assets	**0**	0
investment property	**0**	0
Other financial assets	**282**	165
Trade and other receivables	**8,469**	8,877
Total non-current assets	**64,688**	67,786
Current assets:		
Inventories	**0**	0
Trade and other receivables	**3,282**	8,192
Other financial assets	**7**	0
Other current assets	**0**	0
Cash and cash equivalents	**9**	6
Total current assets	**3,298**	8,198
Non-current assets held for sale	**500**	0
Total current assets	**3,798**	8,198
Total assets	**68,486**	75,984
Current liabilities		
Trade and other payables	**(29,475)**	(32,221)
Other liabilities	**0**	0
Provisions	**(6,078)**	(1,509)
Borrowings	**(553)**	(517)
Other financial liabilities	**0**	0
Total current liabilities	**(36,106)**	(34,247)
Non-current assets plus/less net current assets/liabilities	**32,380**	41,737
Non-current liabilities		
Trade and other payables	0	0
Other Liabilities	0	0
Provisions	(6,019)	(1,459)
Borrowings	(28,516)	(29,142)
Other financial liabilities	0	0
Total non-current liabilities	**(34,535)**	(30,601)
Total Assets Employed:	**(2,155)**	11,136
Financed by taxpayers' equity:		
General fund	(16,252)	(3,660)
Revaluation reserve	14,097	14,796
Total taxpayers' equity:	**(2,155)**	11,136

Chair: Caroline Hewitt

Interim Chief Executive: Christina Craig

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	**8,648**	9,937
Other costs	**537,859**	514,550
Income	**(12,036)**	(11,767)
Net operating costs before interest	**534,471**	512,720
Investment income	**(1,057)**	(1,119)
Other (Gains)/Losses	**0**	(67)
Finance costs	**2,745**	2,709
Net operating costs for the financial year	**536,159**	514,243
Net Operating Costs for the Financial Year including absorption transfers	**536,159**	**514,243**
Of which:		
Administration Costs		
Gross employee benefits	**5,464**	6,797
Other costs	**6,262**	4,818
Income	**(4)**	(265)
Net administration costs for the financial year	**11,722**	**11,350**
Programme Expenditure		
Gross employee benefits	**3,184**	3,140
Other costs	**531,597**	509,732
Income	**(12,032)**	(11,502)
Net programme expenditure before interest	**522,749**	**501,370**
Investment income	**(1,057)**	(1,119)
Other (Gains)/Losses	**0**	(67)
Finance costs	**2,745**	2,709
Net programme expenditure for the financial year	**524,437**	**502,893**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**1,529**	559
Net (gain) on revaluation of property, plant & equipment	**(830)**	(8,607)
Total comprehensive net expenditure for the year	**536,858**	**506,195**

10 POST BALANCE SHEET EVENTS

As disclosed within note 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, The principles for the split of residual balances is still subject to Department of Health guidance.

- 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)	11,692	10,063	1,629
Weighted population (number)	293,651	293,651	-
Management cost per head of weighted population (£)	**40**	**34**	**6**

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 £1.629m (16%) in the year.

Audit

The PCT's external auditor is PricewaterhouseCoopers. During the financial year 2012/13 £130k (including VAT) was paid in respect of carrying out the external audit of the PCT in accordance with the Code of Audit Practice.

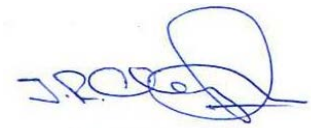
2012/13 Accounts Certificate of Financial Assurance to the Department of Health Director General, Strategy Finance and NHS

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 Bromley 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 Bromley 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 Bromley 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 Care Trust 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 STATEMENT TO THE OFFICER RESPONSIBLE FOR PREPARING THE ACCOUNTS OF BROMLEYPRIMARY CARE TRUST

We have examined the summary financial statements for the year ended 31 March 2013 which comprises the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, the related notes comprising; financial balance, cash performance, capital charges, public sector payment targets, better payment practice code, net operating costs, non-current assets, net liabilities, taxpayers' equity, pensions, post balance sheet events, running costs, audit and the information in the Directors' Remuneration Report that is described as having been audited.

Respective responsibilities of the officer responsible for preparing the accounts and auditor

The officer responsible for preparing the accounts is responsible for preparing the Annual Report and summary financial statement, in accordance with directions issued by the Secretary of State.

Our responsibility is to report to you our opinion on the consistency of the summary financial statement within the Annual Report with the full annual statutory financial statements and the Directors' Remuneration Report and its compliance with the relevant requirements of the directions issued by the Secretary of State.

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

This statement, including the opinion, has been prepared for, and only for, the officer responsible for preparing the accounts of Bromley PCT in accordance with part II of the Audit Commission Act 1998 as set out in paragraph 45 of the Statement of Responsibilities of Auditors and of Audited Bodies (Local NHS Bodies) published by the Audit Commission in March 2010, and for no other purpose. We do not, in giving this opinion, accept or assume responsibility for any other purpose or to any other person to whom this statement is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

We conducted our work in accordance with Bulletin 2008/03 issued by the Auditing Practices Board. Our report on the full annual statutory financial statements describes the basis of our opinion on those financial statements, the Directors' Report and the Directors' Remuneration Report.

Opinion

In our opinion the summary financial statement is consistent with the full annual statutory financial statements, and the Directors' Remuneration Report of the Bromley Primary Care Trust for the

year ended 31 March 2013 and complies with the relevant requirements of the directions issued by the Secretary of State.

Janet Dawson, Engagement Lead

For and on behalf of PricewaterhouseCoopers LLP

Appointed Auditors

7 More London Riverside

London SE1 2RT

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

13. FURTHER INFORMATION

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

Mark Cheung
Chief Financial Officer
Bromley CCG
Bassetts House, Broadwater Gardens, Orpington, Kent BR6 7UA
Tel 01689 880731
Mark.cheung@nhs.net

Department of Health

NHS

Bromley Primary Care Trust

2012-13 Accounts

Published to gov.uk, in PDF format only.

www.gov.uk/dh

Bromley Primary Care Trust

2012-13 Accounts

Bromley PCT
Annual Accounts

Year Ended 31st March 2013

FOREWORD TO THE ACCOUNTS

BROMLEY PRIMARY CARE TRUST

These accounts for the year ended 31st March 2013 have been prepared by the Bromley 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.

Introduction

On 1 April 2011 NHS South East London (NHS SEL) was established as a transitional organisation to take us through to 2013 and the implementation of the new healthcare system. NHS SEL consisted of a single shared corporate management team and six borough based Business Support Units, including one covering Bromley. There was a single accountable officer and executive team, made up of six directors, a chief nurse and medical director, who work with the managing directors of the six BSUs.

A shadow clinical commissioning group (CCG) was set up and had delegated authority to take on responsibility for commissioning health services before being granted statutory authority in its own right from April 2013. This means that GPs and other clinicians in Bromley were already engaged in budgetary decision making processes.

Much of the year was spent with the CCG operating in shadow form, overseen by the NHS Commissioning Board. Following many months of hard work putting together the constitution, governance and operational management arrangements for the new, GP led CCG, authorisation was received from the NHS Commissioning Board in January 2013. Bromley CCG was fully authorised on 1 April 2013 as a new NHS statutory authority for commissioning services in Bromley. From April 2013 Bromley CCG took up its full range of responsibilities as set out in the Health and Social Care Act 2012.

Our Mission and Vision for Health in Bromley

Clinical commissioners have a unique role within the NHS, providing an individual patient perspective to shape the commissioning and delivery of healthcare. Working from the starting point of the health and social care needs of our population in Bromley, as described by the Joint Strategic Needs Assessment, and our assessment of the current state of the local health economy, our Vision has been defined as follows:

Better Health: improve health outcomes and reduce health inequalities across Bromley.
Better Care: transform the landscape of healthcare, by developing partnerships, leading to an integrated healthcare system with improved access and quality.
Better Value: create a sustainable health economy reinforced through collaborative working.

Goal 1: Better Health

Identify and develop programmes to reduce the level of health inequalities in the more deprived areas of Bromley.
To identify and develop programmes which will systematically demonstrate improvements in key health outcomes.
To ensure that patients, service users and their carers are at the centre of all decisions we take around their healthcare, are encouraged to understand and manage their own condition and have a positive experience of care.
Reduce health inequalities by encouraging people to adopt a healthier lifestyle through a programme of education and targeted interventions known to work to increase the control individuals have over their own health and wellbeing.

Goal 2: Better Care

Improve access to and extend choice of services and patients, service users and their carers, ensuring that clinical pathways are fit for purpose and that the services we commission meet the highest possible quality standards, whist increasing the pace of delivery of the quality, innovation, productivity and prevention (QIPP) challenge.
Empower those people in Bromley with long term conditions, particularly older people, to exercise control over their own lives and prevent problems arising or worsening and enabling them to independently manage their own health and well being, thus improving their health, outcomes and preventing them dying prematurely.
To strengthen and fully integrate the infrastructure supporting this cohort of people ensuring that their health needs are met 24/7 in a planned and structured way

Goal 3: Better Value

To work with South London Healthcare NHS Trust and other local healthcare providers and stakeholders to develop and implement a clear and sustainable plan to manage the underlying financial position of the local health economy.
To facilitate the reshaping of provider facilities and resources to reflect the relocation of services closer to patients and their homes, and to encourage integrated services.
To ensure that quality and performance of services remain paramount through this process of change.
To create and maintain a sound business framework for the development of local healthcare services through clinical commissioning.
To undertake a process of education and reform to ensure our provider workforce has the necessary skills to deliver new and challenging pathways of care.

Bromley's Population and Local Health Issues

Bromley has a population of 316,647 (2012 estimate). It has the lowest average population density in London, with 60 per cent of the borough being protected Green Belt or Metropolitan Open Land.
The borough's population is generally affluent, although there are wide geographical variations in health and wellbeing, with pockets of low income populations and high levels of unemployment. Inequalities across these wards are manifest in outcomes such as lower life expectancy and self- reported levels of poor health. The population is projected to rise.

The birth rate within the borough has been rising since 2006, and is predicted to continue to rise. The number of nought to four year olds has gradually been increasing since 2004 and it is estimated that it will peak in 2016. The proportion of older people in Bromley is expected to remain fairly stable at 15.6 per cent over the next 10 years.
The pattern of population change in the different age groups is variable between wards, with some wards such as Bromley Town experiencing a large rise in the proportion of young people and Biggin Hill experiencing a large rise in the over 75s.
The 2011 census shows a rise in the ethnic minority population in Bromley to 22.6 percent (from 13.5 per cent in the 2001

Life expectancy at birth in Bromley has been rising steadily over the last 20 years, and the latest figures (2007 - 2009) report a life expectancy of 79.9 years for men and 83.8 years for women. Whilst these figures are significantly better than the national average, there are areas of Bromley with lower life expectancy. The gap in years of life expectancy between the least and most deprived areas within the local authority (based on mortality data for the five year period 2006 to 2010) is 7.8 years for men and 6.2 years for women.

Bromley has lower 'all cause' mortality rates and infant mortality rates than the national average. The key causes of mortality in Bromley are circulatory disease, cancer and respiratory disease, driven by a variety of factors such as obesity, unhealthy lifestyle and deprivation.

Bromley PCT 2012/13 - Performance against Statutory Financial Duties

In line with other NHS bodies Bromley PCT is required to prepare annual accounts on a resource accounting basis and is required by statute to meet certain financial duties to ensure that public funds are used appropriately.
These duties are:
1 - Not to exceed its Revenue Resource Limit (RRL) or Capital Resource Limit (CRL) and its (combined revenue and capital) Cash
2 - to absorb capital costs in full though a charge calculated at 3.5% of the average relevant assets of the PCT plus depreciation
3 - to demonstrate full cost recovery, on an accruals basis, in relation to provider functions

In 2012/13 Bromley PCT achieved in full its statutory duties as follows:

Revenue and capital resource limits and combined cash limit
Bromley PCT underspent against the 2012/13 Revenue Resource Limit by £5.11 million. (2011/12 £6.111m) and an underspend against the Capital Resource Limit by £27k (2011/12 £25k underspend)

Bromley PCT underdrew against its 2012/13 cash limit of £532.567m by £9m, due to the significant non-cash increase in provisions relating to continuing care and managed within the maximum cash balances determined by the Department of Health as at 31 March 2013.

Bromley PCT has achieved financial balance without the need for unplanned financial assistance. The following table shows the 2012/13 outturn position for Bromley PCT against the 2012/13 resource limits

	RRL	CRL	TOTAL
	£000s	£000s	£000s
Resource Limit 2012/13	541,269	1,405	542,674
Charges against Resource Limit	536,159	1,378	537,537
Underspend/(Overspend)	5,110	27	5,137
%	0.9%	1.9%	0.9%

Under the Department of Health year end carry forward arrangements' revenue resource limit underspends for 2012/13 up to and including the agreed control total will be carried forward in proportion to the new commissioning bodies in 2013/14. The total value of the carry forward will be a maximum of £5.02m. Underspends against capital resource limits are not carried forward.

Payment of Capital Charges
Bromley PCT paid over in full capital charges to the Department of Health in respect of assets held by the PCT.

Provider full cost recovery
The PCT's former provider function became a separate entity on 1 April 2011 as Bromley Health Care Community Interest Company and therefore this duty was not required to be met for 2012/13.

International Financial Reporting Standards
International Financial Reporting Standards (IFRS) are accounting standards issued by the International Accounting Standards Board (IASB). 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). As a result, IFRS was implemented across the NHS from 2009/10 and is now fully embedded in the financial reporting framework.

Counter Fraud & Corruption
The PCT has an agreed Counter Fraud Strategy in place in support of the PCT's Counter Fraud and Corruption Policy. The Strategy ensures that all involved in both the provision and use of the services are engaged in countering fraud and corruption. The importance of counter fraud is embedded across the organisation by training and communications including posters, e-mails and payslip attachments. The PCT's Counter Fraud activities are informed by best practice guidance provided by the Counter Fraud and Security Management Service (CFSMS) in accordance with the Secretary of State Directions.
The Counter Fraud team have been creating awareness amongst staff in relation to the Bribery Act which came into effect in May 2011. The PCT's policies including Whistle blowing, Hospitality and Gifts policies have been updated to reflect the requirements of the Bribery

Corporate Governance
The PCT has in place corporate governance arrangements that have been approved by the Joint Boards in 2011 and are set out in the Corporate Governance and Accountability Framework. This includes detailed Standing Orders and Standing Financial Instructions. During 2012/13 the PCT Cluster Board has kept its governance arrangements under review to ensure that they remain fit for purpose and have made a number of changes to the subcommittee structure.
There is an established Board Assurance Framework and supporting risk register in place as part of our regular integrated Performance and Reporting Framework built upon our annual business plan objectives.

Equity and Excellence: Liberating the NHS

The government published its White Paper, Equity and Excellence: Liberating the NHS in July 2010, setting out its long-term vision for the future of the NHS. The White Paper set out how the government intends to put patients at the heart of everything the NHS does, focus on continuously improving those things that really matter to patients - the quality and outcome of their healthcare and empower and liberate clinicians to innovate, with the freedom to focus on improving healthcare services. This has now been passed into legislation.

For PCTs the key proposals included:

- Commissioning: - the transfer of Commissioning responsibility from PCTs to GP Commissioning consortia, leading to the abolition of Strategic Health Authorities (SHAs) and PCTs and the creation of an NHS England.
- Public Health and wellbeing: including the creation of a Public Health service and the transfer of Health improvement functions to local government.
- Resources: the government has restated its commitment to real terms increases in funds for health, to the need for the NHS to deliver £20 billion efficiency savings and the reduction in NHS management costs by 45 per cent over the next four years.

It is intended that commissioning needs to be outward facing with commissioners drawing on patients, the public, clinicians, partners and staff to share new patterns of care and develop longer term system-wide solutions to the QIPP challenge. The new system will involve developing an integrated commissioning system with the establishment of the National Commissioning Board, GP consortia pathfinders and early implementer Health and Wellbeing Boards. The new system will be supported by key enablers in patient information, empowerment and choice, informatics, education and training, public health and human resources and the national approach to development in these areas.

Commissioning Healthcare

Bromley PCT is still the accountable commissioning organisation in Bromley. It has established a Quality Working Group to provide it with assurance on the quality of the services being commissioned. Looking to the future, clinical commissioning in shadow form in Bromley has been led by the emerging CCG engaging all 47 Bromley practices. In January 2013, the emerging CCG received notification from the NHS Commissioning Board that it had been authorised as a CCG from 1 April 2013. The process of becoming a statutory organisation is known as 'authorisation' and involved a rigorous assessment of the CCG's

Looking to the future, clinical commissioning in shadow form in Bromley has been led by the emerging CCG engaging all 47 Bromley practices. In this period of transition, Bromley PCT has continued working closely with NHS London, the Department of Health and the emerging NHS Commissioning Board to demonstrate that it has the competencies necessary for full authorisation

There has also been a delivery strategy in place. This is part of our Commissioning Support Plan. This delivery strategy has directed the healthcare commissioning work of the outgoing PCT and the emerging CCG. We will look again at this strategy plan and refresh it where necessary so that it is fit for purpose during 2012/13.

Practices in Bromley are grouped together into three clusters. The Local Clinical Commissioning Committee (the shadow CCG governing body in place until authorisation) took delegated responsibility during 2011 from the PCT Board for a wide range of commissioning budgets, including community services, mental health and acute commissioning budgets.

Clinical leadership for the shadow organisation comes from six GPs who were appointed through a selection and an election process held in September 2011. Two non-executive PCT Board members, executive leads and co-opted board members from the London Borough of Bromley and a Bromley Link also sit on the current shadow governing body: the Bromley Clinical Commissioning Committee. Shadow organisation Board meetings are held in public every month.

The year 2012/13 was a crucial transitional period for Bromley CCG. The robust meeting and governance structures now in place will be further developed, reflecting the increasing responsibilities. NHS Bromley has continued to work closely with NHS South East London during the transitional year to transfer remaining responsibilities prior to full authorisation in April 2013.

Authorisation and the complex transitional and handover arrangements from the former PCT have been completed and we also introduced a very full programme of improvements in health care, led by Bromley GPs, of quality improvements in acute services, such as venous thromboembolism assessments in hospital; developing new care pathways that reduce waiting times, improving access and quality for local people, and implementing innovative ways of delivering care through our providers, resulting in a significant reduction in average healing time for leg ulcers.

Probably one of the most significant of these has been the development of our innovative Proactive Management and Integrated Services for the Elderly programme (ProMISE). This programme has been developed to improve the health of older people, particularly those with long term conditions, with the aim of ensuring that patients are able to stay in their own homes rather than in hospital or nursing and residential care homes.

Other service improvements included developing community cardiology, dermatology, gynaecology, physiotherapy, IVF, minor oral surgery, ophthalmology and urgent care services.

As well as reducing waiting times and improving accessibility and quality, these new developments in the community decrease the use of hospital services, and helped us to achieve good value for money.

Much progress was made on the Orpington Health Services Project during the year. With a full programme of public involvement that included a three month formal public consultation exercise and public meetings, we developed and agreed proposals to develop a new Health and Wellbeing Centre in the Orpington area.

In so doing, we had to respond to and accommodate the strongly articulated views of local people in a way that provided the maximum benefit for Orpington residents as a whole and the wider Bromley population. The implementation of this project will continue through 2013/14 and the following year, eventually producing some very real long term healthcare improvements.

Our focus in recent years has been very much on the quality of services provided by the South London Healthcare NHS Trust (SLHT), our main acute services provider, which has been beset with financial problems.

On 16 July 2012 the Secretary of State for Health appointed a Trust Special Administrator (TSA) to South London Healthcare Trust under the Regime for Unsustainable NHS Providers (UPR). He was appointed make recommendations on how to deliver a lasting clinical and financial solution for the Trust. Following a period of consultation, the Secretary of State broadly accepted the recommendations in the TSA's final report as follows:

- Lewisham Hospital to retain its A&E
- South London Healthcare Trust to be dissolved, with each of its hospitals being taken over by a neighbouring hospital Trust (subject to the approval of the relevant regulators)
- All three Hospitals within South London Healthcare NHS Trust - Queen Elizabeth Hospital in Woolwich, Queen Mary's in Sidcup and the Princess Royal in Bromley to make the full £74.9 million of efficiencies identified by the Trust Special Administrator.
- All vacant or poorly utilised premises to be vacated sold where possible.
- The Department of Health to pay for the excess costs of the PFI buildings at the Queen Elizabeth and Princess Royal Hospitals and write off the accumulated debt of the Trust so that the new organisations are not saddled with historic debts. It will also provide an appropriate level of transitional funding to cover implementation planning and subsequent implementation.

The impact of these changes continues to be assessed with Commissioners to ensure that the impact of the required financial improvement is delivered in a manner to maintain quality services in the most appropriate environment for patients.

On the announcement from the Secretary of State that SLHT would be the first NHS Trust to be subject to the Unsustainable Provider Regime arrangements provided for in recent legislation, Bromley PCT took the opportunity to work closely with the Trust Special Administrator (TSA) to achieve the best possible solution for the people of Bromley.

The Secretary of State's decision published in February 2013 included arrangements for King's College Hospital NHS Foundation Trust to take over the management of our local Princess Royal University Hospital. Bromley PCT welcome that decision and are now working with King's to sustain high quality hospital services in the borough.

Bromley CCG are taking the opportunity provided by the eventual withdrawal of SLHT services at Beckenham Beacon to reassess the healthcare needs of the population in the north of the borough and develop a comprehensive range of community and primary care services provided at Beckenham Beacon. Implementation of the TSA decisions will be a major focus for us in 2013/14, and the Bromley CCG will take every available opportunity to bring long term improvements to health services in Bromley.

2011/12 was the 11th and final year of Bromley PCT, and, as in every preceding year, we once again achieved all our statutory financial duties by staying within the revenue resource, cash and capital resource limits. We also achieved the public sector target for timely invoice payments.

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 Bromley 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.....CVincent.....

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 Bromley 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
- 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 Bromley 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

Independent Auditors' Report to the officer responsible for preparing the accounts of Bromley Primary Care Trust

We have audited the financial statements of Bromley Primary Care Trust ("the PCT") for the year ended 31 March 2013 which 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 the accounting policies directed by the Secretary of State for Health with the consent of the Treasury as relevant to the National Health Service in England set out therein.

Respective responsibilities of the officer responsible for preparing the accounts and auditors

As explained more fully in the statement of the responsibilities of the signing officer the officer responsible for preparing the accounts is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view in accordance with accounting policies directed by the Secretary of State, with the consent of the Treasury, as being relevant to the National Health Service in England. Our responsibility is to audit and express an opinion on the financial statements in accordance with Part II of the Audit Commission Act 1998, the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission and International Standards on Auditing (ISAs) (UK and Ireland).Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the officer responsible for preparing the accounts of Bromley Primary Care Trust in accordance with Part II of the Audit Commission Act 1998 as set out in paragraph 45 of the Statement of Responsibilities of Auditors and of Audited Bodies (Local NHS Bodies) published by the Audit Commission in March 2010 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the PCT's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the PCT; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the Annual Report and Accounts to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

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

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with the requirements directed by the Secretary of State with the consent of the Treasury as being relevant to the National Health Service in England;

- 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; and

- the information given in the Directors' report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception
We have nothing to report in respect of the following matters where the Code of Audit Practice issued by the Audit Commission requires us to report to you if:

- in our opinion, the Governance Statement does not comply with the Department of Health's requirements set out in "2012/13 Governance Statements – Guidance " issued on 31 January 2013 or is misleading or inconsistent with information of which we are aware from our audit; or

- we refer a matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or

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

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

Respective responsibilities of the PCT and auditors
The PCT is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the PCT has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

We report if significant matters have come to our attention which prevent us from concluding that the PCT has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the PCT's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

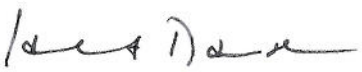
Scope of the review of the arrangements for securing economy, efficiency and effectiveness in the use of resources
We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its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

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

- our review of the Governance Statement;
- the work of other relevant regulatory bodies or inspectorates, to the extent that the results of this work impact on our responsibilities at the Trust; and
- our locally determined risk-based work on governance, financial management, asset and information management, and workforce management.

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 Bromley Primary Care Trust in accordance with the requirements of Part II of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.



Janet Dawson, Engagement Lead

For and on behalf of PricewaterhouseCoopers LLP
Appointed Auditors
7 More London Riverside,
London,
SE1 2RT

4 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	**8,648**	9,937
Other costs	5.1	**537,859**	514,550
Income	4	**(12,036)**	(11,767)
Net operating costs before interest		**534,471**	512,720
Investment income	9	**(1,057)**	(1,119)
Other (Gains)/Losses	10	**0**	(67)
Finance costs	11	**2,745**	2,709
Net operating costs for the financial year		**536,159**	514,243
Net Operating Costs for the Financial Year including absorption transfers		**536,159**	**514,243**
Of which:			
Administration Costs			
Gross employee benefits	7.1	**5,464**	6,797
Other costs	5.1	**6,262**	4,818
Income	4	**(4)**	(265)
Net administration costs for the financial year		**11,722**	**11,350**
Programme Expenditure			
Gross employee benefits	7.1	**3,184**	3,140
Other costs	5.1	**531,597**	509,732
Income	4	**(12,032)**	(11,502)
Net programme expenditure before interest		**522,749**	**501,370**
Investment income	9	**(1,057)**	(1,119)
Other (Gains)/Losses	10	**0**	(67)
Finance costs	11	**2,745**	2,709
Net programme expenditure for the financial year		**524,437**	**502,893**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**1,529**	559
Net (gain) on revaluation of property, plant & equipment	**(830)**	(8,607)
Total comprehensive net expenditure for the year	**536,858**	**506,195**

The notes on pages 15 to 52 form part of these accounts.

Statement of Financial Position at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	12	55,937	58,744
Intangible assets	13	0	0
investment property	15	0	0
Other financial assets	20	282	165
Trade and other receivables	19	8,469	8,877
Total non-current assets		64,688	67,786
Current assets:			
Inventories	18	0	0
Trade and other receivables	19	3,282	8,192
Other financial assets	21.1	7	0
Other current assets	22	0	0
Cash and cash equivalents	23	9	6
Total current assets		3,298	8,198
Non-current assets held for sale	24	500	0
Total current assets		3,798	8,198
Total assets		68,486	75,984
Current liabilities			
Trade and other payables	25	(29,475)	(32,221)
Other liabilities	26,28	0	0
Provisions	32	(6,078)	(1,509)
Borrowings	27	(553)	(517)
Other financial liabilities	36.2	0	0
Total current liabilities		(36,106)	(34,247)
Non-current assets plus/less net current assets/liabilities		32,380	41,737
Non-current liabilities			
Trade and other payables	25	0	0
Other Liabilities	28	0	0
Provisions	32	(6,019)	(1,459)
Borrowings	27	(28,516)	(29,142)
Other financial liabilities	36.2	0	0
Total non-current liabilities		(34,535)	(30,601)
Total Assets Employed:		(2,155)	11,136
Financed by taxpayers' equity:			
General fund		(16,252)	(3,660)
Revaluation reserve		14,097	14,796
Total taxpayers' equity:		(2,155)	11,136

The notes on pages 15 to 52 form part of these accounts.

The financial statements on pages *11 to 14* were approved by the DH Audit Committee on 31 May 2013 and signed on its behalf by

C Vincent

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	Total reserves
	£000	£000	£000
Balance at 1 April 2012	**(3,660)**	**14,796**	**11,136**
Changes in taxpayers' equity for 2012-13			
Net operating cost for the year	(536,159)	0	**(536,159)**
Net gain on revaluation of property, plant, equipment	0	830	**830**
Impairments and reversals	0	(1,529)	**(1,529)**
Total recognised income and expense for 2012-13	**(536,159)**	**(699)**	**(536,858)**
Net Parliamentary funding	523,567	0	**523,567**
Balance at 31 March 2013	**(16,252)**	**14,097**	**(2,155)**
Balance at 1 April 2011	**319**	**8104**	**8,423**
Changes in taxpayers' equity for 2011-12			
Net operating cost for the year	(514,243)	0	(514,243)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment	0	8,607	8,607
Impairments and Reversals	0	(559)	(559)
Transfers between reserves	1,356	(1,356)	0
Total recognised income and expense for 2011-12	(512,887)	6,692	(506,195)
Net Parliamentary funding	508,908	0	508,908
Balance at 31 March 2012	**(3,660)**	**14,796**	**11,136**

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	**(534,471)**	(512,720)
Depreciation and Amortisation	**1,818**	1,975
Impairments and Reversals	**1,168**	605
Interest Paid	**(2,745)**	(2,713)
Decrease in Trade and Other Receivables	**5,318**	1,101
Increase/(Decrease) in Trade and Other Payables	**(2,501)**	695
Provisions Utilised	**(321)**	(2,758)
Increase/(Decrease) in Provisions	**9,450**	(67)
Net Cash Inflow/(Outflow) from Operating Activities	**(522,284)**	**(513,882)**
Cash flows from investing activities		
Interest Received	**1,057**	1,119
(Payments) for Property, Plant and Equipment	**(1,623)**	(181)
(Payments) for Other Financial Assets	**(124)**	0
Proceeds of disposal of assets held for sale (PPE)	**0**	2,578
Loans Repaid in Respect of LIFT	**7**	27
Net Cash Inflow/(Outflow) from Investing Activities	**(683)**	**3,543**
Net Cash Inflow/(Outflow) before financing	**(522,967)**	**(510,339)**
Cash flows from Financing Activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**(597)**	(382)
Net Parliamentary Funding	**523,567**	508,908
Capital grants and other capital receipts	**0**	1,771
Cash Transferred (to)/from Other NHS Bodies (free text note required)	**0**	0
Net Cash Inflow/(Outflow) from Financing Activities	**522,970**	**510,297**
Net increase/(decrease) in cash and cash equivalents	**3**	**(42)**
Cash and Cash Equivalents at Beginning of the Period	**6**	**48**
Cash and Cash Equivalents at year end	**9**	**6**

1. Accounting policies

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

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

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

As a consequence of the Health and Social Care Act 2012, Bromley 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 Bromley 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.

1. Accounting policies (continued)

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

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

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

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 tenants' income in relation to the MES element of the PFI

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 effect of these variations. The difference between the rental charge to tenants and the charge to the statement of comprehensive net expenditure relating to that rental charge is a timing difference and is accounted for as either

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.

1. Accounting policies (continued)

Provisions

The significant critical judgments for the PCT's pension provisions are disclosed in Note 1.24

Redundancy Payment Accruals and Provisions – PCT Reorganisation: The accounts include accruals for redundancies that incurred during March 2013. A 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

Property, plant, and equipment

The PCT's accounting judgments about 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 for 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

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 a number of lease arrangements are finance leases.

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 provided for significant material provisions around continuing care claims, details of which are included in note 32. The PCT does not have any material estimation uncertainty over the completeness of its provisions. Contingent liabilities policy is 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

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 Designation

Bromley Primary Care Trust is not designated as a Care Trust

1.4 Pooled budgets

The PCT has entered into a pooled budget with the London Borough of Bromley. Under the arrangement funds are pooled under S75 of the NHS Act 2006 for Integrated Short Break Services for Young People with Disabilities and a memorandum note to the accounts provides details of the joint income and expenditure.

The PCT's contribution is not material in relation to the PCT accounts.

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

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

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

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

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

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

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

Subsequent expenditure

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

1. Accounting policies (continued)

1.8 Intangible Assets

Recognition

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

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

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

Measurement

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

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

1.9 Depreciation, amortisation and impairments

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

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

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

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

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

1. Accounting policies (continued)

1.10 Donated assets

Following the accounting policy change outlined in the Treasury FREM for 2011-12, a donated asset reserve is no longer maintained. Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Donated income is deferred only where conditions attached to the donation have not been met.

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. Government Grant income is deferred only where conditions attached to the grant have not been met.

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

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

1.14 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.

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.

The provisions for clinical negligence claims on behalf of the PCT are included in the NHSLA accounts as reported in 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 rate of 2.2% (2.8% in respect of early staff departures) in real terms.

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

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

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

1. Accounting policies (continued)

1.25 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. [Disclose how fair value is determined]

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

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. 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

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

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

2 Operating segments

Following the transfer of its provider services to Bromley Healthcare Community Interest Company, a social enterprise, on 1 April 2011, Bromley PCT has only one operating 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 Net operating cost plus (gain)/loss on transfers by absorption	**536,159**	514,243
Revenue Resource Limit	**541,269**	520,354
Under/(Over)spend Against Revenue Resource Limit (RRL)	5,110	6,111

3.2 Capital Resource Limit

	2012-13 £000	2011-12 £000
The PCT is required to keep within its Capital Resource Limit.		
Capital Resource Limit	**1,405**	2,066
Charge to Capital Resource Limit	**(1,378)**	(2,091)
Under/(Over)spend Against CRL	**27**	**(25)**

3.3 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**523,567**	508,908
Cash Limit	**532,567**	508,908
Under/(Over)spend Against Cash Limit	**9,000**	**0**

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

	2012-13 £000
Total cash received from DH (Gross)	463,793
Sub total: net advances	**463,793**
Plus: cost of Dentistry Schemes (central charge to cash limits)	10,887
Plus: drugs reimbursement (central charge to cash limits)	48,887
Parliamentary funding credited to General Fund	**523,567**

4 Miscellaneous Revenue

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Fees and Charges	4	4	0	0
Dental Charge income from Contractor-Led GDS & PDS	298	0	298	256
Dental Charge income from Trust-Led GDS & PDS	2,466	0	2,466	2,369
Prescription Charge income	1,996	0	1,996	1,928
Strategic Health Authorities	1,851	0	1,851	1,273
NHS Trusts	2,016	0	2,016	1,824
Primary Care Trusts - Other	958	0	958	1,066
Local Authorities	1,165	0	1,165	1,485
Education, Training and Research	200	0	200	624
Rental revenue from operating leases	746	0	746	906
Other revenue	336	0	336	36
Total miscellaneous revenue	12,036	4	12,032	11,767

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	**21,209**	0	21,209	15,439
Non-Healthcare	**2,488**	2,488	0	848
Total	**23,697**	**2,488**	**21,209**	**16,287**
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	**191,678**	0	191,678	190,737
Goods and services (other, excl Trusts, FT and PCT))	**28**	28	0	73
Total	**191,706**	**28**	**191,678**	**190,810**
Goods and Services from Foundation Trusts	**118,409**	51	118,358	116,062
Purchase of Healthcare from Non-NHS bodies	**83,594**	0	83,594	69,157
Expenditure on Drugs Action Teams	**1,860**	0	1,860	2,381
Non-GMS Services from GPs	**263**	263	0	972
Contractor Led GDS & PDS (excluding employee benefits)	**13,743**	0	13,743	13,168
Chair, Non-executive Directors & PEC remuneration	**32**	32	0	26
Executive committee members costs	**568**	568	0	126
Consultancy Services	**275**	260	15	33
Prescribing Costs	**41,991**	0	41,991	44,960
G/PMS, APMS and PCTMS (excluding employee benefits)	**39,999**	0	39,999	38,442
Local Pharmaceutical Services Pilots	**23**	0	23	21
New Pharmacy Contract	**10,126**	0	10,126	9,740
General Ophthalmic Services	**2,691**	0	2,691	2,564
Supplies and Services - Clinical	**706**	43	663	1,315
Supplies and Services - General	**822**	385	437	598
Establishment	**718**	485	233	981
Transport	**44**	43	1	55
Premises	**2,763**	675	2,088	3,980
Impairments & Reversals of Property, plant and equipment	**1,168**	0	1,168	262
Impairments and Reversals of non-current assets held for sale	**0**	0	0	343
Depreciation	**1,818**	0	1,818	1,975
Impairment of Receivables	**(98)**	0	(98)	31
Audit Fees	**130**	130	0	190
Education and Training	**131**	131	0	71
Grants for capital purposes	**655**	655	0	0
Other	**25**	25	0	0
Total Operating costs charged to Statement of Comprehensive Net Expenditure	**537,859**	**6,262**	**531,597**	**514,550**
Employee Benefits (excluding capitalised costs)				
PCT Officer Board Members	**472**	472	0	322
Other Employee Benefits	**8,176**	4,962	3,214	9,615
Total Employee Benefits charged to SOCNE	**8,648**	**5,434**	**3,214**	**9,937**
Total Operating Costs	**546,507**	**11,696**	**534,811**	**524,487**
Analysis of grants reported in total operating costs				
For capital purposes				
Grants to Private Sector to Fund Capital Projects	**655**	655	0	0
Total Capital Grants	**655**	**655**	**0**	**0**
Total Grants	**655**	**655**	**0**	**0**

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**11,692**	9,867	1,825
Weighted population (number in units)*	**293,651**	293,651	293,651
Running costs per head of population (£ per head)	**40**	**34**	**6**
PCT Running Costs 2011-12			
Running costs (£000s)	**10,063**	8,421	1,642
Weighted population (number in units)	**293,651**	293,651	293,651
Running costs per head of population (£ per head)	**34**	**29**	**6**

5.2 Analysis of operating expenditure by expenditure classification	2012-13 £000	2011-12 £000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	39,999	38,796
Prescribing costs	41,991	44,960
Contractor led GDS & PDS	10,766	13,168
General Ophthalmic Services	2,691	2,564
Local Pharmaceutical Services Pilots	23	21
New Pharmacy Contract	8,132	9,740
Non-GMS Services from GPs	263	874
Total Primary Healthcare purchased	**103,865**	110,123
Purchase of Secondary Healthcare		
Learning Difficulties	2,576	2,592
Mental Illness	42,013	42,916
Maternity	14,125	14,356
General and Acute	262,016	257,153
Accident and emergency	21,520	16,901
Community Health Services	46,219	37,225
Other Contractual	26,910	27,973
Total Secondary Healthcare Purchased	**415,379**	399,116
Grant Funding		
Grants for capital purposes	655	0
Total Healthcare Purchased by PCT	**519,899**	**509,239**
Healthcare from NHS FTs included above	**116,631**	114,860

6. Operating Leases

6.1 PCT as lessee

	Buildings £000	Other £000	2012-13 Total £000	2011-12 £000
Payments recognised as an expense				
Minimum lease payments	**3,097**	**0**	**3,097**	2,933
Contingent rents	**0**	**0**	**0**	0
Sub-lease payments	**0**	**0**	**0**	0
Total	**3,097**	**0**	**3,097**	**2,933**
Payable:				
No later than one year	**56**	**0**	**56**	46
Between one and five years	**223**	**0**	**223**	180
After five years	**576**	**0**	**576**	576
Total	**855**	**0**	**855**	**802**

Total future sublease payments expected to be received	0	0

The General Medical Services contract entered into by Bromley PCT with GPs includes conditions relating to the use of GP premises.

Under IFRIC 4 'Determining whether an arrangement contains a lease' the PCT has determined that those conditions are in accordance with operating leases. As the GMS contract does not have a defined term, it is not possible to analyse the financial impact of the arrangements over future financial years. The premises cost included the GMS payments in the Statement of Comprehensive Net Expenditure of £2.5m (2011-12 £2.5m)

Lease expenses include payments for seven properties, the largest of which is Addington Road Surgery.

The lease properties are used for Community Health Clinics and administration offices.

The expiry dates on property leases range from 1 to 13 Years.

6.2 PCT as lessor

	2012-13 £000	2011-12 £000
Recognised as income		
Rental Revenue	**527**	692
Contingent rents	**219**	214
Total	**746**	906
Receivable:		
No later than one year	**1,062**	1,069
Between one and five years	**4,200**	4,207
After five years	**4,168**	4,390
Total	**9,430**	9,666

The PCT leases eight properties to Hyde Housing Association Limited for a nominal charge of £1
These properties are used for residential accommodation for people who are mentally handicapped or suffer from illnesses.

Included in the non cancellable operating lease element of the LIFT contract with SLHT, the operating lease with the GP practice and GP Led Health Centre at Beckenham Beacon.
The PCT sub leases 26 properties to Bromley Healthcare CIC (Community Interest Company), on a 5 year term.

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	7,379	4,631	2,748	4,069	2,426	1,643	3,310	2,205	1,105
Social security costs	522	365	157	522	365	157	0	0	0
Employer Contributions to NHS BSA - Pensions Division	669	468	201	669	468	201	0	0	0
Termination benefits	78	0	78	78	0	78	0	0	0
Total employee benefits	8,648	5,464	3,184	5,338	3,259	2,079	3,310	2,205	1,105
Less recoveries in respect of employee benefits (table belo	0	0	0	0	0	0	0	0	0
Total - Net Employee Benefits including capitalised costs	8,648	5,464	3,184	5,338	3,259	2,079	3,310	2,205	1,105
Employee costs capitalised	0	0	0	0	0	0	0	0	0
Gross Employee Benefits excluding capitalised costs	8,648	5,464	3,184	5,338	3,259	2,079	3,310	2,205	1,105
Gross Employee Benefits excluding capitalised costs	8,648			5,338			3,310		

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	8,800	5,314	3,486
Social security costs	496	496	0
Employer Contributions to NHS BSA - Pensions Division	641	641	0
Total gross employee benefits	9,937	6,451	3,486
Gross Employee Benefits excluding capitalised costs	9,937	6,451	3,486

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	5	5	0	5	5	0
Administration and estates	110	80	30	91	80	11
Healthcare assistants and other support staff	12	12	0	4	4	0
Nursing, midwifery and health visiting staff	14	14	0	11	11	0
Scientific, therapeutic and technical staff	8	8	0	8	8	0
Other	0	0	0	1	1	0
TOTAL	149	119	30	120	109	11

7.3 Staff Sickness absence and ill health retirements

	2012-13 Number	2011-12 Number
Total Days Lost	1,701	6,225
Total Staff Years	339	735
Average working Days Lost	5.02	8.47

	2012-13 Number	2011-12 Number
Number of persons retired early on ill health grounds	1	1
	£000s	£000s
Total additional pensions liabilities accrued in the year	5	14

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	**2**	**0**	**2**	0	0	**0**
£10,001-£25,000	**0**	**0**	**0**	0	0	**0**
£25,001-£50,000	**3**	**0**	**3**	0	0	**0**
£50,001-£100,000	**3**	**0**	**3**	0	0	**0**
£100,001 - £150,000	**1**	**0**	**1**	0	0	**0**
£150,001 - £200,000	**0**	**0**	**0**	0	0	**0**
>£200,000	**0**	**0**	**0**	0	0	**0**
Total number of exit packages by type (total cost	**9**	**0**	**9**	**0**	**0**	**0**
	£s	**£s**	**£s**	**£s**	**£s**	**£s**
Total resource cost	446,419	0	**446,419**	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 Pension 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 agreed with staff 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

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

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	**10,969**	**49,987**	11,626	48,178
Total Non-NHS Trade Invoices Paid Within Target	**10,823**	**49,000**	11,338	47,465
Percentage of NHS Trade Invoices Paid Within Target	98.67%	98.03%	97.52%	98.52%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**4,006**	**368,159**	3,604	372,378
Total NHS Trade Invoices Paid Within Target	**3,926**	**365,952**	3,551	368,815
Percentage of NHS Trade Invoices Paid Within Target	98.00%	99.40%	98.53%	99.04%

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

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

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

9. Investment Income

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest Income				
LIFT: equity dividends receivable	17	0	17	0
LIFT: loan interest receivable	1,040	0	1,040	1,119
Subtotal	1,057	0	1,057	1,119
Total investment income	1,057	0	1,057	1,119

10. Other Gains and Losses

Bromley PCT had no other gains or losses for the year ended 31 March 2013 and 31 March 2012.

11. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest on obligations under LIFT contracts:				
- main finance cost	2,509	0	2,509	2,562
- contingent finance cost	236	0	236	151
Total interest expense	2,745	0	2,745	2,713
Provisions - unwinding of discount	0		0	(4)
Total	2,745	0	2,745	2,709

12.1 Property, plant and equipment

2012-13	Land	Buildings excluding dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:								
At 1 April 2012	**20,632**	**35,944**	**420**	**5,046**	**2**	**5,268**	**209**	**67,521**
Additions of Assets Under Construction			0					**0**
Additions Purchased	0	597		0	0	781	0	**1,378**
Reclassifications	0	274	(420)	0	0	146	0	**0**
Reclassifications as Held for Sale	(500)	0	0	0	0	0	0	**(500)**
Disposals other than for sale	0	0	0	(2,037)	(2)	(3,749)	(122)	**(5,910)**
Upward revaluation/positive indexation	379	451	0	0	0	0	0	**830**
Impairments/negative indexation	(295)	(1,234)	0	0	0	0	0	**(1,529)**
At 31 March 2013	**20,216**	**36,032**	**0**	**3,009**	**0**	**2,446**	**87**	**61,790**
Depreciation								
At 1 April 2012	**0**	**0**	**0**	**4,611**	**0**	**3,983**	**183**	**8,777**
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	(2,037)	0	(3,751)	(122)	**(5,910)**
Upward revaluation/positive indexation	0	0	0	0	0	0	0	**0**
Impairments	0	1,168	0	0	0	0	0	**1,168**
Reversal of Impairments	0	0	0	0	0	0	0	**0**
Charged During the Year	0	971	0	156	0	673	18	**1,818**
At 31 March 2013	**0**	**2,139**	**0**	**2,730**	**0**	**905**	**79**	**5,853**
Net Book Value at 31 March 2013	**20,216**	**33,893**	**0**	**279**	**0**	**1,541**	**8**	**55,937**
Purchased	20,216	33,893	0	279	0	1,541	8	**55,937**
Total at 31 March 2013	**20,216**	**33,893**	**0**	**279**	**0**	**1,541**	**8**	**55,937**
Asset financing:								
Owned	14,566	16,016	0	279	0	1,541	8	**32,410**
On-SOFP PFI contracts	5,650	17,877	0	0	0	0	0	**23,527**
Total at 31 March 2013	**20,216**	**33,893**	**0**	**279**	**0**	**1,541**	**8**	**55,937**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	**7,736**	**6,314**	**0**	**0**	**0**	**0**	**0**	**14,050**
Movements	334	(783)	0	0	0	0	0	**(449)**
At 31 March 2013	**8,070**	**5,531**	**0**	**0**	**0**	**0**	**0**	**13,601**

Property impairments of net £449k were charged to the Revaluation Reserve in respect of the DV revaluation of the PCT estate.

The Revaluation Reserve on the asset held for sale is separately disclosed in Note 24.

12.2 Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:								
At 1 April 2011	**16,585**	**36,116**	**0**	**5,118**	**124**	**5,268**	**217**	**63,428**
Additions - purchased	0	0	420	0	0	0	0	**420**
Reclassified as held for sale	(1,201)	(1,663)	0	0	0	0	0	**(2,864)**
Disposals other than by sale	0	0	0	(72)	(284)	0	(8)	**(364)**
Revaluation & indexation gains	5,412	3,192	0	0	0	0	0	**8,604**
Impairments	(134)	(425)	0	0	0	0	0	**(559)**
Cumulative dep netted off cost following revaluatic	0	(919)	0	0	0	0	0	**(919)**
At 31 March 2012	**20,662**	**36,301**	**420**	**5,046**	**(160)**	**5,268**	**209**	**67,746**
Depreciation								
At 1 April 2011	**0**	**0**		**4,482**	**116**	**3,295**	**164**	**8,057**
Reclassifications as Held for Sale	0	(13)		0	0	0	0	**(13)**
Disposals other than for sale	0	0		(72)	(280)	0	(8)	**(360)**
Impairments	30	232	0	0	0	0	0	**262**
Charged During the Year	0	1,057		201	2	688	27	**1,975**
Cumulative dep netted off cost following revaluatic	0	(919)	0	0	0	0	0	**(919)**
At 31 March 2012	**30**	**357**	**0**	**4,611**	**(162)**	**3,983**	**183**	**9,002**
Net Book Value at 31 March 2012	**20,632**	**35,944**	**420**	**435**	**2**	**1,285**	**26**	**58,744**
Purchased	20,632	35,944	420	435	2	1,285	26	**58,744**
Donated	0	0	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	0	0	**0**
At 31 March 2012	**20,632**	**35,944**	**420**	**435**	**2**	**1,285**	**26**	**58,744**
Asset financing:								
Owned	14,982	16,262	420	435	2	1,285	26	**33,412**
Held on finance lease	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	5,650	19,682	0	0	0	0	0	**25,332**
PFI residual: interests	0	0	0	0	0	0	0	**0**
At 31 March 2012	**20,632**	**35,944**	**420**	**435**	**2**	**1,285**	**26**	**58,744**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2011	3,531	4,103	0	470	0	0	0	**8,104**
Movements (specify)	4,205	2,211	0	(470)	0	0	0	**5,946**
At 31 March 2012	7,736	6,314	0	0	0	0	0	**14,050**

The Revaluation Reserve on the asset held for sale is separately disclosed in Note 24.

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 1st April 2013 by 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.

The valuation of each property is on the basis of Market Value subject to the following :
"the Market Value on the assumption that the property is sold following a cessation of the existing operations" (in effect the traditional understanding of Market Value).

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 change of asset lives/residual values and thus no effect in the current and/or future years.

	2012-13		2011-12	
The economic lives of non-current assets were:	**Min life Years**	**Max life Years**	**Min life Years**	**Max life Years**
Buildings excl. Dwellings	**5**	**55**	6	46
Plant & Machinery	**5**	**10**	0	10
Transport Equipment	**5**	**10**	0	0
Information Technology	**3**	**15**	1	3
Furniture and Fittings	**10**	**15**	1	5

13. Intangible non-current assets

Bromley PCT had no Intangible non-current assets at 31 March 2013 and 31 March 2012.

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	1,168	0	1,168
Total charged to Departmental Expenditure Limit	**1,168**	**0**	**1,168**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Loss or damage resulting from normal operations	1,529	0	1,529
Total impairments for PPE charged to reserves	**1,529**	**0**	**1,529**
Total Impairments of Property, Plant and Equipment	**2,697**	**0**	**2,697**
Total Impairments charged to Revaluation Reserve	1,529	0	1,529
Total Impairments charged to SoCNE - DEL	1,168	0	1,168
Overall Total Impairments	**2,697**	**0**	**2,697**
Of which:			
Impairment on revaluation to "modern equivalent asset" basis	**1,168**	0	1,168

Property impairments of £1,168k were taken to SoCNE in respect of the DV revaluation of the PCT estate, as there was insufficient balance within the revaluation reserve for these particular assets.

Property impairments of £1,529k were charged to the Revaluation reserve in respect of the DV revaluation of the PCT estate.

15. Investment property

Bromley PCT does not have any Investment Property

16. Commitments

16.1 Capital commitments

Bromley PCT had no capital commitments at 31 March 2013 and 31 March 2012.

16.2 Other financial commitments

Bromley PCT had no other financial commitments at 31 March 2013 and 31 March 2012.

17. Intra-Government and other balances

	Current receivables	Non-current receivables	Current payables	Non-current payables
	£000s	£000s	£000s	£000s
Balances with other Central Government Bodies	935	0	174	0
Balances with NHS Trusts and Foundation Trusts	324	0	9,387	0
Balances with bodies external to government	2,023	8,469	19,914	28,516
At 31 March 2013	**3,282**	**8,469**	**29,475**	**28,516**
prior period:				
Balances with other Central Government Bodies	940	0	935	0
Balances with NHS Trusts and Foundation Trusts	717	0	5,436	0
Balances with bodies external to government	6,535	8,877	25,850	29,142
At 31 March 2012	**8,192**	**8,877**	**32,221**	**29,142**

18. Inventories

Bromley PCT does not have any Inventories

19.1 Trade and other receivables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
NHS receivables - revenue	**1,259**	1,657	**0**	0
Non-NHS receivables - revenue	**2,013**	2,080	**0**	0
Non-NHS prepayments and accrued income	**0**	4,442	**0**	22
Provision for the impairment of receivables	**(316)**	(414)	**0**	0
VAT	**118**	202	**0**	0
Finance lease receivables	**208**	197	**8,469**	8,855
Other receivables	**0**	28	**0**	0
Total	**3,282**	8,192	**8,469**	8,877
Total current and non current	**11,751**	17,069		

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.

Included in the non-current receivables is the LIFT finance lease with South London Healthcare Trust in respect of the Beckenham Beacons.

All non NHS receivables aged over 6 months have been provided for as a bad debt.

19.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	**401**	517
By three to six months	**0**	252
By more than six months	**0**	39
Total	**401**	808

19.3 Provision for impairment of receivables

	2012-13 £000	**2011-12 £000**
Balance at 1 April 2012	**(414)**	(383)
Amount written off during the year	**0**	0
Amount recovered during the year	**0**	35
Decrease/(Increase) in receivables impaired	**98**	(66)
Balance at 31 March 2013	**(316)**	(414)

20. NHS LIFT investments

	Loan £000	Share capital £000	Total £000
Balance at 1 April 2012	**165**	**0**	**165**
Additions	**124**	**0**	**124**
Disposals	**0**	**0**	**0**
Loan repayments	**(7)**	**0**	**(7)**
Balance at 31 March 2013	**282**	**0**	**282**
Balance at 1 April 2011	192	0	192
Additions	0	0	0
Disposals	0	0	0
Loan repayments	(27)	0	(27)
Balance at 31 March 2012	**165**	**0**	**165**

21.1 Other financial assets - Current

	31 March 2013 £000	31 March 2012 £000
Opening balance 1 April	0	0
Loans repayable within 12 months	7	0
Closing balance 31 March	**7**	0

21.2 Other Financial Assets - Non Current

	31 March 2013 £000	31 March 2012 £000
Opening balance 1 April	**165**	192
Additions	124	0
Loan repayments	(7)	(27)
Disposals	0	0
Transfers (to)/from Other Public Sector Bodies in year	0	0
Total Other Financial Assets - Non Current	**282**	165

21.3 Other Financial Assets - Capital Analysis

	31 March 2013 £000	31 March 2012 £000
Capital Expenditure	**124**	0
Capital Income	**0**	0
	124	**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	**6**	48
Net change in year	**3**	(42)
Closing balance	**9**	6
Made up of		
Cash with Government Banking Service	**9**	6
Cash and cash equivalents as in statement of financial position	**9**	6
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**9**	6

24. Non-current assets held for sale

	Land	Buildings, excl. dwellings	Total
	£000	£000	£000
Balance at 1 April 2012	0	0	**0**
Plus assets classified as held for sale in the year	500	0	**500**
Balance at 31 March 2013	**500**	**0**	**500**
Liabilities associated with assets held for sale at 31 March 2013	**0**	**0**	**0**
			0
Balance at 1 April 2011	0	0	**0**
Plus assets classified as held for sale in the year	1,201	1,650	**2,851**
Less assets sold in the year	(1,011)	(1,496)	**(2,507)**
Less impairment of assets held for sale	(190)	(154)	**(344)**
Balance at 31 March 2012	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2012	0	0	**0**

The PCT has submitted the business case for the disposal of the Penge clinic.

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

At 31 March 2012	746
At 31 March 2013	496

25. Trade and other payables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
NHS payables - revenue	**6,135**	1,912	**0**	0
NHS payables - capital	**0**	270	**0**	0
NHS accruals and deferred income	**3,426**	3,625	**0**	0
Family Health Services (FHS) payables	**14,612**	15,169	0	0
Non-NHS payables - revenue	**1,666**	405	**0**	0
Non-NHS payables - capital	**108**	83	**0**	0
Non_NHS accruals and deferred income	**2,578**	10,091	**0**	0
Social security costs	**49**	200	**0**	0
Tax	**40**	0	**0**	0
Other	**861**	466	0	0
Total	**29,475**	32,221	**0**	0
Total payables (current and non-current)	**29,475**	**32,221**		

26. Other liabilities

Bromley PCT had no other current or non-current liabilities at 31 March 2013 and 31 March 2012.

27. Borrowings

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
LIFT liabilities:				
Main liability	**553**	517	**28,516**	29,142
Total	**553**	**517**	**28,516**	**29,142**
Total other liabilities (current and non-current)	**29,069**	**29,659**		

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

30. Finance lease obligations

Bromley PCT had no Finance Lease obligations at 31 March 2013 and 31 March 2012

31. Finance lease receivables as lessor

Amounts receivable under finance leases (buildings)	**Gross investments in leases**		**Present value of minimum lease payments**	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Within one year	**1,079**	197	**1,079**	197
Between one and five years	**4,184**	937	**4,184**	937
After five years	**14,919**	7,918	**3,414**	7,918
Less future finance charges	**(11,505)**	0	**-**	-
Present value of minimum lease payments	**8,677**	9,052	**8,677**	9,052
Total finance lease receivable recognised in the statement of financial position	**8,677**	**9,052**	**8,677**	**9,052**
Included in:				
Current finance lease receivables			**208**	197
Non-current finance lease receivables			**8,469**	8,855
			8,677	9,052

32. Provisions

	Total £000s	Pensions to Former Directors £000s	Continuing Care £000s	Agenda for Change £000s	Other £000s	Redundancy £000s
Balance at 1 April 2012	**2,968**	0	1,986	62	191	729
Arising During the Year	**10,791**	0	10,791	0	0	0
Utilised During the Year	**(321)**	0	(167)	0	0	(154)
Reversed Unused	**(1,341)**	0	(572)	(62)	(161)	(546)
Balance at 31 March 2013	**12,097**	**0**	**12,038**	**0**	**30**	**29**
Expected Timing of Cash Flows:						
No Later than One Year	**6,078**	**0**	**6,019**	**0**	**30**	**29**
Later than One Year and not later than Five Years	**6,019**	**0**	**6,019**	**0**	**0**	**0**
Later than Five Years	**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 347 claims representing a significant financial risk to the organisation. The process of assessing the impact of these claims has been ongoing 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	574
As at 31 March 2012	442

33. Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities		
Equal Pay	**0**	0
Other - *NHSLA*	**(21,700)**	(5)
Amounts Recoverable Against Contingent Liabilities	**0**	0
Net Value of Contingent Liabilities	**(21,700)**	(5)

The Contingent Liability relates to the balance of claims for the Continuing Healthcare costs estimate for which no provision has been made.

34. PFI and LIFT

The PCT entered into a 'Local Improvement Finance Trust' procurement arrangement in 2005 for premises developments and improvements with Bexley and Greenwich PCTs. Beckenham Beacon was fully operational from spring 2009. Services delivered from the Beckenham Beacon include General Practice, Community, Urgent Care Centre, Diagnostics and Outpatients. The current lease plus arrangement is for a period of 25 years which expires on 30th January 2034.

As a consequence of the Health and Social Care Act 2012, Bromley PCT was dissolved on 31st March 2013. The assets and liabilities relating to the LIFT scheme will be transferred to Community Health Partnership as direct by Department of Health, on 1 April 2013.

The current gross rental payment is £3.2m per annum. The PCT has the option to purchase the asset at the end of the lease. Under IFRIC 12 the asset is treated as an asset of the PCT, the substance of the contract is that the PCT has a finance lease and payments comprise the two elements-imputed finance lease charges and service charges.

Charges to operating expenditure and future commitments in respect of on and off SOFP LIFT	**31 March 2013 £000**	31 March 2012 £000
Service element of on SOFP LIFT charged to operating expenses in year	**272**	368
Total	**272**	368

	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	**276**	272
Later than One Year, No Later than Five Years	**1,242**	1,202
Later than Five Years	**6,848**	7,165
Total	**8,366**	8,639

Imputed "finance lease" obligations for on SOFP LIFT Contracts due	**31 March 2013 £000**	31 March 2012 £000
No Later than One Year	**3,017**	3,025
Later than One Year, No Later than Five Years	**11,736**	11,924
Later than Five Years	**53,104**	56,007
Subtotal	**67,857**	70,956
Less: Interest Element	**(38,788)**	(41,297)
Total	**29,069**	29,659

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	**1,036**	0	1,036
Interest Expense	**2,509**	0	2,509
Impairment charge - DEL	**415**	0	415
Revenue Receivable from subleasing	**(3,735)**	0	(3,735)
Total IFRS Expenditure (IFRIC12)	**225**	**0**	**225**
Net IFRS change (IFRIC12)	**225**	**0**	**225**

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 risk.

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

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

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

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

36.1 Financial Assets	Loans and receivables	Available for sale	Total
	£000	£000	£000
Embedded derivatives	0	0	**0**
Receivables - NHS	1,259	0	**1,259**
Receivables - non-NHS	1,697	0	**1,697**
Cash at bank and in hand	9	0	**9**
Other financial assets	8,677	0	**8,677**
Total at 31 March 2013	**11,642**	**0**	**11,642**
Embedded derivatives	0	0	0
Receivables - NHS	1,657	0	1,657
Receivables - non-NHS	6,360	0	6,360
Cash at bank and in hand	1	0	1
Other financial assets	9,052	0	9,052
Total at 31 March 2012	17,070	0	17,070

Other financial assets of £8,677k (£9,052k- 2011/12) relates to the LIFT finance lease for Beckenham Beacon that South London Healthcare NHS Trust occupies.

36.2 Financial Liabilities	Other	Total
	£000	£000
Embedded derivatives	0	**0**
NHS payables	9,561	**9,561**
Non-NHS payables	18,964	**18,964**
Other borrowings	29,069	**29,069**
Other financial liabilities	861	**861**
Total at 31 March 2013	**58,455**	**58,455**
Embedded derivatives	0	0
NHS payables	5,807	5,807
Non-NHS payables	25,948	25,948
Other borrowings	29,659	29,659
Other financial liabilities	466	466
Total at 31 March 2012	61,880	61,880

There are no differences in the fair value of financial assets or financial liabilities from carrying book amounts.

37. Related party transactions

Bromley 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 Bromley Primary Care Trust as follows:

	Services Received from Organisation	Payments to Related Party £
Dr Andrew Parson-Chislehurst Medical Practice	Primary Care	1,700,132
Dr Jon Doyle - Southview lodge practice	Primary Care	637,858
Dr Atul Arora-Sundridge Medical Practice	Primary Care	571,957
Dr Ruchira Paranjape-Knoll Rise Surgery	Primary Care	814,811
Dr Mark Essop - Summercroft Surgery	Primary Care	1,452,007
Meredith Collins - Mereditch Collins Ltd	Consultancy	195,891

The Department of Health, as Bromley PCT's parent department, is regarded as a related party. During the year 2012/13, Bromley 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
South London Healthcare Trust	161,673
Guys And St Thomas NHS Foundation Trust	37,536
Kings College Hospital NHS Foundation Trust	31,776
Oxleas NHS Foundation Trust	35,651

2011/12	Services Received from Organisation	Payments to Related Party £
Dr Andrew Parson-Chislehurst Medical Practice	Primary Care	1,459,690
Dr Jon Doyle	Primary Care	623,442
Dr Atul Arora-Sundridge Medical Practice	Primary Care	568,605
Dr Ruchira Paranjape-Knoll Rise Surgery	Primary Care	758,633
Mark da Rocha-Vineconnect Limited	Consultancy	104,490
Luke O'Byrne-Dynamic Delivery	Consultancy	114,666

	£000
South London Healthcare Trust	158,883
Guys And St Thomas NHS Foundation Trust	35,809
Kings College Hospital NHS Foundation Trust	30,109
Oxleas NHS Foundation Trust	36,751

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	2,825	10
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	2,825	10
Total special payments	0	0
Total losses and special payments	2,825	10

Bromley PCT had no losses or special payments in 2011-12

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. Cash flows relating to exceptional items

There have been no exceptional cash movements during the year.

41. Integrated short break service for children and young people with disabilities pooled budget

Bromley PCT has a pooled budget arrangement with the London Borough of Bromley. Bromley PCT is the host. The memorandum account for the pooled budget is not required to be included in the accounts. The PCT's share of the income and expenditure handled by the pooled budget in the financial year were:

2012-13	2011-12
£000	£000
782	782

42. Events after the end of the reporting period

As disclosed within note 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 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, The principles for the split of residual balances is still subject to Department of Health guidance.

- 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.

Bromley Primary Care Trust

Annual Governance Statement 2012/2013

Bromley Primary Care Trust

Organisation Code: 5A7

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 Bromley 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 Bromley 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.

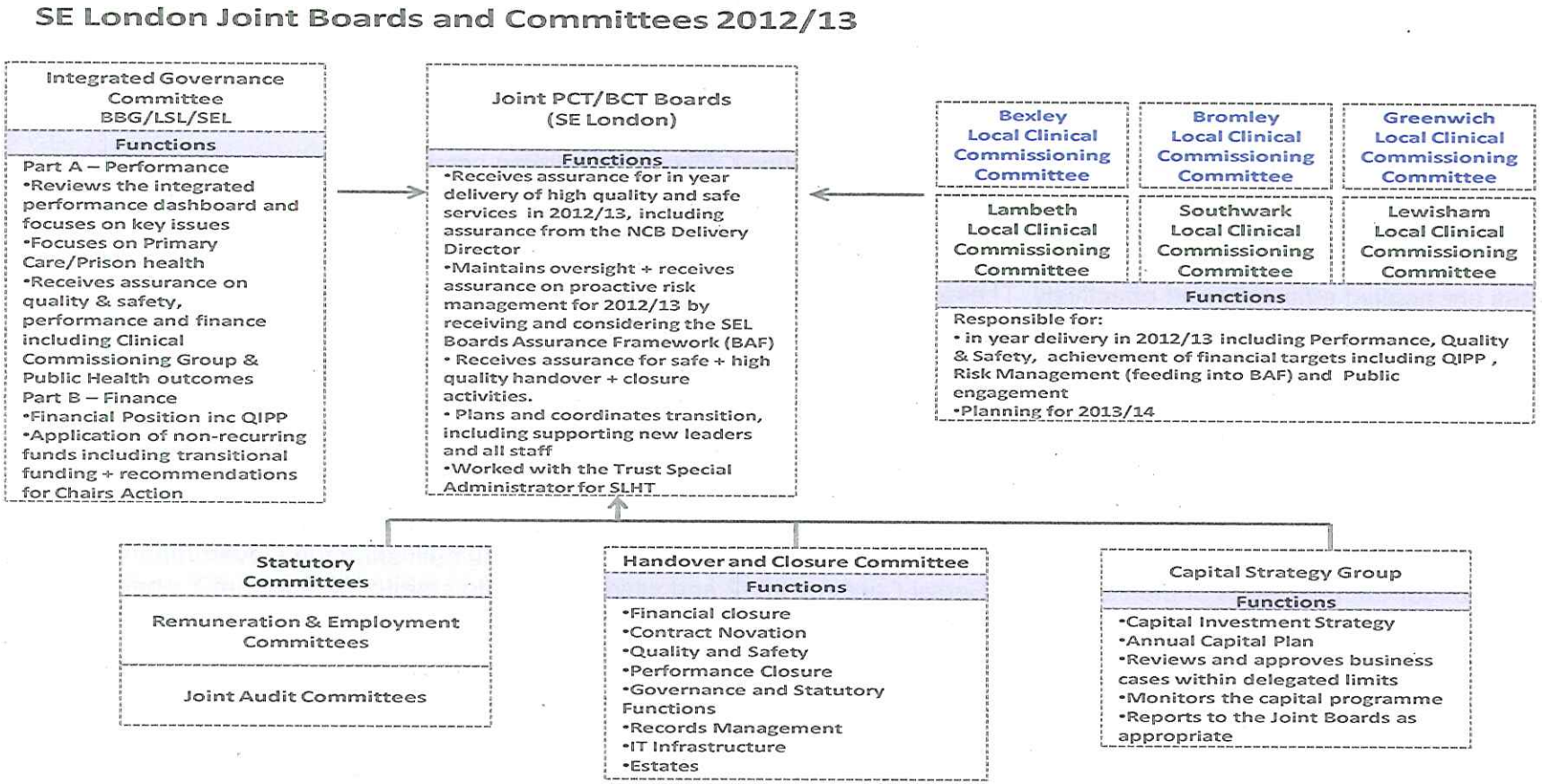
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Bromley 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 Bromley 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.

2. The governance framework of the organisation

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



Joint South East London PCT/Care Trust Boards

- 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 Bromley 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 publically 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 solicited via an anonymous online survey. Twenty-two returns were received out of 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; and
- 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 comments noted 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.

Bromley Clinical Commissioning Committee (LCCC)

- Bromley Clinical Commissioning Committee is a committee of Bromley PCT Board. It has also acted since 1 October 2012 as the Shadow Governing Body of Bromley Clinical Commissioning Group. Its role during 2012/13 has been to take on full delegated responsibility from the Joint PCT Board for commissioning those areas for which the Bromley Clinical Commissioning Group will be statutorily responsible from 1 April 2013. These include; prescribing, community services, jointly commissioned services, mental health services and acute services. It has also successfully overseen the arrangements and process for achieving authorisation from the NHS Commissioning Board for the establishment of NHS Bromley Clinical Commissioning Group from 1 April 2013. The membership of this clinically led body comprises the 47 GP practices in the Borough of Bromley, organised into 3 localities supported by its own management team and services commissioned from the South London Commissioning Support Unit. Its key task is to identify local healthcare needs and commission services for the population of Bromley based on agreed strategic priorities. During 2012/13 the LCCC also undertook the duties of the Professional Executive Committee (PEC), and provided oversight of local performance, including quality.
- The LCCC/Shadow CCG Governing Body provided a summary to every meeting of the Joint PCT Boards, including reporting on delegated responsibilities. A full copy of the agenda papers and minutes of LCCC meetings is made available on the NHS South East London public website.
- The LCCC/Shadow CCG Governing Body held 7 business meetings in 2012/13, all of which were quorate and held in public.

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. .
- On 9 January 2013 the JAC 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 Bromley 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, Bromley 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.

Bromley 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.

Bromley 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 Bromley 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 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.

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.

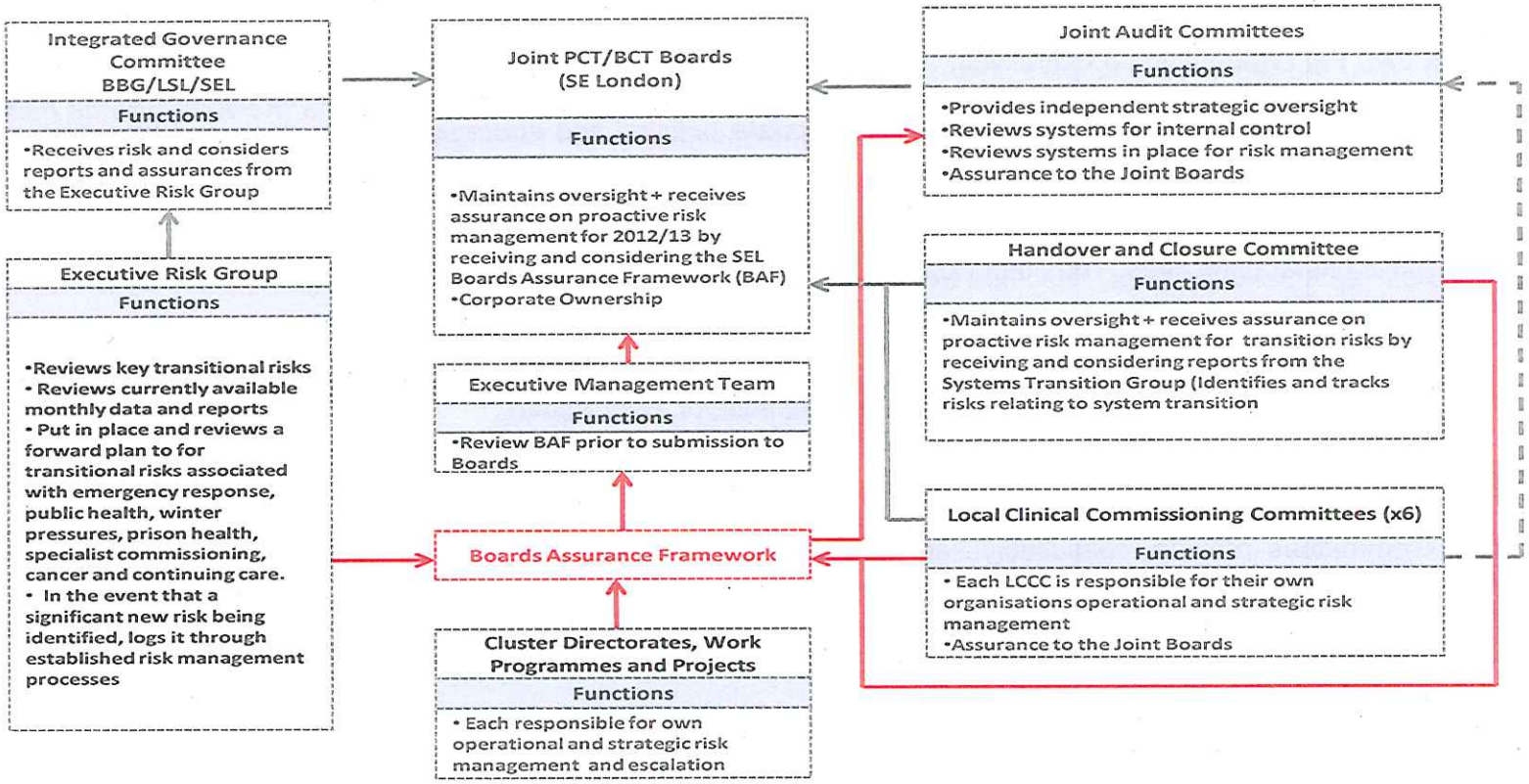
3.4. Description of terms and definitions

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.

SE London Risk Management Structure 2012/13



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.

Local Clinical Commissioning Committees (Assurance)

Bromley LCCC provides oversight, challenge and review of local issues, management response and interaction / dependencies with cluster activities. The LCCC 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 LCCC 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.

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 Bromley 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.

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:-

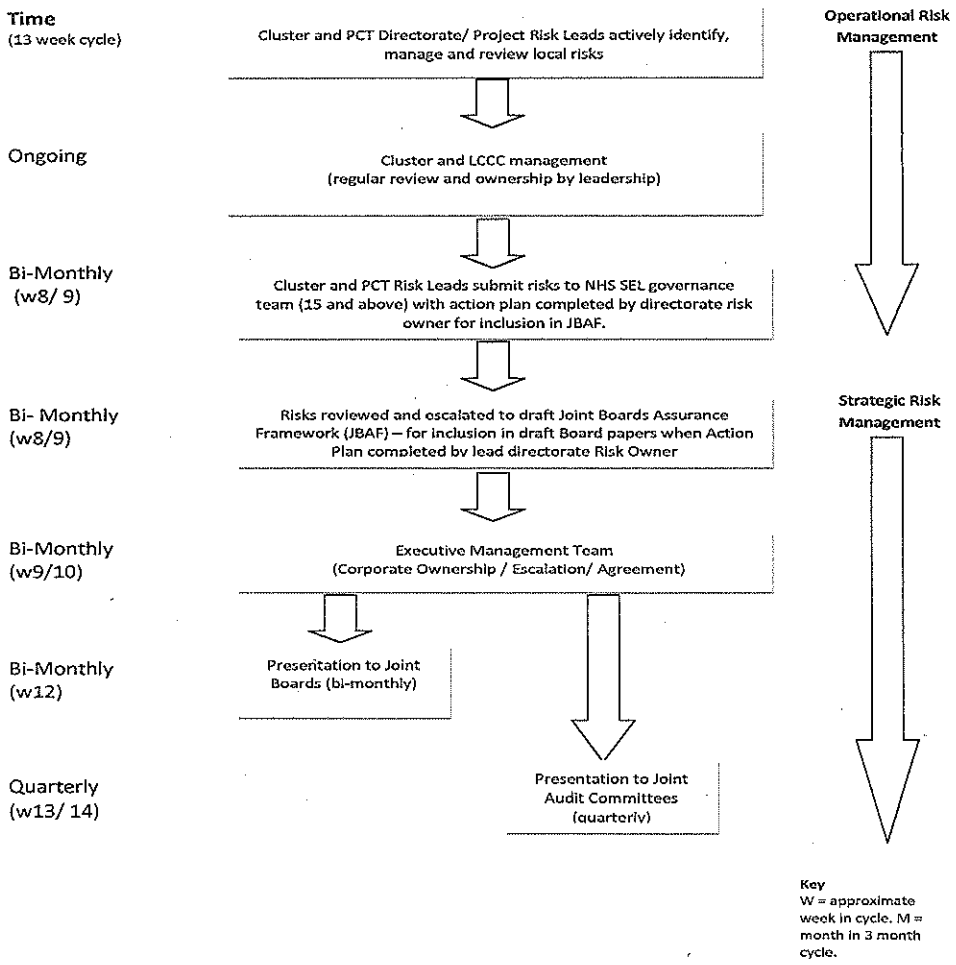
  - Reporting incidents/accidents and near misses using the agreed channels.
  - Complying with all cluster Rules, regulations, guidance and instructions to protect the health, safety and welfare of anyone affected by the Cluster's business.
  - Complying with all rules, regulations, guidance and instructions 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.

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
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
BRO1213	Service Development	01/05/2012	Strategic	Development of services in Orpington - There is a risk that it will not be possible to create a financially viable, sustainable and workable solution leading to failure to achieve project objectives.	16	No: deescalated from JBAF or closed		Bromley PCT

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 A summary of the above RED risks for Bromley PCT still on the JBAF at March 2013 by work stream is given below:

Work Stream	Red
Information Governance	1
Total	1

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	Bromley
Adult Safeguarding		✓
Child Safeguarding		✓
Emergency planning	✓	✓
Staff Retention	✓	✓
Conflicts of Interest		✓
Reputational risk	✓	✓

At 31st March 2013 the following actions are underway for the above zero tolerance risks:

Adult safeguarding: Further development of the arrangements has included a thorough review of the Vulnerable Adults Policy and the appointment of an interim Designated Nurse for Adult Safeguarding. The arrangements have successfully addressed remaining conditions for authorisation required by NHS England.
Child safeguarding: A further review of the Child Safeguarding Policy and Procedure has been undertaken. Overall responsibility for safeguarding has been transferred to the Director of Quality, Governance and Patient Safety. The arrangements have successfully addressed remaining conditions for authorisation required by NHS England.
Emergency planning: This risk related to the transfer of category 1 responder EPRR functions to NHS England in March 2013 and possible disruption to EPRR services. Ongoing EPRR actions for Bromley CCG relate to responsibilities as a Category 2 responder

from April 2013 including development of a Business Continuity Policy, updating EPRR risk assessments and the organisational Business Continuity Plan to ensure continued safe support for health services.
Staff retention: This risk relates to gaps in staff recruitment impacting on the delivery of the organisation's plans.
Conflicts of Interest: The closing residual risk score reflects the implementation of further refinements incorporated into the Conflict of Interest Policy as recommended by Internal Audit and in line with the latest NHS England guidance.
Reputational Risk: The key risk for Bromley PCT related to the Orpington Health Services Project, where a rigorous public consultation was undertaken. Following the consultation, no referral was made to the Secretary of State of the decisions made in respect of the project.

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.

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

7.3 Bromley CCG Heat Map – 31 March 2013

Risk Matrix / Likelihood	Impact: Negligible 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Rare 1	1	2	3	4 (E)	5
Unlikely 2	2	4	6	8 (F, A, Q, C)	10
Possible 3	3	6	9 (N)	12 (M, I, S, H)	15
Likely 4	4	8	12 (R)	16	20
Almost Certain 5	5	10	15	20	25

		Risk Description	Movement
A	BRO1201	QIPP Delivery	↔
C	BRO1203	Level of Cluster Support for QIPP Delivery	↔
E	BRO1205	Staff Retention	Accept risk
F	BRO1206	Compliance with Data Protection Act	↔
H	BRO1208	Services at local acute provider	↔
I	BRO1209	Financial Concerns re local acute trust	↔
M	BRO1213	Development of services in Orpington (objectives)	↔
N	BRO1214	Beckenham Beacon (Efficient Usage)	↔
Q	BRO1217	Safeguarding arrangements	↔
R	BRO1218	Continuing Care Claims	↔
S	BRO1219	TSA	↔

CLOSED

B	BRO1202	PROMISE Programme	CLOSED - merged with BRO 12 01
P	BRO1216	Reprovision of Learning	reprovision complete CLOSED
K	BRO1211	AQP Commissioning	Accept risk - CLOSED
D	BRO1204	CCG Authorisation (achieved)	CLOSED
G	BRO1207	Conflicts of Interest	CLOSED
J	BRO1210	Waiting time for bariatric surgery	CLOSED
L	BRO1212	Development of services in Orpington (engagement)	CLOSED
O	BRO1215	Transfer of Public Health	CLOSED

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

The report concluded that the risk management structures and controls put in place by the CCGs that form NHS South East London (SEL) require improvement. Each CCG has adopted the recommendations raised in the prior review, but there is still scope for improvement in the controls in place for managing risk specifically around ensuring that forward action plans are SMART so that governance committees can track these translating in to new assurances and controls to reduce residual risk ratings.
We have raised a further series of recommendations as part of this year's review. All CCGs need to ensure that they have documented and agreed a formal risk appetite statement before the cluster and its Joint committees demise over the coming weeks.

However, the overall view of the report is that each CCG has put in place an adequate risk management framework which ensures that key clinical, financial and corporate risks are identified and monitored both at governing body and directorate levels. Local reporting lines and governance structures for risk management are clearly stated in risk management strategy documents for all CCGs. Evidence of the assignment of risk owners and timely monitoring at a directorate level of risks were clearly evidenced from review of directorate risk registers.

Zero tolerance risks that have been identified for delegation to the CCGs have been reflected accurately in corporate risk registers and continue to be monitored in the latest iteration of the corporate risk register. Each CCG governing body has oversight of the latest version of the corporate risk register/assurance framework either through submission of a risk report detailing movements in risks since the last iteration or through a heat map or risk distribution map giving a graphical description to the total number of risks captured on the corporate risk register/assurance framework.

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).

	High (1)	Medium (2)	Low (3)	Total
Bromley PCT	**0**	**2**	**2**	**4**

Risk	Recommendation Area	
2 (two)	**Lack of evidence of review by sub-committee prior to review by the governing body** Weakness in design For Bromley there is no formal sub-committee review of the assurance framework prior to submission to the governing body as it is currently the responsibility of the Head of Corporate Affairs to review the assurance framework and it has not yet been decided how to incorporate sub-committee review within the governance structure for risk management. We recommend: Review of the corporate risk register is made a standing item on the agenda of a sub-committee prior to it being submitted to the governing body to ensure that directorate leads are made accountable for managing high scoring risks. The focus of discussions at sub-committees should be on high scoring risks that have moved since the last iteration to ensure that review of the risk register is focused on those risks and actions that have changes actions since the last iteration.	**Agreed** Following the first meeting of the CCG Shadow Audit Committee in December the arrangement we have adopted in Bromley is that the Corporate Risk Register is considered and agreed by the Executive Team before being submitted first to the Integrated Governance Committee and then to the Governing Body.
2 (two)	**Risk appetite and tolerance levels for the escalation of risks to the governing body not determined and communicated in risk management strategies** Bromley have not formally set out a tolerance level for the escalation of directorate risks into the assurance framework as their risk appetite has not yet been formally agreed upon	**Agreed** Directors/risk owners in Bromley CCG will be making recommendations

	and is expected to be ratified at the first meeting of the statutory body of the CCG. We recommend: On an annual basis the CCG should review its expected risk appetite in line with the setting of strategic objectives for the year. A formal statement should be set out within the risk management strategy clearly stating the threshold by which risks are escalated for review by the governing body .	to the Integrated Governance Committee and then to the Governing body with regard to risk appetite and identification of zero tolerance risks. These assessments will be reviewed on an annual basis, linked to the strategic objectives/plan
3 (three)	**Unclear tracing of directorate risks to corporate risk registers** For Bromley risks are escalated on to the assurance framework based on their relevance to the strategic objectives of the CCG. However it is unclear as to what risks have been escalated from directorate risk registers as the names of the work streams used in the assurance framework are not the same as the directorate names. We recommend: The work streams identified within the assurance framework for Bromley are in line with the directorate names.	**Agreed** Currently being addressed
3 (three)	**Clear identification of zero tolerance risks** It is not clear what risks are classified as zero tolerance on the Bromley and Southwark assurance framework/corporate risk register as they are not clearly signposted as zero tolerance. It is recommended that where identified, zero tolerance risk headings are provided (adult and child safeguarding etc) and are highlighted in bold in the risk register.	**Agreed** We will address this in line with our arrangements for identification and review of zero tolerance risks

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

There were no reportable lapses of data security during 2012/13.

10. Significant Issues

This section sets out: first, an overview of the major challenges that we expect Bromley 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

2013/14 will be a challenging year for Bromley 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 Bromley CCG. Our commissioners are continuing to deliver service redesign schemes to maximise the benefits of our local community services and acute services providers. In Bromley community services are provided by Bromley Healthcare, a social enterprise organisation, and acute services by the South London Healthcare NHS Trust.

These organisations are working with other South East London clinical commissioners to deliver the NHS single number '111' programme. 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.

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

1. The future of Bromley's local acute trust, South London Healthcare NHS Trust (SLHT), a challenged provider, was subject during 2012/13 to the first ever use of the Trust Special Administrator (TSA) arrangements provided for in Chapter 5A of Part 2 of the National Health Service Act 2006. The members of the shadow Bromley CCG and its management support were consulted on the development of the proposals by the Trust Special Administrator and the shadow Membership Body met on 5 December 2012 to agree its response to the draft proposals. These were considered by the Secretary of State's for Health who published his decisions 31 January 2013.

In Bromley the main outcomes were:

- King's Healthcare NHS Foundation Trust to take over management of the Princess Royal University Hospital that is the main provider of acute services to the people of Bromley
- Services previously provided by SLHT at the Beckenham Beacon to be withdrawn
- Endorsement of the proposal to develop a Health and Wellbeing Centre in Orpington and to dispose of the Orpington Hospital site.
- Development of Community based Care in Bromley providing more services close to home, and less reliance on hospital services
- Elected Care Centres to be provided at Lewisham Hospital, the Princess Royal University Hospital and at Queen Mary's Hospital, Sidcup.
- Provision of an A & E department at Lewisham Hospital but not for the most serious cases
- Transfer of a number of outpatient facilities from the Princess Royal University Hospital to Queen Mary's Sidcup, and the

development of inpatient services there, managed by the Oxleas Foundation NHS Trust.

- Write off of the historic debt of SLHT by the Department of Health and continuing contribution to the PFI cost of the Princess Royal University Hospital.

The implementation of these decisions should provide resolution to the long running issues for Bromley PCT and the ensuing CCG arising from the challenging financial situation of SLHT. However, their implementation from 1 June 2013 will require close involvement of Bromley CCG, which will also need to forge new working relationships with Southwark CCG, the other main commissioner of acute services from King's.

The acute services contract for 2013/14 is being negotiated with the TSA on behalf of SLHT and will transfer to King's during the course of the financial year.

2. 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	Bromley
Conflicts of Interest	1	1
HR Staff Records	3	

3. NHS Continuing Care

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 347 claims representing a significant financial risk to the

organisation. The process of assessing the impact of these claims has been ongoing 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.

There are no other significant issues to report.

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