Department of Health

NHS

Enfield Primary Care Trust

2012-13 Annual Report and Accounts

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Enfield Primary Care Trust

2012-13 Annual Report

NHS

North Central London

Annual Report and Accounts 2012/13

Enfield Primary Care Trust

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Welcome from Enfield PCT Chair and Vice Chair

It's been a strong year for Enfield Primary Care Trust (Enfield PCT) and there is much that we can be proud of. We have consistently achieved the admitted, non-admitted and incomplete pathways standards in a year of great change. Over the past 12 months we sustained achievement of most of the cancer waiting time targets and seen significant improvements in performance against the national measures for stroke services with Enfield PCT exceeding the 80% threshold since Quarter 2 of 2012/13 for time on a stroke unit.

Our performance with stroke saw us achieve the 60% standard for TIA (Transient Ischaemic Attack) access within 24 hours for stroke victims. We saw higher activity volumes and sustained performance which means that that more people are accessing the right service within Enfield for stroke.

We consistently maintained performance within the tolerance level of less than 1% of patients waiting longer than six weeks for a diagnostic tests and Enfield is the only borough within NHS North Central London Cluster to achieve the 70% standard with 72% of eligible women screened for cancer.

With a focused improvement plan for immunisation, for which Enfield has been commended by NHS London, work continued to be delivered to track.

As we hand on the baton of healthcare in Enfield to the Clinical Commissioning Groups, it is time for us to look back over the life of Enfield PCT and say how proud we are of achievements which have benefited the residents of Enfield both in their overall health and in their health needs in times of emergency. These include:

- new primary care centres have opened (Forest and Evergreen) with several GPs working with services such as nursing, phlebotomy (blood tests), baby clinics, family planning, a leg ulcer clinic, speech and language therapy, drug and alcohol services and health visiting. Lots of tests and treatments that could only be done in large hospitals are now being done in these community settings
- more phlebotomy, including blood tests for children, is now being done in clinics within GP surgeries and housebound patients are having tests done in their own homes
- further improvements include:
    - a community colorectal service
    - community gynaecology services
    - more community-based ophthalmology services.

The number of single-handed practices has been reduced, with the consolidation of five GP practices into the Evergreen Health Centre in Edmonton, which also provides an out-of-hours walk-in service until 8pm on weekday evenings and 8am-8pm at weekends. The range of primary care and other services being provided in community settings has also been expanded, including ultrasound (in two GP practices), DEXA scans, MRI and Echo tests, ophthalmology, oral surgery, gynaecology and genito urinary medicine.

Our Adult and Older People's Services are formed of five service groups:

Long-term conditions – The emphasis of long term conditions management is to target patients at risk of admission to hospital and to provide specialist-nursing expertise across a range of conditions (Community Matron Service). An initial audit has shown that over 60% of the contacts made with the service result in fewer admissions to hospital.

The Heart Failure Nurse Service has been established for two years and is very well received by the GPs who refer into it. Feedback indicates that GPs appreciate being able to refer patients directly for an echocardiogram at Forest Primary Care Centre.

The Respiratory Nurse Service is also being fully utilised by GPs. Primary Care has the responsibility for routine spirometry testing which enables the nurse specialist to manage the more complex patients referred to the service, providing support to patients suffering from chronic respiratory disease such as Chronic Obstructive Pulmonary Disease.

A Parkinson's Disease Specialist Nurse post is now established in Enfield. The nurse specialist is involved with supporting individuals and their carers, and educating colleagues to improve the quality of life of those affected. The local Parkinson's Disease Society has campaigned for many years for this role in Enfield and is delighted with the appointment.

Adult therapy services – The Community Physiotherapy, Nutrition and Dietetics, and the Adult Speech and Language Therapy services moved into a refurbished base at St Michael's Centre in December 2008. There is now a central referral system for these services and only one number for patients to call to find out information about their appointments.

The Musculoskeletal Physiotherapy Service was divided in January 2009, with Barnet and Chase Farm Hospitals NHS Trust now managing referrals via their own consultants and NHS Enfield Community Services taking patients who have been referred by an Enfield GP.

As we hand over our services, and on behalf of our Board, we would like to thank our partner organisations and stakeholders and our staff for their support during this transition period.

We wish all those working to deliver health care across Enfield a successful future.

Thank you

Paula Kahn
Chair

Karen Trew
Vice-Chair

Directors' Report

Enfield Primary Care Trust and NHS North Central London - providing health care for Enfield residents

NHS North Central London was established in April 2011 as a collaborative working arrangement between Barnet, Camden, Enfield, Haringey and Islington Primary Care Trusts.

Enfield PCT held the budget for all health services in the Borough. They were responsible for a number of different things including:

- measuring the health needs of local residents and developing an understanding of these needs
- commissioning (buying) the right services to meet local people's needs, for instance from GPs, hospitals and mental health services
- monitoring the quality of local health services
- improving the overall health of local communities, and
- making sure local organisations delivering NHS services, such as hospitals and GP surgeries, worked well together.

Enfield PCT was responsible for planning and buying all local NHS health services for approximately 289,265 people living in Enfield making sure local people have good health and good healthcare.

As part of the changes to the NHS brought about by the Health and Social Care Act 2012, all NHS North Central London responsibilities (and those of Enfield PCT) were taken over by Clinical Commissioning Groups (CCGs), NHS England (formerly the NHS Commissioning Board), Local Authorities and other organisations. Enfield PCT, and all other PCTs in the NHS North Central London ceased to exist at the end of March 2013.

CCGs are made up of local GPs and other local clinical professionals, who will ensure that local healthcare services are commissioned by local clinical leaders in Enfield with good knowledge of the needs of local people.

During 2012/13, NHS North Central London handed over all current functions to the CCGs and NHS England (formerly the NHS Commissioning Board). Public Health functions were transferred to Local Authorities and will be managed through Public Health England.

We are pleased to report that Enfield PCT met the control total surplus of £2.8m as set by the Department of Health. However, this was achieved through non-recurrent financial support provided by other PCTs within the North Central London Cluster.

With this support, Enfield PCT met all of our statutory duties, namely:

- financial balance in year
- spending within our capital allocation
- spending within our cash limits.

These achievements are a credit to the whole organisation, which has maintained focus on delivering value for money for our patients and public at a time of substantial organisational change within the NHS.

During 2012/13 NHS North Central London Cluster worked very closely with North East London and the City clusters, providing services in adjacent boroughs, to develop new Commissioning Support Units (CSUs). These CSUs support all the local GP-led Clinical Commissioning Groups (CCGs) as they become the new commissioners of local health services alongside other providers including the local authority, NHS England and Public Health England.

The top priorities for Enfield PCT for 2012/13 were to ensure we commissioned services which were safe and of increasing quality for the people we serve; to deliver the NHS North Central London Commissioning Strategy and Quality, Innovation, Productivity and Prevention (QIPP) Plan; and to deliver key organisational objectives and a secure transition to the commissioning landscape in line with the Health and Social Care Act 2012.

Throughout the year, we kept our focus clearly on improving services for local people, by working closely with Enfield CCG and with the local authority, local hospitals, mental health and community healthcare Trusts and other partner organisations.

The PCT also liaised closely with the Local Involvement Network (LINk) and local charity health providers and organisations providing health services to ensure a smooth transition of health services. Formal assurances for this handover have been given to the relevant receiving organisations.

Enfield Primary Care Trust – who was who

Enfield PCT's Board met concurrently with the Boards of the other four PCTs which made up the NHS North Central London cluster of PCTs (Barnet, Camden, Enfield, Haringey and Islington).

Each of the five PCT Boards shared a Board Chair, an Audit Committee Chair, a Chief Executive and a Director of Finance. The PCTs also shared some non-executive directors between them, as well as some executive directors.

Enfield PCT's Board provided the strategic leadership of the organisation and was responsible for making sure that the PCT works in the best interests of the local community. The Board was accountable to the public for the services provided in Enfield and for the organisation's use of public funds. In 2012/13 the following people constituted Enfield PCT's Board:

Voting Members

Name	Title	Notes
Non-executive Directors		
Paula Kahn	Chair	
Karen Trew	Vice Chair	
Deborah Fowler	Non-Executive Director	
Cathy Herman	Non-Executive Director	
Sue Baker	Non-Executive Director	
Caroline Rivett	Audit Chair	
Executive Directors		
Caroline Taylor	Chief Executive	
Ann Johnson	Director of Finance	To August 2012
Bev Evans	Director of Finance	From August 2012
Dr Shahed Ahmed	Director of Public Health	

Non-voting Members

Name	Title	Notes
Executive Directors		
Jeremy Burden	Director of Contracts	To July 2012
Simon Currie	Director of Contracts	From July 2012 to December 2012
Liz Wise	Director of QIPP / Borough Director Enfield	April 2011 to March 2013

Alison Pointu	Director of Quality & Safety	
Helen Pettersen	Director of Transition and Corporate Affairs	To December 2012
Dr Douglas Russell	Medical Director – Primary Care	To July 2012
Dr Henrietta Hughes	Medical Director – Primary Care	From July 2012
Dr Nick Losseff	Medical Director – Secondary Care	
Aurea Jones	Director of Workforce Transformation	To June 2012
Ian Fuller	Director of HR	To October 2012
Marion McCrindle	Director of HR	From October 2012
Sarah Thompson	Borough Director Enfield	From September 2011 to September 2012
Sarah Price	Joint Director of Public Health	From April 2011 to March 2013

Professional Executive Committee (PEC) Members

Name	**Title**	**Notes**
Janet High	PEC Chair	
Lynne Pope	PEC Nurse	

The Patient Advice and Liaison (PALS) and Complaints Service

The Patient Advice and Liaison Service (PALS) and Complaints Service was set up to provide information and advice on local healthcare services, help the public resolve problems with healthcare services quickly and effectively and, where necessary, advise people on how to make formal complaints.

All compliments, comments, concerns and complaints were monitored, to help PCTs and healthcare providers to improve services.

The PALS and Complaints Service for NHS North Central London had 4131 contacts between April and March 2013.

- 71% of contacts were seeking advice or information on accessing services in NHS North Central London 12% were concerns handled by the PALS team
- 16% were complaints about services
- 92% of complaints were acknowledged within 3 working days
- 69% of complaints were responded to within the 25 working day timeframe

Table 1: Type of contact

	Barnet	Camden	Enfield	Haringey	Islington	NCL	NCL Providers	Other	**Total**
Complaint	143	120	120	127	86	20	44	8	**668**
Concern	105	81	89	83	64	25	47	7	**501**
Advice & Information	448	465	385	437	328	458	228	197	**2,946**
FOI	2	2	1	0	0	4	0	0	**9**
Compliment	3	1	0	0	0	1	2	0	**7**
Total	**701**	**669**	**595**	**647**	**478**	**508**	**321**	**212**	**4,131**

There were a high number of issues relating to appointments at GP practices and a majority of manner and attitude issues related to how issues with access were handled by practices. Access to GP practices in the morning and evening were the key issues raised along with difficulty accessing practices by phone. A number of reviews of complaints have taken place by the Practitioner Performance team; these reviews resulted in recommendations for service improvement.

As the first point of contact for patients or their families raising concerns about services commissioned by NHS North Central London Cluster, the PALS and Complaints Service held an important role in identifying the need for service improvements through the complaints or concerns raised by service users.

- A number of areas of concern regarding charging by dental practices and quality of work undertaken have been highlighted with the assistance of the Primary Care team and were investigated.
- Letters relating to concerns raised by patients and their advocates in 2012 about difficulties in registering with GP practices led to NHS London completing and approving GP registration guidelines for London; these have been distributed and provide further clarity for practices in London on this process.
- Following contact from the General Dental Council (GDC) contact information for dentists in the cluster were updated on NHS Choices.

From April 2013 complaints about primary care services (including GPs, dentists and pharmacists) are being managed by NHS England (formerly NHS Commissioning Board). Contact details or information about complaints can be found on www.ncl.nhs.uk or on CCG websites.

Making it happen in NHS North Central London

In January 2013, NHS North Central London published its annual report on equalities which highlighted how we provided 'due regard' to our Public Sector Equality Duty (PSED) as defined by the Equality Act 2010 through each of the five PCTs. In addition we also reported on our workforce broken down by their 'Protected Characteristics'. Each PCT has good examples of how they have addressed equality issues including use of services for people in Barnet who are deaf, deafened or hard of hearing. For instance, in Enfield, Health Trainers work with disadvantaged people giving one-to-one support and advice to help them make lifestyle changes. The full report is available on the website www.ncl.nhs.uk

NHS North Central London Cluster staff

Since 2011, the cluster moved to a single employer arrangement hosted via Islington Primary Care Trust. Human Resources employment terms and conditions were harmonised to enable ease of working for all staff and managers and equity wherever possible.

Wherever possible, staff transitioned into new roles across the CCG or CSU or other new NHS bodies such as NHS England. Displaced staff were mentored and coached to find alternative roles.

NHS North Central London's policies in relation to discrimination and equal opportunity

NHS North Central London Cluster and its constituent Primary Care Trusts recognised that discrimination and victimisation was unacceptable and worked hard to ensure that no employee or job applicant received less favourable facilities or treatment (either

directly or indirectly) in recruitment or employment on grounds of age, disability, gender/gender reassignment, marriage/civil partnership, pregnancy/maternity, race, religion or belief, sex, or sexual orientation (the protected characteristics). It had policies in place which were published to ensure that staff were made aware that no form of discrimination would be tolerated and that each employee was respected. These policies and associated arrangements operated in accordance with statutory requirements. In addition, full account was taken of guidance and Codes of Practice issued by the Equality and Human Rights Commission, Government Departments, and other statutory bodies.

Number of staff employed [1]

2012/13	2011/12
88	189

Gender

Whole cluster (%) [1]

Male	37.85%
Female	62.15%

Ethnicity

Whole cluster (%)[1]

White	61.45%
Mixed	3.21%
Asian/Asian British	14.96%
Black or Black British	13.86%
Other ethnic group	3.31%
Unknown	0.80%
Declined to provide	2.41%

[1] Data extracted from ESR system as at 31 March 2013

Sickness absence

The rate of sickness for NHS North Central London Cluster was 2.73%. This is under the average rate for NHS England as a whole (3.9 %[2]).

[2] Data taken from NHS Information Centre for sickness absence rates for the NHS in England for the calendar year January to December 2012

National Staff Survey

A national decision was taken to allow close-down organisations not to take part in the 2012 National Staff Survey.

Estates across North Central London

The Estates and Facilities teams developed a single management operating model across the five PCTs to enhance operational effectiveness and prepare for the transfer of properties in line with the national transition plans.

Properties owned by the PCTs (in their own name and that of their predecessors)

In accordance with central direction some properties were transferred to other NHS Trusts or transferred to NHS Property Services Limited. In the case of LIFT schemes, these transferred to Community Health Partnerships Limited. Both NHS Property Services Limited and Community Health Partnerships Limited are wholly owned by the Government.

Capturing significant assets within the properties

The Estates and Facilities team has worked to capture all service contracts and map activity against each property portfolio.

During this process a high quality facilities management service was delivered to the tenants of our buildings. In 2012/13 we completed a number of significant capital projects which included:

- Health and safety works in line with CQC guidelines
- Opening of the new Finchley Memorial Hospital
- Completion of the refurbishment of Brunswick Park Health Centre.

All these schemes will benefit the local community by enabling and supporting the delivery of better quality care.

In 2012/13 there were no service failures which had a significant impact on patients.

Emergency planning for NHS North Central London

Over the last twelve months the NHS North Central London Emergency Planning and Business Continuity Team instigated measures to ensure robust and resilient systems were in place to coordinate the response of NHS North Central London, local NHS Trusts and Primary Care Contractors to any major incident or business continuity event that may have occurred.

The team took the lead in coordinating North Central London's planning for the London 2012 Olympic and Paralympic Games. A North Central London Olympic Planning Group was established and work programme of actions created to ensure the organisation and provider Trusts were fully prepared for the games. We ran a series of staff Olympic briefings to ensure all staff were aware of the likely transport impact and worked with provider Trusts and primary care contractors to support their Olympic Planning.

During the Games the North Central London Olympic Control Room provided a coordination point for the management of issues that affected NHS operations and shared updates with the NHS London Games Time Coordination Centre.

Overall the impact of the Games was far less than anticipated both in terms of transport and capacity/demand for services for provider Trusts and primary care providers.

The success of the Games in terms of logistics, transport and coordination can be attributed to the excellent coordinated planning between agencies and staff across all sectors, heeding advice to work in different ways to avoid causing severe transport congestion.

A key legacy from the Olympic Games was the development of closer working relationships between NHS and Local Authority organisations, particularly through Safety Advisory Groups and a 'system-wide' consideration of local impacts from large events taking place within London. Teleconference arrangements for managing seasonal surge capacity in acute trusts will build on the successful formula used during the Olympics. Finally, NHS organisations noted that Olympic Planning had provided more resilience to the supply chain for key commodities.

In addition to providing support during the Olympics, the Emergency Planning Team was involved in supporting provider organisations with the response to a number of other incidents. These included a siege situation on Tottenham Court Road in April 2012, a fire and power failure at Chase Farm Hospital in June 2012, and a suspect package incident at Whittington Hospital in August 2012.

To embed lessons identified from these events, NHS North Central London Cluster was involved in and ran a number of training and exercise events. These included monthly communications tests with provider Trusts, a winter planning event called Exercise Bleak Winter in October 2012, a Cluster Public Health Emergency Planning transition event in November 2012 and a transition planning event called Exercise Ermine, in January 2013.

As part of the wider changes under the Health and Social Care Act 2012, Emergency Preparedness is led by NHS England under the revised system from April 2013. The team has been central in supporting the transition of the service into NHS England, as well as providing expert advice and training to assist the Clinical Commissioning Groups embed their support role as a Category Two responder under the Civil Contingencies Act.

Sustainability

The latest version of our sustainability report was developed during the year, presented to the Joint Boards of the cluster and approved in September 2012. Having an up to date Sustainable Development Management Plan ensured that the organisation fulfilled its commitment to conducting all activities with due consideration to sustainability, whilst providing high quality patient care.

NHS North Central London remained committed to the Government's target for the environment including lower carbon emissions and sustainability. The NHS aims to reduce its carbon footprint by 10% between 2009 and 2015, thereby reducing the amount of energy used as well as contributing to a financial benefit.

Plans were put in place across North Central London to reduce carbon emissions and improve our environmental sustainability. The potential for delivering cost effective savings through schemes such as the Mayor of London's REFIT scheme (which offers

assistance under a structured framework to achieve carbon reductions in London) was investigated.

A staff energy awareness campaign ran throughout 2012/13. Surveys carried out for the NHS Sustainable Development Unit show that we compare well against peers.

NHS North Central London had in place a Sustainable Transport Plan.

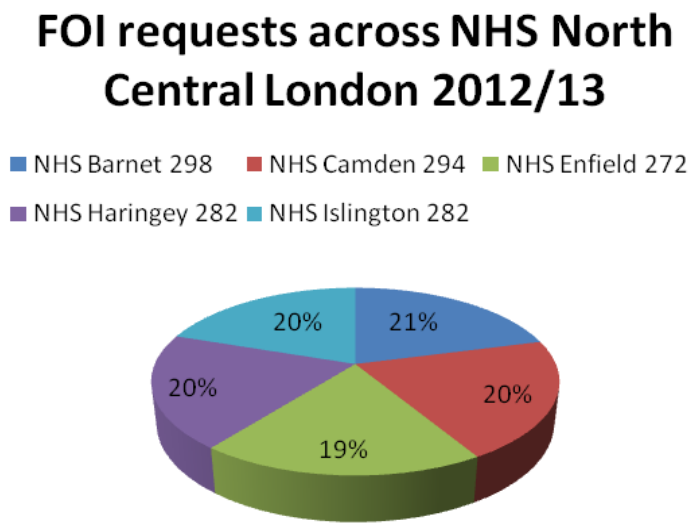
Freedom of Information Act management

The Freedom of Information Act 2000 (FOIA) recognises that the public has the right to know how public services are organised, how they carry out their duties, why they make the decisions they do and how they spend public money.

All Primary Care Trusts within NHS North Central London Cluster are required to respond to freedom of information requests within 20 working days. NHS North Central London monitored the performance of the targets to identify the causes of any delays and to see how these can be addressed to improve future performance.

The majority of requests were responded to within 20 working days. Those missing the target were largely due to the complexity of the information requested, or multiple issues needing investigating.

Between 1 April 2012 and 28 March 2013, a total of 1,428 Freedom of Information requests were processed across the cluster.



The FOI disclosure logs of information provided by NHS North Central London Cluster were published on the website at http://www.ncl.nhs.uk/about/freedom-of-information.aspx

From April 2013, all Freedom of Information requests are managed by the Commissioning Support Unit (CSU) on behalf of the five new Clinical Commissioning Groups. Their contact details are at the rear of this report.

Annual General Meeting

Because of the closure of NHS North Central London and PCTs in March 2013, these organisations no longer legally exist and therefore it was not deemed possible for Enfield PCT to hold an AGM.

Enfield PCT Annual Governance Statement: April 2012 toMarch 2013

Scope of responsibility

I am assured by the former Chief Executive of Enfield PCT, who was the Accountable Officer responsible for ensuring the proper stewardship of public funds and assets and who was accountable for the overall performance of the executive functions of the PCT, that the work of ensuring the discharge of obligations under Financial Directions was carried out in line with the requirements of the Accountable Officer Memorandum for PCT Chief Executives issued by the Department of Health.

I am assured by the Accountable Officer that she had carried out her responsibilities which included ensuring the following:

- management systems for safeguarding public funds and assets and assisting in the implementation of corporate governance;
- achieving value for money with the resources available;
- expenditure and income; and
- effective and sound financial management systems.

I am reassured by the former Accountable Officer who was accountable to the Chair and Non-Executive members of the PCT Board for ensuring that its decisions were implemented, that the organisation worked effectively, in accordance with Government policy and public service values, and for the maintenance of proper financial stewardship. Within the Standing Financial Instructions, it was acknowledged that the Chief Executive was ultimately accountable to the Board, and as Accountable Officer, to the Secretary of State, for ensuring that the PCT Board met its obligation to perform its functions within the available financial resources.

The former Chief Executive and Accountable Officer had overall executive responsibility for the PCT's activities and the achievement of its objectives; responsibility to the Chair and the PCT Board for ensuring that its financial obligations and targets were met; and had overall responsibility for the PCT's system of internal control. The essence of that role as Accountable Officer was to see that the Trust carried out these functions in a way which ensured the proper stewardship of public money and assets. Effective and sound financial management and information are of fundamental importance. I am assured by the former Accountable Officer that this occurred.

The system of internal control had been in place at Enfield PCT for the year ended 31 March 2013 and up to the date of approval of the annual report and accounts.

With these assurances from the former Accountable Officer I have signed the Summarised Accounts of Health Bodies in England, and the Resource Accounts of the Department of Health.

The Summarised Accounts are derived from the statutory accounts of the PCT. Together with the Director of Finance, the former Accountable Officer was responsible for ensuring that the accounts of the PCT were prepared under principles and in a format directed by the Secretary of State with the approval of the Treasury. These accounts disclose a true and fair view of the PCT's income and expenditure, and of its state of affairs. These accounts have been signed by the former Director of Finance on behalf of the PCT Board.

Robust arrangements were put in place for the preparation and audit of the accounts of the PCT following closedown of North Central London PCTs as statutory bodies. These arrangements are in line with Department of Health Guidance for financial closedown. A local delivery team was secured to prepare the accounts and a sub-committee of the Department of Health Audit and Risk Committee was established to review the accounts with retained Non Executive Directors, the former Director of Finance, the external and internal auditors and the former Accountable Officer.

The Codes of Conduct and Accountability incorporated in the Corporate Governance Framework Manual issued to NHS Boards by the Secretary of State were fundamental in exercising my responsibilities for regularity, propriety and probity. Every member of the PCT Board had subscribed to these codes which were adopted in April 2011.

In April 2011, the PCT entered into a collaborative arrangement with other PCTs in North Central London and underwent significant structural and organisational change.

The "Cluster" of NHS North Central London was formed of five PCTs: Barnet, Camden, Enfield, Haringey and Islington.

The London Strategic Health Authority confirmed the "Cluster" was compliant with Primary Care Trust regulations and Primary Care Trust Cluster Implementation Guidance. The London Strategic Health Authority reviewed the Corporate Governance Framework outlining the shared working arrangements that was agreed by the PCT Board in February 2011 and confirmed it as compliant with PCT regulations and PCT Cluster Implementation Guidance.

The Framework was revised in September 2012 to reflect the transitional development of the new system as described in the Health and Social Care Act 2012. A single management team performed its role on behalf of each of the PCTs, who retained their statutory duties and powers. All PCT statutory functions, powers and duties were mapped to ensure that they were aligned to the new cluster management structure.

The former Chief Executive of Enfield PCT and Accountable Officer was also the Accountable Officer for the other four PCTs.

In March 2012, Enfield CCG received delegated responsibility for medicines' management and received delegated responsibility for all other commissioning budgets in October 2012.

The NHS National Commissioning Board Decision Panel was held on 6 March 2013 to consider the additional evidence submitted on 20 February 2012 to address the 14 outstanding issues.

Enfield CCG was authorised with seven conditions on 6th March 2013, and action plans were in place to address the outstanding criteria.

The governance framework of the organisation

The Primary Care Trust was a statutory body which came into existence on 1 April 2002 under The Primary Care Trust (Establishment) Order 2002 No 100, (the Establishment Order). The principal place of business of the Enfield PCT was Stephenson House, 75 Hampstead Road, London, NW1 2PL.

Composition of the Board

The Primary Care Trust (PCT) Board met concurrently with the other four Primary Care Trusts Boards of NHS North Central London. The Chair, Audit Chair, Chief Executive and Director of Finance also fulfilled these roles for the other PCTs within NHS North Central London. The other Non-Executive Directors of each PCT had Non-Executive Director roles in one other PCT within NHS North Central London. This change to the membership arrangements was made permissible by the passing of Statutory Instrument 2010 2539 which removed the disqualification which prevents a person who was a Chair or member of one PCT from being appointed as the Chair or a non-officer member of another PCT.

Each PCT Board had a Professional Executive Committee (PEC) Chair, PEC Nurse and Director of Public Health as voting members. In the case of the PEC Nurse and Director of Public Health, there was a cluster designated Director of Public Health (Islington), and a PEC Nurse (Barnet) who attended on behalf of their peers unless there was specific business relating to an individual PCT for which the presence of a specific member would be required. The PCT Cluster-designated Director of Public Health and PEC Nurse were only eligible to vote on decisions for their own PCT Board.

Committees

In line with statutory requirements, the Primary Care Trust (PCT) Board resolved in April 2011 to establish the:

- Audit Committee;

- Professional Executive Committee;
- Remuneration Committee; and
- Primary Care Reference Committee.

The Board also established such other Committees, as required, to discharge the PCT's responsibilities. It resolved to establish the:

- Quality and Safety Committee;
- Financial Recovery and Quality, Innovation, Productivity and Prevention Committee;
- London Specialised Commissioning Group Board; and
- Joint Committee of PCTs for the purposes of formal public consultation and decision making about the provision of Paediatric Cardiac Surgery Services in England.

The PCT Board agreed the terms of reference of these Committees and their delegated powers and responsibilities in April 2011 and reviewed the terms of reference in September 2012 to reflect the increased role in assurance to the Joint Boards and the increasing delegated responsibilities to Clinical Commissioning Groups (CCGs) and other new legal entities as set out in the Health and Social Care Act 2012.

The Remuneration Committee remit was extended to incorporate wider responsibilities to oversee the transfer of staff and the capacity of the cluster management during the final stages of transition.

A new Transition Committee of the Joint Boards was established in September 2012 to manage the oversight of all transition, handover and closure business required as a consequence of the Health and Social Care Act 2012. This Committee reflected the governance arrangements for transition and closure across the NHS in London.

The Enfield PCT Board established Enfield CCG Board as a Committee on 28 March 2012.

The Board's performance

The Chair of the Joint Boards of NHS North Central London conducted a review of the effectiveness of the Board and its Committees in early 2012 and presented the findings of the review at the March 2012 Board meeting. This internal assessment indicated that Board members were satisfied with the working of the Committees and their effectiveness in discharging their delegated responsibilities, and these were seen as an essential part of Board governance. Following the review NHS North Central London continued to embed best practice in governance across all functions.

Highlights of Board Committees' reports

Highlights of the work of key Committees are provided below.

Audit Committee:

- The Audit Committee met concurrently with the Audit Committees of the other PCTs within NHS North Central London. Whilst each Committee had a discrete agenda, shared membership and meeting arrangements further enabled positive assurance across all areas of business.
- The Committee approved the annual accounts, external and internal audit opinions and an Annual Governance Statement for 2011/12 on behalf of Primary Care Trust (PCT) Board for submission to the Department of Health. Legacy and key control issues identified during 2011/12 were factored in to the planning of the internal audit programme for 2012/13.
- The Committee reviewed internal and external audit plans and reports, and sought assurance that recommended actions were completed and that all issues were managed comprehensively. The Committee received reports on counter fraud and security services, and waivers to competitive tender requirements.
- The Committee provided assurance to the PCT Board on areas of governance and risk, providing detailed oversight of the Board Assurance Framework (BAF). Meetings considered specific areas of business in depth to enable substantive assurance through focussed discussion and challenge with Executive officers on their areas of responsibility within the BAF. The Committee looked in detail at risks and assurances on a number of key topics including PCT finance and Quality, Innovation, Productivity and Prevention (QIPP) targets, primary care performance, and quality and safety.

Quality and Safety Committee:

- Clinical Quality Review meetings were established for all services, including acute, mental health and community services.
- The Organisational Intelligence Tool and the quality and safety dashboard provided information on key quality indicators for all providers. The report was a standing agenda item for the Quality and Safety Committee and the Clinical Commissioning Group (CCG) Quality Committees.
- A high-level review of quality and safety across mental health and learning disability services was completed; a series of recommendations were made and an action plan agreed.
- A multi-agency working group was established to improve the quality of nursing home service and patient experience in the northern boroughs of NHS North Central London.
- Workshops and shadowing opportunities for CCG staff helped to prepare for transfer of quality & safety functions and accountability.
- The committee supported emerging CCGs to introduce Patient Stories to CCG Governing Body meetings to ensure that patient experience set the context for the business of the meeting.
- The Committee supported working to improve patient experience with other organizations, e.g. the Making a Difference Board at University College London Hospitals NHS Foundation Trust (UCLH) and the implementation of the “walk the

pathway" programme led by Patient Experience Manager involving Local Involvement Networks (LINks) and Non-Executive Directors, including visits to dementia and stroke services.

- Quality summits were held to share intelligence about providers ensuring that early warning systems are in place to improve patient safety.

Financial Recovery and Quality, Innovation, Productivity & Prevention (QIPP) Committee:

The Committee provided a robust mechanism for review and challenge of progress against financial targets for each PCT. This was achieved through oversight of the delivery of savings plans and budgets; review and development of the NHS North Central London QIPP Plan and associated implementation plans; and review and approval of procurements, contracts and investment business cases in line with the Scheme of Delegation.

Highlights from the year include:

- Completion of an alignment process to ensure leadership and ownership of finance and QIPP plans for 2012/13. The Clinical Commissioning Groups (CCGs) were actively engaged in developing QIPP and investment plans achieved through programme management support which was phased over to the CCGs to help the CCGs in their delivery of the programme for 2013/14. Additional resource was given to support the development of local ownership and skills. There was a strong commitment to ensuring that investments were supported by future commissioning plans and that QIPP plans were in place to deliver savings earlier in the financial year going forward. All this could not have been achieved without the enthusiasm and commitment of the CCGs to produce a QIPP plan that reflected local need understood through direct clinical experience.
- Increased focus on underlying recurrent run rate positions of the PCTs in the Cluster
- Continuing reduction in historical debtors and creditors
- Revised terms of reference to include monitoring the legacy, handover and closedown arrangements for the PCT including finance department transition to the new NHS bodies.

Remuneration and Terms of Service Committee:

The Remuneration and Terms of Service Committee met periodically to consider and approve payments for PCT staff following the organisational transition into the North Central London Cluster management structure. The Committee's terms of reference were extended in September 2012 to reflect the need to closely monitor the movement of staff during transition to new commissioning bodies.

An account of Corporate Governance

The Primary Care Trust's (PCT) Corporate Governance arrangements were set out in the Corporate Governance Framework Manual agreed by the Board in April 2011 and revised in September 2012. The Manual included the organisation's Standing Orders, Standing Financial Instructions, Schemes of Reservation & Delegation and Codes of Accountability & Conduct. These arrangements have been drawn up in line with:

- The Primary Care Trust (Executive Committees and Standing Financial Instructions) Directions 2007, National Health Service Act 2006; and
- Department of Health PCT Cluster Implementation Guidance (31 January 2011).

The Manual was regularly reviewed and updated throughout the year to take account of changes in the governance environment:

- The creation of new legal entities and their authorisation to undertake delegated responsibilities including Clinical Commissioning Groups (CCG) and NHS England (formerly the NHS Commissioning Board); NHS Trust Development Authority (NTDA)
- States of readiness through the transition period as organisations became ready to exercise their new responsibilities.

In September 2012, the Corporate Governance Framework Manual was revised to take account of changes in NHS commissioning landscape and the introduction of London's Interim Operating Plan.

The internal auditors conducted an audit of the PCT's governance as part of the approved internal audit plan for 2012/13. The objective of the review was to provide assurance that there was an appropriate management structure, robust governance arrangements and organisational form to deliver the organisation's objectives. The auditor opinion provided substantial assurance in relation to the design, application and effectiveness of the governance arrangements and the audit report highlighted a number of areas of good practice.

Risk management and the control framework

The Primary Care Trust (PCT) Board approved the NHS North Central London Risk Management Strategy in December 2011 and the PCT has embedded the strategy into practice throughout 2012. The emerging Clinical Commissioning Groups (CCGs) have worked within the Strategy throughout 2012/13. The strategy outlined the organisation's approach to risk management, including:

- Identifying committees and groups which have responsibility for risk management;

- Roles and responsibilities of staff with regards to risk management;
- The process for identification, assessment and management of risk;
- The process for managing, and Board review of, the Risk Register and Board Assurance Framework; and
- The risk appetite of the organisation, which sets out the thresholds for toleration, management and reporting of different orders of risk.

The Risk Management Strategy reflected best practice, taking into account a range of governance standards.

Risk assessment

Risk assessment is a systematic and effective method of determining the level of risks. All identified risks were assessed using a clearly defined risk assessment matrix by determining the likelihood and consequence of the risk to calculate an overall risk rating. Risks were categorised as low, moderate, high or extreme, and their categorisation informed the organisation's approach to management and monitoring of the risk.

The risk and control framework

The Board Assurance Framework (BAF) and Risk Register assessed the effectiveness of systems of internal control and provided assurances that risk management processes are effective. Both were dynamic documents that captured the understanding of the risk environment at any given time.

The BAF outlined NHS North Central London Cluster's principal objectives, the risks to achieving those objectives, key controls and assurances, and gaps in controls and assurances. The Risk Register contained a mixture of strategic and operational risks at organisational and directorate level as well as the arrangements in place to mitigate these.

Risks were identified in a variety of ways, including incidents, complaints and claims; committee reports; external assessments and audits; and management reviews. All risks were assigned a relevant Executive Director who had accountability for overseeing the management of the risk by identifying the most effective means to minimise, transfer or remove it, and ensuring the quality of action plans, controls and assurances. A Lead Officer was assigned with management responsibility for delivering the action plan, developing robust controls and identifying sources of assurance.

The PCT had a structured approach for the reporting and monitoring of risk. The Joint Boards reviewed the BAF and Extreme Risk Report at every meeting, and risk and BAF were a standing item on all committee agendas. The Senior Leadership Team reviewed the Board Assurance Framework and Risk Register on a monthly basis. The PCT Board also took assurance from external assessments and audits, and from the work programme of the Audit Committee.

Risk profile

The 2012/13 Board Assurance Framework (BAF) identified the following strategic risks within three Principal Objectives:

1. To ensure we commission services, which are safe, and of increasing quality for the people we serve.

1.1 Transition and the underlying financial position in North Central London may impact on the quality and safety of services.

1.2 Increased alerts received in relation to standards of care in nursing/care homes in particular Barnet, Enfield and Haringey and capacity issues at Borough level could lead to safety/safeguarding concerns for adult resident patients.

1.3 Due to the effect of transition on workforce capacity, recruitment & retention, organisational memory and differing stages of receiving organisations' readiness of quality arrangements - there was a risk that embedding Quality and Safety in the new health system would not be effective.

2. To deliver the NHS North Central London Cluster Commissioning Strategy and Quality, Innovation, Productivity and Prevention (QIPP) Plan.

2.1 Sustainable QIPP delivery on the scale and timescales required given the scale of financial challenge; there was a risk that we do not deliver the transformational change programme needed to bring the health economy back into balance at the required pace – due to:

- Capacity, capability and clinical leadership;
- Pace of delivery; and
- Engagement with providers.

2.2 Following the delegation of responsibility to Clinical Commissioning Groups (CCGs), and during the period of shadow running and transition to March 2013, there was a risk that the cluster loses grip on the delivery of QIPP and financial turnaround.

2.3 There was risk that the CCGs are not sufficiently developed to manage delegated responsibility and achieve authorisation due to:

- Capacity and capability of CCGs;
- Ownership of the agenda; and
- Underlying financial position of the Cluster.

2.4 There was a risk of dislocation between or misalignment of different elements of the commissioning system leading to:

- Gaps in delivery;
- Differences in expectations between parts of the system (e.g. Commissioning Support Unit offer does not align to CCG need); and
- Ineffective commissioning partnerships.

2.5 The scale and complexity of forthcoming changes meant there was a risk that functions or knowledge may not be adequately transferred to receiving organisations or that the statutory organisations would not safely close down.

2.6 There was a risk that ineffective alignment of resources during the transition period (1 October 2012 to 31 March 2013) would impact the delivery of key Cluster objectives and reduce organisational effectiveness.

3. To deliver key organisational objectives and a secure transition to the commissioning landscape in line with the Health and Social Care Act 2012.

3.1 Following the delegation of responsibility to CCGs and during the period of shadow running and transition to March 2013, there was a risk that the Cluster loses grip on the delivery of QIPP and financial turnaround.

3.2 There was risk that the CCGs are not sufficiently developed to manage delegated responsibility and achieve authorisation due to:

- Capacity and capability of CCGs;
- Ownership of the agenda; and
- Underlying financial position of the Cluster.

3.3 There was a risk of dislocation between or misalignment of different elements of the commissioning system leading to:

- Gaps in delivery;
- Differences in expectations between parts of the system (e.g. Commissioning Support Unit offer does not align to CCG need); and
- Ineffective commissioning partnerships.

3.4 The scale and complexity of forthcoming changes meant there was a risk that functions or knowledge may not be adequately transferred to receiving organisations or that the statutory organisations would not safely close down.

3.5 There was a risk that ineffective alignment of resources during the transition period (1 October 2012 - 31 March 2013) will impact the delivery of key Cluster objectives and reduce organisational effectiveness.

4. Other significant risks on the PCT's Risk Register:

4.1 There were risks around ensuring the robustness of processes for safeguarding children during the transition period. Sound working relationships have been established with partner organisations to mitigate this.

4.2 Risks relating to the commissioning of continuing care and high cost placements could have impacted on the PCT's ability to deliver QIPP savings. A revised continuing care policy was implemented.

Review of Effectiveness of risk management and internal control

The PCT Board and its committees were fully supportive of the risk management process which was scrutinised and challenged as part of the PCT Board, Financial Recovery and QIPP, and Audit Committees functions.

RSM Tenon undertook an audit of the Risk Management and Assurance Framework as part of its audit plan for 2012/13.The final advisory report was issued in October 2012

NHS North Central London continued to embed the use of their Board Assurance Framework into their routine and this was evidenced by the commitment from the Joint Boards of NHS North Central London, Audit Committee and Senior Leadership Team in ensuring that this Framework operated as effectively as possible.

RSM Tenon identified the need to keep focus on where risks would be transferred to during transition. As a consequence a revised BAF and Risk Register was received and accepted by the Board in September 2012 which had been reviewed in order to focus and refine the content so that it accurately reflected the main strategic risks for the remainder of the financial year.

Significant issues in 2012/13

Over the year the PCT Board and its committees have considered issues that might have had a prejudicial impact on the corporate objectives, the business plan or the reputation of the NHS locally.

Continuing Care Reviews

The Joint Boards of NHS North Central London requested a review of continuing care across all PCTs areas in 2012/13. In-year review of action showed a considerable improvement in the level of compliance and paperwork around continuing care commissioning, but identified a number of issues in borough teams' performance in 2012/13. This resulted in an amber/red opinion being issued. An action plan was in place to support the improvement across all areas and was being closely monitored by the Financial Recovery and QIPP Committee. Continuing care services are complex and high volume. Issues were identified in accounts payable and these highlighted to the management team particular issues in relation to the control and management of continuing care and funded nursing care. The requirement to manage these services properly was a clinical priority to ensure quality of services, as well as a financial imperative. As a result, Internal Audit was asked to prioritise the audit of continuing care arrangements. A number of weaknesses in control were identified including:

- Quality of care – backlogs in assessment;
- The budget setting process;

- Implementation of service level agreements and contracts for care packages; and
- The adequacy of management information tools to manage and control this complex service.

The management team, including the Director of Quality and Safety, agreed a detailed action plan to close the identified gaps in control and progressed the implementation of internal audit recommendations.

Primary Care Payments

An internal review of the accuracy and authorisation of primary care payments was undertaken in 2012/13.

It found that Enfield, Haringey and Islington Primary Care Trusts (PCTs) were still using manual systems to manage the process. During 2012 this has been rectified and all PCTs now operate the same electronic system.

An action plan was put in place to address a further five medium rated recommendations. The Joint PCT Boards could take some assurance at this point that the controls upon which the organisation relied to manage risk were suitably designed, consistently applied and effective.

Transition to new commissioning arrangements in the NHS

The Joint Boards agreed the NHS North Central London Transition Plan in December 2011. Detailed function led work streams supported this high-level plan in 2012 and 2013.

A sub-committee of the Joint Boards was established in December 2012 building on the working group that had led the implementation of the action plan and monitored the delivery in line with national policy and guidance.

The organisation agreed and handed over functions from January 2013 to nominated legal receivers: NHS England (formerly the NHS Commissioning Board (London)), Clinical Commissioning Groups, Local Authorities, NHS Property Services and Public Health England.

General assets and liabilities were also transferred after dialogue with nominated receivers.

Property and leases transferred in most cases to NHS Property Services and some buildings were transferred to Foundation Trusts as the most appropriate receiver.

A Statutory Instrument was approved by Parliament giving NHS England and Clinical Commissioning Groups powers to enter into contracts from 1 February 2013.

NHS England (London) moved toward full operating mode from 7 January 2013 following transfer of functions from PCTs.

National Priorities set out in the NHS Operating Framework: Improving performance in Enfield – 2012/13

Acute Measures

Waiting times in A&E

A&E performance for Enfield PCT patients focused on Barnet and Chase Farm and North Middlesex. Performance against the A&E four hour maximum waiting time target for both trusts was strong throughout the first two quarters of 2012/13. However, the winter of 2012/13 proved more challenging than the previous year. During November and December 2012 outbreaks of Norovirus resulted in over 900 bed closures at Barnet and Chase Farm. The allocation of winter funding to both Trusts aimed to support whole-system resilience plans.

Referral to treatment waiting times

At a PCT level Enfield's performance against all referral to treatment standards has remained strong throughout the year, consistently achieving the admitted, non-admitted and incomplete pathways standards. At a provider level Barnet and Chase Farm NHS Trust achieved all three standards until December 2012 when performance on the incomplete pathways fell just below the 92% standard to 91.7%. North Middlesex University Hospital NHS Trust achieved all three standards throughout 2012/13 to date. Barnet and Chase Farm Hospital had a plan in place to reduce the number of patients waiting for longer than 52 weeks to zero in-line with the renewed national focus. No patients were reported as waiting longer than 52 weeks at North Middlesex.

Cancer waiting times

Enfield PCT sustained achievement of most of the cancer waiting time targets during 2012/13. NHS North Central London continued intensive monitoring and analysis of Trusts who failed these standards to ensure plans remained focused on turnaround and sustainability of performance.

Access to Stroke Services

There was a significant improvement in performance against the national measures for stroke services with Enfield exceeding the 80% threshold since Quarter 2 of 2012/13 for time on a stroke unit and also achieved the 60% standard for TIA (Transient Ischaemic Attack) access within 24 hours.

Higher activity volumes and sustained performance showed that more people were accessing the right service within Enfield for stroke.

Access to Diagnostics

Enfield consistently maintained performance within the tolerance level of less than 1% of patients waiting longer than six weeks for a diagnostic test with December performance reported at 0.6%.

Access to Single Sex Accommodation

Patient privacy and dignity remains high on the NHS agenda with a zero tolerance against mixed sex accommodation. Barnet and Chase Farm Hospital was particularly affected this year contributing to 83 out of 106 incidences which impacted on Enfield's performance.

Non-acute performance

Access to screening services

Diabetic Retinopathy

All boroughs within NHS North Central London Cluster exceeded the target of 95% for diabetic retinopathy screening and this performance was further enhanced by the commissioning of the UCLH site and new referral pathways that were scheduled for implementation from 1 April 2013.

Cancer Screening

Enfield was the only PCT within NHS North Central London Cluster to achieve the 70% standard with 72% of eligible women screened. Despite continued underperformance for bowel screening, Enfield demonstrated the most significant improvement within NHS North Central London Cluster of 56.1% uptake against a target of 60%.

The uptake of cervical screening over the first nine months of the year generally mirrored that of last year. Work continued to raise awareness and identify exclusions to ensure that performance was accurately reported. The turnaround time of cervical screening results continued to be good with Enfield achieving the 98% threshold for the majority of months during the year.

NHS Health Checks

Increased offering and take-up of NHS health checks supported the reduction in health inequalities by identifying and addressing health needs in previously undiagnosed people.

Enfield PCT remained below trajectory with immediate actions being taken through GP clinical leads actively promoting the health check programme and public health leads contacting practices.

Early Access to Maternity Care

Improving outcomes for babies and children was one of the priorities for NHS North Central London and closely aligned to women accessing maternity care before 12 completed weeks of pregnancy. This was a challenging target to achieve with performance at 79.0% against the 90% standard. Enfield PCT continued to undertake remedial actions to promote early access through initiatives to raise awareness amongst hard to reach communities and education of primary care staff to facilitate early access to maternity care.

Through collaborative ventures amongst commissioners and providers, plans were put in place to implement initiatives to turn around cultural awareness and simplify access to services.

Childhood Immunisations Coverage

With a focused improvement plan, for which Enfield PCT was commended by NHS London, work continued to be delivered to track and monitor outstanding immunisations underpinned by stronger clinical leadership, data collection and extraction. Quarter 2 data showed that performance was improved by Enfield and despite three out of the six immunisation programmes being below target; this position improved, showing a much smaller gap to close.

Financial recovery

There was a clear difference in the financial health between the north (Barnet, Enfield and Haringey) and South (Camden and Islington) of the NHS North Central London Cluster over recent years. The financial strategy was focussed on transformational change across the whole £2.5 billion portfolio with programmes to rebalance the health economy in the patch, without destabilising hospitals. The financial plan for 2012/13 was the second in an original three year programme to return all five PCTs to financial stability on a recurrent basis. By exception the Department of Health agreed deficit plans for Barnet, Enfield and Haringey PCTs at the start of the year. In year revised plans were agreed resulting in all five PCTs delivering a surplus income and expenditure position. Camden and Islington PCTs have a history of financial stability, underpinned by well funded, sound community and primary care provision, and planned to deliver a healthy surplus.

During 2012/13 there was a continuation of the previous years' programme of financial recovery and turnaround including identification, development and delivery of QIPP plans in year and looking forward to the future clinical commissioning groups. All five PCTs over-delivered against agreed budgets. Camden PCT and Islington PCT exit in recurrent run rate surplus and Barnet PCT, Enfield PCT and Haringey PCT improved their respective run rate positions. Delivery of this programme was fundamental to ensuring the financial resilience of the future commissioning organisations.

Review of Quality and Safety

As a result of a review of quality and safety in 2011 which found that services were of a generally high quality and safe; improvement trajectories were agreed in 2012 with providers. Implementation and performance was monitored through the Clinical Quality Review Groups. These recommendations have been worked on throughout 2012 and as a result:

- Organisational Intelligence Tool quality and safety dashboard embedded for key indicators for all providers. The report was a standing agenda item for the Quality & Safety Committee and the CCG quality committees;
- Multi-agency Working Group established to drive up quality of nursing home service and patient experience in the northern boroughs of NHS North Central London; and
- There were no significant areas of slippage at the time of this annual report.

Data loss incident

There were no data loss incidents between April and December 2012.

Barnet, Enfield and Haringey Clinical Strategy

The implementation plans for delivering the Barnet, Enfield and Haringey Clinical Strategy were progressed according to the timetable and to deliver the proposed changes in November 2013. Key milestones were met including the approval of both Barnet and Chase Farm Hospitals NHS Trust and North Middlesex University Hospitals NHS Trust full business cases for the capital investment to improve the buildings.

Significant work took place within both Trusts and across the Trusts in the key work streams of Emergency Care, Maternity, Paediatrics and Planned Care alongside primary and community care improvements and refreshed of the models of urgent care at all three hospital sites. The enabling work streams of workforce, transport and communications and engagement continued to deliver their programme plans. The governance arrangements were strengthened and reviewed. More information can be found at www.enfieldccg.nhs.uk/about-us/beh-clinical-strategy.htm.

Primary Care Strategy – Transforming Primary Care

2012/13 was the first year of implementing the three-year strategy 'Transforming Primary Care'. There was progress in all the workstreams including the development of networks, service improvements focusing on improving access, the delivery of care closer to home including the development of integrated care. The enabling workstreams of Information Management & Technology and premises made significant progress this year. The one area of workforce development has proved challenging in the first year.

There was a plan to spend a full year budget of £12m in Year 1, of the £47.7m identified over three years. The majority of the budget was spent but there was an element of underspend due to time to engage fully at a local level, delay in approvals processes across the system and delay in time to implement some of the schemes in the year of CCG authorisation.

Plans for the remaining two years of the implementation of the strategy were that the five Clinical Commissioning Groups would lead the implementation locally and ensure that all developments are in line with local strategies whilst being committed to the overall ambition of the initial strategy adopted by NHS North Central London Cluster in January 2012.

Clinical Commissioning Groups (CCGs)

- All five CCGs in NHS North Central London successfully secured delegated responsibility for all eligible budgets within agreed timeframes
- All five CCGs in NHS North Central London submitted authorisation documentation within the agreed national timeframes
- Positive external assurance was received from NHS London on the progress of CCGs' authorisation
- CCGs' Integrated Performance management approach was in place – CCGs demonstrating leadership and financial management through monthly Integrated Performance Meetings
- Positive assurance received through internal audit of CCGs development activity, management and support given by NHS North Central London PCTs.

The new health system in Enfield: April 2013 onwards

The Health and Social Care Act 2012

The Health and Social Care Act 2012 gained Royal Assent on 27 March 2012 and set out major changes to the NHS. The changes, including the abolition of primary care trusts and the establishment of new statutory bodies came into effect on 1 April 2013.

Clinical commissioning – CCGs and CSU

Acute, mental health and community NHS care is now commissioned by clinical commissioning groups, which gives GPs and other clinicians responsibility for using resources to secure high-quality services for local people.

An NHS Enfield Clinical Commissioning Group was working in shadow form during 2012/13 and undergoing a national assessment programme in readiness to take on full statutory responsibilities for commissioning acute, mental health and community health services from April 2013.

Alongside this CCG development work, a significant work programme was underway to develop a commissioning support unit for north central and north east London's 12 CCGs. This programme included consultation with staff and staffside representatives on structures and matching and recruitment process.

NHS England

At a national level, NHS England ensures the new NHS architecture is fit for purpose and provides clear national standards and accountability. Many of its functions are carried out at a more local level, and therefore NHS England has a regional office for London.

Commissioning of GPs, dentists, pharmacies and optometrists is the responsibility of NHS England, as is the commissioning of some specialist services.

The London regional office of NHS England has close relationships with clinical commissioning groups, professional and clinical leadership functions and relationships with local government and Healthwatch, the new independent consumer champion created to gather and represent the views of the public.

NHS England is responsible for the 2013/14 commissioning planning round and future performance management of CCGs.

Health and wellbeing boards

With the establishment of health and wellbeing boards in each borough, leaders of the local health and care system have been brought together – with CCGs, elected representatives, social care, public health and local Healthwatch at the core – to work with a common purpose to drive improved services and outcomes. They link with local communities and other local public services, and, through the role of elected representatives, strengthen local accountability, enabling outcomes to be measured and demonstrated.

The board members work together to develop a joint strategic needs assessment (JSNA) and joint health and wellbeing strategy for the borough to tackle issues that matter most to the local community. Integrating services, joint commissioning and pooling resources will be central to translating the needs assessment and joint strategy into action.

The health and wellbeing board have a duty to encourage commissioners of health services and commissioners of social care services to work in an integrated manner.

Public health

From April 2013 local authorities took on a new duty to take steps to improve the health of their population. They are largely free to determine their own priorities and services, to meet the needs of the local population, but will also be required to provide a small number of mandatory services, including:

- appropriate access to sexual health services
- NHS Health Check assessments
- plans to protect the health of the population
- weighing and measuring children for the National Child Measurement Programme
- providing public health advice to NHS commissioners.

The London Borough of Enfield took responsibility for these public health functions.

Financial overview and summary financial statements

Financial Performance

Enfield PCT has met the control total surplus of £2.8m as set by the Department of Health. However, this was achieved through non-recurrent financial support provided by other PCTs within the NHS North Central London Cluster.

With this support, Enfield PCT has met all of the statutory duties, namely;

- Financial balance in year
- Spending within capital allocation
- Spending within cash limits.

These achievements were a credit to the whole organisation, which maintained focus on delivering value for money for our patients and public at a time of substantial organisational change within the NHS.

Capital Structure

The PCT funded its assets using an annual allocation set by the Department of Health. It had no bank borrowings. Where the PCT has revalued assets, the extent of that revaluation was reflected in the revaluation reserve.

The PCT normally carries out a full revaluation of its estate every five years. A full revaluation was undertaken this financial year.

Treasury Policy and Objectives

The total limited cash available was based on the PCT's revenue reserve and capital resource limits. There was no flexibility to exceed the notified cash limit and the PCT must manage this source of cash.

The PCT planned cash requisitions to ensure that there were minimal month end balances and no supplementary advances in month. Monthly cash drawings were requisitioned by the date advised by the DH. This was managed by forecasting all material cash transactions in the forthcoming month. Month and year end balances were maintained to a minimum level and closing cash balances for the year were less than £100k. The PCT maximised use of Citi Bank services. CHAPs payments were only made in exceptional circumstances.

Charging for Information

The PCT complied with Treasury guidance for setting charges as per appendix 6.3 of the Managing Public Money guidance. This advices that it is government policy that as much information as possible about public services should be made available at either free or at low cost. The PCT freely posted information about its activities and services on the internet.

Principles for Remedy

The PCT complied with Treasury guidance for Principles for Remedy as per appendix 4.14 of the Managing Public Money guidance. There are six principles that represent best practice and these were directly applicable to the PCT.

Summary financial statements

The financial statements for Enfield PCT have been prepared in accordance with International Financial Reporting Standards (IFRS) and the 2012/13 Financial Reporting Manual issued by HM Treasury.

The accounts have been prepared under the historical cost convention, modified by the application of current cost principles to tangible fixed assets, and in accordance with directions issued by the Secretary of State for Health and approved by HM Treasury.

The summary financial statements attached are an extract from the PCT's full audited annual accounts for the year ended 31 March 2013.

A copy of the full accounts will be available on the Department of Health's website https://www.gov.uk/government/organisations/department-of-health

The accounts for the year ended 31 March 2013 have been prepared by the PCT under Section 98(2) of the NHS Act 1977 (as amended by Section 24(2), Schedule 2, of the National Health Service and Community Care Act 1990) in the form which the Secretary of State has directed. The main source of funding was income from the Department of Health.

Audit Functions

Enfield PCTs Audit Committee has two Non-Executive Directors and members. At the end of 2012/13 they were Deborah Fowler and Caroline Rivett.

Enfield PCT's external auditor for 2012/13 was Grant Thornton and the cost of Audit Services provided by them in the year was £107k.

Statement of the Responsibilities of the Signing Officer of Enfield 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 Enfield PCT 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 was 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 

Peter Coates
Director of PICD, Strategy, Finance and NHS
Department of Health

Date 5 June 2013

Independent Auditor's Report to the Department of Health's Accounting Officer in respect of Enfield PCT

We have examined the summary financial statement for the year ended 31 March 2013 which comprise: the statement of comprehensive net expenditure for the year ended 31 March 2013, the statement of financial position at 31 March 2013, the statement of changes in taxpayers equity for the year ended 31 March 2013, the statement of cash flows for the year ended 31 March 2013 and related notes set out on pages 39 to 47.

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

Respective responsibilities of signing officer and auditor

The signing officer is responsible for preparing the Annual Report.

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

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

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

Opinion

In our opinion the summary financial statement is consistent with the statutory financial statements of the Enfield PCT for the year ended 31 March 2013.

Paul Hughes
Senior Statutory Auditor, for and on behalf of Grant Thornton UK LLP
Grant Thornton House
Melton Street
Euston Square
London
NW1 2EP

5 June 2013

Statement of comprehensive net expenditure for the year ended 31 March 2013

	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure		
Gross employee benefits	**5,106**	9,671
Other costs	**535,980**	517,032
Income	**(19,924)**	(13,978)
Net operating costs before interest	**521,162**	512,725
Investment income	**(28)**	(35)
Finance costs	**728**	507
Net Operating Costs for the Financial Year including absorption transfers	**521,862**	**513,197**
Of which:		
Administration Costs		
Gross employee benefits	**4,172**	8,052
Other costs	**17,922**	10,872
Income	**(297)**	(6,071)
Net administration costs before interest	**21,797**	**12,853**
Investment income	**(28)**	0
Finance costs	**0**	507
Net administration costs for the financial year	**21,769**	**13,360**
Programme Expenditure		
Gross employee benefits	**934**	1,619
Other costs	**518,058**	506,160
Income	**(19,627)**	(7,907)
Net programme expenditure before interest	**499,365**	**499,872**
Investment income	**0**	(35)
Finance costs	**728**	0
Net programme expenditure for the financial year	**505,093**	**499,837**

Other Comprehensive Net Expenditure	**2012-13 £000**	**2011-12 £000**
Impairments and reversals put to the Revaluation Reserve	**1,922**	643
Net (gain) on revaluation of property, plant & equipment	**(768)**	(967)
Total comprehensive net expenditure for the year*	**523,016**	**512,873**

* This is the sum of the rows above plus net operating costs for the financial year after absorption accounting adjustments.

Statement of financial position as at 31 March 2013

	31 March 2013	31 March 2012
	£000	£000
Non-current assets:		
Property, plant and equipment	**39,758**	41,283
Intangible assets	**34**	103
Other financial assets	**328**	299
Trade and other receivables	**201**	201
Total non-current assets	**40,321**	41,886
Current assets:		
Trade and other receivables	**9,328**	10,389
Cash and cash equivalents	**17**	67
Total current assets	**9,345**	10,456
Total assets	**49,666**	52,342
Current liabilities		
Trade and other payables	**(40,048)**	(36,526)
Provisions	**(1,961)**	(965)
Borrowings	**(156)**	(89)
Total current liabilities	**(42,165)**	(37,580)
Non-current assets plus/less net current assets/liabilities	**7,501**	14,762
Non-current liabilities		
Provisions	(6,941)	(4,282)
Borrowings	(6,270)	(6,425)
Total non-current liabilities	**(13,211)**	(10,707)
Total Assets Employed:	**(5,710)**	4,055
Financed by taxpayers' equity:		
General fund	(19,652)	(11,444)
Revaluation reserve	13,942	15,499
Total taxpayers' equity:	**(5,710)**	4,055

Statement of changes in taxpayers' equity for the year ended 31 March 2013

	General fund £000	Revaluation reserve £000	Total reserves £000
Balance at 1 April 2012	**(11,444)**	**15,499**	**4,055**
Changes in taxpayers' equity for 2012-13			
Net operating cost for the year	(521,862)		**(521,862)**
Net gain on revaluation of property, plant, equipment		768	**768**
Impairments and reversals		(1,922)	**(1,922)**
Transfers between reserves*	403	(403)	**0**
Total recognised income and expense for 2012-13	**(521,459)**	**(1,557)**	**(523,016)**
Net Parliamentary funding	513,251		**513,251**
Balance at 31 March 2013	**(19,652)**	**13,942**	**(5,710)**
Balance at 1 April 2011	**12,088**	**15,175**	**27,263**
Changes in taxpayers' equity for 2011-12			
Net operating cost for the year	(513,197)		(513,197)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment		967	967
Impairments and Reversals		(643)	(643)
Total recognised income and expense for 2011-12	(513,197)	324	(512,873)
Net Parliamentary funding	489,665		489,665
Balance at 31 March 2012	**(11,444)**	**15,499**	**4,055**

* The transfer between reserves relates to the realised depreciation impact upon the revaluation reserve.

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	**(521,162)**	(512,725)
Depreciation and Amortisation	**2,511**	3,145
Impairments and Reversals	**846**	1,187
Interest Paid	**(669)**	(453)
(Increase)/Decrease in Trade and Other Receivables	**1,033**	5,981
Increase/(Decrease) in Trade and Other Payables	**2,449**	12,897
Provisions Utilised	**(5,690)**	(629)
Increase/(Decrease) in Provisions	**9,286**	1,220
Net Cash Inflow/(Outflow) from Operating Activities	**(511,396)**	**(489,377)**
Cash flows from investing activities		
Interest Received	**28**	35
(Payments) for Property, Plant and Equipment	**(1,844)**	(97)
Net Cash Inflow/(Outflow) from Investing Activities	**(1,816)**	**(62)**
Net cash inflow/(outflow) before financing	**(513,212)**	**(489,439)**
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**(89)**	(189)
Net Parliamentary Funding	**513,251**	489,665
Net Cash Inflow/(Outflow) from Financing Activities	**513,162**	**489,476**
Net increase/(decrease) in cash and cash equivalents	**(50)**	**37**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**67**	**30**
Cash and Cash Equivalents (and Bank Overdraft) at year end	**17**	**67**

Statutory financial duties

Enfield PCT was required to meet three statutory financial duties in 2012/13, namely:

- In year financial balance
- Spending within our capital allocation
- Spending within the cash limit

Enfield PCT's performance for the year ended 31 March 2013 is as follows:

Revenue Resource Limit	**2012-13**	**2011-12**
	£000	**£000**
The PCT's performance for the year ended 2012-13 is as follows:		
Total Net Operating Cost for the Financial Year		513,197
Net operating cost plus (gain)/loss on transfers by absorption	**521,862**	
Revenue Resource Limit	**524,702**	496,009
Under/(Over)spend Against Revenue Resource Limit (RRL)	2,840	(17,188)

The underspend in 2012/13 (and overspend in 2011/12) against the Revenue Resource Limit was planned and agreed with the Department of Health and the NHS London Strategic Health Authority.

Capital Resource Limit	**2012-13**	**2011-12**
	£000	**£000**
The PCT is required to keep within its Capital Resource Limit.		
Capital Resource Limit	**2,959**	1,255
Charge to Capital Resource Limit	**2,917**	561
(Over)/Underspend Against CRL	**42**	**694**
The PCT kept within its Capital Resource Limit.		

Under/(Over)spend against cash limit	**2012-13**	**2011-12**
	£000	**£000**
Total Charge to Cash Limit	**513,251**	489,665
Cash Limit	**513,251**	497,273
Under/(Over)spend Against Cash Limit	**0**	**7,608**
The PCT kept within its Cash Limit.		

Better payment practice code

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. The disclosure below shows the value of invoices by volume and amount paid within 30 days, with the remaining invoices being paid later than 30 days.

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	**9,679**	**31,946**	9,472	40,282
Total Non-NHS Trade Invoices Paid Within Target	**5,694**	**16,320**	4,294	20,821
Percentage of NHS Trade Invoices Paid Within Target	58.83%	51.09%	45.33%	51.69%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3,634**	**370,267**	2,847	360,749
Total NHS Trade Invoices Paid Within Target	**1,575**	**357,825**	1,017	340,651
Percentage of NHS Trade Invoices Paid Within Target	43.34%	96.64%	35.72%	94.43%

Running costs

The PCT's running costs for 2012/13 are shown in the table below.

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**22,133**	21,435	698
Weighted population (number in units)*	**289,265**	289,265	289,265
Running costs per head of population (£ per head)	**76.5**	**74.1**	**2.4**
PCT Running Costs 2011-12			
Running costs (£000s)	**14,547**	12,067	2,480
Weighted population (number in units)	**289,265**	289,265	289,265
Running costs per head of population (£ per head)	**50.3**	**41.7**	**8.6**

* Weighted population figures are not available for 2012-13 as the weighted capitation formula for PCT allocations was not updated for 2012-13. This was because it was decided to give all PCTs the same percentage growth in their allocations in this transitional year rather than differential growth based on a weighted capitation formula. Therefore 2011-12 weighted populations have been used when calculating the running costs per head of population in 2012-13.

The management costs' figures have been calculated using the definition provided by the Department of Health, based on staff costs only, excluding infrastructure and headquarter costs. The staff costs that are included in the Department of Health definition incorporate the following elements:

- Board and Executive committee functions
- Corporate functions
- Clinical and operational functions
- Support service functions.

Related party transactions

Enfield PCT is a body corporate established by the order of the Secretary of State for Health.

During the year, with the exception of the GP Board members and GP Professional Executive Committee members, none of the Board Members or members of the key management staff or parties related to them has undertaken material transactions with Enfield PCT.

The members of the Clinical Executive Committee are also practicing GPs in the borough of Enfield, and as such receive practice income from the PCT.

HM Treasury considers Government Departments and their agencies, and Department of Health Ministers, their close families and entities controlled or influenced by them, as being parties related to NHS bodies. Related party transactions are to be disclosed if material to either party.

The table below shows the relationship between Enfield PCT's Senior Managers and related parties, i.e. organisations they control or can influence. The amounts disclosed below are transactions with the related parties and not the individuals.

Name/ Title	Related Party	Relationship with Related Party	Annual		31 March 2013	
			Expenditure	Income	Payables	Receivable
			£000's	£000's	£000's	£000's
Paula Kahn - Chair						
	Barnet PCT	Chair	58	5,237	0	5,070
	Camden PCT	Chair	500	446	498	446
	Haringey PCT	Chair	0	419	0	742
	Islington PCT	Chair	7,531	176	1,151	27
Caroline Rivett - Non-Executive Director						
	Barnet PCT	Audit Chair	58	5,237	0	5,070
	Camden PCT	Audit Chair	500	446	498	446
	Haringey PCT	Audit Chair	0	419	0	742
	Islington PCT	Audit Chair	7,531	176	1,151	27
Deborah Fowler - Non-Executive Director						
	Camden & Islington Foundation Trust	Member	147	0	11	0
	Camden PCT	Non Executive Director	500	446	498	446
Karen Trew - Non-Executive Director						
	Camden PCT	Non Executive Director	500	446	498	446
Cathy Herman - Non-Executive Director						
	Haringey PCT	Non Executive Director	0	419	0	742
Sue Baker - Non-Executive Director						
	Haringey PCT	Non Executive Director	0	419	0	742
Caroline Taylor - Chief Executive						
	Barnet PCT	Chief Executive	58	5,237	0	5,070
	Camden PCT	Chief Executive	500	446	498	446
	Haringey PCT	Chief Executive	0	419	0	742
	Islington PCT	Chief Executive	7,531	176	1,151	27
Beverley Evans - Interim Director of Finance						
	Maidstone and Tunbridge Wells NHS Trust	Non-Executive Director	13	0	7	0
Mo Abedi - PEC Member						
	Medicare Medical Services LLP	Director/Shareholder	1,115	0	0	0
	Enfield Health Partnership Ltd	Shareholder	288	73	0	45
	Evergreen Surgery Ltd	Director/Shareholder	1	173	0	173
Mike Gocman - CCG Member-Elected GP Representative						
	Barndoc Healthcare Ltd	Shareholder	1,791	0	0	0
Alpesh Patel - CCG Chair-Elected GP Representative						
	Barndoc Healthcare Ltd	Shareholder	1,791	0	0	0
	Medicare Medical Services LLP	Shareholder				
	White Lodge Medical Practice	Director/Shareholder	15	0	0	
	Enfield Health Partnership Ltd	Shareholder	288	73	0	45
	Evergreen Surgery Ltd	Director/Shareholder	1	173	0	173
Ujjal Sarkar - CCG Member-Elected GP Representative						
	Barndoc Healthcare Ltd	Member	1,791	0	0	0

Dr Anshu Baghat - CCG Member-Elected GP Representative					
Barndoc Healthcare Ltd	Shareholder	1,791	0	0	0
Tim Fenn - CCG Member-Elected GP Representative					
Forest Road Group Practice	GP Principal	2	72	0	19
Richard Quinton - Head of Finance					
QFM Ltd	Director	173	0	0	0
Ray James - CCG Member - Director of Health, Housing					
London Borough of Enfield	Director of Health	12,117	1,229	6,977	967

The Department of Health is regarded as a related party. During the year Enfield PCT has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

NHS Organisation	Annual Expenditure £000's
Barnet And Chase Farm Hospitals NHS Trust	107,026
North Middlesex University Hospital NHS Trust	67,531
Barnet, Enfield And Haringey Mental Health NHS Trust	57,239
Croydon PCT	31,387
University College London NHS Foundation Trust	26,466
Royal Free London NHS Foundation Trust	16,447
Barts Health NHS Trust	9,605
London Ambulance Service NHS Trust	9,584
Whittington Hospital NHS Trust	6,548
Great Ormond Street Hospital for Children NHS Foundation Trust	4,500
Moorfields Eye Hospital NHS Foundation Trust	3,858
Central And North West London MH NHS Foundation Trust	2,515
The Royal National Orthopaedic Hospital NHS Trust	2,490
Guys And St Thomas NHS Foundation Trust	2,456
Homerton University Hospital NHS Foundation Trust	1,763

In addition, the PCT has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with the London Borough of Enfield.

Remuneration report

The Remuneration Committee's key purpose is to advise the Board on the remuneration and terms of service for the Chief Executive and board level Directors. The committee also oversees exit terms for this group of staff and all other staff.

The Joint Boards Remuneration Committee Membership during 2012/13 was as follows:

- Paula Kahn – Chair of Joint Boards
- John Carrier (Chair) – Camden PCT Vice Chair and NED Barnet PCT
- David Riddle – Barnet PCT Vice Chair and NED Islington PCT
- Karen Trew – Enfield PCT Vice Chair and NED Camden PCT
- Cathy Herman – Haringey PCT Vice Chair and NED Enfield PCT
- Anne Weyman – Islington PCT Vice Chair and NED Haringey PCT

The Chief Executive and Director of Human Resources and Corporate Affairs attended the meetings to provide support as required. The Chief Executive was not present for discussions related to her own remuneration.

Statement of the remuneration policy for senior managers:

The Cluster's remuneration policy for senior managers was consistent with the standard NHS Very Senior Manager (VSM) guidelines and to set salaries in conjunction with NHS London procedures.

Performance related remuneration:

VSM performance assessment processes were used during 2012/13 including NHS London review of performance bonuses for appropriate roles. The remuneration committee voted not to pay any performance bonuses in 2012/13 regardless of individual or collective performance.

Policy on duration of contracts and notice periods:

Contract and notice terms are standard as set out in VSM guidelines. The PCTs have been cognisant of future changes and have employed and retained some resources on fixed term or interim contracts to reduce future redundancy liabilities. Notice periods for senior staff are normally three months, and in some instances are six months based on inherited contracts.

Policy on termination and exit payments:

Termination payments have been made in accordance with the standard NHS policy and regulations that apply to redundancy or early retirement with no additional or non-contractual payment.

Salary and allowances of senior managers 2012/13 (PCT share)

(These tables have been audited)

	NAME	TITLE	2012-13 Salary (bands of £5,000) £000	Other Rem's (bands of £5000) £000	Bonus Pmts (bands of £5000) £000	Benefits in kind (bands of £100 £00	Dates served Commenced	Ceased
	VOTING MEMBERS							
	Non Executive Directors							
*	Ms Paula Kahn	Chair	5-10	0	0	0	01/04/2011	31/03/2013
**	Ms Karen Trew	Vice Chair NED Camden	5-10	0	0	0	01/04/2011	31/03/2013
**	Ms Deborah Fowler	NED Camden	0-5	0	0	0	01/04/2011	31/03/2013
*	Ms Caroline Rivett	Audit Chair	0-5	0	0	0	01/04/2011	31/03/2013
**	Ms Cathy Herman	Vice Chair Haringey	5-10	0	0	0	01/04/2011	31/03/2013
**	Ms Sue Baker	NED Haringey	0-5	0	0	0	01/04/2011	31/03/2013
	Executive Directors							
*	Ms Caroline Taylor	Chief Executive Officer	25-30	0	0	0	01/04/2011	31/03/2013
*	Ms Ann Johnson	Director of Finance	10-15	0	0	0	01/04/2011	04/09/2012
*	Mrs Bev Evans (1)	Director of Finance	35-40	0	0	0	05/09/2012	31/03/2013
***	Dr Shahad Ahmad	Director of Public Health - Enfield	115-120	0	0	0	01/04/2011	31/03/2013
	NON VOTING MEMBERS							
	Executive Directors							
*	Mr Jeremy Burden (3)	Director of Contracts	0-5	0	0	0	01/05/2011	31/03/2013
*	Mr Simon Currie (1)	Director of Contracts	20-25	0	0	0	11/06/2012	26/11/2012
*	Ms Liz Wise (5)	Director of QIPP	20-25	0	0	0	01/04/2011	31/03/2013
*	Ms Alison Pointu	Director of Quality & Safety	20-25	0	0	0	01/04/2011	31/03/2013
*	Ms Sarah Price (6)	Director of Public Health	20-25	0	0	0	01/04/2011	31/12/2012
*	Ms Helen Pettersen (4)	Director of Transition and Corporate affairs	20-25	0	0	0	01/04/2011	31/03/2013
*	Dr Douglas Russell	Medical Director (Primary Care)	5-10	0	0	0	01/04/2011	31/07/2012
*	Dr Henrietta Hughes	Medical Director (Primary Care)	15-20	0	0	0	01/07/2012	31/03/2013
*	Dr Nick Losseff (2)	Medical Director (Secondary Care)	5-10	0	0	0	01/04/2011	31/03/2013
*	Mr Ian Fuller	Director of HR	10-15	0	0	0	01/04/2011	31/10/2012
*	Ms Marion McCrindle (1)	Director of HR	15-20	0	0	0	15/10/2012	31/03/2013
****	Ms Sarah Thompson	Borough Director Enfield	50-55	0	0	0	18/09/2011	07/09/2012
	PEC Members							
***	Dr Janet High	PEC Chair Enfield	35-40	0	0	0	01/07/2011	31/03/2013
***	Ms Lynn Pope	Nurse Rep Enfield	10-15	0	0	0	01/04/2011	01/06/2012

Notes
(1) Paid through consultancy company
(2) Seconded from another NHS organisation
(3) Seconded to another NHS organisation from July 2012
(4) North East London CSU from October 2012
(5) Accountable Officer Enfield CCG from October 2012
(6) Accountable Officer Haringey CCG from November 2012

Main Board members serve on all 5 PCTs of the NCL Cluster and their remuneration is charged to all five PCTs accordingly.

The PCT share is shown above and the members full amount below.

Prior year comparison figures are included below but not apportioned to individual PCTs.

See below for reference to asterisks

Full Salary and allowances of Senior Managers 2012/13

	NAME	TITLE	2012-13			2011-12		
			Salary (bands of £5,000) £000	Other Rem's (bands of £5000) £000	Bonus Pmts (bands of £5000) £000	Salary (bands of £5,000) £000	Other Rem's (bands of £5000) £000	Bonus Pmts (bands of £5000) £000
	VOTING MEMBERS							
	Non Executive Directors							
*	Ms Paula Kahn	Chair	40-45	0	0	40-45	0	0
**	Ms Karen Trew	Vice Chair NED Camden	10-15	0	0	10-15	0	0
**	Ms Deborah Fowler	NED Camden	5-10	0	0	5-10	0	0
*	Ms Caroline Rivett	Audit Chair	10-15	0	0	10-15	0	0
**	Ms Cathy Herman	Vice Chair Haringey	10-15	0	0	10-15	0	0
**	Ms Sue Baker	NED Haringey	5-10	0	0	5-10	0	0
	Executive Directors							
*	Ms Caroline Taylor	Chief Executive Officer	145-150	0	0	145-150	0	0
*	Ms Ann Johnson	Director of Finance	60-65	0	0	120-125	0	0
*	Mrs Bev Evans (1)	Director of Finance	180-185	0	0	0	0	0
***	Dr Shahad Ahmad	Director of Public Health - Enfield	115-120	0	0	105-110	0	0
	NON VOTING MEMBERS							
	Executive Directors							
*	Mr Jeremy Burden (3)	Director of Contracts	20-25	0	0	95-100	0	0
*	Mr Simon Currie (1)	Director of Contracts	115-120	0	0	0	0	0
*	Ms Liz Wise (5)	Director of QIPP	115-120	0	0	115-120	0	0
*	Ms Alison Pointu	Director of Quality & Safety	100-105	0	0	95-100	0	0
*	Ms Sarah Price (6)	Director of Public Health	100-105	0	0	100-105	0	0
*	Ms Helen Pettersen (4)	Director of Transition and Corporate affairs	115-120	0	0	115-120	0	0
*	Dr Andy Watts	Medical Director (Primary Care)	0	0	0	30-35	0	0
*	Dr Douglas Russell	Medical Director (Primary Care)	40-45	0	0	95-100	0	0
*	Dr Henrietta Hughes	Medical Director (Primary Care)	95-100	0	0	0	0	0
*	Dr Nick Losseff (2)	Medical Director (Secondary Care)	40-45	0	0	40-45	0	0
*	Mr Ian Fuller	Director of HR	60-65	0	0	85-90	0	0
*	Ms Marion McCrindle (1)	Director of HR	80-85	0	0	0	0	0
**	Mr Nigel Beverley (1)	Borough Director Enfield	0	0	0	30-35	0	0
****	Ms Sarah Thompson	Borough Director Enfield	50-55	0	0	110-115	0	0
	PEC Members							
***	Dr Janet High	PEC Chair Enfiled	35-40	0	0	20-25	0	0
***	Ms Lynn Pope	Nurse Rep Enfield	10-15	0	0	60-65	0	0

Key
* Salary costs apportioned to the 5 PCTs (20%)
** Salary costs apportioned to 2 PCTs (50%)
*** Salary costs charged to the PCT (100%)
**** Salary costs from date transferred from Camden PCT

See above for explanation of notes

There were no benefits in kind for Senior Managers in 2012/13 or 2011/12.

Full Salary and allowances of Senior Managers 2011-12

	NAME	TITLE	2011-12			Dates served during 2011/12	
			Salary (bands of £5,000)	Other Rem'n (bands of £5000)	Bonus Pmts (bands of £5000)	Commenced	Ceased
			£000	£000	£000		
	VOTING MEMBERS						
	Non Executive Directors						
*	Ms Paula Kahn	Chair	5-10	0	0	01/04/2011	
**	Ms Karen Trew	Vice Chair	5-10	0	0	01/04/2011	
**	Ms Deborah Fowler		0-5	0	0	01/04/2011	
*	Ms Caroline Rivett	Audit Chair	0-5	0	0	01/04/2011	
**	Ms Cathy Herman		5-10	0	0	01/04/2011	
**	Ms Sue Baker		0-5	0	0	01/04/2011	
	Executive Directors						
*	Ms Caroline Taylor (2)	Chief Executive Officer	25-30	0	0	01/04/2011	
*	Ms Ann Johnson (2)	Director of Finance	20-25	0	0	01/04/2011	
***	Dr Shahad Ahmad	Director of Public Health - Enfield	105-110	0	0	01/04/2011	
	NON VOTING MEMBERS						
	Executive Directors						
*	Mr Jeremy Burden	Director of Contracts	15-20	0	0	01/05/2011	
*	Ms Liz Wise	Director of QIPP	20-25	0	0	01/04/2011	
*	Ms Alison Pointu	Director of Quality & Safety	15-20	0	0	01/04/2011	
*	Ms Sarah Price	Director of Public Health	20-25	0	0	01/04/2011	
*	Ms Helen Pettersen	Director of Transition and Corporate affairs	20-25	0	0	01/04/2011	
*	Dr Andy Watts	Medical Director (Primary Care)	5-10	0	0	01/04/2011	03/07/2011
*	Dr Douglas Russell	Medical Director (Primary Care)	15-20	0	0	04/07/2011	
*	Dr Nicholas Losseff (2)	Medical Director (Secondary Care)	5-10	0	0	01/04/2011	
**	Mr Nigel Beverley (1)	Borough Director Enfield	40-45	0	0	01/04/2011	18/09/2011
****	Ms Sarah Thompson	Borough Director Enfield	105-110	0	0	01/07/2011	
	PEC MEMBERS						
***	Dr Janet High	PEC Chair (voting)	20-25	0	0	01/07/2011	
***	Ms Lynn Pope	PEC Nurse (voting)	60-65	0	0	01/04/2011	

Notes (1) Paid through consultancy company. Spend includes travel and non-recoverable VAT

(2) Seconded from another NHS organisation (Caroline Taylor on secondment until February 2012)

Some Board members serve on more than one of the boards of the 5 PCTs of the NCL Cluster and their remuneration is shared between the relevant PCTs.

The PCTs share is shown above and the members full amount below.

There were no benefits in kind for Senior Managers in 2011/12.

Pension benefits of senior managers 2012/13 (PCT share)

Name	Title	Real increase/ decrease in pension at age 60 (bands of 2500)	Real increase/ decrease in related lump sum at age 60 (bands of £2500)	Total accrued pension at age 60 at 31 March 2013 (bands of £5000)	Total accrued related lump sum at age 60 at 31 March 2013 (bands of £5000)	Cash Equivalent Transfer Value (CETV) at 31 March 2013	Cash Equivalent Transfer Value (CETV) at 31 March 2012	Real increase/ decrease in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension
		£000	£000	£000	£000	£000	£000	£000	£000
Board Members									
Ms Caroline Taylor	Chief Executive Officer	0-2.5	0-2.5	10-15	35-40	280	258	9	0
Ms Ann Johnson	Director of Finance	0-2.5	0-2.5	0-5	5-10	29	23	4	0
Mr Jeremy Burden	Director of Contracts	(0-2.5)	(0-2.5)	5-10	20-25	128	120	2	0
Ms Liz Wise	Director of QIPP	0-2.5	0-2.5	0-5	10-15	95	87	4	0
Ms Alison Pointu	Director of Health & Safety	0-2.5	0-2.5	5-10	25-30	202	179	14	0
Ms Sarah Price	Director of Public Health	0-2.5	0-2.5	5-10	15-20	88	81	3	0
Ms Helen Pettersen	Director of Transformation	0-2.5	0-2.5	5-10	20-25	129	118	4	0
Mr Nick Losseff	Medical Director	0-2.5	2.5-5	5-10	25-30	149	138	4	0
Mr Ian Fuller	Director of Human Resources	0-2.5	0-2.5	2.5-5	10-15	67	63	0	0
Ms Sarah Thompson	Borough Director Enfield	(7.5-10)	(32.5-35)	25-30	65-70	598	619	(53)	0
Dr Shahad Ahmed	Director of Public Health Enfield	0-2.5	0-2.5	25-30	75-80	395	361	15	0
PEC Members									
Dr Janet High	PEC Chair Enfield	(0-2.5)	(0-2.5)	60-65	190-195	1412	1324	46	0
Ms Lynn Pope	Nurse Rep Enfield	(0-2.5)	(0-2.5)	10-15	30-35	210	202	(2)	0
Note:									
Dr Henrietta Hughes	Medical Director Primary Care	Information not available as sessional figures not collated by the pension agency.							

Some Board members serve on more than one of the boards of the five PCTs of the NHS North Central London Cluster and their remuneration is shared between the relevant PCTs.

The PCT's share is shown above and the members full amount below.
Prior year comparison figures are included below but not apportioned to individual PCTs.

As non-executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for non-executive members.

Full Pension benefits of senior managers 2012/13

Name	Title	Real increase/ decrease in pension at age 60 (bands of 2500)	Real increase/ decrease in related lump sum at age 60 (bands of £2500)	Total accrued pension at age 60 at 31 March 2013 (bands of £5000)	Total accrued related lump sum at age 60 at 31 March 2013 (bands of £5000)	Cash Equivalent Transfer Value (CETV) at 31 March 2013	Cash Equivalent Transfer Value (CETV) at 31 March 2012	Real increase/ decrease in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension
		£000	£000	£000	£000	£000	£000	£000	£000
Board Members									
Ms Caroline Taylor	Chief Executive Officer	0-2.5	0-2.5	60-65	190-195	1,400	1,288	45	0
Ms Ann Johnson	Director of Finance	0-2.5	2.5-5	5-10	25-30	144	115	23	0
Mr Jeremy Burden	Director of Contracts	(0-2.5)	(0-2.5)	35-40	105-110	639	598	9	0
Ms Liz Wise	Director of QIPP	0-2.5	0-2.5	20-25	65-70	477	433	21	0
Ms Alison Pointu	Director of Health & Safety	0-2.5	5-7.5	45-50	145-150	1,012	895	70	0
Ms Sarah Price	Director of Public Health	0-2.5	0-2.5	25-30	75-80	440	406	13	0
Ms Helen Pettersen	Director of Transformation	0-2.5	0-2.5	35-40	105-110	643	592	19	0
Mr Nick Losseff	Medical Director	0-2.5	2.5-5	40-45	120-125	747	690	22	0
Mr Ian Fuller	Director of Human Resources	0-2.5	0-2.5	15-20	50-55	334	316	1	0
Ms Sarah Thompson	Borough Director Enfield	(7.5-10)	(30-32.5)	25-30	65-70	598	619	(53)	0
Dr Shahad Ahmed	Director of Public Health Enfield	0-2.5	0-2.5	25-30	75-80	395	361	15	0
PEC Members									
Dr Janet High	PEC Chair Enfield	(0-2.5)	(2.5-5)	60-65	190-195	1,412	1,324	46	0
Ms Lynn Pope	Nurse Rep Enfield	(0-2.5)	(0-2.5)	10-15	30-35	210	202	(2)	0
Note:									
Dr Henrietta Hughes	Medical Director Primary Care	Information not available as sessional figures not collated by the pension agency.							

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

Cash Equivalent Transfer Values

The Government Actuary Department ('GAD') factors for the calculation of Cash Equivalent Transfer Factors ('CETVs') assume that benefits are indexed in line with CPI which is expected to be lower than RPI which was used previously and hence will tend to produce lower 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 arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to 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 other pension details include the value of any benefits in another scheme or arrangement which the individual has transferred to the NHS Pension 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.

Pension liability

Past and present employees are covered by the provisions of the NHS Pension 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 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.

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 Enfield PCT the financial year 2012-13 was £115k to £120k (2011/12: £145k-£150k). This was 2.9 (2011/12: 4.0) times the median remuneration of the workforce, which was £40,517 (2011/12: £38,790). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. In 2012/13 The workforce median calculation is based on the North Central London Cluster sector average, due to the fact that the majority of staff in 2012/13 were employed by Islington PCT and costs recharged to other sector bodies through inter PCT recharges.

Off Payroll Engagements

The PCT is from 2012/13 required to disclose information about 'off payroll engagements'. The following tables show the number of off payroll engagements in place at 31st January 2012, (Table 1) and new engagements during the period 23 August 2012 and 31 March 2013 (Table 2).

Table 1: For off-payroll engagements at a cost of over £58,200 per annum which were in place as of 31 January 2012.

No. In place on 31 January 2012	**6**
Of which:	
No. that have since been re-negotiated /reengaged 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	
No. that have come to an end	(6)
Total as at 31 March 2013	**0**

Table 2: For all new off payroll engagements between 23 August 2012 and 31 March 2013, for more than £220 per day and more than 6 months.

No. of new engagements	**0**
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.	0
Of which:	0
No. for whom assurance has been accepted and received	0
No. for whom assurance has been accepted and not received	0
No. that have been terminated as a result of assurance not being received	0
No. that have been terminated as a result of PCT closure.	0
Total as at 31 March 2013	**0**

Register of Board members' interests

NAME	NAME OF ORGANISATION AND NATURE OF ITS BUSINESS	POSITION HELD/ NATURE OF INTEREST	DATE DECLARED	DATE UPDATED
Non-Executive Directors				
Paula Kahn	Cripplegate Foundation	Governor	24/05/2012	24/05/2012
	THE EW Group which has contracts with a number of NHS Trusts/SHA/Institute of Innovation - none with the NCL Cluster or Islington PCT	Partner is Freelance Consultant	24/05/2012	24/05/2012
	Barnet, Camden, Haringey and Islington Primary Care Trusts	Chair	24/05/2012	24/05/2012
Karen Trew	NHS Camden Primary Care Trust	Non-Executive Director	24/05/2012	24/05/2012
	Shadow Enfield Clinical Commissioning Group Governing Body	Lay Member	11/10/2012	11/10/2012
Caroline Rivett	Synodex UK (Provides Medical Record Analysis)	Director	07/03/2012	07/03/2012
	NHS Haringey, Islington, Barnet, Camden and Enfield Primary Care Trusts	Audit Chair	07/03/2012	07/03/2012
	Unthank Consulting	Spouse is Director	07/03/2012	07/03/2012
Deborah Fowler	NHS Camden Primary Care Trust	Non Executive Director	22/05/2012	22/05/2012
	Employment Tribunals for Her Majesty's Courts Service	Lay Member	22/05/2012	22/05/2012
	Health Professions Council Fitness to Practise Panel	Lay Member	22/05/2012	22/05/2012
	Landscape Institute	Trustee	22/05/2012	22/05/2012
	Camden and Islington Mental Health Trust	Member	22/05/2012	22/05/2012
	University College Hospitals London	Member	22/05/2012	22/05/2012
Catherine Herman	Community Development Foundation.	Associate	04/03/2012	04/03/2012
	Independent Consultant		04/03/2012	04/03/2012
	Bowes Park Community Association	Trustee	04/03/2012	04/03/2012
	NHS Haringey Primary Care Trust	Vice Chair	04/03/2012	04/03/2012
Sue Baker	Cascade Health LTD	Director/Owner	24/03/2012	12/04/2012
	Cascade Partnership LLP	Director/Owner	24/03/2012	12/04/2012
	Haringey Advisory Group on Alcohol (HASA)	Trustee	24/03/2012	12/04/2012
	Cricklewood Homeless Concern	Spouse is Director/CEO	24/03/2012	12/04/2012
	NHS Haringey Primary Care Trust	Non-Executive Director	24/03/2012	12/04/2012
Voting Senior Leadership Team Members				
Caroline Taylor	Husband is an education consultant who might on occasions work as an associate with a company with whom the NHS does business.		23/04/2012	23/04/2012
	NHS Barnet, Camden, Haringey and Islington Primary Care Trusts	Chief Executive Officer	24/05/2012	24/05/2012
Beverley Evans	White House Accountancy and Consulting Limited	Owner, Director and majority share holder	28/02/13	28/02/13
	Maidstone and Turnbridgewells NHS Trust	Non-Executive Director	28/02/13	28/02/13
Shahed Ahmad	UCLH and BCF NHS Trust	Wife is a Consultant Oncologist	09/05/2012	02/11/2012

Non-voting Members				
Alpesh Patel	Whitel Lodge Medical Practice GP Partnership	GP Partner	24/05/2012	04/07/2012
	White Lodge Medical Practice Limited (Pharmacy)	Director/Shareholder	24/05/2012	04/07/2012
	Evergreen Surgery Limited (GP Practice)	Director/Shareholder	24/05/2012	04/07/2012
	Magnolia Limited	Director/Shareholder	24/05/2012	04/07/2012
	Equity Health LLP	Director/Shareholder	24/05/2012	04/07/2012
	Medicare Medical Services LLP (Walk in service)	Shareholder	24/05/2012	04/07/2012
	Prime Point Limited	Shareholder	24/05/2012	04/07/2012
	Enfield Health Partnership Limited	Shareholder	24/05/2012	04/07/2012
	Barndoc Healthcare Limited	Shareholder	24/05/2012	04/07/2012
	BEHMHT	Wife is a CAMHS Consultant	24/05/2012	04/07/2012
	Ordnance Health Ltd - company tendering for the APMS Contract at Ordnance Road Surgery	Shareholder	19/12/2012	19/12/2012
David Cryer	No interests declared		11/04/2012	11/04/2012
Alison Pointu	No interests declared		19/03/2012	19/03/2012
Liz Wise	No interests declared		10/05/2012	10/05/2012
Nick Losseff	UCLH	Consultant	23/05/2012	23/05/2012
Professional Executive Committee Representatives				
Mo Abedi	Medicare Medical Services LLP	Director / Shareholder	11/05/2012	11/05/2012
	Equity Health LLP	Director / Shareholder	11/05/2012	11/05/2012
	DM786 Ltd.	Director	11/05/2012	11/05/2012
	Prime Point Ltd.	Director / Shareholder	11/05/2012	11/05/2012
	Evergreen Surgery Ltd.	Director / Shareholder	11/05/2012	11/05/2012
	East Enfield Medical Practice	GP principle	11/05/2012	11/05/2012
	Enfield Health Partnership Ltd.	Shareholder	11/05/2012	11/05/2012
	Enfield Health Partnership Ltd.	Spouse has same interests	11/05/2012	11/05/2012
	Ordnance Health Ltd - company tendering for the APMS Contract at Ordnance Road Surgery	Shareholder	11/05/2012	20/12/2012

Glossary

Expenditure:	Payments made and accruals, where an accrual is a payment due to be made but not yet released
Assets:	Resources, properties and possessions owned by the PCT
Current Assets:	Cash and other possessions which are likely to be converted into cash or used within a year
Fixed Assets:	Possessions and resources which are likely to be owned for more than a year
Tangible Assets:	Physical resources and possessions
Intangible Assets:	Non physical resources such as the PCT's software programmes
Liabilities:	Amounts owed by the PCT including any long-term financial obligation
Provisions:	Amounts retained by the PCT due to obligations to make future payments, for example ill-health and premature retirement pension payments
Taxpayer's equity:	Contribution by taxpayers to the net assets of the PCT
Impairment:	Reduction in value
Surplus:	Excess of income or gains over expenditure or losses
Operating costs:	Expenses that have arisen from the performance of the PCT's usual activities
Gross:	Overall or whole figure
Net:	The remaining amount after taking into account offsetting reductions
Capital:	Resources, properties and possessions owned by the PCT which are likely to be owned for more than a year or used to purchase property and possessions which are likely to be owned for more than a year
Revenue:	Resources and income to be used within a year
Remuneration:	Salaries and allowances
Operating Cost Statement:	Summarises, on an accruals basis, the net operating costs of the PCT. Operating costs and miscellaneous income is shown analysed between the commissioning and provider functions of the PCT.
Balance Sheet:	A quantitative summary of a company's financial condition at a specific point in time, including assets, liabilities and net worth.
IFRS:	International Financial Reporting Standards: accounting standards
Public Sector Payments Policy:	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.
Related Party Transactions:	A material transaction (i.e. a payment or a contract) between the PCT and a senior employee, other than salary or expenses. This can also extend to material transactions between the PCT and the senior employee's close family members, entities controlled by the senior employee or entities controlled by a close family member.

Further information

How to contact those responsible for providing health services for Enfield residents:

Enfield Clinical Commissioning Group

Holbrook House
Cockfosters Road
Barnet
Hertfordshire
EN4 0DR
www.enfieldccg.nhs.uk

London Borough of Enfield

Civic Centre
Silver Street
Enfield
EN1 3XA
www.enfield.gov.uk

NHS England

Quarry House
Quarry Hill
Leeds
LS2 7UE
www.england.nhs.uk

North & East London Commissioning Support Unit
Clifton House
75-77 Worship Street
London
EC2A 2DU

www.nelondoncsu.nhs.uk

Public Health England

www.healthandcare.dh.gov.uk/category/public-health/phe/

Department of Health

NHS

Enfield Primary Care Trust

2012-13 Accounts

Published to gov.uk, in PDF format only.

www.gov.uk/dh

Enfield Primary Care Trust

2012-13 Accounts

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 Enfield 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.

Peter Coates
Director of PICD, Strategy, Finance and NHS
Department of Health

Signed.....

Date: 5 June 2013

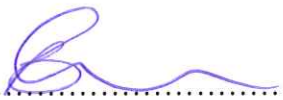
2012/13 ACCOUNTS FINANCE CERTIFICATE OF ASSURANCE TO THE DEPARTMENT OF HEALTH DIRECTOR GENERAL, STRATEGY FINANCE AND NHS

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 Enfield 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.

Name: Beverley Evans (Former Director of Finance)

Signed:  .....

Date: 5 June 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 Enfield Primary Care Trust (PCT) in order to comply with the Department's 2012/13 accounts finalisation process.

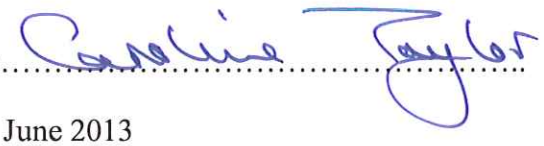
To assist you in that process, I can confirm that for the year ended 31 March 2013 based on my own knowledge of internal control matters and through experience in my role as Accountable Officer until 31 March 2013, the PCT:

- 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: Caroline Taylor (Former Chief Executive)

Signed: 

Date: 5 June 2013

Enfield PCT Annual Governance Statement: April 2012 – March 2013

Scope of Responsibility

I am assured by the former Chief Executive of Enfield Primary Care Trust (PCT), who was the Accountable Officer responsible for ensuring the proper stewardship of public funds and assets and who was accountable for the overall performance of the executive functions of the PCT, that the work of ensuring the discharge of obligations under Financial Directions was carried out in line with the requirements of the Accountable Officer Memorandum for PCT Chief Executives issued by the Department of Health.

I am assured by the Accountable Officer that she had carried out her responsibilities which included ensuring the following:

- management systems for safeguarding public funds and assets and assisting in the implementation of corporate governance;
- achieving value for money with the resources available;
- expenditure and income; and
- effective and sound financial management systems.

I am reassured by the former Accountable Officer who was accountable to the Chair and Non-Executive members of the PCT Board for ensuring that its decisions were implemented, that the organisation worked effectively, in accordance with Government policy and public service values, and for the maintenance of proper financial stewardship. Within the Standing Financial Instructions, it was acknowledged that the Chief Executive was ultimately accountable to the Board, and as Accountable Officer, to the Secretary of State, for ensuring that the PCT Board met its obligation to perform its functions within the available financial resources.

The former Chief Executive and Accountable Officer had overall executive responsibility for the PCT's activities and the achievement of its objectives; responsibility to the Chair and the PCT Board for ensuring that its financial obligations and targets were met; and had overall responsibility for the PCT's system of internal control. The essence of that role as Accountable Officer was to see that the Trust carried out these functions in a way which ensured the proper stewardship of public money and assets. Effective and sound financial management and information are of fundamental importance. I am assured by the former the Accountable Officer that this occurred.

The system of internal control had been in place at Enfield PCT for the year ended 31 March 2013 and up to the date of approval of the annual report and accounts.

With these assurances from the former Accountable Officer I have signed the Summarised Accounts of Health Bodies in England, and the Resource Accounts of the Department of Health.

The Summarised Accounts are derived from the statutory accounts of the PCT. Together with the Director of Finance, the former Accountable Officer was responsible

for ensuring that the accounts of the PCT were prepared under principles and in a format directed by the Secretary of State with the approval of the Treasury. These accounts disclose a true and fair view of the PCT's income and expenditure, and of its state of affairs. These accounts have been signed by the former Director of Finance on behalf of the PCT Board.

Robust arrangements were put in place for the preparation and audit of the accounts of the PCT following closedown of North Central London PCTs as statutory bodies. These arrangements are in line with Department of Health Guidance for financial closedown. A local delivery team was secured to prepare the accounts and a sub-committee of the Department of Health Audit and Risk Committee was established to review the accounts with retained non executive directors, the former Director of Finance, the external and internal auditors and the former Accountable Officer.

The Codes of Conduct and Accountability incorporated in the Corporate Governance Framework Manual issued to NHS Boards by the Secretary of State were fundamental in exercising my responsibilities for regularity, propriety and probity. Every member of the PCT Board had subscribed to these codes which were adopted in April 2011.

In April 2011, the PCT entered into a collaborative arrangement with other PCTs in North Central London and underwent significant structural and organisational change.

The "Cluster" of NHS North Central London was formed of five PCTs: Barnet, Camden, Enfield, Haringey and Islington.

The Strategic Health Authority confirmed the "Cluster" was compliant with Primary Care Trust regulations and Primary Care Trust Cluster Implementation Guidance. The Strategic Health Authority reviewed the Corporate Governance Framework outlining the shared working arrangements that was agreed by the PCT Board in February 2011 and confirmed it as compliant with PCT regulations and PCT Cluster Implementation Guidance.

The Framework was revised in September 2012 to reflect the transitional development of the new system as described in the Health and Social Care Act 2012. A single management team performed its role on behalf of each of the PCTs, who retained their statutory duties and powers. All PCT statutory functions, powers and duties were mapped to ensure that they were aligned to the new cluster management structure. The former Chief Executive of Enfield Primary Care Trust (PCT), and Accountable Officer was also the Accountable Officer for the other four PCTs.

In March 2012, Enfield CCG received delegated responsibility for medicines' management and received delegated responsibility for all other commissioning budgets in October 2012.

The NHS National Commissioning Board Decision Panel was held on 6 March 2013 to consider the additional evidence submitted on 20 February 2012 to address the 14 outstanding issues.

The Governance Framework of the Organisation

The Primary Care Trust was a statutory body which came into existence on 1 April 2002 under The Primary Care Trust (Establishment) Order 2002 No 100, (the Establishment Order). The principal place of business of the Enfield Primary Care Trust was Stephenson House, 75 Hampstead Road, London, NW1 2PL.

Composition of the Board

The Primary Care Trust (PCT) Board met concurrently with the other four Primary Care Trusts Boards of NHS North Central London. The Chair, Audit Chair, Chief Executive and Director of Finance alsofulfil these roles for the other PCTs within NHS North Central London. The other Non-Executive Directors of each PCT had Non-Executive Director roles in one other PCT within NHS North Central London. This change to the membership arrangements was made permissible by the passing of Statutory Instrument 2010 2539 which removed the disqualification which prevents a person who was a Chair or member of one PCT from being appointed as the Chair or a non-officer member of another PCT.

Each PCT Board had a Professional Executive Committee (PEC) Chair, PEC Nurse and Director of Public Health as voting members. In the case of the PEC Nurse and Director of Public Health, there was a cluster designated Director of Public Health (Islington), who attended on behalf of their peers unless there was specific business relating to an individual PCT for which the presence of a specific member would be required. The PCT Cluster-designated Director of Public Health were only eligible to vote on decisions for their own PCTBoard.

Committees

In line with statutory requirements, the Primary Care Trust (PCT) Board resolved in April 2011 to establish the:

- Audit Committee;
- Professional Executive Committee;
- Remuneration Committee; and
- Primary Care Reference Committee.

The Board also established such other Committees, as required, to discharge the PCT's responsibilities. It resolved to establish the:

- Quality and Safety Committee;
- Financial Recovery and Quality, Innovation, Productivity and Prevention Committee;
- London Specialised Commissioning Group Board; and
- Joint Committee of PCTs for the purposes of formal public consultation and decision making about the provision of Paediatric Cardiac Surgery Services in England.

The PCT Board agreed the terms of reference of these Committees and their delegated powers and responsibilities in April 2011 and reviewed the terms of reference in September 2012 to reflect the increased role in assurance to the Joint Boards and the increasing delegated responsibilities to Clinical Commissioning Groups (CCGs) and other new legal entities as set out in the Health and Social Care Act 2012.

The Remuneration Committee remit was extended to incorporate wider responsibilities to oversee the transfer of staff and the capacity of the cluster management during the final stages of transition.

A new Transition Committee of the Joint Boards was established in September 2012 to manage the oversight of all transition, handover and closure business required as a consequence of the Health and Social Care Act 2012. This Committee reflected the governance arrangements for transition and closure across the NHS in London.

The Enfield PCT Board established Enfield CCG Board as a Committee on 28 March 2012.

The Board's performance

The Chair of the Joint Boards of NHS North Central London conducted a review of the effectiveness of the Board and its Committees in early 2012 and presented the findings of the review at the March 2012 Board meeting. This internal assessment indicated that Board members were satisfied with the working of the Committees and their effectiveness in discharging their delegated responsibilities, and these were seen as an essential part of Board governance. Following the review NHS North Central London continued to embed best practice in governance across all functions.

Highlights of Board Committees' reports

Highlights of the work of key Committees are provided below.

Audit Committees:

- The Audit Committee met concurrently with the Audit Committees of the other PCTs within NHS North Central London. Whilst each Committee had a discrete agenda, shared membership and meeting arrangements further enabled positive assurance across all areas of business.
- The Committee approved the annual accounts, external and internal audit opinions and an Annual Governance Statement for 2011 / 2012 on behalf of Primary Care Trust (PCT) Board for submission to the Department of Health. Legacy and key control issues identified during 2011 / 2012 were factored in to the planning of the internal audit programme for 2012 / 2013.
- The Committee reviewed internal and external audit plans and reports, and sought assurance that recommended actions were completed and that all issues were managed comprehensively. The Committee received reports on counter fraud and security services, and waivers to competitive tender requirements.

- The Committee provided assurance to the PCT Board on areas of governance and risk, providing detailed oversight of the Board Assurance Framework (BAF). Meetings considered specific areas of business in depth to enable substantive assurance through focussed discussion and challenge with Executive officers on their areas of responsibility within the BAF. The Committee looked in detail at risks and assurances on a number of key topics including PCT finance and Quality, Innovation, Productivity and Prevention (QIPP) targets, primary care performance, and quality and safety.

Quality and Safety Committee:

- Clinical Quality Review meetings were established for all services, including acute, mental health and community services.
- The Organisational Intelligence Tool and the quality and safety dashboard provides information on key quality indicators for all providers. The report was a standing agenda item for the Quality and Safety Committee and the Clinical Commissioning Group (CCG) Quality Committees.
- A high-level review of quality and safety across mental health and learning disability services was completed; a series of recommendations were made and an action plan agreed.
- A multi-agency working group was established to improve the quality of nursing home service and patient experience in the northern boroughs of NHS North Central London.
- Workshops and shadowing opportunities for CCG staff helped to prepare for transfer of quality& safety functions and accountability.
- Supporting emerging CCGs to introduce Patient Stories to CCG Governing Body meetings to ensured that patient experience set the context for the business of the meeting.
- The Committee supported working to improve patient experience with other organisationse.g., the Making a Difference Board at University College London Hospitals NHS Foundation Trust (UCLH) and the implementation of the "walk the pathway" programme led by Patient Experience Manager involving Local Involvement Networks (LINks) and Non-Executive Directors, including visits to dementia and stroke services.
- Quality summits were held to share intelligence about providers ensuring that early warning systems are in place to improve patient safety.

Financial Recovery and QIPP Committee

The Committee provided a robust mechanism for review and challenge of progress against financial targets for each PCT. This was achieved through oversight of the delivery of savings plans and budgets; reviewed and development of the NHS North Central London QIPP Plan and associated implementation plans; and review and approval of procurements, contracts and investment business cases in line with the Scheme of Delegation.

Highlights from the year include:

- Completion of an alignment process to ensure leadership and ownership of finance and QIPP plans for 2012 / 2013. The Clinical Commissioning Groups (CCGs) were actively engaged in developing QIPP and investment plans achieved through programme management support which was phased over to the CCGs to help the CCGs in their delivery of the programme for 2013/14 Additional resource was given to support the development of local ownership and skills. There was a strong commitment to ensuring that investments were supported by future commissioning plans and that QIPP plans were in place to deliver savings earlier in the financial year going forward. All this could not have been achieved without the enthusiasm and commitment of the CCGs to produce a QIPP plan that reflected local need understood through direct clinical experience.
- Increased focus on underlying recurrent run rate positions of the PCTs in the Cluster
- Continuing reduction in historical debtors and creditors
- Revised terms of reference to include monitoring the legacy, handover and closedown arrangements for the PCT including finance department transition to the new NHS bodies.

Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee met periodically to consider and approve payments for PCT staff following the organisational transition into the North Central London management structure. The Committee's terms of reference were extended in September 2012 to reflect the need to closely monitor the movement of staff during transition to new commissioning bodies.

An account of Corporate Governance

The Primary Care Trust's (PCT) Corporate Governance arrangements were set out in the Corporate Governance Framework Manual agreed by the Board in April 2011 and revised in September 2012. The Manual included the organisation's Standing Orders, Standing Financial Instructions, Schemes of Reservation & Delegation and Codes of Accountability & Conduct. These arrangements have been drawn up in line with:

- The Primary Care Trust (Executive Committees and Standing Financial Instructions) Directions 2007, National Health Service Act 2006; and
- Department of Health PCT Cluster Implementation Guidance (31 January 2011).

The Manual was regularly reviewed and updated throughout the year to take account of changes in the governance environment:

- The creation of new legal entities and their authorisation to undertake delegated responsibilities: Clinical Commissioning Groups (CCG) and NHS England (formerly the NHS Commissioning Board); National Training Development Agency.
- States of readiness through the transition period as organisations become ready to exercise their new responsibilities.

In September 2012, the Corporate Governance Framework Manual was revised to take account of changes in NHS commissioning landscapeand the introduction of London's Interim Operating Plan.

The internal auditors conducted an audit of the PCT's governance as part of the approved internal audit plan for 2012 / 2013. The objective of the review was to provide assurance that there was an appropriate management structure, robust governance arrangements and organisational form to deliver the organisation's objectives. The auditor opinion provided substantial assurance in relation to the design, application and effectiveness of the governance arrangements and the audit report highlighted a number of areas of good practice.

Risk Management and the Control Framework

The Primary Care Trust (PCT) Board approved the NHS North Central London Cluster Risk Management Strategy in December 2011 and the PCT has embedded the strategy into practice throughout 2012. The emerging Clinical Commissioning Groups (CCGs) have worked within the Strategy throughout 2012 / 2013. The strategy outlined the organisation's approach to risk management, including:

- Identifying committees and groups which have responsibility for risk management;
- Roles and responsibilities of staff with regards to risk management;
- The process for identification, assessment and management of risk;
- The process for managing, and Board review of, the Risk Register and Board Assurance Framework; and
- The risk appetite of the organisation, which sets out the thresholds for toleration, management and reporting of different orders of risk.

The Risk Management Strategy reflected best practice, taking into account a range of governance standards.

Risk assessment

Risk assessment is a systematic and effective method of determining the level of risks. All identified risks were assessed using a clearly defined risk assessment matrix by determining the likelihood and consequence of the risk to calculate an overall risk rating. Risks were categorised as low, moderate, high or extreme, and their categorisation informed the organisation's approach to management and monitoring of the risk.

The risk and control framework

The Board Assurance Framework (BAF) and Risk Register assessed the effectiveness of systems of internal control and provide assurances that risk management processes are effective. Both were dynamic documents that captured the understanding of the risk environment at any given time.

The BAF outlined NHS North Central London Cluster's principal objectives, the risks to achieving those objectives, key controls and assurances, and gaps in controls and assurances. The Risk Register contained a mixture of strategic and operational risks at organisational and directorate level as well as the arrangements in place to mitigate these.

Risks were identified in a variety of ways, including incidents, complaints and claims; committee reports; external assessments and audits; and management reviews. All risks were assigned a relevant Executive Director who had accountability for overseeing the management of the risk by identifying the most effective means to minimise, transfer or remove it, and ensuring the quality of action plans, controls and assurances. A Lead Officer was assigned with management responsibility for delivering the action plan, developing robust controls and identifying sources of assurance.

The PCT had a structured approach for the reporting and monitoring of risk. The Joint Boards reviewed the BAF and Extreme Risk Report at every meeting, and risk and BAF were a standing item on all committee agendas. The Senior Leadership Team reviewed the Board Assurance Framework and Risk Register on a monthly basis. The PCT Board also takes assurance from external assessments and audits, and from the work programme of the Audit Committee.

Risk profile

The 2012 / 2013 Board Assurance Framework (BAF) identified the following strategic risks within three Principal Objectives:

1. To ensure we commission services, which are safe, and of increasing quality for the people we serve.

1.1 Transition and the underlying financial position in North Central London may impact on the quality and safety of services.

1.2 Increased alerts received in relation to standards of care in nursing / care homes in particular Barnet, Enfield and Haringey and capacity issues at Borough level could lead to safety / safeguarding concerns for adult resident patients.

1.3 Due to the effect of transition on workforce capacity, recruitment & retention, organisational memory and differing stages of receiving organisations' readiness

of quality arrangements - there was a risk that embedding Quality and Safety in the new health system will not be effective.

2. To deliver the NHS North Central London Commissioning Strategy and Quality, Innovation, Productivity and Prevention (QIPP) Plan.

2.1 Sustainable QIPP delivery on the scale and timescales required given the scale of financial challenge; there was a risk that we do not deliver the transformational change programme needed to bring the health economy back into balance at the required pace – due to:

- Capacity, capability and clinical leadership;
- Pace of delivery; and
- Engagement with providers.

2.2 Following the delegation of responsibility to Clinical Commissioning Groups (CCGs), and during the period of shadow running and transition to March 2013, there was a risk that the cluster loses grip on the delivery of QIPP and financial turnaround.

2.3 There was risk that the CCGs are not sufficiently developed to manage delegated responsibility and achieve authorisation due to:

- Capacity and capability of CCGs;
- Ownership of the agenda; and
- Underlying financial position of the Cluster.

2.4 There was a risk of dislocation between or misalignment of different elements of the commissioning system leading to:

- Gaps in delivery;
- Differences in expectations between parts of the system (eg Commissioning Support Unit offer does not align to CCG need); and
- Ineffective commissioning partnerships.

2.5 The scale and complexity of forthcoming changes means there was a risk that functions or knowledge may not be adequately transferred to receiving organisations or that the statutory organisations are not safely closed down.

2.6 There was a risk that ineffective alignment of resources during the transition period (1 October 2012 - 31 March 2013) will impact the delivery of key Cluster objectives and reduces organisational effectiveness.

3. To deliver key organisational objectives and a secure transition* to the commissioning landscape in line with the Health and Social Care Act 2012.

3.1 Following the delegation of responsibility to CCGs and during the period of shadow running and transition to March 2013, there was a risk that the Cluster loses grip on the delivery of QIPP and financial turnaround.

3.2 There was risk that the CCGs are not sufficiently developed to manage delegated responsibility and achieve authorisation due to:

- Capacity and capability of CCGs;
- Ownership of the agenda; and
- Underlying financial position of the Cluster.

3.3 There was a risk of dislocation between or misalignment of different elements of the commissioning system leading to:

- Gaps in delivery;
- Differences in expectations between parts of the system (eg Commissioning Support Unit offer does not align to CCG need); and
- Ineffective commissioning partnerships.

3.4 The scale and complexity of forthcoming changes means there was a risk that functions or knowledge may not be adequately transferred to receiving organisations or that the statutory organisations are not safely closed down.

3.5 There was a risk that ineffective alignment of resources during the transition period (1 October 2012 - 31 March 2013) will impact the delivery of key Cluster objectives and reduces organisational effectiveness.

4. Other significant risks on the PCT's Risk Register:

4.1 There are risks around ensuring the robustness of processes for safeguarding children during the transition period. Sound working relationships have been established with partner organisations to mitigate this.

4.2 Risks relating to the commissioning of continuing care and high cost placements could have impacted on the PCT's ability to deliver QIPP savings. A revised continuing care policy was implemented.

Review of Effectiveness of Risk Management and Internal Control

The PCT Board and its committees were fully supportive of the risk management process which was scrutinised and challenged as part of the PCT Board, Financial Recovery and QIPP, and Audit Committees functions.

RMS Tenon undertook an audit of the Risk Management and Assurance Framework as part of its audit plan for 2012/13.The final advisory report was issued in October 2012

NHS North Central London Cluster continued to embed the use of their Board Assurance Framework into their routine and this was evidenced by the commitment from the Joint Boards of NHS NCL, Audit Committee and Senior Leadership Team in ensuring that this Framework operates as effectively as possible.
Board Assurance Framework (including Risk Management) 4.12/13 p1

The RMS Tenon identified the need to keep focus on where risks would be transferred to during transition. As a consequence a revised BAF and Risk Register was received and accepted by the Board in September 2012 which had been reviewed in order to focus and refine the content so that it accurately reflected the main strategic risks for the remainder of the financial year.

Significant Issues in 2012 / 2013

Over the year the PCT Board and its committees have considered issues that might have had a prejudicial impact on the corporate objectives, the business plan or the reputation of the NHS locally.

Continuing Care Reviews

The Joint Boards of NHS North Central London Cluster requested a review of continuing care across all PCTs areas in 2012 / 2013. In-year review of action showed a considerable improvement in the level of compliance and paperwork around continuing care commissioning but identified a number of issues in borough teams' performance in 2012 / 2013. This resulted in an amber / red opinion being issued. An action plan was in place to support the improvement across all areas and was been closely monitored by the Financial Recovery and QIPP Committee. Continuing care services are complex and high volume. Issues were identified in accounts payable and these highlighted to the management team particular issues in relation to the control and management of continuing care and funded nursing care. The requirement to manage these services properly was a clinical priority to ensure quality of services, as well as a financial imperative. As a result, Internal Audit was asked to prioritise the audit of continuing care arrangements. A number of weaknesses in control were identified including:

- Quality of care – backlogs in assessment;
- The budget setting process;
- Implementation of service level agreements and contracts for care packages; and
- The adequacy of management information tools to manage and control this complex service.

The management team, including the Director of Quality and Safety, agreed a detailed action plan to close the identified gaps in control and was progressing the implementation of internal audit recommendations.

Primary Care Payments

An internal review of the accuracy and authorisation of primary care payments was undertaken in 2012 / 2013.

It found that Enfield, Haringey and Islington Primary Care Trusts (PCTs) still used manual systems to manage the process. During 2012 this has been rectified and all PCTs now operate the same electronic system.

An action plan was put in place to address a further five medium rated recommendations. The Joint PCT Boards can take some assurance at this point that the controls upon which the organisations relies to manage risk are suitably designed, consistently applied and effective

Transition to New Commissioning Arrangements in the NHS

The Joint Boards agreed the NHS North Central London Cluster Transition Plan in December 2011. Detailed function led work streams supported this high-level plan in 2012 and 2013.

A sub-committee of the Joint Boards was established in December 2013 building on the working group that had led the implementation of the action plan and monitored the delivery in line with national policy and guidance.

The organisation agreed and handed over functions from January 2013 to nominated legal receivers: NHS England (formerly the NHS Commissioning Board (London)), Clinical Commissioning Groups, Local Authorities, NHS Property Services and Public Health England.

General assets and liabilities were also transferred after dialogue with nominated receivers.

Property and leases transferred to NHS Property Services in most cases, some buildings were transferred to Foundation Trusts when identified as most the appropriate receiver.

A Statutory Instrument was approved by Parliament giving NHS England and Clinical Commissioning Groups powers to enter into contracts from 1 February 2013.

NHS Commissioning Board (London) moved toward full operating mode from 7 January 2013 following transfer of functions from PCTs.

General assets and liabilities were also transferred after dialogue with nominated receivers.

Property and leases transferred to NHS Property Services in most cases, some buildings were transferred to Foundation Trusts when identified as most the appropriate receiver.

A Statutory Instrument was approved by Parliament giving NHS England and Clinical Commissioning Groups powers to enter into contracts from the 1 February 2013.

NHS England entered full operating mode on 7 January 2013 following transfer of functions from PCTs.

National Priorities set out in the NHS Operating Framework: Improving Performance in Enfield – 2012 / 2013

Acute Measures

Waiting times in A&E

A&E performance for Enfield PCT patients focused on Barnet and Chase Farm and North Middlesex. Performance against the A&E four hour maximum waiting time target for both trusts was strong throughout the first two quarters of 2012 / 2013. However, the winter of 2012 / 2013 proved more challenging than the previous year. During November and December 2013 outbreaks of Norovirus resulted in over 900 bed closures at Barnet and Chase Farm. The allocation of winter funding to both Trusts aimed to support whole-system resilience plans.

Referral-to treatment times

At a PCT level Enfield's performance against all referral to treatment standards has remained strong throughout the year, consistently achieving the admitted, non-admitted and incomplete pathways standards. At a provider level Barnet and Chase Farm achieved all three standards until December 2012 when performance on the incomplete pathways fell just below the 92% standard to 91.7%. North Middlesex achieved all three standards throughout 2012 / 2013 to date. Barnet and Chase Farm Hospital had a plan in place to reduce the number of patients waiting for longer than 52 weeks to zero in-line with the renewed national focus. No patients were reported as waiting longer than 52 weeks at North Middlesex.

Cancer waiting times

Enfield sustained achievement of most of the cancer waiting time targets during 2012 / 2013. NHS North Central London continued intensive monitoring and analysis of Trusts who fail these standards to ensure plans remain focused on turnaround and sustainability of performance.

Access to Stroke Services

There was a significant improvement in performance against the national measures for stroke services with Enfield exceeding the 80% threshold since Quarter 2 of 2012 / 2013 for time on a stroke unit and also achieved the 60% standard for TIA (Transient Ischaemic Attack) access within 24 hours.

Higher activity volumes and sustained performance showed that more people were accessing the right service within Enfield for stroke.

Access to Diagnostics

Enfield consistently maintained performance within the tolerance level of less than 1% of patients waiting longer than six weeks for a diagnostic test with December performance reported at 0.6%.

Access to Single Sex Accommodation

Patient privacy and dignity remains high on the NHS agenda with a zero tolerance against mixed sex accommodation. Barnet and Chase Farm Hospital was particularly affected this year contributing to 83 out of 106 incidences which impacted on Enfield's performance.

Non-acute Performance

Access to screening services

Diabetic Retinopathy

All boroughs within NHS North Central London exceeded the target of 95% for diabetic retinopathy screening and this performance was further enhanced by the commissioning of the UCLH site and new referral pathways that were scheduled for implementation from 1 April 2013.

Cancer Screening

Enfield was the only PCT within NHS North Central London to achieve the 70% standard with 72% of eligible women screened. Despite continued underperformance for bowel screening. Enfield demonstrated the most significant improvement within NCL of 56.1% uptake against a target of 60%.

The uptake of cervical screening over the first nine months of the year generally mirrored that of last year. Work continued to raise awareness and identify exclusions to ensure that performance was accurately reported. The turnaround time of cervical screening results continued to be good with Enfield achieving the 98% threshold for the majority of months during the year.

NHS Health Checks

Increased offering and take-up of NHS health checks supported the reduction in health inequalities by identifying and addressing health needs in previously undiagnosed people.

Enfield remained below trajectory with immediate actions being taken through GP clinical leads actively promoting the health check programme and public health leads contacting practices.

Early Access to Maternity Care

Improving outcomes for babies and children was one of the priorities for NHS North Central London and closely aligned to women accessing maternity care before 12 completed weeks of pregnancy. This was a challenging target to achieve with performance at 79.0% against the 90% standard. Enfield PCT continued to undertake remedial actions to promote early access through initiatives to raise awareness amongst hard to reach communities and education of primary care staff to facilitate early access to maternity care.

Through collaborative ventures amongst commissioners and providers, plans were put in place to implement initiatives to turn around cultural awareness and simplify access to services.

Childhood Immunisations Coverage

With a focused improvement plan, for which Enfield PCT was commended by NHS London, work continued to be delivered to track and monitor outstanding immunisations underpinned by stronger clinical leadership, data collection and extraction. Quarter 2 data showed that performance was improved by Enfield and despite three out of the six immunisation programmes being below target; this position improved, showing a much smaller gap to close.

Financial Recovery

There was a clear difference in the financial health between the north (Barnet, Enfield and Haringey) and south (Camden and Islington) of the North Central London Cluster over recent years. The financial strategy was focussed on transformational change across the whole £2.5 billion portfolio with programmes to rebalance the health economy in the patch, without destabilising hospitals. The financial plan for 2012/13 was the second in an original three year programme to return all five PCTs to financial stability on a recurrent basis. By exception the Department of Health agreed deficit plans for Barnet, Enfield and Haringey PCTs at the start of the year. In year revised plans were agreed resulting in all five PCTs delivering a surplus income and expenditure position. Camden and Islington PCTs have a history of financial stability, underpinned by well funded, sound community and primary care provision, and planned to deliver a healthy surplus.

During 2012/13 there was a continuation of the previous years' programme of financial recovery and turnaround including identification, development and delivery of QIPP plans in year and looking forward to the future clinical commissioning groups. All five PCTs over-delivered against agreed budgets. Camden PCT and Islington PCT exit in recurrent run rate surplus and Barnet PCT, Enfield PCT and Haringey PCT improved their respective run rate positions. Delivery of this programme was fundamental to ensuring the financial resilience of the future commissioning organisations.

Review of Quality and Safety

As a result of a review of quality and safety in 2011 which found that services were of a generally high quality and safe; improvement trajectories were agreed in 2012 with providers. Implementation and performance was monitored through the Clinical Quality Review Groups. These recommendations have been worked on throughout 2012 and now:

- Multi-agency Working Group established to drive up quality of nursing home service and patient experience in the northern boroughs of NHS North Central London; and
- There were no significant areas of slippage at the time of this annual report.

Data loss incident

There were no data loss incidents between April and December 2012.

Barnet, Enfield and Haringey Clinical Strategy

The implementation plans for delivering the Barnet, Enfield and Haringey Clinical Strategy were progressed according to the timetable and to deliver the changes in November 2013. Key milestones were met including the approval of both Barnet and Chase Farm Hospitals NHS Trust and North Middlesex University Hospitals Trust full business cases for the capital investment to improve the buildings. Significant work took place within both Trusts and across the Trusts in the key work streams of Emergency Care, Maternity, Paediatrics and Planned Care alongside primary and community care improvements and refreshed of the models of urgent care at all three hospital sites. The enabling work streams of workforce, transport and communications and engagement continued to deliver their programme plans. The governance arrangements were strengthened and reviewed.

Primary Care Strategy – Transforming Primary Care

2012 / 13 was the first year of implementing the three-year strategy 'Transforming Primary Care'. There was progress in all the workstreams including the development of networks, service improvements focusing on improving access, the delivery of care closer to home including the development of integrated care. The enabling workstreams of Information Management & Technology and premises made significant progress this year. The one area of workforce development has proved challenging in the first year.

There was a plan to spend a full year budget of £12m in Year 1, of the £47.7m identified over three years. The majority of the budget was spent but there was an element of underspend due to time to engage fully at a local level, delay in approvals processes

across the system and delay in time to implement some of the schemes in the year of CCG authorisation.

Plans for the remaining two years of the implementation of the strategy were that the five Clinical Commissioning Groups would lead the implementation locally and ensure that all developments are in line with local strategies whilst being committed to the overall ambition of the initial strategy adopted by NHS North Central London in January 2012.

Clinical Commissioning Groups (CCGs)

- All five CCGs in North Central London successfully secured delegated responsibility for all eligible budgets within agreed timeframes
- All five CCGs in North Central London have submitted authorisation documentation within agreed national timeframes
- Positive external assurance was received from NHS London on the progress of CCGs' authorisation
- CCGs' Integrated Performance management approach in place – CCGs demonstrating leadership and financial management through monthly Integrated Performance Meetings
- Positive assurance received through internal audit of CCGs development activity, management and support given by NHS North Central London PCTs.

Organisation: Enfield Primary Care Trust

Accountable Officer: Peter Coates, Director of PICD, Strategy, Finance and NHS Department of Health

Signature: .....

Date: 5th June 2013

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

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

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

- the table of salaries and allowances of senior managers and related narrative notes on pages 49;
- the table of pension benefits of senior managers and related narrative notes on page 52; and
- the pay multiples narrative notes on page 54.

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

Respective responsibilities of the signing officer and auditor

As explained more fully in the Accounts Certificate of Assurance to the Department of Health Director General, Strategy, Finance and NHS, the signing officer is responsible for overseeing the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

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

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

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

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

Opinion on other matters

In our opinion:

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

Matters on which we report by exception

We report to you if:

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

We have nothing to report in these respects.

Other matters on which we are required to conclude

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

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

· our review of the annual governance statement;

· the work of other relevant regulatory bodies or inspectorates, to the extent the results of the work have an impact on our responsibilities; and

· our locally determined risk-based work on the value for money criteria specified by the Audit Commission.

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 Enfield PCT in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Paul Hughes
Senior Statutory Auditor, for and on behalf of Grant Thornton UK LLP

Grant Thornton House
Melton Street
Euston Square
London
NW1 2EP

5 June 2013

Statement of Comprehensive Net Expenditure for year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure			
Gross employee benefits	7.1	**5,106**	9,671
Other costs	5.1	**535,980**	517,032
Income	4	**(19,924)**	(13,978)
Net operating costs before interest		**521,162**	512,725
Investment income	9	**(28)**	(35)
Finance costs	10	**728**	507
Net Operating Costs for the Financial Year including absorption transfers		**521,862**	**513,197**
Of which:			
Administration Costs			
Gross employee benefits	7.1	**4,172**	8,052
Other costs	5.1	**17,922**	10,872
Income	4	**(297)**	(6,071)
Net administration costs before interest		**21,797**	**12,853**
Investment income	9	**(28)**	0
Finance costs	10	**0**	507
Net administration costs for the financial year		**21,769**	**13,360**
Programme Expenditure			
Gross employee benefits	7.1	**934**	1,619
Other costs	5.1	**518,058**	506,160
Income	4	**(19,627)**	(7,907)
Net programme expenditure before interest		**499,365**	**499,872**
Investment income	9	**0**	(35)
Finance costs	10	**728**	0
Net programme expenditure for the financial year		**500,093**	**499,837**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**1,922**	643
Net (gain) on revaluation of property, plant & equipment	**(768)**	(967)
Total comprehensive net expenditure for the year*	**523,016**	**512,873**

*This is the sum of the rows above plus net operating costs for the financial year after absorption accounting adjustments.

The notes on pages 5 to 33 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	11	**39,758**	41,283
Intangible assets	12	**34**	103
Other financial assets	16.1	**328**	299
Trade and other receivables	15.1	**201**	201
Total non-current assets		**40,321**	41,886
Current assets:			
Trade and other receivables	15.1	**9,328**	10,389
Cash and cash equivalents	17	**17**	67
Total current assets		**9,345**	10,456
Total assets		**49,666**	52,342
Current liabilities			
Trade and other payables	18	**(40,048)**	(36,526)
Provisions	21	**(1,961)**	(965)
Borrowings	19	**(156)**	(89)
Total current liabilities		**(42,165)**	(37,580)
Non-current assets plus/less net current assets/liabilities		**7,501**	14,762
Non-current liabilities			
Provisions	21	(6,941)	(4,282)
Borrowings	19	(6,270)	(6,425)
Total non-current liabilities		**(13,211)**	(10,707)
Total Assets Employed:		**(5,710)**	4,055
Financed by taxpayers' equity:			
General fund		(19,652)	(11,444)
Revaluation reserve		13,942	15,499
Total taxpayers' equity:		**(5,710)**	4,055

The notes on pages 5 to 33 form part of these accounts.

The financial statements on pages 1 to 33 were approved by the signing officer on 5 June 2013.

Peter Coates ..... Date: 05/06/13

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	**(11,444)**	**15,499**	**4,055**
Changes in taxpayers' equity for 2012-13			
Net operating cost for the year	(521,862)		**(521,862)**
Net gain on revaluation of property, plant, equipment		768	**768**
Impairments and reversals		(1,922)	**(1,922)**
Transfers between reserves*	403	(403)	**0**
Total recognised income and expense for 2012-13	**(521,459)**	**(1,557)**	**(523,016)**
Net Parliamentary funding	513,251		**513,251**
Balance at 31 March 2013	**(19,652)**	**13,942**	**(5,710)**
Balance at 1 April 2011	**12,088**	**15,175**	**27,263**
Changes in taxpayers' equity for 2011-12			
Net operating cost for the year	(513,197)		(513,197)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment		967	967
Impairments and Reversals		(643)	(643)
Total recognised income and expense for 2011-12	(513,197)	324	(512,873)
Net Parliamentary funding	489,665		489,665
Balance at 31 March 2012	**(11,444)**	**15,499**	**4,055**

* The transfer between reserves relates to the realised depreciation impact upon the revaluation reserve.

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	(521,162)	(512,725)
Depreciation and Amortisation	2,511	3,145
Impairments and Reversals	846	1,187
Interest Paid	(669)	(453)
(Increase)/Decrease in Trade and Other Receivables	1,033	5,981
Increase/(Decrease) in Trade and Other Payables	2,449	12,897
Provisions Utilised	(5,690)	(629)
Increase/(Decrease) in Provisions	9,286	1,220
Net Cash Inflow/(Outflow) from Operating Activities	(511,396)	(489,377)
Cash flows from investing activities		
Interest Received	28	35
(Payments) for Property, Plant and Equipment	(1,844)	(97)
Net Cash Inflow/(Outflow) from Investing Activities	(1,816)	(62)
Net cash inflow/(outflow) before financing	(513,212)	(489,439)
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	(89)	(189)
Net Parliamentary Funding	513,251	489,665
Net Cash Inflow/(Outflow) from Financing Activities	513,162	489,476
Net increase/(decrease) in cash and cash equivalents	(50)	37
Cash and Cash Equivalents at Beginning of the Period	67	30
Cash and Cash Equivalents at year end	17	67

1. Accounting policies

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

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

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

1.1 Accounting Conventions

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

Going Concern

Under the provisions of the Health and Social Care Act 2012 (Commencement No.4. Transitional Savings and Transitory Provisions) Order 2013, Enfield Primary Care Trust was dissolved on 1st April 2013. The PCT's functions, assets and liabilities transferred to other public sector entities as outlined in Note 30 Events after the Reporting period. Where reconfigurations of this nature take place within the public sector, Government accounting requires that the activities concerned are to be considered as continuing operations, and so the closing entity prepares accounts on a "going concern" basis.

The Statement of Financial Position has therefore been drawn up at 31 March 2013 on the same basis as in previous years, reporting balances on the same basis as would a continuing entity. The usual annual revaluation of land and buildings has been undertaken by the District Valuer, on the same basis as any other year again assuming continuing operations.

Acquisitions and Discontinued Operations

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

Critical accounting judgements and key sources of estimation uncertainty

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

Critical judgements in applying accounting policies

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

PFI & LIFT

The PCT has determined that a LIFT building under IFRS is recorded as a Finance Lease. The Statement of Comprehensive Net Expenditure only reflects the service charge and Interest payment element of the rents. The asset has been capitalised and a long term liability with the relevant party is shown in the accounts.

The measurement and recognition of the LIFT Co. investment at cost is deemed to be a reasonable approximation of fair value given that the nature of the future dividends and subordinated debt repayments is uncertain.

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

1. Accounting policies (continued)

- Land and buildings are restated at current cost using professional DV valuations. The PCT obtained an up to date revaluation at 31st March 2013 from the District Valuer. This valuation was completed on a Modern Equivalent Asset basis which is in accordance with the recent RICS guidance. The PCT has taken the option to use annual full DV valuations of its assets rather than applying any indices to index its assets and has accounted for movements mainly through its asset reserves. Assets brought into use for the first time have also been revalued with other assets and where there is an impairment any excesses over reserves are charged to the Operating Cost Statement.

- All assets are depreciated over their useful economic lives (UEL) in accordance with the PCT's depreciation policy. For equipment assets the PCT has made an assumption of the average asset life for each category of assets (see Note 12.3 on page 24). For land and building assets the UEL is determined by the District Valuer when a formal revaluation is undertaken. The PCT has reviewed the useful economic lives of IT assets and estimated that all IT assets should be depreciated over 3 years.

Although the PCT believes that its estimates of the relevant expected useful lives, its assumptions concerning the environment and developments in the industry in which the PCT operates and its estimations of the discounted future cashflows are appropriate, changes in assumptions or circumstances could require changes in the analysis. This could lead to additional impairment charges in the future or to valuation write-backs should the trends expected by the PCT reverse.

- The central costs of the North Central Cluster have been equally apportioned across all the 5 PCTs that comprise the cluster.

- The PCT has estimated a provision in respect of retrospective continuing care claims which are likely to arise, relating to episodes of care during the period 1st April 2004 to 31st March 2013.

1.2 Revenue and Funding

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

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

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

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

1.3 Pooled budgets

During the year, the PCT entered into a pooled budget arrangement with the London Borough of Enfield. Under the arrangement funds are pooled under S75 of the NHS Act 2006 for a joint Director of Public Health, Drug Action Teams, Adult Safeguarding, Adult Joint commissioning, Learning Disabilities and community equipment.

The pool is hosted by the London Borough of Enfield. 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.

1.4 Taxation

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

1.5 Administration and Programme Costs

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

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

1. Accounting policies (continued)

1.6 Property, Plant & Equipment

Recognition

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

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

Valuation

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

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

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

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

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

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

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

Subsequent expenditure

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

1. Accounting policies (continued)

1.7 Capital Charges

The Department of Health no longer applies a cost of capital charge of 3.5% of the net average assets less liabilities (excluding donated assets and cash balances with the Government Banking Services), so this item of expenditure does not appear in the 2012/13 expenditure analysis. The Department continues however to apply the cost of capital charge to the PCT's resource allocation and this is reflected in the revenue resource limit shown in the accounts.

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.

1. Accounting policies (continued)

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.

1.10 Donated assets

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

1.11 Government grants

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

1.12 Non-current assets held for sale

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

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

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

1. Accounting policies (continued)

1.13 Cash and cash equivalents

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

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

1.14 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).

1.15 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 21.

1.16 Employee benefits

Short-term employee benefits

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.

1.17 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.

1.18 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.

1.19 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)

1.20 Contingencies

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

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

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

1.21 Leases

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

The PCT as lessee

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

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

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

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

The PCT as lessor

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

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

1.22 Provisions

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

1. Accounting policies (continued)

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

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

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

1.23 Financial Instruments

Financial assets

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

Financial assets are initially recognised at fair value.

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

Financial assets at fair value through profit and loss

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

Held to maturity investments

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

Available for sale financial assets

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

The PCT's investment in LIFT is disclosed at note 23, at the total of the current carrying value of the loan and the share capital, as this is considered an appropriate basis for fair value of the asset.

Loans and receivables

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

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.

1. Accounting policies (continued)

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

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

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

Financial liabilities

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

Financial liabilities are initially recognised at fair value.

Financial liabilities are classified as either financial liabilities 'at fair value through profit and loss' or other financial liabilities.

Other financial liabilities

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

1.24 Private Finance Initiative (PFI) and NHS LIFT transactions

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

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

a) Services received

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

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

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

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

1. Accounting policies (continued)

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

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

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.

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

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

IAS 27 - Separate Financial Statements - subject to consultation
IAS 28 - Investments in Associates and Joint Ventures - subject to consultation
IFRS 9 - Financial Instruments - subject to consultation
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

The PCT has no separate Operating Segments to report in 2012/13 and there were no Operating Segments reported in 2011/12.

3. Financial Performance Targets

3.1 Revenue Resource Limit

The PCT's performance for the year ended 2012-13 is as follows:

	2012-13 £000	2011-12 £000
Total Net Operating Cost for the Financial Year	521,862	513,197
Net operating cost plus (gain)/loss on transfers by absorption	524,702	496,009
Revenue Resource Limit	2,840	(17,188)
Under/(Over)spend Against Revenue Resource Limit (RRL)		

The underspend in 2012/13 (and overspend in 2011/12) against the Revenue Resource Limit was planned and agreed with the Department of Health and the NHS London Strategic Health Authority.

3.2 Capital Resource Limit

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

	2012-13 £000	2011-12 £000
Capital Resource Limit	2,959	1,255
Charge to Capital Resource Limit	2,917	561
(Over)/Underspend Against CRL	42	694

3.3 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	513,251	489,665
Cash Limit	513,251	497,273
Under/(Over)spend Against Cash Limit	0	7,608

The PCT kept within its Capital Resource Limit.

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

	2012-13 £000
Total cash received from DH (Gross)	456,038
Sub total: net advances	456,038
Plus: cost of Dentistry Schemes (central charge to cash limits)	12,649
Plus: drugs reimbursement (central charge to cash limits)	44,564
Parliamentary funding credited to General Fund	513,251

The PCT kept within its Cash Limit.

4. Miscellaneous Revenue

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
Dental Charge income from Contractor-Led GDS & PDS	2,587	0	2,587	2,583
Dental Charge income from Trust-Led GDS & PDS	0	0	0	(11)
Prescription Charge income	2,400	0	2,400	2,274
Strategic Health Authorities	121	0	121	18
NHS Trusts	5,063	0	5,063	3,170
NHS Foundation Trusts	619	0	619	86
Primary Care Trusts - Other	6,428	297	6,131	3,129
Local Authorities	725	0	725	705
Education, Training and Research	903	0	903	918
Other Non-NHS Patient Care Services	0	0	0	19
Rental revenue from finance leases	51	0	51	0
Rental revenue from operating leases	770	0	770	0
Other revenue	257	0	257	1,087
Total miscellaneous revenue	19,924	297	19,627	13,978

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	31,795	0	31,795	24,764
Non-Healthcare	7,914	7,914	0	60
Total	39,709	7,914	31,795	24,824
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	265,145	65	265,080	290,907
Goods and services (other, excl Trusts, FT and PCT)	949	0	949	989
Total	266,094	65	266,029	291,896
Goods and Services from Foundation Trusts	63,614	0	63,614	42,250
Purchase of Healthcare from Non-NHS bodies	34,199	0	34,199	29,062
Social Care from Independent Providers	4,519	0	4,519	4,283
Expenditure on Drugs Action Teams	3,011	0	3,011	3,050
Non-GMS Services from GPs	104	0	104	0
Contractor Led GDS & PDS (excluding employee benefits)	15,337	0	15,337	15,519
Salaried Trust-Led PDS & PCT DS (excluding employee benefits)	0	0	0	5
Chair, Non-executive Directors & PEC remuneration	110	110	0	50
Executive committee members costs	424	424	0	62
Consultancy Services	1,183	1,012	171	232
Prescribing Costs	40,529	0	40,529	39,236
G/PMS, APMS and PCTMS (excluding employee benefits)	40,807	0	40,807	40,630
Pharmaceutical Services	83	0	83	41
New Pharmacy Contract	10,775	0	10,775	10,126
General Ophthalmic Services	2,358	0	2,358	2,812
Supplies and Services - Clinical	218	214	4	291
Supplies and Services - General	436	427	9	341
Establishment	424	424	0	1,350
Transport	48	48	0	72
Premises	3,448	1,809	1,639	3,252
Impairments & Reversals of Property, plant and equipment	846	0	846	1,187
Depreciation	2,442	2,442	0	3,110
Amortisation	69	0	69	35
Impairment of Receivables	1,141	0	1,141	285
Audit Fees	107	107	0	178
Other Auditors Remuneration	21	21	0	33
Clinical Negligence Costs	30	0	30	23
Education and Training	848	0	848	859
Other **	3,046	2,905	141	1,938
Total Operating costs charged to Statement of Comprehensive Net Expenditure	535,980	17,922	518,058	517,032
Employee Benefits (excluding capitalised costs)				
PCT Officer Board Members	257	257	0	120
Other Employee Benefits	4,849	3,915	934	9,551
Total Employee Benefits charged to SOCNE (See note 7.1)	5,106	4,172	934	9,671
Total Operating Costs	541,086	22,094	518,992	526,703

* The increase in spend on goods and services from Foundation Trusts is due to an increased number of Trusts becoming Foundation Trusts. This is confirmed by a like reduction in goods and services from NHS Trusts.

** Increase in "Other" as it includes costs to settle early retirement and back to back provisions with the NHS Pensions Agency and NHS Trusts.

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	22,133	21,435	698
Weighted population (number in units)*	289,265	289,265	289,265
Running costs per head of population (£ per head)	76.5	74.1	2.4
PCT Running Costs 2011-12			
Running costs (£000s)	14,547	12,067	2,480
Weighted population (number in units)	289,265	289,265	289,265
Running costs per head of population (£ per head)	50.3	41.7	8.6

* Weighted population figures are not available for 2012-13 as the weighted capitation formula for PCT allocations was not updated for 2012-13. This was because it was decided to give all PCTs the same percentage growth in their allocations in this transitional year rather than differential growth based on a weighted capitation formula. Therefore 2011-12 weighted populations have been used when calculating the running costs per head of population in 2012-13.

5.2 Analysis of operating expenditure by expenditure classification

	2012-13 £000	2011-12 £000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	40,807	40,630
Prescribing costs	40,529	39,236
Contractor led GDS & PDS	15,337	15,519
Trust led GDS & PDS	0	5
General Ophthalmic Services	2,358	2,812
Pharmaceutical services	83	41
New Pharmacy Contract	10,775	10,126
Total Primary Healthcare purchased	**109,889**	108,369
Purchase of Secondary Healthcare		
Learning Difficulties	6,716	11,256
Mental Illness	47,433	42,379
Maternity	18,230	18,563
General and Acute	267,017	262,390
Accident and emergency	12,816	13,708
Community Health Services	46,572	33,369
Other Contractual	5,526	13,500
Total Secondary Healthcare Purchased	**404,310**	395,165
Total Healthcare Purchased by PCT	**514,199**	**503,534**
Included above:		
Social Care from Independent Providers	4,519	4,283
Healthcare from NHS FTs included above	63,614	42,250

6. Operating Leases

6.1 PCT as lessee

	Land £000	Buildings £000	Other £000	2012-13 Total £000	2011-12 £000
Payments recognised as an expense					
Minimum lease payments				**737**	737
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**737**	**737**
Payable:					
No later than one year	**0**	**737**	**0**	**737**	737
Between one and five years	**0**	**2,472**	**0**	**2,472**	2,948
After five years	**0**	**2,650**	**0**	**2,650**	3,466
Total	**0**	**5,859**	**0**	**5,859**	**7,151**
Total future sublease payments expected to be received				0	0

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	Prog £000	Total £000	Admin £000	Prog £000
Employee Benefits - Gross Expenditure									
Salaries and wages	4,255	3,436	819	3,202	2,541	661	1,053	895	158
Social security costs	290	240	50	290	240	50	0	0	0
Employer Contributions to NHS BSA - Pensions Division	378	313	65	378	313	65	0	0	0
Termination benefits	183	183	0	183	183	0	0	0	0
Total employee benefits	5,106	4,172	934	4,053	3,277	776	1,053	895	158
Less recoveries in respect of employee benefits	0	0	0	0	0	0	0	0	0
Total - Net Employee Benefits including capitalised costs	5,106	4,172	934	4,053	3,277	776	1,053	895	158
Employee costs capitalised	0	0	0	0	0	0	0	0	0
Gross Employee Benefits excluding capitalised costs	5,106	4,172	934	4,053	3,277	776	1,053	895	158
Recognised as:									
Commissioning employee benefits	5,106			4,053			1,053		
Provider employee benefits	0			0			0		
Gross Employee Benefits excluding capitalised costs	5,106			4,053			1,053		

Islington PCT became the host payroll provider for NHS North Central London Sector in 2012/13 and host for staff providing services across NHS North Central London Sector. Staff working solely for each of the PCTs remained on their respective payrolls and are included within the employee benefits note above. Therefore, employee benefits increased considerably in 2012/13 within Islington PCT and decreased in the other Sector PCTs, Barnet PCT, Enfield PCT, Haringey PCT and Camden PCT. Islington PCT recharged Enfield PCT and the other Sector PCTs their share of the pay costs on an equal apportionment which is shown within Note 5.1, Goods and services from other PCTs - Non Healthcare.

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	8,702	7,907	795
Social security costs	402	402	0
Employer Contributions to NHS BSA - Pensions Division	547	547	0
Termination benefits	20	20	0
Total gross employee benefits	9,671	8,876	795
Less recoveries in respect of employee benefits	0	0	0
Total - Net Employee Benefits including capitalised costs	9,671	8,876	795
Employee costs capitalised	0	0	0
Gross Employee Benefits excluding capitalised costs	9,671	8,876	795
Recognised as:			
Commissioning employee benefits	9,671		
Provider employee benefits	0		
Gross Employee Benefits excluding capitalised costs	9,671		

7.2 Staff Numbers

	Total Number	2012-13 Permanently employed Number	Other Number	Total Number	2011-12 Permanent employed Number	Other Number
Average Staff Numbers						
Medical and dental	2	2	0	1	1	0
Ambulance staff	0	0	0	0	0	0
Administration and estates	78	60	18	157	137	20
Healthcare assistants and other support staff	22	15	7	21	19	2
Nursing, midwifery and health visiting staff	8	6	2	4	4	0
Scientific, therapeutic and technical staff	5	5	0	6	6	0
TOTAL	115	88	27	189	167	22
Of the above - staff engaged on capital projects	0	0	0	0	0	0

7.3 Staff Sickness absence and ill health retirements

The rate of sickness for NHS North Central London was 2.8%.(2011/12: 2.73%) This is under the average rate for NHS England as a whole 3.9% (2011/12: 3.97%)*.

* Data taken from NHS Information Centre for sickness absence rates for the NHS in England for the calandar year January to December 2012 (2011/12: July to September 2011)

	2012-13 Number	2011-12 Number
Number of persons retired early on ill health grounds	0	1
	£000s	£000s
Total additional pensions liabilities accrued in the year	0	58

7.4 Exit Packages agreed during 2012-13

	2012-13			2011-12		
Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**
	Number	**Number**	**Number**	**Number**	**Number**	**Number**
Lees than £10,000	**0**	**0**	**0**	1	2	**3**
£10,001-£25,000	**0**	**0**	**0**	6	0	**6**
£25,001-£50,000	**0**	**0**	**0**	1	1	**2**
£50,001-£100,000	**0**	**0**	**0**	3	1	**4**
£100,001 - £150,000	**0**	**0**	**0**	1	0	**1**
£150,001 - £200,000	**1**	**0**	**1**	0	0	**0**
Total number of exit packages by type (total cost)	**1**	**0**	**1**	**12**	**4**	**16**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Total resource cost	175	0	**175**	473	126	**599**

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 Agenda for Change. Where the PCT has agreed early retirements, the additional costs are met by the PCT and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

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

7.5 Pension costs

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

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

a) Accounting valuation

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

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

b) Full actuarial (funding) valuation

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

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

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

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

c) Scheme provisions

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

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

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

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

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

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

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

8. Better Payment Practice Code

8.1 Measure of compliance

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**9,679**	**31,946**	9,472	40,282
Total Non-NHS Trade Invoices Paid Within Target	**5,694**	**16,320**	4,294	20,821
Percentage of NHS Trade Invoices Paid Within Target	58.83%	51.09%	45.33%	51.69%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3,634**	**370,267**	2,847	360,749
Total NHS Trade Invoices Paid Within Target	**1,575**	**357,825**	1,017	340,651
Percentage of NHS Trade Invoices Paid Within Target	43.34%	96.64%	35.72%	94.43%

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. The disclosure above shows the value of invoices by volume and amount paid within 30 days, with the remaining invoices being paid later than 30 days.

9. Investment Income

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
Interest Income				
LIFT: loan interest receivable	**28**	**28**	**0**	35
Total investment income	**28**	**28**	**0**	35

10. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
Interest on obligations under LIFT contracts:				
- main finance cost	**435**	**0**	**435**	453
- contingent finance cost	**234**	**0**	**234**	0
Total interest expense	**669**	**0**	**669**	**453**
Provisions - unwinding of discount	**59**	**0**	**59**	54
Total	**728**	**0**	**728**	**507**

11.1 Property, plant and equipment

2012-13	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:									
At 1 April 2012	**21,890**	**19,268**	**219**	**674**	**482**	**0**	**8,775**	**1,194**	**52,502**
Additions of Assets Under Construction				0					**0**
Additions Purchased	0	1,552	112		0	0	1,253	0	**2,917**
Reclassifications	0	404	0	(560)	0	0	156	0	**0**
Upward revaluation/positive indexation	357	402	9	0	0	0	0	0	**768**
Impairments/negative indexation	(432)	(1,459)	(31)	0	0	0	0	0	**(1,922)**
At 31 March 2013	**21,815**	**20,167**	**309**	**114**	**482**	**0**	**10,184**	**1,194**	**54,265**
Depreciation									
At 1 April 2012	**216**	**2,637**	**9**	**0**	**238**	**0**	**7,306**	**813**	**11,219**
Reclassifications		(11)	11		0	0	0	0	**0**
Impairments	12	616	71	114	0	0	33	0	**846**
Charged During the Year	140	753	6		43	0	1,406	94	**2,442**
At 31 March 2013	**368**	**3,995**	**97**	**114**	**281**	**0**	**8,745**	**907**	**14,507**
Net Book Value at 31 March 2013	**21,447**	**16,172**	**212**	**0**	**201**	**0**	**1,439**	**287**	**39,758**
Purchased	21,447	16,172	212	0	201	0	1,439	287	**39,758**
Total at 31 March 2013	**21,447**	**16,172**	**212**	**0**	**201**	**0**	**1,439**	**287**	**39,758**
Asset financing:									
Owned	18,897	8,837	212	0	201	0	1,439	287	**29,873**
On-SOFP PFI contracts	2,550	7,335	0	0	0	0	0	0	**9,885**
Total at 31 March 2013	**21,447**	**16,172**	**212**	**0**	**201**	**0**	**1,439**	**287**	**39,758**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	**7,854**	**7,453**	**153**	**0**	**3**	**0**	**0**	**36**	**15,499**
Movements (Note 1 below)	(75)	(1,432)	(27)	0	(3)	0	0	(20)	**(1,557)**
At 31 March 2013	**7,779**	**6,021**	**126**	**0**	**0**	**0**	**0**	**16**	**13,942**

Note 1: Revaluation of Assets: - Land and buildings have been independently and externally revalued by The District Valuer (RICS) as at 31 March 2013 which has been reflected in the accounts. The valuation was carried out on a Modern Equivalent Asset (MEA) basis in accordance with International Financial Reporting Standards (IFRS). This resulted in an upward revaluation of £768k. Impairments totalled £2,735k of which £1,922k was offset against the revaluation reserve and £813k was charged to the operating cost statement. The previous valuation was also carried out by the District Valuer on 1 April 2012 on a MEA basis. Information Technology assets were also impaired in 2012/13 by £33k.

11.2 Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:									
At 1 April 2011	**21,779**	**19,078**	**196**	**113**	**482**	**0**	**8,775**	**1,194**	**51,617**
Additions - purchased	0	0	0	561	0	0	0	0	**561**
Revaluation & indexation gains	111	833	23	0	0	0	0	0	**967**
Impairments	0	(643)	0	0	0	0	0	0	**(643)**
At 31 March 2012	**21,890**	**19,268**	**219**	**674**	**482**	**0**	**8,775**	**1,194**	**52,502**
Depreciation									
At 1 April 2011	**109**	**805**	**9**		**194**	**0**	**5,123**	**682**	**6,922**
Impairments	107	1,080	0	0	0	0	0	0	**1,187**
Charged During the Year	0	752	0		44	0	2,183	131	**3,110**
At 31 March 2012	**216**	**2,637**	**9**	**0**	**238**	**0**	**7,306**	**813**	**11,219**
Net Book Value at 31 March 2012	**21,674**	**16,631**	**210**	**674**	**244**	**0**	**1,469**	**381**	**41,283**
Purchased	21,674	16,631	210	674	244	0	1,469	381	**41,283**
At 31 March 2012	**21,674**	**16,631**	**210**	**674**	**244**	**0**	**1,469**	**381**	**41,283**
Asset financing:									
Owned	21,674	8,995	210	674	244	0	1,469	381	**33,647**
On-SOFP PFI contracts	0	7,636	0	0	0	0	0	0	**7,636**
At 31 March 2012	**21,674**	**16,631**	**210**	**674**	**244**	**0**	**1,469**	**381**	**41,283**

12.1 Intangible non-current assets

2012-13	Software purchased	Total
	£000	£000
At 1 April 2012	249	249
At 31 March 2013	249	249
Amortisation		
At 1 April 2012	146	146
Charged during the year	69	69
At 31 March 2013	215	215
Net Book Value at 31 March 2013	34	34
Net Book Value at 31 March 2013 comprises		
Purchased	34	34
Total at 31 March 2013	34	34

12.2 Intangible non-current assets

2011-12	Software purchased	Total
	£000	£000
At 1 April 2011	249	249
At 31 March 2012	249	249
Amortisation		
At 1 April 2011	111	111
Charged during the year	35	35
At 31 March 2012	146	146
Net Book Value at 31 March 2012	103	103
Net Book Value at 31 March 2012 comprises		
Purchased	103	103
Total at 31 March 2012	103	103

12.3 Economic Lives of Non-Current Assets

	Min Life Years	Max Life Years
Intangible Assets		
Software Licences	1	3
Property, Plant and Equipment		
Buildings exc Dwellings	10	90
Dwellings	10	90
Plant & Machinery	1	7
Information Technology	1	3
Furniture and Fittings	0	8

Open Market Value of Assets at balance sheet date	Land	Buildings excl. dwellings	Dwellings
	£000s	£000s	£000s
Open Market Value at 31 March 2013	21,447	16,172	212
Open Market Value at 31 March 2012	21,674	16,631	210

13. 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			
Total charged to Departmental Expenditure Limit	0	0	0
Changes in market price	846		846
Total charged to Annually Managed Expenditure	**846**		**846**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Changes in market price	1,922		
Total impairments for PPE charged to reserves	**1,922**		
Total Impairments of Property, Plant and Equipment	**2,768**	**0**	**846**

14. Intra-Government and other balances

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with other Central Government Bodies	6,695	0	2,232	0
Balances with Local Authorities	967	0	6,977	0
Balances with NHS Trusts and Foundation Trusts	1,724	0	7,839	0
Balances with bodies external to government	(58)	201	23,000	0
At 31 March 2013	**9,328**	**201**	**40,048**	**0**
prior period:				
Balances with other Central Government Bodies	4,612	0	2,162	0
Balances with Local Authorities	1,482	0	4,566	0
Balances with NHS Trusts and Foundation Trusts	3,342	0	11,196	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	953	201	18,602	0
At 31 March 2012	**10,389**	**201**	**36,526**	**0**

15.1 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	**8,345**	7,929	**0**	0
Non-NHS receivables - revenue	**2,225**	1,900	**0**	0
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**121**	958	**201**	201
Provision for the impairment of receivables	**(1,437)**	(446)	**0**	0
VAT	**74**	48	**0**	0
Total	**9,328**	10,389	**201**	201
Total current and non current	**9,529**	10,590		
Included above:				
Prepaid pensions contributions	**0**	0		

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

15.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	**73**	1,262
By three to six months	**0**	0
By more than six months	**17**	0
Total	**90**	1,262

15.3 Provision for impairment of receivables

	2012-13 £000	**2011-12 £000**
Balance at 1 April 2012	**(446)**	(161)
Amount written off during the year	**150**	0
Amount recovered during the year	**50**	0
(Increase)/decrease in receivables impaired	**(1,191)**	(285)
Balance at 31 March 2013	**(1,437)**	(446)

16. NHS LIFT investments

	Loan £000	Share capital £000	Total £000
Balance at 1 April 2012	**336**	**1**	**337**
Disposals	**(8)**	**0**	**(8)**
Balance at 31 March 2013	**328**	**1**	**329**
Balance at 1 April 2011	336	1	337
Balance at 31 March 2012	**336**	**1**	**337**

16.1 Other Financial Assets - Non Current

	31 March 2013 £000	31 March 2012 £000
Opening balance 1 April	**299**	299
Additions	29	0
Total Other Financial Assets - Non Current	**328**	299

16.2 Other Financial Assets - Capital Analysis

	31 March 2013 £000	31 March 2012 £000
Capital Expenditure	**29**	0
Capital Income	**0**	0

17. Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**67**	30
Net change in year	**(50)**	37
Closing balance	**17**	67
Made up of		
Cash with Government Banking Service	**17**	67
Cash and cash equivalents as in statement of financial position	**17**	67
Cash and cash equivalents as in statement of cash flows	**17**	67
Patients' money held by the PCT, not included above	**0**	0

18. 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	**8,176**	12,684	**0**	0
NHS payables - capital	**1,389**	561	**0**	0
NHS accruals and deferred income	**(32)**	113	**0**	0
Family Health Services (FHS) payables	**10,420**	7,295		
Non-NHS payables - revenue	**9,347**	15,369	**0**	0
Non-NHS payables - capital	**337**	92	**0**	0
Non-NHS accruals and deferred income	**9,749**	0	**0**	0
Social security costs	**51**	0		
Tax	**125**	0		
Other	486	412	0	0
Total	**40,048**	36,526	**0**	0
Total payables (current and non-current)	**40,048**	**36,526**		

19. Borrowings

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
LIFT liabilities:				
Main liability	**156**	89	**6,270**	6,425
Total	**156**	**89**	**6,270**	**6,425**
Total other liabilities (current and non-current)	**6,426**	**6,514**		

Borrowings/Loans - Payment of Principal Falling Due in:

	DH £000s	**Other £000s**	**Total £000s**
0 - 1 Years	0	156	**156**
1 - 2 Years	0	225	**225**
2 - 5 Years	0	571	**571**
Over 5 Years	0	5,474	**5,474**
TOTAL	**0**	**6,426**	**6,426**

20. Finance lease obligations

The PCT has no finance lease obligations other than LIFT leases as reported in disclosure note 23 (2011/12;£Nil).

21. Provisions

		Comprising:				
	Total £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Continuing Care £000s	Other £000s	Redundancy £000s
Balance at 1 April 2012	**5,247**	2,034	174	754	1,807	478
Arising During the Year	**10,731**	1,198	0	7,674	1,859	0
Utilised During the Year	**(5,690)**	(3,096)	0	0	(2,149)	(445)
Reversed Unused	**(1,445)**	(193)	(25)	(1,194)	0	(33)
Unwinding of Discount	**59**	57	0	0	2	0
Balance at 31 March 2013	**8,902**	**0**	**149**	**7,234**	**1,519**	**0**
Expected Timing of Cash Flows:						
No Later than One Year	**1,961**	**0**	**149**	**1,808**	**4**	**0**
Later than One Year and not later than Five Years	**3,633**	**0**	**0**	**3,617**	**16**	**0**
Later than Five Years	**3,308**	**0**	**0**	**1,809**	**1,499**	**0**

Included within the closing balance of Other Provisions are dilapidations in respect of leased buidlings £1,466k and Injury benefit provisions of £53k.

Enfield PCT received claims for continuing Healthcare costs relating to episodes of care from the period 1st April 2004 to 31st March 2012 amounting to £ 24,114k as at 31st March 2013. The PCT has sought internal and external advice on the range of likely outcomes and success factors to determine the likelihood of claims being paid and made a provision of £7,234k (30%) included above. The PCT therefore acknowledges a contingent liability of up to £16,880k in 2012/13 (2011/12 - £500k to £1,500k). See note 22 below.

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

As at 31 March 2013	0
As at 31 March 2012	0

22. Contingencies

Contingent liabilities

The PCT acknowledges a contingent liability in respect to Continuing Care of up to £16,880k in 2012/13 (2011/12 - £500k to £1,500k). See note 21 above. Plus a further £2k is acknowledged in respect to on going legal claims currently in the hands of the NHS Litigation Authority.

23. PFI and LIFT - additional information

The PCT has one LIFT scheme which is on-Statement of Financial Position under International Financial Reporting Standard IFRIC 12. It is reported on the Property Plant and Equipment Register under Land and Buildings.

NHS LIFT is a variant of PFI. Enfield PCT has an interest in a NHS LIFT scheme for the facilities at Forest Road Primary Care Centre. Facilities are constructed and maintained by a 40:60 Public:Private company, the LIFTCo. Half of the 40% public shareholding is owned by the national organisation. Partnerships for Health and is owned equally by the 3 participating PCTs - Barnet PCT, Haringey TPCT and Enfield PCT.

The LIFTCo own the asset. The development and property risks are borne by the LIFTCo. Enfield PCT's stake-holding is in the form of £500 shares and loan stock in the form of sub-debt. At the end of the lease there is an option for Enfield PCT to buy the asset on favourable terms. In addition Enfield PCT will retain its shareholding in the LIFTCo. Based on the assumptions made, the modelling and accounting treatment applied are based on the PCTs intention not to exercise the right to purchase at the end of the 25 year term (2031).

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	**149**	149
Total	**149**	149

	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	**149**	87
Later than One Year, No Later than Five Years	**595**	595
Later than Five Years	**1,908**	1,908
Total	**2,652**	2,590

Imputed finance lease obligations for on SOFP LIFT Contracts due	**31 March 2013 £000**	31 March 2012 £000
No Later than One Year	**586**	525
Later than One Year, No Later than Five Years	**2,373**	2,558
Later than Five Years	**8,443**	8,845
Subtotal	**11,402**	11,928
Less: Interest Element	**(4,977)**	(5,414)
Total	**6,425**	6,514

24. Financial Instruments

Financial risk management

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

Currency risk

The PCT/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 risks.

24.1 Financial Assets	At 'fair value through profit and loss' £000	Loans and receivables £000	Available for sale £000	Total £000
Receivables - NHS		8,345		**8,345**
Receivables - non-NHS		983		**983**
Cash at bank and in hand		17		**17**
Other financial assets	0	529	0	**529**
Total at 31 March 2013	**0**	**9,874**	**0**	**9,874**
Receivables - NHS		7,929		7,929
Receivables - non-NHS		2,461		2,461
Cash at bank and in hand		67		67
Other financial assets	0	499	0	499
Total at 31 March 2012	0	10,956	0	10,956

24.2 Financial Liabilities	At 'fair value through profit and loss' £000	Other £000	Total £000
NHS payables		9,533	**9,533**
Non-NHS payables		30,515	**30,515**
Other borrowings		6,426	**6,426**
Other financial liabilities	0	8,902	**8,902**
Total at 31 March 2013	**0**	**55,376**	**55,376**
NHS payables		13,358	13,358
Non-NHS payables		23,168	23,168
Other borrowings		6,514	6,514
Other financial liabilities	0	5,247	5,247
Total at 31 March 2012	**0**	48,287	48,287

25. Related party transactions

HM Treasury considers Government Departments and their agencies, and Department of Health Ministers, their close families and entities controlled or influenced by them, as being parties related to NHS bodies. Related party transactions are to be disclosed if material to either party.

The table below shows the relationship between Enfield PCT's Senior Managers and related parties, i.e. organisations they control or can influence. The amounts disclosed below are transactions with the related parties and not the individuals.

Name / Title	Related Party	Relationship with Related Party	Payments to Related Party £000's	Receipts from Related Party £000's	Amounts owed to Related Party £000's	Amounts due from Related Party £000's
Paula Kahn(Chair)						
	Barnet PCT	Chair	58	5,237	0	5,070
	Camden PCT	Chair	500	446	498	446
	Haringey PCT	Chair	0	419	0	742
	Islington PCT	Chair	7,531	176	1,151	27
Caroline Rivett(Non-Executive Director)						
	Barnet PCT	Audit Chair	58	5,237	0	5,070
	Camden PCT	Audit Chair	500	446	498	446
	Haringey PCT	Audit Chair	0	419	0	742
	Islington PCT	Audit Chair	7,531	176	1,151	27
Deborah Fowler(Non-Executive Director)						
	Camden & Islington Foundation Trust	Member	147	0	11	0
	Camden PCT	Non Executive Director	500	446	498	446
Karen Trew(Non-Executive Director)						
	Camden PCT	Non Executive Director	500	446	498	446
Cathy Herman(Non-Executive Director)						
	Haringey PCT	Non Executive Director	0	419	0	742
Sue Baker(Non-Executive Director)						
	Haringey PCT	Non Executive Director	0	419	0	742
Caroline Taylor(Chief Executive)						
	Barnet PCT	Chief Executive	58	5,237	0	5,070
	Camden PCT	Chief Executive	500	446	498	446
	Haringey PCT	Chief Executive	0	419	0	742
	Islington PCT	Chief Executive	7,531	176	1,151	27
Beverley Evans(Interim Director of Finance)						
	Maidstone and Tunbridge Wells NHS Trus	Non-Executive Director	13	0	7	0
Mo Abedi(PEC Member)						
	Medicare Medical Services LLP	Director/Shareholder	1,115	0	0	0
	Enfield Health Partnership Ltd	Shareholder	288	73	0	45
	Evergreen Surgery Ltd	Director/Shareholder	1	173	0	173
Mike Gocman(CCG Member-Elected GP Representative)						
	Barndoc Healthcare Ltd	Shareholder	1,791	0	0	0
Alpesh Patel(CCG Chair-Elected GP Representative)						
	Barndoc Healthcare Ltd	Shareholder	1,791	0	0	0
	Medicare Medical Services LLP	Shareholder				
	White Lodge Medical Practice	Director/Shareholder	15	0	0	
	Enfield Health Partnership Ltd	Shareholder	288	73	0	45
	Evergreen Surgery Ltd	Director/Shareholder	1	173	0	173
Ujjal Sarkar(CCG Member-Elected GP Representative)						
	Barndoc Healthcare Ltd	Member	1,791	0	0	0
Dr Anshu Baghat(CCG Member-Elected GP Representative)						
	Barndoc Healthcare Ltd	Shareholder	1,791	0	0	0
Tim Fenn(CCG Member-Elected GP Representative)						
	Forest Road Group Practice	GP Principal	2	72	0	19
Richard Quinton(Head of Finance)						
	QFM Ltd	Director	173	0	0	0
Ray James(CCG Member - Director of Health, Housing)						
	London Borough of Enfield	Director of Health	12,117	1,229	6,977	967

The Department of Health is regarded as a related party. During the year Enfield PCT has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department.

	£000's		£000's
Royal Free London NHS Foundation Trust	16,447	Barts Health NHS Trust	9,605
University College London NHS Foundation Trust	26,466	Barnet, Enfield & Haringey Mental Health NHS Trust	57,239
Moorfields Eye Hospital NHS Foundation Trust	3,858	Barnet And Chase Farm Hospitals NHS Trust	107,026
Great Ormond Street Hospital for Children NHS Foundation Trust	4,500	Croydon PCT	31,387
Central And North West London MH NHS Foundation Trust	2,515	The Royal National Orthopaedic Hospital NHS Trust	2,490
Whittington Hospital NHS Trust	6,548	Guys And St Thomas NHS Foundation Trust	2,456
North Middlesex University Hospital NHS Trust	67,531	Homerton University Hospital NHS Foundation Trust	1,763
London Ambulance Service NHS Trust	9,584		

In addition, the PCT has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with the London Borough of Enfield.

Related party transactions 2011-12

HM Treasury considers Government Departments and their agencies, and Department of Health Ministers, their close families and entities controlled or influenced by them, as being parties related to NHS bodies. Related party transactions are to be disclosed if material to either party.

The table below shows Enfield PCT's Senior Managers and related parties, i.e. organisations they control or can influence. The amounts disclosed below are transactions with the related parties and not the individuals.

Name	Related Party	Payments to Related Party £000's	Receipts from Related Partv £000's	Amounts owed to Related Partv £000's	Amounts due from Related Partv £000's
Deborah Fowler					
	Camden And Islington Nhs Foundation Trust	81	0	60	0
	University College London Hospitals NHS FT	25,006	0	2,366	0
Dr Janet High					
	Park Lodge Medical	897	0	0	0
Dr Nicholas Losseff					
	University College London Hospitals NHS FT	25,006	0	2,366	0

The Department of Health is regarded as a related party. During the year Enfield PCT has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department.

	£000's
Barnet and Chase Farm Hospitals NHS Trust	105,895
North Middlesex University Hospital NHS Trust	68,046
Barnet, Enfield & Haringey Mental Health NHS Trust	56,908
University College London Hospitals Nhs Foundation Trust	25,006
Croydon PCT	24,495
Royal Free Hampstead NHS Trust	23,098
London Ambulance Service NHS Trust	9,613
Barts and The London NHS Trust	8,056
Whittington Hospital NHS Trust	6,509
Moorfields Eye Hospital NHS Foundation Trust	4,386
Great Ormond Street Hospital NHS Trust	4,168
Central And North West London Mental Health Nhs Foundation Trust	3,407
Guy's And St Thomas' NHS Foundation Trust	2,335
The Royal National Orthopaedic Hospital NHS Trust	2,309
Homerton University Hospital NHS Foundation Trust	1,957
Imperial College Healthcare NHS Trust	1,460
Royal Brompton & Harefield	1,080
Central London Community Healthcare NHS Trust	1,021

In addition, the PCT has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with the London Borough of Enfield.

Enfield PCT operates a charitable fund which is pooled with other NHS organisations under the management of the Barnet Enfield & Haringey Mental Health NHS Charitable Fund. A member of staff sits on the Charitable Fund Committee. There were no material transactions with the Fund during the year under review.

26. 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	150,825	55
Special payments - PCT management costs	500	1
Total losses	150,825	55
Total special payments	500	1
Total losses and special payments	**151,325**	56

The total number of losses cases in 2011-12 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Total losses and special payments	0	0

Losses - PCT management costs: Relates to debts written off in year by the PCT, after having first exhausted all methods of collection, including referral to a third party debt collection agency. All such write-offs are then the subject of pre-approval by the Audit Committee.

27. Pooled Budgets

Enfield PCT has two pooled budget arrangements with the London Borough of Enfield. These are the S28 and S75 arrangements hosted by London Borough of Enfield for Learning Disability Services. There is also a Drug Action and Alcohol Team arrangement that operates as a pooled budget.

Drug Action and Alcohol Team

The PCT receives national funding for the DAAT scheme and pays all its related costs. Any costs incurred on behalf of London Borough of Enfield are recharged to that body. Similarly any costs incurred by the London Borough of Enfield on behalf of the PCT are recharged to the PCT.

S28a and S75 Pooled Budgets for Learning Disabilities

Enfield PCT has pooled budget arrangements for the provision of Learning Disability Services with London Borough of Enfield. The section 28 arrangement allows for the placement of individuals, whilst the Section 75 arrangement provides joint staffing.

Enfield PCT's contributions to the pooled budgets are set annually and the contribution is invoiced regularly by London Borough of Enfield

	2012/13	2011/12
	£000	£000
S28 Pooled Fund	-	3,006
S75 Pooled Fund	**5,685**	1,438

28. Events after the end of the reporting period

The main functions carried out by Enfield PCT in 2012-13 are to be carried out in 2013-14 by the following public sector bodies:
NHS Enfield Clinical Commissioning Group.
NHS England (NHS Commissioning Board)
NHS Business Services Authority
The London Borough of Enfield
Public Health England
NHS Property Services

All assets and liabilities have transferred to receiver organisations as at 1st April 2013.

Fixed asset have been transferred to the following receivers:
NHS Enfield Clinical Commissioning Group.
NHS Property Services.
Community Health Partnerships Ltd
Central London Community Healthcare NHS Trust
North Middlesex Foundation Trust
Barnet Enfield & Haringey Mental Health Trust

These were considered operational at the year end, and so have not been impaired in the PCT books. It is for the successor body to consider whether, in 2013-14, it is necessary to review these for impairment.

Current assets and liabilities to be managed by the local legacy management teams to wind down these balances.

The Department of Health has made detailed arrangements for the transfer of balances (assets / liabilities / contractual commitments) at their recognised carrying value such that there will be no profit or loss arising from this transfer.

Enfield PCT has a Transfer Agreement showing the expected destination of these balances but the final details have not yet been confirmed. The Department's arrangements ensure that all assets, liabilities and contractual obligations of Enfield PCT will be transferred to other bodies that form part of the NHS controlled by the Department of Health.