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Kensington and Chelsea Primary Care Trust

2012-13 Annual Report and Accounts

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Kensington and Chelsea Primary Care Trust

2012-13 Annual Report

NHS
Kensington and Chelsea

Annual REPORT

2012/13

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Chair and Chief Executive NHS North West London joint statement

Welcome to the annual report for NHS Kensington and Chelsea covering the primary care trust's (PCT's) final year, from 1 April 2012 to 31 March 2013. This report reviews the work of the PCT and highlights what we achieved working closely with our partners.

NHS Kensington and Chelsea was part of a cluster of eight PCTs in North West London. The eight PCTs were Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea and Westminster.

In April 2011, we reorganised the management of the eight PCTs into three sub clusters, each with a common management team: Brent and Harrow, Inner North West London (Hammersmith and Fulham, Kensington and Chelsea, and Westminster) and Outer North West London (Ealing, Hillingdon and Hounslow). This change helped to reduce management costs while maintaining a local focus.

In April 2012, we took this one step further, with further integration of the management of the PCTs. For the remainder of the year, we had a single senior team overseeing the work of all eight PCTs, with the PCT boards having the same members and meeting at the same time.

Together, these PCTs had responsibility to buy and oversee healthcare for the residents of their areas – nearly two million people in total across North West London. Their job was to work with GPs, other community based professionals and hospitals to improve healthcare for residents, and to make it easier to access services when they need them.

The challenge for the PCTs in 2012/13 was both to meet the ever increasing health demands of the populations they served while balancing their budgets. While the NHS's overall budget has been protected, demands and costs are increasing, so the task for the health service is to improve efficiency while maintaining high quality. To help us achieve this, with clinical colleagues across North West London, we developed 'Shaping a Healthier Future', a strategy to improve the quality of and access to services across North West London. To help develop these plans, the North West London PCTs worked with GPs, hospitals, community service providers, mental health trusts and local authorities. We also had an extensive programme of patient and public involvement in order to listen to and take into account people's views.

The year also saw a new organisational structure starting to be developed as a result of the reforms to healthcare commissioning contained in the Health and Social Care Act 2012. Through a carefully planned transition, we set up new GP-led clinical commissioning groups in shadow form. The eight clinical commissioning groups in North West London were authorised by NHS England in 2012/13, which gave them the responsibility for the commissioning of many health care services in their areas from 1 April 2013.

The CCGs decided to manage themselves in two groups of four to best use their expertise and resources while maintaining a crucial local link. The PCTs supported the creation of the new organisations, providing support and guidance to develop the structures and systems, and to appoint and train staff.

We also created the North West London Commissioning Support Unit (NWL CSU) which was also authorised by the Department of Health to provide commissioning support services to the CCGs from April 2013.

The shadow CCGs started to lead the commissioning process from 1 October 2012, including contract negotiations for the provision of healthcare services from 2013/14 onwards. They also specified their commissioning support needs from the NWL CSU.

Since 1 April 2013, PCTs, along with strategic health authorities, no longer exist, and staff in the PCTs moved to the CCGs, NWL CSU, local authority public health teams or NHS England. We worked closely with staff to make sure that the expertise that they held was not lost to the NHS. Most staff took on roles within the new system, and the NHS has thus fortunately retained much of the experience, skills and relationships developed during the life of the PCTs.

We would like to record our thanks to our many partners – GPs, patient representatives, other primary and community care providers, NHS Trusts, local authorities and voluntary sector organisations, for working with us so energetically to meet our shared aims.

Lastly, we would like to thank all the dedicated staff across the North West London PCTs who continued to work so hard through these major changes. The changes affected people personally but it is to their immense credit that they remained focused on ensuring that the very best healthcare possible is provided to residents in North West London.

Jeff Zitron – Chair, NHS North West London

Anne Rainsberry – Chief Executive, NHS North West London

CCG Chair and Chief Officer Joint Statement

Working together to improve services for patients during a period of organisation change is how the year of 2012/13 can be best summed up. We started the year with NHS Kensington and Chelsea leading local health services but over the course of the year NHS West London Clinical Commissioning Group has increasingly taken a lead in making decisions on health services.

We have faced significant challenges in the last year and we have developed a strong partnership with local GPs and our neighbouring clinical commissioning groups, NHS trusts, the local authority, the voluntary sector and with NHS North West London. This has enabled us to work together to improve services for patients.

In this report you can read about the many examples of how we have worked with our GP member practices and our partners to improve services for patients. These include a range of projects and programmes to improve Out of Hospital care such as the new NHS 111 Service, which members of the public can call to get urgent medical advice, and Coordinate My Care, a service dedicated to preserving dignity and autonomy at the end of life. The CCG also reaffirmed our commitment to developing St Charles Health and Wellbeing Centre and opened the Earls Court Health and Wellbeing Centre.

Delivering more services in a community setting has been a key theme of the Shaping a Healthier Future consultation to improve NHS services across North West London, including Kensington and Chelsea. There have, understandably, been many concerns from local residents about the proposals, and we will continue to work hard to ensure we get the best possible services for Kensington and Chelsea. We have also made clear that changes to hospital services can only take place once there have been significant improvements to community based services.

We are also committed to learn the lessons from The Mid Staffordshire NHS Foundation Trust Public Inquiry and the Winterbourne View Care Home scandal. We want to ensure patient safety and do all we can to guarantee that our residents receive high quality care. We will be holding providers of NHS services to account to ensure that they do so.

In order to deliver effective services we need to work in partnership, none more so than with the Royal Borough of Kensington and Chelsea, with whom we are developing integrated and coordinated services. Our thanks also go to all our partners within the health, voluntary and private sectors for their support.

In 2012 we have formed a collaboration with the Hammersmith and Fulham, Hounslow and Central London CCGs, which has enabled us to share a number of our staff costs including the Chief Officer, Chief Financial Officer, Clinical Governance and Strategy roles without affecting our autonomy.

In addition to developing our new NHS West London CCG Governing Body and members' practices, all staff in NHS Kensington and Chelsea have gone through a restructuring process as part of the changes underway across the NHS. Staff have

moved either to work in the clinical commissioning group, the new commissioning support unit, local authority public health teams, or in NHS England.

Some staff were not able to identify a role and we supported these staff to find alternative employment. Organisational restructuring is always a stressful process for everyone involved, and we would like to pay tribute to the hard work by all staff throughout the year, even though everyone's personal future has been uncertain.

Organisations are only as good as their people, and the progress and successes we have achieved in Kensington and Chelsea in 2012/13 is a reflection of the high calibre of staff we are fortunate to have. We would like to pay tribute to our GP member practices, Clinical Leads and the Management Team for all their hard work and contribution, which has put NHS West London CCG in a very good position to start its work as a statutory body.

2012/13 has been a challenging year and the next year is set to be as challenging. However, we are confident that with a continued focus on quality services, patient outcomes and the hard work undertaken by everyone in 2012/13 we have a solid base on which to go forward.

Dr Mark Sweeney, Chair, NHS West London Clinical Commissioning Group

Daniel Elkeles, Chief Officer, NHS West London Clinical Commissioning Group

The NHS in Kensington and Chelsea

NHS Kensington and Chelsea was established on 1 April 2002 and is the local NHS organisation responsible for securing world class health care for local residents and reducing health inequalities in the borough. The PCT used its budget to commission, or buy, services from a wide range of health providers including hospitals, mental health and community providers, GPs, dentists and community pharmacies.

The PCT was also responsible for helping residents lead a healthier lifestyle through programmes addressing issues such as smoking, alcohol abuse, exercise and healthy eating.

The main hospital services in our area are provided by:

- Chelsea and Westminster Hospitals NHS Foundation Trust
- Imperial College Healthcare Trust

Mental health services are provided by Central and North West London NHS Foundation Trust and community services from Central London Community Healthcare Trust. The PCT also commissioned services from a number of private and voluntary sector providers.

We worked closely with the Royal Borough of Kensington and Chelsea with whom we jointly commissioned and provided a range of children and adult services.

The work of PCTs was managed by a board comprising executive and non-executive directors with board meetings held in public. On 1 April 2011, NHS Kensington and Chelsea was clustered together with seven other PCTs: Brent, Ealing, Harrow, Hillingdon, Hounslow, Hammersmith and Fulham and Westminster to form NHS North West London. This was the largest cluster in London and governance was managed by an eight-PCT level, with a Board in Common and one Chair.

Changes in the NHS

Major changes to the way primary and secondary care is commissioned across the NHS were introduced on 1 April 2013 as a result of Government's Health and Social Care Act 2012.

The key changes to healthcare were:

Clinical Commissioning Groups

NHS Kensington and Chelsea disbanded on 31 March 2013 and responsibility for commissioning a range of services passed to NHS West London Clinical Commissioning Group (WLCCG). CCGs are made up of local GPs, meaning they can make commissioning decisions based on the performance of providers and the feedback they receive about these providers from their patients. You can find out more about WLCCG later in this report.

NHS England

NHS England has taken on many of the functions of the former primary care trusts with regard to the commissioning of primary care health services, as well as some of the nationally-based functions previously undertaken by the Department of Health. This includes pharmaceutical and primary ophthalmic services, dental services and some other specialist services. It is a single national organisation, although many of its functions are carried out at a local level.

Public health
From April 2013 local authorities were given a new duty to improve the health of their population. To help the Royal Borough of Kensington and Chelsea fulfill this duty, the public health team that was previously based in Inner North West London PCTs moved over to the tri-borough, hosted by Westminster City Council. A national body, Public Health England, was established to protect and improve the nation's health and wellbeing, and to reduce health inequalities.

Commissioning support units
Commissioning support units provide a range of business functions designed to help clinical commissioning groups make better decisions for their patients and improve health services. North West London Commissioning Support Unit provides commissioning support to the eight CCGs in North West London, including West London CCG.

Healthwatch England
Kensington and Chelsea Local Information Networks (LINk), which used to look after the interests of users of publicly funded health and social care services, was replaced by Healthwatch Kensington and Chelsea, part of Healthwatch England. Healthwatch England is the new, independent consumer champion for health and social care in England.

Health and wellbeing board
A new health and wellbeing board was established for Kensington and Chelsea that brought together the leaders of the local healthcare systems to work towards a common purpose to improve services and outcomes. The board members work together to develop a joint strategic needs assessment and joint health and wellbeing strategy for the borough. Integrating services, joint commissioning and pooling resources is central to translating their needs assessment and joint strategy into action.

NHS West London Clinical Commissioning Group

From 1 April 2013 NHS West London Clinical Commissioning Group became a fully legal entity with responsibility for designing local health services that are focused on delivering better outcomes and responding to the needs and wishes of patients.

The CCG will do this by commissioning or buying the health and care services our residents need including:

- Elective hospital care
- Rehabilitation care

- Urgent and emergency care
- Most community health services
- Mental health and learning disability services

WLCCG is co-terminous with the Royal Borough of Kensington and Chelsea (RBKC) and covers the Queen's Park and Paddington area of Westminster City Council (WCC). Our Governing body is made up of GPs, nurses, practice managers, lay members as well as accountable officers.

During 2012, with the support of NHS Kensington and Chelsea and NHS North West London the CCG started to operate in shadow form, learning about its new role and developing the structures needed to move forward. Applying to become authorised involved gathering and presenting a large number of pieces of evidence to the NHS England to demonstrate that our CCG was ready to become an NHS statutory body.

Members of the Governing Body, including patients and colleagues from Public Health and the Royal Borough of Kensington and Chelsea, took part in a rigorous assessment day with a panel from NHS England where they were able to scrutinise any areas which were seen to require further discussion and evidence.

The feedback from the assessment days for the CCG was very positive and a testament to the work that our patients and colleagues in the CCG, NHS Kensington and Chelsea, NHS Northwest London and the Royal Borough of Kensington and Chelsea have been doing over the past year and in many cases, several years. Authorisation by the NHS National Commissioning Board showed that our CCG was safe and effective and ready to take on the task in hand.

WLCCG works closely with our partners from local government, NHS and the voluntary and community sector and are committed to involving our residents in the decisions that affect local health services. Working closely with colleagues in The Royal Borough of Kensington and Chelsea, we consider the wider needs of Kensington and Chelsea residents and visitors, taking into account both health and social care services, to develop a joint Health and Wellbeing strategy. This strategy helps inform how we align our priorities and the services we commission, which in turn addresses the health needs of our population but also identifies opportunities for stronger integration between health and social care service.

At the same time, the CCG has been developing its plans for how it wants local health services to deliver care, with an emphasis on improving clinical safety, quality and the patient experience. These plans are set out in a range of policies and documents available on our website including our commissioning intentions and Out of Hospital strategy.

The CCG recognises that equality and diversity is a key statutory responsibility of Clinical Commissioning Groups. To enable the organisation to commission effectively and to the highest standards, the CCG board has agreed that patient leads should sit on the working groups for different CCG projects, provide PPE and Equality and Diversity training for staff, members and the Board and continuing support for GP practice Patient Participation Groups

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effectively and to the highest standards, the CCG Board has agreed to the recruitment of patient leads to sit on the working groups for different CCG projects, providing PPE and Equality and Diversity Training for staff, members and the Board and continuing support for GP practice Patient Participation Groups;

We also work with three of our local CCGs: Central London, Hammersmith and Fulham, and Hounslow in collaboration because the majority of our providers, whether they are emergency, elective, community based or mental health providers, are shared between us. Working together to manage spend and foster successful inter-relationships with these providers enables us to make decisions jointly where that makes sense and manage financial resources to prioritise patient needs.

We also work collaboratively with Brent, Ealing, Harrow and Hounslow CCGs, who operate as the BEHH Federation, on areas that affect all the CCGs such as the Shaping a Healthier Future consultation and the associated implementation work. The eight CCGs in North West London have also appointed a joint Director of Strategy, allowing us the best opportunity to commission services with improved outcomes for local people, as well as sharing best knowledge and practice.

You can find out more about West London CCG by viewing it's 2013 Prospectus or visiting its website www.westlondonccg.nhs.uk.

About the Borough

Kensington and Chelsea is a small and very densely populated borough situated in the centre of London, bordered by Westminster to the east and Hammersmith and Fulham to the west. The borough is popular for tourism and retail, with areas such as Chelsea, Kensington High Street, Notting Hill, South Kensington and Ladbroke Grove.

The Office for National Statistics estimated the resident population in 2010 to be 169,500 people, with 179,700 patients registered with Kensington and Chelsea GPs. The population is expected to rise in the medium to long term, with a particular focus in development areas such as Canal Way in the far north of the borough.

The population is characterised by a large proportion of young working age residents, high levels of migration in and out the borough, and ethnic and cultural diversity. Although residents have the highest life expectancy in the country, there are significant pockets of poor health in the more deprived areas and therefore large inequalities.

Age

The age profile in Kensington and Chelsea is typical of urban areas in having a high proportion of young working age adults and a smaller proportion of children. There are a similar proportion of older people to London but far fewer than nationally. The 117,500 residents aged 16 to 64 represent 69.3% of the total population. This population structure impacts on the types and range of servicesrequired in the borough.

Gender

There are slightly more women than men living in the borough. As with elsewhere, there are a greater number of older women due to longer life expectancy.

Ethnicity

The borough has a smaller proportion of residents from White British, Black and Asian ethnic groups in comparison to London. There are more people from the other/mixed category and three times more from the White Other category – the highest in the country. The White Other category includes those from Europe, Ireland, the Americas and Australia. 76% of the borough's state school children are from ethnic groups other than White British.

Nationality and language

Analysis of data on patients registered with GPs suggests there are significant populations from the Americas, Western Europe, Australia, the Philippines, the former USSR and Iran. Common minority languages spoken include Arabic, French, Spanish, Italian and Portuguese. English is spoken as an additional language by 54% of the borough's state school children.

Households

There are around 83,500 households in Kensington and Chelsea with an average household size of 2.0 persons. Around half of households in Kensington and Chelsea are single households, one of the highest nationally. Under a fifth of the borough's households are occupied by families, and less than 1 in 10 by lone parents, and single elderly households account for 15%. The proportion of private rented housing is very high compared to London and England.

Population mobility

Kensington and Chelsea had the sixth highest population mobility rate in England and Wales in 2001, with one in five residents moving address in the previous year. Population churn can create challenges around effective delivery of public health programmes such as screening and immunisation.

Deprivation

The Index of Multiple Deprivation (IMD) combines economic, social and housing indicators into a single score, allowing the ranking of areas by deprivation. In 2010, Kensington and Chelsea was ranked 103rd out of 354 most deprived local authority in the country, although significant areas of deprivation were indicated in the four northerly electoral wards.

Child wellbeing and child poverty

The Child Wellbeing Index (CWI) is a composite index with seven domains: material wellbeing, health, education, crime, housing, environment, and children in need. Based on these, the borough is ranked 127th lowest out of 354 in England for wellbeing. Figures from the Index of Multiple Deprivation Affecting Children (IDACI) suggest that 21% of the borough's children live in income-deprived households.

Employment and unemployment

The majority of jobs in the borough fall into the service and retail sectors. The unemployment rate for residents is currently 7.3%, the 7th lowest in London. The Job Seekers Allowance (JSA) claimant rate (2.8%) is below London (4.4%) and Great Britain (4.1%), although the rate for claimants for over 12 months is similar.

Incapacity benefit for mental health

Golborne, St Charles and Notting Barns are in the top ten wards in London with the highest level of working age incapacity benefit claimants for mental health reasons. Colville and Cremorne are also within the top 20% of wards in London with high claim rates.

Health and life expectancy

The average life expectancy is 85.1 years for men and 89.8 for women, the highest in the country. Life expectancy in Kensington and Chelsea was the fastest improving in the country over the last decade, with an increase of 7.8 years for men and 7.5 years for women.

Disability-free life expectancy

Disability-free life expectancy is increasing, but at a slower rate than life expectancy: people are experiencing longer periods of time living with disability. This is as a result of improved survival rates from major diseases such as stroke, heart disease and cancer.

National modelling predicts women aged 65 in 2030 will live for four years with a disability, compared to three years today. Given large numbers living alone locally, this is likely to increasingly impact on the level of support required from services and carers.

Health inequality

There is variation in life expectancy across the social gradient in Kensington and Chelsea. The Slope Index of Inequality, which measures the absolute difference in life expectancy between the most and least deprived areas, shows a 6.9 year life expectancy gap for men and a 2.5 year gap for women (2006-10). These are lower than the median figures for England (8.9 and 6.0 respectively).

There appears to be a narrowing of the gap among women over the past 5 years, and improvements in life expectancy appear to have been experienced across the social spectrum. However, the lack of a strong trend across areas and over time means confidence in these findings is low.

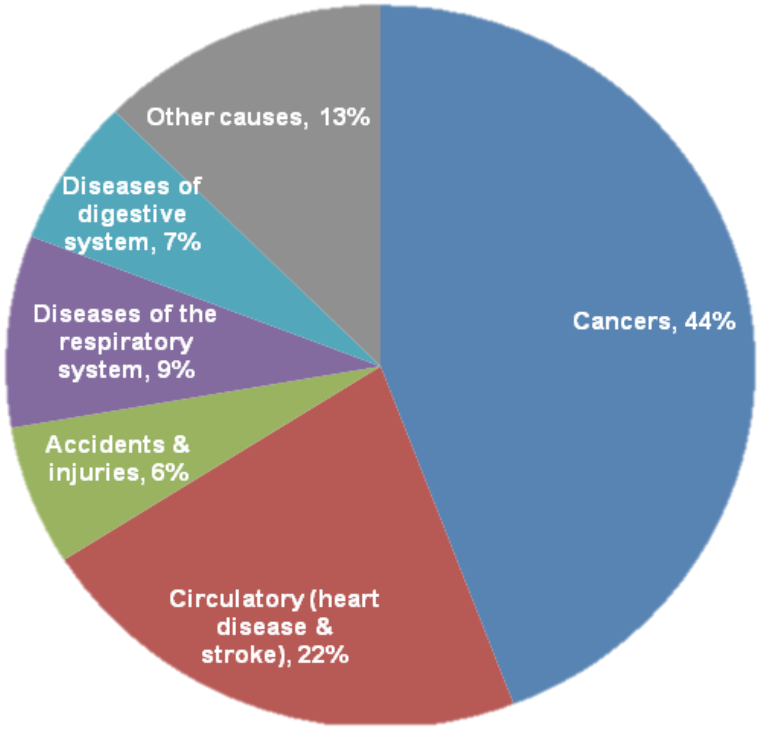
Health inequality is highlighted by the variation in premature death in the borough: almost two-fold between the four northerly wards and the rest of the borough.

Causes of premature death

The principal cause of premature death in Kensington and Chelsea is cancer, followed by cardiovascular disease (CVD) (which includes heart disease and stroke). A significant number of people also die from respiratory diseases. Accidents and

injuries are most common among younger residents. This is pattern is broadly similar to the rest of the country.

Premature death by causes, 2011



Tackling these chronic diseases using a range of factors, particularly lifestyle change and improved services for those with chronic disease, has resulted in a reduction of around 120 early deaths a year over the last decade, with differing levels of success across disease types.

For further information see Prioritising Health and Wellbeing Needs, Kensington and Chelsea Joint Strategic Needs Assessment Highlight Report 2012.

NHS Kensington and Chelsea performance

NHS Kensington and Chelsea has a statutory duty to report on the performance of key services against the national operating framework indicators for 2012/13.

In 2012/13 NHS Kensington and Chelsea met the following national indicators:

- The number of hospital and community acquired infections for clostridium difficile remained low and within national standards.
- Ambulance response times: category A response within 8 minutes
- Ambulance response times: category A response within 19 minutes
- 18 weeks referral to treatment: admitted performance within 18 weeks*
- 18 weeks referral to treatment: non-admitted performance within 18 weeks*
- 18 weeks referral to treatment: incomplete pathways performance within 18 weeks*

- Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer is not initially suspected**
- Cancer two week wait – percentage seen within two weeks of an urgent GP referral for suspected cancer.
- Cancer 62 day wait percentage treated in 62 days from urgent GP referral for suspected cancer*

NHS Kensington and Chelsea did not fully meet the following indicators:

- Methicillin-resistant *Staphylococcus aureus* bacteraemia: 3 cases against a tolerance of 2 cases

The new NHS organisations established in April 2013, including West London CCG will have responsibility for improving those areas where performance is poor.

*Following a review of the management of waiting lists by the NHS IST, Imperial College Healthcare NHS Trust did not submit performance data to the DoH on 18 weeks RTT for April and May 2012. This is therefore excluded from the YTD 18 weeks performance positions.

**Chelsea & Westminster Hospital NHS Foundation Trust had an issue with submitting cancer data for M12, therefore performance has not been reported for these indicators and will be excluded from the overall CCG positions.

Our year in focus

2012/13 has been marked by the wider strategic changes in London overall and North West London in particular, most notably the consultation on Shaping a Healthier Future which looked at the reconfiguration of acute services across North West London. There is more information about this project later in this report.

As the year has progressed, WLCCG has increasingly taken the lead in making decisions on health services in the borough by developing its Out of Hospital strategy with a focus on strengthening primary care, urgent care and rapid response, improving integrated care by rolling out more robust joint working arrangements and providing outpatient care in a community setting, closer to patients' homes.

At the same time we have kept our focus on ensuring we are commissioning high quality and safe services for the registered population while managing the transition to the new CCG and keeping within budget. We have also needed to ensure we are delivering our key performance indicators and continued to drive through our service improvement agenda through the Quality Innovation Productivity and Prevention (QIPP) Plan.

We have had many successes in delivering healthcare and developing new innovative services that will make a real difference to local residents' health and wellbeing. In some cases these are local initiatives driven by local clinicians and our partners, and some are local implementation of national initiatives.

St Charles Hospital Development

St Charles, as a Centre for Health and Wellbeing and its place in the community, continues to develop with the establishment of new healthcare services at the centre and the opening of a number of different services operated by non-NHS organisations to support the local community and promote improved health and wellbeing for local residents. This has included the creation, in conjunction with the Royal Borough of Kensington and Chelsea, of the new community gardens.

NHS West London CCG has been leading a review of the future role of the site and the range of healthcare and wellbeing services, which could be offered there in the short medium and long term.

Earls Court Health and Wellbeing Centre officially opens

The Earls Court Health and Wellbeing centre was open by Dr Christian Jessen. An innovative new health centre was opened this year in Earls Court offering pioneering integrated primary and social care for patients, including walk-in services. The Earl's Court Health and Wellbeing Centre in London provides a range of services including dentistry, a GP practice, sexual health, wellbeing advice and community services. NHS Kensington and Chelsea funded the clinic including an extensive range of free health and social care under one roof. The centre delivers NHS services which treat medical conditions, and also address physical, mental and social wellbeing.

The Earl's Court Health and Wellbeing Centre also provides a space for local people to use and a timetable of community classes and activities. Other opportunities include a peer mentoring service where people with long-term conditions support one another and a Time Bank to link local people together to share their skills and help each other with everyday activities.

NHS Continuing HealthCare – Un-assessed Periods of Care

NHS Continuing Healthcare is the name given to a package of care which is arranged and funded solely by the NHS for individuals outside of hospital who have ongoing healthcare needs. Continuing Healthcare can be provided in any setting, including a person's home or a care home.

NHS Continuing Healthcare is free, unlike help from social services for which a financial charge might be made depending on a person's income and savings. Continuing Healthcare can be provided in a person's home which means that the NHS will pay for healthcare (e.g. services from a community nurse or specialist therapist) and personal care (e.g. help with bathing, dressing and laundry) or within a Nursing Home.

On 15 March 2012, the Department of Health announced the introduction of deadlines for individuals to request an assessment of eligibility for NHS Continuing Healthcare funding, for cases during the period 1 April 2004 – 31 March 2012.

Individuals or their representatives were asked to contact their local Primary Care Trust in respect of previously un-assessed periods of time where there was evidence that they should have been assessed for eligibility for NHS Continuing Healthcare funding.

NHS Kensington and Chelsea received 24 requests for reviews which are currently being processed in line with NHS London guidelines. Overall 4000 requests for

reviews were submitted across the whole of London. The process for assessing all the appeals is expected to be completed by Autumn 2013.

Learning Disabilities

In 2012/13 two main factors influenced developments across Learning Disability commissioning: Winterbourne View Hospital and the successful completion of the Learning Disability Self Assessment Framework.

Following an investigation of the abuse at Winterbourne View Hospital, a range of measures were introduced to ensure that the commissioning and provision of services to people with Learning Disabilities were safe and of sufficient quality. This includes more focussed mapping of the use of Assessment and Treatment Units (ATUs) and placements outside the local area including:

- Identification of numbers of people in (ATUs)
- Numbers of people placed outside of the locality
- Length of stay
- Cost
- Review dates
- Access to Advocacy

A multi-disciplinary task group was established to explore future actions to be taken in relation to the Government report on Winterbourne View Hospital and an action plan will be produced and circulated for discussion, before being implemented through 2013.

The Learning Disability Self-Assessment Framework has been submitted and validated with a positive outcome. The framework includes a range of targets on quality and safety including lessons learnt from Winterbourne View Hospital, the Mental Capacity Act and restraint. This covers policy, training and implementation, including regular audits of practice and the inclusion of service user and carer involvement in monitoring contracts, engagement and co-production.

Improving Out of Hospital care

People are living longer with more long-term conditions and the population is increasing. In the past year we have continued to make the changes needed to meet the health needs of local people in the future. We want to provide more care closer to home so people can get easier and earlier access to care. This means working in partnership with the London Boroughs of Kensington and Chelsea and other partners in public, voluntary as well as private sectors to ensure that we create joined up coordinated care that focuses on the needs of the patient. Our local framework for doing this is called Putting Patients First.

We want to help people stay healthy longer and pick up potentially life threatening diseases at an earlier stage; when treatment is much more likely to be successful and can avoid patients ending up in hospital. Treatment and support in people's homes and in the community allows people to maintain their independence, to recover more quickly and also reduces the risk of acquiring healthcare infections. The vision that has been developed is to provide people with:

- Easy access to highquality care
- Simpler, planned care pathways

- Quick responses to urgent health problems
- Coordinated care for people with long-term condition
- Less time spent in hospital

In Kensington and Chelsea, Queens Park and Paddington in Westminster, we plan to spend between £5 million and £7 million more per year on health services in the community.

- We will provide additional health staff including GPs and nurses
- We have established quality standards for all services in the community
- We will ensure care is provided in the most appropriate care setting and have already developed high-quality facilities such as the St Charles Centre for Health and Wellbeing, the Earl's Court Health and Wellbeing Centre and the Earls Court Medical Centre. In the next few years, we want to further develop these and additional primary care centres.

This year we have commenced work on developing two new health networks across Kensington and Chelsea, and Queens Park and Paddington in Westminster. The vision is to develop well-integrated networks of all those delivering care (social care, mental health, community nursing, hospital providers, GPs, voluntary organisations etc.) to the population of the WLCCG area.

By bringing these various providers together and enabling them to work more closely, there is a great opportunity to innovate and to shape the future of how care is delivered, in the community, closer to home and around patients and their carers' requirements.

Improved local health centres will form a key part of the networks by providing a local site to perform tests and treat more complex conditions in the community so that patients don't need to go to hospital so often.

Easy access to high quality care

Our aim is that urgent cases will be dealt with within four hours and non-urgent cases within 24 hours, or patients can choose to have an appointment with their own GP within 48 hours. One area where we have made big process is with new NHS 111 Service which launched in March 2012, where patients can call the freephone number and be directed to the most appropriate care, 24 hours a day, seven days a week.

This might be to an urgent care centre, pharmacist, their own GP, district nurse or A&E. If it is a real emergency, patients are put through to the London Ambulance Service straight away who will then dispatch an ambulance. In addition, staff can, in some cases, book appointments at some GP practices. We want to expand this offer to all GP practices and other health settings.

Simpler planned care pathways

This year we redesigned the Musculoskeletal **(**MSK) pathway and procured a new Multidisciplinary Clinical Assessment and Treatment Service (MCATS). The aim is to provide an integrated approach to meeting patient need and demand through:

- Improved access through a single point of referral and central booking system
- 6 days a week access and extended hours of operation
- A range locations across the borough
- Quick and easy access to face to face assessment and treatment
- An integrated care pathway across clinical disciplines and health settings which will improve navigation and communication for both the patient and the referrer
- Implementation of health outcome and patient related outcome key performance indicators across the different specialities

Working with a range of partners including CCGs, hospitals, community services and patients, we have commenced work on developing simpler care pathways for respiratory, diabetes and cardiology services. The aim is to ensure services improve quality, deliver care closer to home, and respond to the challenges of the future. These new pathways will be implemented in 2013/14.

Coordinated care for people with a long-term condition

In 2012/13 a key initiative delivering local integrated care is our 'Putting Patients First' framework. Putting Patients First (PPF) describes NHS West London CCG's approach to ensuring that care provided for patients is seamless with joined- up working between all professionals. Clear communication with patients is key to ensuring they understand their condition, treatment plan and options for self-management where appropriate. The key elements of this initiative include:

- Providing support to patients to improve the self-management of their own conditions and illnesses.
- Proactive care coordination and care planning of patients with complex health and social care needs to ensure smooth transition between services and supportive early discharge.
- Specialist community services in place to support GPs in providing care for patients.
- Joined-up working supported by clear pathways of care, which allows a patient's care to be stepped up when their condition worsens and they need extra help, and stepped down when their condition improves. The aim is to facilitate ease of movement between services, for example, hospital to primary care.
- Improved liaison with the Out of Hours service and the Rapid Response Team to ensure that patients have rapid access to appropriate care if they become acutely unwell at home.
- Joined up working with social services to provide appropriate social support and help at home.
- GP responsibility for continuity and quality of care across the care pathway to feed into contract monitoring and service evaluation.
- Drawing on GPs skills and expertise through monthly meetings of all GPs practices in Commissioning Learning Sets.

Alongside the PPF, the Integrated Care Pilot (ICP) in West London helps people aged over 75, or with diabetes. The ICP makes sure hospitals, community-care services, social care and local authorities all work together to identify the patients most at risk of needing a hospital admission.

Coordinated care for people with a long-term condition

Now in its second year, the Integrated Care Pilot (ICP) in Kensington and Chelsea helps people aged over 75, or with diabetes. The ICP makes sure hospitals, community care services, social care and local authorities all work together to identify the patients most at risk of needing a hospital admission. They will proactively work to enable people to live at home with a coordinated care plan, developed with the patient.

Coordinate My Care

We launched Coordinate My Care (CMC) in January 2013, a service dedicated to preserving dignity and autonomy at the end of life. CMC was developed in response to the national End of Life Care Strategy with the aim of improving care for patients, irrespective of diagnosis, during the last year and ultimately the end of their life. The aim is to increase the number of patients dying in their preferred place, which is often in their own home.

CMC works by putting patients at the centre planning and providing better coordinated services by improving communications between professionals. A patient's medical history and wishes are loaded onto a secure website that GPs, ambulance staff and health professionals working in out of hours, community and emergency services can use a password to access. Whilst local data is not yet available, data from pilot areas is encouraging. Of the patients with a CMC record who have died (CMC data August 2011), 73% died in their preferred place and 75% died outside hospital so hopes for the service are high.

Stopping Suicide: Prevention work across Inner North West London

With suicide numbers remaining high in Inner North West London when compared to London and England, a range of agencies have come together to promote mental wellbeing including local mental health trusts, London Underground, acute trusts, local authority, public health, police, academic institutions, community providers and service users.

The aim was to promote effective inter-agency working in communicating, managing and preventing suicide incidents across Kensington and Chelsea, Hammersmith and Fulham and Westminster with a suicide joint strategic needs assessment produced that will be used in developing a suicide prevention strategy and ensuring key actions are implemented effectively.

We also want to raise awareness of suicide as a public health concern, promote support services using social marketing techniques, train frontline staff in basic mental health awareness and campaign for improved reporting of suicide incidences. Some examples of the work include:

- Campaign Against Living Miserably (CALM) implements a project that uses social marketing techniques to raise awareness of depression amongst young men by working with the music, sport and media industries, to encourage young men to open up and discuss their concerns
- Work with Samaritans to install posters with helpline numbers at car parks and underground stations
- Deliver basic mental health awareness training for frontline London Underground staff and British Transport Police.

- Produce a resource pack developed jointly with families bereaved by suicide. This will provide systematic information that could help families navigate through the bereavement process.

This work has attracted a wide range of local and national recognition. In May 2012 the Director of Public Health was invited to the House of Commons to appear before the All Party Parliamentary Suicide and Self-Harm Prevention Group to give evidence on our work, and one of our providers, CALM, was recently voted as charity of the year by IPC Media and received a Guardian Charity Award.

Dental Public Health

During 2012/13 dental public health activities in Kensington and Chelsea have centred on implementing the North West London Child Oral Health Improvement Strategy's recommendations. These cover three domains: making oral health everybody's business, the integration of oral health within other public health and children's programmes and increasing children's exposure to fluoride.

Specific activities have included:

- The delivery of *Brushing for Life* by Health Visitors (distributing toothpaste and toothbrush packs with oral health messages at child development reviews);
- An outreach fluoride varnish programme in targeted primary schools with the highest levels of poor oral health, and
- Training of Health Visitors and School Nurses in the impact and prevention of poor oral health.

These activities have resulted in raised awareness of oral health issues and ways to prevent tooth decay opportunistically; and the delivery of consistent messages around diet and oral health across professionals working with children. Closer cross-agency working and improved data collection has helped to provide greater understanding of the reach of targeted children's oral health programmes to inform future commissioning.

Launch of a Healthy Schools Partnership

Schools across Hammersmith and Fulham, Kensington and Chelsea and Westminster welcomed a new local Healthy Schools Partnership, launched in October. The aim of the partnership is to build on and progress the excellent work of previous years on the key relationship between health, achievement and happiness of pupils both while at school and lifelong. Schools can gain recognition for their achievements with Bronze, Silver and Gold Awards. Schools will have access to free practical guidance and training opportunities available from the Healthy Schools Partnership Network of local organisations as well as specialist advisers on healthy eating and catering, physical activity, personal social, health and economic education and emotional health and wellbeing.

For further information about any of these projects and the work of the NHS West London Clinical Commissioning Group as it moves forward please email wlccg.team@inwl.nhs.uk or call 020 7150 8000.

Shaping a Healthier Future

The Shaping a Healthier Future programme across North West London aims to improve healthcare for the two million people living in the area.

It is led by the clinical commissioning groups and clinicians who have seen first-hand the health inequalities and changing needs in the area. North West London has a growing and ageing population and at present specialists are too thinly spread over too many sites and some facilities are inadequate.

The aim of the programme is to ensure that the right care is delivered in the right places. Clinicians believe that more investment needs to be made in local healthcare so that it is of a more consistently high standard.

The Shaping a Healthier Future vision is to:

- Bring care nearer to patients' homes so people are encouraged to access care earlier and more regularly to identify diseases so they can be more successfully treated and to better manage long term conditions;
- Concentrate complex services (including A&Es) in five major hospitals in order to ensure senior doctors can be present at evenings and weekends as well as during the day and improve the safety and quality of services. Other sites would become local hospitals and elective hospitals, while specialist hospitals would remain largely as they are;
- Develop a more co-ordinated, seamless system that works better to keep people well and independent in the community, improves their quality of life and not just the quality of care they receive and relieve pressures on NHS services.

All nine current acute hospitals in North West London (Charing Cross Hospital, Chelsea and Westminster Hospital, Central Middlesex Hospital, Ealing Hospital, Hammersmith Hospital, Hillingdon Hospital, Northwick Park Hospital, St Mary's Hospital and West Middlesex Hospital) would continue to provide local hospital services, including a 24/7 urgent care centre (UCC) and outpatient and diagnostic services. These UCCs would be able to treat most illnesses and injuries that people go to hospital for. For those patients at a UCC who do need to go to an A&E, staff would generally dial 999 and an ambulance would take them to the nearest major hospital. On average this would take no more than six minutes longer than it does currently.

In determining which hospitals should become major hospitals, the programme assessed the options in great detail, looking at which would deliver the best clinical quality of care and access to care, whether they were affordable and could be delivered, and which would be best for research and education. This resulted in three options that were consulted on, including one preferred option.

Between 2 July and 8 October 2012, the programme ran a public consultation, attending over 200 meetings; arranging two road shows in all eight boroughs plus additional road shows in the neighbouring boroughs of Camden, Richmond and Wandsworth; sending over 73,000 consultation documents out to libraries, doctors'

surgeries, pharmacies, hospitals, town halls; and taking part in three major public debates.

Clinicians and managers considered all consultation responses and reconsidered the proposals in light of all the issues and concerns. A number of changes were made to the proposals as a result of issues raised during the consultation. The final recommendations were discussed at a meeting of the Joint Committee of Primary Care Trusts 19February 2013 (JCPCT) which represented the eight primary care trusts in North West London.

At this meeting the JCPCT unanimously agreed to give the go ahead to:

- Investing over £190m more in Out of Hospital care to improve community facilities and the care provided by GPs and others across NW London.
- Investing in five major hospitals at Chelsea and Westminster; Hillingdon; Northwick Park; St Mary's; and West Middlesex.
- Developing two hospitals – Central Middlesex and Hammersmith – as hospitals specialising in elective or planned care (for example, pre-planned procedures such as hip operations), as well as having a 24/7 urgent care centre.
- Looking at further proposals for Ealing and Charing Cross hospitals, which were originally going to be local hospitals (also with urgent care centres) but may now have more services put into them, depending on further planning and costing work.

This is a large programme of change and final implementation will take between three and five years in total. Improvements to services outside hospital,such as GP and other local NHS facilities in the community, will happen first. The major changes to hospital will not happen until these community facilities have first been improved.

More detail can be found on the Shaping a Healthier Future website at: www.healthiernorthwestlondon.nhs.uk

Complaints

The NHS believes complaints are a valuable source of feedback that help to shed light on the quality of local health services. A national complaints process applies to all NHS organisations and seeks to provide complainants with an explanation and where appropriate an apology, and the correction of an error or other remedial action. The NHS also seeks to learn from complaints and improve procedures to prevent problems being repeated. The NHS complaints procedure adheres to the Principles of Remedy published by the Parliamentary and Health Service Ombudsman.

In 2012/13 we received a total of 39 complaints of which 3 related to services provided directly by the primary care trust, 36 related to primary care services including general practice, dentists and pharmacist.

On occasion patients complain to the PCT either because the PCT is the commissioner of services or because they are not sure which organisation they

should raise their complaint with. In these cases complaints are forwarded to the relevant organisation to investigate and respond. Where appropriate the PCT requests a copy of the final response for monitoring purposes. 11 such complaints were received for NHS Kensington and Chelsea, NHS Hammersmith and Fulham and NHS Westminster.

Informal complaints and concerns raised though the Patient Advice and Liaison Service are also a useful source of information on the quality of service local people receive from the NHS.

Complaints in future

From 1 April 2013, comments or complaints about a GP, dentist, pharmacy or optician that can't be resolved locally with the Practice Manager should be dealt with through NHS England. To contact NHS England email england.contactus@nhs.net or call 0300 311 22 33.

If you have any comment or complaint about a hospital, mental health or community trust please contact them directly.

If you have a comment or complaint about any other local health service, please contact your CCG at cwhh.complaints@nhs.net or call 020 3350 4567.

Emergency Planning

The 2004 Civil Contingencies Act (CCA) provides the framework for national civil protection and emergency planning. It outlines the duties, roles and responsibilities required for local responders to deal with the efforts of serious emergencies and major incidents. Primary care trusts were defined as category one responders and are therefore responsible for complying with the six key elements of the CCA.

Emergency preparedness resilience and recovery is a cluster function in North West London, with the eight boroughs of Ealing, Hammersmith and Fulham, Westminster, Kensington and Chelsea, Hillingdon, Hounslow, Brent and Harrow served by a joint team. The team possessed a wealth of local knowledge developed over many years of responding, planning and exercising with local responders in the health community and Local Authorities.

There were a number of major national events that the emergency planning team was involved in during 2012/13. The team was an integral member of the planning in North West London for the Diamond Jubilee and the Olympics and Paralympic Games, ensuring and assuring that the health providers and commissioned services within the cluster could deliver all critical services should an incident happen.

The team also supported NHS North West London, community providers, mental health, acute trusts and the directly commissioned services to develop business continuity procedures.

The on-call system was reviewed and revised and all staff participating in the on-call rota received training on the process that had been put in place. An extensive training programme was delivered to primary care, specifically in relation hazardous materials. The team delivered various training sessions throughout the health

community, tailored to meet individual's needs, focusing on the organisation's ability to respond and recover should and incident occur. The emergency planning function transferred to NHS England with effect from early in the New Year.

The legacy of the North West London emergency planning team is a comprehensive, detailed portfolio of emergency plans to support the response and recovery of the health community should an incident occur.

Taking care of the environment

A North West London-wide waste strategy was introduced which focused on increasing recycling rates, thus saving money through reducing the amount of waste being sent to landfill, saving on landfill tax. Throughout the year recycling was introduced to sites that had not previously had any, and recycling rates steadily improved.

Several initiatives throughout North West London were invested in, including continuing the installation of automatic meter readers at health centre and clinic sites across the cluster. This allowed remote monitoring of electricity and gas consumption data. Anomalies are spotted more effectively and irregular usage investigated and managed. Energy efficient lighting was installed in some sites and wherever boiler replacements were carried out, they were replaced with the most energy efficient model possible.

A travel survey was conducted during the year to ascertain staff travel habits and included calculating carbon footprint for individual staff which encouraged them to look at how they could change their travel arrangements. Cycle maintenance kits were provided at various sites where there were a high percentage of cyclists and could be used for basic maintenance work.

New contract clauses were developed, including key performance indicators to ensure that all provider contracts include sustainability as standard. Display energy certificates (DECs) were put in place in buildings where it is a legal requirement to display one.

Utility contracts were renegotiated within the Office of Government Commerce framework, thus providing stability for the next two years. New contracts included the purchase of some green energy as part of the commitment to carbon reduction

Personal data related incidents and serious incidents

Information Commissioner's Office in 2012/13 for NHS Kensington and Chelsea.

Summary of other personal data related to incidents in 2012/13		
Category	**Nature of incident**	**Amount**
I.	Loss/theft of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	0
II.	Loss/theft of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	0
III.	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV.	Unauthorised disclosure	4
V.	Other	3
Total		7

"Other" are incidents reported that were data quality related incidents

About our workforce

Following the introduction of a single management structure across the eight PCTs we established an effective working partnership with staff trade unions. This helped to collectively address the challenges of working through the transition to nine separate organisations, as well as the transfer of public health teams to their respective local authorities, and the movement of other staff to other new NHS organisations.

The Chief Executive and her senior team held regular staff briefings across the PCTs to facilitate engagement and discussion with employees about the transition process. Dedicated newsletters and areas on the intranet created opportunities for staff to

receive and discuss updates on plans for the future of the NHS, including the successor organisations coming into place in 2013.

A consultation with staff and staff side representatives took place on structures for the commissioning support unit (CSU) and CCGs, and on the matching and recruitment process for the CSU.

Staff were supported throughout the transition period, and given CV and interview training in order to prepare themselves fully for job interviews where they were not matched across to similar roles in the new organisations. Staff that were unable to secure roles in the new structures in NW London were encouraged and supported to find roles elsewhere either in other NHS organisations or more widely.

Equality and diversity and disabled employees

We recognise that equality is not solely a minority issue: it is important for everyone and directly or indirectly affects the whole population.

NHS Kensington and Chelsea served a diverse population and has a wide staff demographic. As a large employer and as a commissioner of services, we remained constantly committed to promoting diversity and equality by eliminating discrimination and complying fully with the statutory duties under the single equality scheme.

Staff sickness and absence

Staff sickness absence	2012/13	2011/12
Total days lost	758	793
Total staff years	123	170
Average working days lost	6.18	4.66

- Figures given are in calendar years.
- Total Staff Years relates to the number of Whole Time Equivalents in post during the calendar year.
- Sickness data is collated centrally by Department of Health.

Off payroll engagement

The Treasury requires NHS bodies to publish information on off payroll engagements. Information on the off payroll engagements at a cost of over £58,200 per annum that were in place as of 31 January 2012 is not available to the PCT.

Information on all new offpayroll engagements between 23 August 2012 and 31 March 2013, for more than £220 per day and more than 6 months, is set out below, based on information collated by the Human Resources department at NHS North West London cluster.

Engagement	FTE
No. of new engagements No. of new engagements which include contractual clauses giving the organisation the right to request assurance in relation to income tax and National insurance obligations	1 1
Of which:	
No. for whom assurance has been accepted and received	1
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
Total	1

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 NHS Kensington and Chelsea 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.

nb: sign and date in any colour ink except black

Signed.....

Date.....

Richard Douglas, Signing Officer

Finance Report

Statutory financial duties

PCTs are required to achieve three statutory financial duties. In addition, PCTs are expected to pay creditors within a 30 day period – the Better Payment Practice Code. NHS Kensington and Chelsea's performance against each is summarised below.

Duties	Our performance in 2012/13	Duty met?
1 Meet revenue resource limit	NHS Kensington & Chelsea has a surplus of £16.144 million against a revenue resource limit of £393.041 million	Yes
2 Meet capital resource limit	Fully spent on capital resource limit of £2.800 million	Yes
3 Meet cash limit (revenue and capital) with no unplanned borrowing at year end	We underspent by £15.448 million against the cash limit of £386.785 million and therefore operated within the cash limit allocated	Yes
4 To meet the Better Payment Practice Code by paying 95% of non-NHS trade invoices within 30 days of the invoice date	NHS Kensington and Chelsea achieved 91.5% (on volume) and 94.7% (on value)	No

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

Where the money came from

In 2012/13 NHS Kensington and Chelsea received funding (Revenue Resource Limit) of £393.041m from the Department of Health which was used to commission health services for the residents of the London Borough of Kensington and Chelsea.

How the money was spent

NHS Kensington and Chelsea's expenditure for 2012/13 totalling £376.897m is analysed by budget and for 2012/13 over the page.

External Auditors

NHS Kensington and Chelsea external auditors for 2012/13 is KPMG. The costs of the work performed in respect of the reporting period is £108,000.

Summary Finance Statements

Financial performance targets

Revenue Resource Limit

	2012-13 £000	2011-12 £000
The PCTs' performance for the year ended 2012-13 is as follows:		
Total Net Operating Cost for the Financial Year		363,355
Net operating cost plus (gain)/loss on transfers by absorption	**376,897**	
Adjusted for prior period adjustments in respect of errors	**0**	0
Revenue Resource Limit	**393,041**	373,521
Under/(Over)spend Against Revenue Resource Limit (RRL)	16,144	10,166

The £16.1m surplus reported in 2012/13 is within the surplus target set by NHS North West london to achieve the overall NHS North West London financial plan.

2011-12 performance data has not been adjusted in respect of restated items and remains as shown in the 2011-12 published accounts.

This reflects the way in which PCT performance is recorded by the Department.

Capital Resource Limit

	2012-13 £000	2011-12 £000
The PCT is required to keep within its Capital Resource Limit.		
Capital Resource Limit	**2,800**	2,885
Charge to Capital Resource Limit	**2,800**	2,882
(Over)/Underspend Against CRL	**0**	**3**

Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**371,337**	376,595
Cash Limit	**386,785**	381,362
Under/(Over)spend Against Cash Limit	**15,448**	**4,767**

Reconciliation of Cash Drawings to Parliamentary Funding (current year)

	2012-13 £000
Total cash received from DH (Gross)	344,095
Less: Trade Income from DH	0
Less/(Plus): movement in DH working balances	0
Sub total: net advances	**344,095**
(Less)/plus: transfers (to)/from other resource account bodies (free text note required)	0
Plus: cost of Dentistry Schemes (central charge to cash limits)	6,012
Plus: drugs reimbursement (central charge to cash limits)	21,230
Parliamentary funding credited to General Fund	**371,337**

Statement of comprehensive net expenditure for year ended 31 March 2013

	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure		
Gross employee benefits	**10,117**	8,122
Other costs	**383,352**	373,380
Income	**(16,812)**	(18,188)
Net operating costs before interest	**376,657**	363,314
Investment income	**0**	0
Other (Gains)/Losses	**0**	0
Finance costs	**240**	41
Net operating costs for the financial year	**376,897**	363,355
Transfers by absorption -(gains)	**0**	
Transfers by absorption - losses	**0**	
Net (gain)/loss on transfers by absorption	**0**	
Net Operating Costs for the Financial Year including absorption transfers	**376,897**	**363,355**
Of which:		
Administration Costs		
Gross employee benefits	**7,132**	4,070
Other costs	**10,780**	5,400
Income	**(3,191)**	(609)
Net administration costs before interest	**14,721**	**8,861**
Investment income	**0**	0
Other (Gains)/Losses	**0**	0
Finance costs	**0**	0
Net administration costs for the financial year	**14,721**	**8,861**
Programme Expenditure		
Gross employee benefits	**2,985**	4,052
Other costs	**372,572**	367,980
Income	**(13,621)**	(17,579)
Net programme expenditure before interest	**361,936**	**354,453**
Investment income	**0**	0
Other (Gains)/Losses	**0**	0
Finance costs	**240**	41
Net programme expenditure for the financial year	**362,176**	**354,494**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**3,606**	1,388
Net (gain) on revaluation of property, plant & equipment	**(1,770)**	(393)
Net (gain) on revaluation of intangibles	**0**	0
Net (gain) on revaluation of financial assets	**0**	0
Net (gain)/loss on other reserves	**0**	0
Net (gain)/loss on available for sale financial assets	**0**	0
Net (gain) /loss on Assets Held for Sale	**0**	
Release of Reserves to Statement of Comprehensive Net Expenditure	**0**	
Net actuarial (gain)/loss on pension schemes	**0**	0
Reclassification Adjustments		
Reclassification adjustment on disposal of available for sale financial assets	**0**	0
Total comprehensive net expenditure for the year*	**378,733**	**364,350**

*This is the sum of the rows above plus net operating costs for the financial year after absorption accounting adjustments.
The notes on pages "Note 1" to "Note 42" form part of this account.

Statement of financial position at 31 March 2013

	31 March 2013	31 March 2012
	£000	£000
Non-current assets:		
Property, plant and equipment	**81,235**	83,631
Intangible assets	**0**	8
investment property	**0**	0
Other financial assets	**0**	0
Trade and other receivables	**0**	0
Total non-current assets	**81,235**	83,639
Current assets:		
Inventories	**0**	0
Trade and other receivables	**2,228**	8,493
Other financial assets	**0**	0
Other current assets	**0**	0
Cash and cash equivalents	**0**	23
Total current assets	**2,228**	8,516
Non-current assets held for sale	**0**	0
Total current assets	**2,228**	8,516
Total assets	**83,463**	92,155
Current liabilities		
Trade and other payables	**(23,807)**	(26,787)
Other liabilities	**0**	0
Provisions	**(2,740)**	(163)
Borrowings	**(110)**	0
Other financial liabilities	**0**	0
Total current liabilities	**(26,657)**	(26,950)
Non-current assets plus/less net current assets/liabilities	**56,806**	65,205
Non-current liabilities		
Trade and other payables	0	0
Other Liabilities	0	0
Provisions	(396)	(1,399)
Borrowings	0	0
Other financial liabilities	0	0
Total non-current liabilities	**(396)**	(1,399)
Total Assets Employed:	**56,410**	63,806
Financed by taxpayers' equity:		
General fund	31,473	37,020
Revaluation reserve	24,937	26,786
Other reserves	0	0
Total taxpayers' equity:	**56,410**	63,806

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

	General fund	Revaluation reserve	Other reserves	Total reserves
	£000	£000	£000	£000
Balance at 1 April 2012	**37,020**	**26,786**	**0**	**63,806**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(376,897)			**(376,897)**
Net gain on revaluation of property, plant, equipment		1,770		**1,770**
Net gain on revaluation of intangible assets		0		**0**
Net gain on revaluation of financial assets		0		**0**
Net gain on revaluation of assets held for sale		0		**0**
Impairments and reversals		(3,606)		**(3,606)**
Movements in other reserves			0	**0**
Transfers between reserves*	13	(13)		**0**
Release of Reserves to SOCNE		0		**0**
Reclassification Adjustments				
Transfers between Revaluation Reserve & General Fund in respect of assets transferred under absorption	0	0		**0**
Net actuarial gain/(loss) on pensions	0		0	**0**
Total recognised income and expense for 2012-13	**(376,884)**	**(1,849)**	**0**	**(378,733)**
Net Parliamentary funding	371,337			**371,337**
Balance at 31 March 2013	**31,473**	**24,937**	**0**	**56,410**
Balance at 1 April 2011	**23780**	**27783**	**0**	**51,563**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(363,355)			(363,355)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment		393		393
Net Gain / (loss) on Revaluation of Intangible Assets		0		0
Net Gain / (loss) on Revaluation of Financial Assets		0		0
Net Gain / (loss) on Assets Held for Sale		0		0
Impairments and Reversals		(1,388)		(1,388)
Movements in other reserves			0	0
Transfers between reserves*	0	0		0
Release of Reserves to Statement of Comprehensive Net Expenditure		(2)		(2)
Reclassification Adjustments				
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0	0
On disposal of available for sale financial assets	0	0	0	0
Net actuarial gain/(loss) on pensions	0		0	0
Total recognised income and expense for 2011-12	(363,355)	(997)	0	(364,352)
Net Parliamentary funding	376,595			376,595
Balance at 31 March 2012	**37,020**	**26,786**	**0**	**63,806**

Statement of cash flows for year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities			
Net Operating Cost Before Interest		**(376,657)**	(363,314)
Depreciation and Amortisation		**2,148**	2,406
Impairments and Reversals		**1,220**	1,750
Other Gains / (Losses) on foreign exchange		**0**	0
Donated Assets received credited to revenue but non-cash		**0**	0
Government Granted Assets received credited to revenue but non-cash		**0**	0
Interest Paid		**(7)**	(1)
Release of PFI/deferred credit		**0**	0
(Increase)/Decrease in Inventories		**0**	0
(Increase)/Decrease in Trade and Other Receivables		**6,265**	(3,863)
(Increase)/Decrease in Other Current Assets		**0**	0
Increase/(Decrease) in Trade and Other Payables		**(3,709)**	(8,535)
(Increase)/Decrease in Other Current Liabilities		**0**	0
Provisions Utilised		**(1,406)**	(259)
Increase/(Decrease) in Provisions		**2,747**	(567)
Net Cash Inflow/(Outflow) from Operating Activities		**(369,399)**	**(372,383)**
Cash flows from investing activities			
Interest Received		**0**	0
(Payments) for Property, Plant and Equipment		**(2,196)**	(4,203)
(Payments) for Intangible Assets		**0**	0
(Payments) for Other Financial Assets		**0**	0
(Payments) for Financial Assets (LIFT)		**0**	0
Proceeds of disposal of assets held for sale (PPE)		**125**	0
Proceeds of disposal of assets held for sale (Intangible)		**0**	0
Proceeds from Disposal of Other Financial Assets		**0**	0
Proceeds from the disposal of Financial Assets (LIFT)		**0**	0
Loans Made in Respect of LIFT		**0**	0
Loans Repaid in Respect of LIFT		**0**	0
Rental Revenue		**0**	0
Net Cash Inflow/(Outflow) from Investing Activities		**(2,071)**	**(4,203)**
Net cash inflow/(outflow) before financing		**(371,470)**	**(376,586)**
Cash flows from financing activities			
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**0**	0
Net Parliamentary Funding		**371,337**	376,595
Capital Receipts Surrendered		**0**	0
Capital grants and other capital receipts		**0**	0
Cash Transferred (to)/from Other NHS Bodies (free text note required)		**0**	0
Net Cash Inflow/(Outflow) from Financing Activities		**371,337**	**376,595**
Net increase/(decrease) in cash and cash equivalents		**(133)**	**9**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**23**	**14**
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies		**0**	0
Cash and Cash Equivalents (and Bank Overdraft) at year end		**(110)**	**23**

PCT running costs

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**14,721**	13,980	741
Weighted population (number in units)*	**183,794**	183,794	183,794
Running costs per head of population (£ per head)	**80**	**76**	**4**
PCT Running Costs 2011-12			
Running costs (£000s)	**9,033**	8,344	689
Weighted population (number in units)	**183,794**	183,794	183,794
Running costs per head of population (£ per head)	**49**	**45**	**4**

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

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

Better payment practice code

Measure of compliance	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**13,548**	**77,050**	13,551	79,295
Total Non-NHS Trade Invoices Paid Within Target	**12,398**	**72,939**	11,956	71,403
Percentage of NHS Trade Invoices Paid Within Target	91.51%	94.66%	88.23%	90.05%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3,750**	**280,514**	4,071	284,112
Total NHS Trade Invoices Paid Within Target	**3,382**	**275,969**	3,538	271,249
Percentage of NHS Trade Invoices Paid Within Target	90.19%	98.38%	86.91%	95.47%

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

Related party transactions

Members of the Cluster Board with related party transactions include Sarah Cuthbert whose husband is a Partner in Deloitte. Deloitte worked on 'Shaping a Healthier Future' during the year. The contract of £191k was held by Westminster PCT. Deloitte are also the external auditors for Hillingdon and Harrow PCTs

Dr Mark Spencer held shares in Harmoni Ltd which were sold in year. Harmoni Ltd is the Out of Hours provider for Hounslow, Hillingdon, Ealing and Harrow and the 111 provider for Hounslow, Brent, Ealing and Harrow.

The following related party transactions were reported by the Shadow Clinical Commissioning Board that relate to Kensington and Chelsea Primary Care Trust. The GMS payments shown below relates to services provided by the practice which the Shadow Clinical Commissioning member is a partner rather than payments to Shadow Clinical Commissioning members themselves. The payment is the total paid to the practices as a whole before taking into account practice expenses in delivering services.

Shadow Clinical Commissioning Board - PMS or GMS Costs	**Payments to Related Party**	
	2012/13	**2011/12**
	£'000	**£'000**
Dr Iain Blake (Colville Health Centre)*	654	504
Dr Val Dias (The Surgery 112 Princedale Rd)*	422	412
Dr Andrew Rose (Dr Rose's Surgery)*	478	456
Dr Fiona Butler (The Redcliffe Surgery)*	1,581	1,335
Dr Mark Sweeney (North Kensington Medical Centre)*	1,487	1,482
Dr Naomi Katz (The New Elgin Practice)*	741	800
Dr Puvana Rajakulendran (Earls Court Medical Practice)*	994	985
Dr Rachael Garner (Notting Hill Medical Centre)*	727	600
Dr Simon Ramsden (The Pembridge Villas Surgery)*	1,555	1,309

* The above monies relate to payments made by the PCT to GP practices of which the individuals are partners.

The Department of Health is regarded as a related party. During the year NHS Kensington & Chelsea 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. The entities with transactions greater than 1% of NHS Kensington & Chelsea net operating cost for the financial year are:

	Income £'000	Expenditure £'000	Receivables £'000	Payables £'000
A Primary care Trust				
Brent Teaching PCT	373	60	0	0
Croydon PCT	0	26,743	0	0
Ealing PCT	18	18	0	1
Hounslow PCT	34	1,327	40	1,320
Richmond And Twickenham PCT	0	24	0	0
Hammersmith And Fulham PCT	1,638	760	15	244
Westminster PCT	3,639	10,072	949	377
B Trusts				
Central London Community Healthcare NHS Trust	4,916	40,087	2	204
Epsom And St Helier University Hospitals NHS Trust	0	63	0	12
Imperial College Healthcare NHS Trust	794	58117	166	743
Kingston Hospital NHS Trust	0	109	0	0
London Ambulance Service NHS Trust	0	5,024	0	5
North Middlesex University Hospital NHS Trust	0	27	0	2
North West London Hospitals NHS Trust	0	779	0	15
Royal Free Hampstead NHS Trust	0	0	0	0
St Georges Healthcare NHS Trust	0	834	0	62
The Royal National Orthopaedic Hospital NHS Trust	0	423	31	0
West London Mental Health NHS Trust	0	1,495	0	5
Whittington Hospital NHS Trust	0	127	5	0
C Foundation Trusts				
Central And North West London MH NHS Foundation Trust	650	36,246	0	324
Chelsea And Westminster Hospital NHS Foundation Trust	0	57,177	0	963
Great Ormond Street Hospital for Children NHS Foundation Trust ***FT status 01/03/12***	0	0	0	0
Guys And St Thomas NHS Foundation Trust	0	2,435	0	73
Homerton University Hospital NHS Foundation Trust	0	68	0	18
Kings College Hospital NHS Foundation Trust	0	876	0	0
Moorfields Eye Hospital NHS Foundation Trust	0	677	0	41

North East London NHS Foundation Trust	0	11	0	1
Royal Brompton And Harefield NHS Foundation Trust	0	17,520	37	0
Royal Surrey County NHS Foundation Trust	0	34	0	10
South London And Maudsley NHS Foundation Trust	0	320	13	0
The Hillingdon Hospital NHS Foundation Trust	0	146	0	41
The Royal Marsden Hospital NHS Foundation Trust	0	3,638	0	18
University College London NHS Foundation Trust	0	5,062	0	114
D Others				
London Strategic Health Authority	0	0	0	0
E Local Councils				
The Royal Borough of Kensington & Chelsea	942	16,034	533	948

Remuneration report

Membership of the Remuneration and Terms of Services Committee

Membership of the Remuneration and Terms of Services Committee are:

- Martin Roberts, Non-Executive Director (Chair)
- Jeff Zitron, Non-Executive Director
- Trish Longdon, Non-Executive Director
- Arif Kamal, Non-Executive Director

The Committee advises the Board on appropriate remuneration and terms of service for the Chief Executive and Trust Directors. The Committee monitors and evaluates the performance of the Chief Executive, Directors and individual officer members of the Professional Executive Committee – having proper regard to the PCT's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate.

The Committee reports the basis for its recommendations to the Board which uses the Committee's report as the basis for its decisions on remuneration. However, the Board remains accountable for taking final decisions on the remuneration and terms off service for the Chief Executive and Trust

Directors

For Directors' pay increases, the following factors are considered:

- current national market rates of comparable Director posts;
- the individual performance of Directors;
- internal comparators;
- changes to Director portfolios;
- NHS pay awards for other staff groups;
- any national guidance relating to maximum pay bill increases;
- significant recruitment and/or retention issues; and
- financial position of the PCT.

Performance measurement

Directors' performance is appraised on an annual basis by the Chief Executive. The Chief Executive's performance is appraised on an annual basis by the Chief Executive of the Strategic Health Authority, now called NHS London.

Summary and explanation of policy on duration of contracts, and notice periods and termination payments

Senior managers are permanent employees of the PCT, and in the event of redundancy, they are subject to standard NHS severance packages.

Senior Managers' Remuneration

Cluster Board

		2012/13		
		Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in Kind (bands of £1000)
		£000	£000	£000
Chair and Non Executives				
J Zitron	2	40-45		
T Longdon	2	10-15		
E Rantzen	2	10-15		
F Cass	2	10-15		
S Cuthbert	4	10-15		
A Kamal	3	5-10		
C Somani	3	10-15		
M Roberts	4	5-10		
Directors				
A Rainsberry: Chief Executive	1	165-170		
D Elkeles: Director of Strategy/Chief Officer designate, CWHH CCGs	2	120-125		
R Larkman: Chief Officer designate BEHH CCGs (from 1 October 2012)	6	70-75		
C Parker: Director of Finance, Hammersmith and Fulham, Hounslow, Kensington and Chelsea and Westminster PCTs (from 1 October 2012)	5	55-60		
D Slegg: Director of Finance (until 30 September 2012)	4	70-75		

J Wise: Director of Finance, Brent, Ealing, Harrow and Hillingdon PCTs (from 1 October 2012)	3	60-65
S Weldon: Director of Commissioning and Performance (until 30 September 2012)	2	60-65
M Spencer: Medical Director	2	85-90
A Howe: Director of Public Health	3	120-125
D Chaffer: Director of Nursing (until 30 June 2012)	2	30-35
J Webster: Acting Director of Nursing (from 1 July 2012)	4	70-75

The Cluster Board came into effect from 1st April 2012 therefore there are no comparatives shown

1 Employed by NHS London and no recharge of costs made to Cluster
2 Employed By Inner Cluster comprising Hammersmith and Fulham, Kensington and Chelsea and Westmister
3 Employed by Brent and Harrow PCTs
4 Employed By Outer Cluster comprising of Ealing, Hillingdon and Hounslow PCTs
5 Employed by NHS Islington and no recharge of costs made to Cluster
6 Employed by NHS Camden and recharged to Brent and Harrow

Shadow West London CCG Board*	2012/13			2011/12		
Name and Title	Salary (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000	Benefits in Kind (bands of £1000) £000	Salary (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000	Benefits in Kind (bands of £1000) £000
Dr Puvana Rajakulendran	65-70	0	0	0	30-35	0
Dr Val Dias	35-40	0	0	0	20-25	0
Dr Andrew Rose	50-55	0	0	0	15-20	0
Dr Simon Ramsden	10-15	0	0	0	25-30	0
Dr Rachel Garner	60-65	0	0	0	40-45	0
Dr Naomi Katz	60-65	0	0	0	50-55	0
Dr Mark Sweeney	135-140	0	0	0	65-70	0
Dr Fiona Butler	80-85	0	0	0	75-80	0
Dr Iain Blake	85-90	0	0	0	60-65	0
Yvonne Fraser	15-20	0	0	0	10-15	0
Afsaneh Tork	0-5	0	0	0	0-5	0
A Barnes	0	0	0	0	0-5	0
Catherine Mulroy	0				0-5	
Dr Alan Hakim	0-5	0	0	0	0	0
Ken Macdonald	0	0	0	0	0	0
Sonia Richardson	0-5	0	0	0	0	0
Sandra Mounier-Jacks	0-5	0	0	0	0	0

NHS Kensington and Chelsea is required to disclose the relationship between the remuneration of the highest-paid director and the median remuneration of the organisation's workforce. The calculation for the median remuneration does not include agency employees covering vacancy staff as this information is impracticable to retrieve.

The banded remuneration of the highest paid director in NHS Kensington and Chelsea in the financial year 2012/13 was £165,000 - £170,000 (2011/12, £145,000 -£150,000). This was 3.7 times the median remuneration of the workforce, which was £45,068 in 2012/13 (£41,401 in 2011/12).

In 2012/13, 0 (2011/12, one) employee received remuneration in excess of the highest-paid director.
Remuneration ranged from £22,000 -£125,000 (2011/12, £9000 – £140,000) excluding the highest paid Director.
Total remuneration includes salary, nonconsolidated 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. No employee was paid any bonuses in 2012/13.

Corporate Register of Declaration of Interests

Name	Director/ Non Executive Director title and position	Interests Disclosed
Jeff Zitron	Chairman Non Executive Director	1. Chairman and Shareholder, TIAA Ltd 2. Chairman and Shareholder, Altair Consultancy and Advisory Services Ltd 3. Director and Shareholder, DMJ Consulting Ltd 4. Chairman and Shareholder, Soho Housing Association 5. Board Member, Kensington and Chelsea Tenant Management Organisation 6. On associate consultancy list for housing and regeneration-related assignments for Firsa Ltd, a business acquisition strategy company
Trish Longdon	Vice Chairman Non Executive Director	1. Director, Trish Longdon Associates Ltd
Elizabeth Rantzen	Vice Chairman Non Executive Director	1. Director of the Paul Getty Junior Trust
Martin Roberts	Remuneration Committee Chairman Non Executive Director	1. None
Fergus Cass	Audit Chairman Non Executive Director	1. Hospices of Hope Book Aid International Melton Court Parking Ltd.
Arif Kamal	Health and Safety Committee Chairman Non Executive Director	1. Finance Director and a shareholder in GL Hearn Limited 2. Wife is a Medical Doctor with NWLH and also works for the Deanery
Chandresh Somani	Non Executive Director	1. Declared two lunches with Deloitte LLP in Brent and Harrow Cluster Register
Sarah Cuthbert	Non Executive Director	1. Husband is a partner in Deloitte LLP, within drivers Jonas Deloitte (property)
Anne Rainsberry	Chief Executive	None
Daniel Elkeles	Director of Strategy/ Chief Officer Designate	None

	CWHH CCGs	
Mark Spencer	Medical Director	1. Partner at Hillcrest Surgery 2. 1 share with Harmoni (OOH provider) 3. 1 share with SMART (primary care provider) 4. Primary Care Editor of Respiratory Disease in Practice 5. Meal with LMC – March 2012
Jonathan Webster	Acting Director of Nursing	1. Through academic link – City and Christ Church Canterbury university 2. RCN Membership
Rob Larkman	Chief Officer Designate BEHH CCGs	None
Sarah Whiting	Managing Director Designate NWL CSU	1. Husband works for GSK, with shares in the company
Jonathan Wise	Director of Finance/ Chief Financial Officer BEHH CCGs	None
Clare Parker	Director of Finance/ Chief Financial Officer CWHH CCGs	None

Cluster Arrangement

The eight PCTs in North West London (Brent, Harrow, Ealing, Hillingdon, Hounslow, Hammersmith and Fulham, Kensington and Chelsea and Westminster) form the NHS NWL Cluster. PCTs within the NHS were 'clustered' from 2011 to 2012 to form single management bodies, whilst continuing to operate through their constituent PCTs, which remained the statutory bodies.

The Cluster Chief Executive has overall accountability for the eight PCTs, discharging this responsibility through a central cluster management team and sub cluster teams. NHS Westminster is the host organisation for the North West London Cluster central management team.

The proportion of remuneration can be found in the respective PCT's annual report. Pensions information has remained with their respective organisation of employment and are reported in the respective PCT annual report.

Events after the end of the reporting period

The main functions carried out by NHS Kensington and Chelsea in 2012-13 are to be carried out in 2013-14 by the following public sector bodies:

NHS England

NHS West London Clinical Commissioning Group

The Royal Borough of Kensington and Chelsea

Certain Land, Property, Plant & Equipment have transferred to NHS Property Services, NHS Trusts and Community Health Partnership on 31 March 2013. These were considered operational at the year end, and so have not been impaired in the PCT books. It is for the successor body to consider whether, in 2013-14, it is necessary to review these for impairment. The associated Borrowings and Revaluation Reserves have also transferred.

Clinical Commissioning Group

The Health and Social Bill through parliament (Department of Health 2011) set out the new structure for the commissioning of NHS services. This saw the Primary care Trust (PCTs) being abolished from 31 March 2013 and replaced by GP-led Clinical Commissioning Groups (CCGs).

Within the North West London region this saw the introduction of eight CCGs.

- NHS Brent CCG
- NHS Central London (Westminster) CCG
- NHS Ealing CCG
- NHS Hammersmith and Fulham CCG
- NHS Harrow CCG
- NHS Hillingdon CCG
- NHS Hounslow CCG
- NHS West London (Kensington and Chelsea, Queen's Park and Paddington) CCG

The NWL CCGs operated in shadow form from 1 October 2013 as sub committees of the cluster Board, with the following responsibilities:

- Ensuring a rigorous assurance and reporting process during the shadow period from 1 October 2012 – 31 March 2013.
- Agree governance that reflects new responsibilities.
- Liberate CCGs to lead 13/14 commissioning round whilst providing effective support.
- Support development of CCGs proactive risk management.
- Fully align with national guidance - Nolan Principles.
- Clarify accountability and responsibility – reflecting London changes.
- Ensure CCGs governance is capable of receiving relevant PCTs Committee business.
- Continue resource shift to enable CCGs capacity and capabilities.
- Reduce complexity and avoid duplication – adding value not work.
- Build on well developed arrangements to manage a safe and orderly transition and closure programme.

Pensions

		Real Increase in pension at age 60 and related lump sum		Total accrued pension at age 60 and related lump sum		Cash Equivalent Transfer Value				
		(bands of £2,500)		(bands of £5,000)						
		Pension	Lump Sum	Pension	Lump Sum	at 31 March 2012	at 31 March 2013	Real increase	Employer's contribution to growth in CETV for the year	
		£000	£000	£000	£000	£000	£000	£000	£000	
A Rainsberry: Chief Executive	1	0	0	55-60	165-170	880	940	14	10	
D Elkeles: Director of Strategy/Chief Officer designate, CWHH CCGs	2	0-2.5	2.5-5	20-25	60-65	242	281	27	19	
R Larkman: Chief Officer designate BEHH CCGs (from 1 October 2012)	6	0-2.5	2.5-5	35-40	105-110	644	751	36	25	
C Parker: Director of Finance, Hammersmith and Fulham, Hounslow, Kensington and Chelsea and Westminster PCTs (from 1 October 2012)	5	0-2.5	0-2.5	20-25	70-75	297	324	6	4	
D Slegg: Director of Finance (until 30 September 2012)	4	2.5-5	5-10	65-70	195-200	1216	1439	80	56	

J Wise: Director of Finance, Brent, Ealing, Harrow and Hillingdon PCTs (from 1 October 2012)	3	0-2.5	5-7.5	45-50	140-145	747	878	46	32	
S Weldon: Director of Commissioning and Performance (until 30 September 2012)	2	0-2.5	2.5-5	20-25	70-75	309	378	26	19	
M Spencer: Medical Director	2	0	0	50-55	155-160	948	1021	23	16	
A Howe: Director of Public Health	3	0-2.5	2.5-5	25-30	85-90	453	519	42	30	
D Chaffer: Director of Nursing (until 30 June 2012)	2	0-2.5	0-2.5	30-35	90-95	544	611	10	7	
J Webster: Acting Director of Nursing (from 1 July 2012)	4	0-2.5	5-7.5	25-30	85-90	389	467	44	31	
	The Cluster Board came into effect from 1st April 2012 therefore there are no comparatives shown									
1	Employed by NHS London and no recharge of costs made to Cluster									
2	Employed By Inner Cluster comprising Hammersmith and Fulham, Kensington and Chelsea and Westminster									
3	Employed by Brent and Harrow PCTs									
4	Employed By Outer Cluster comprising of Ealing, Hillingdon and Hounslow PCTs									
5	Employed by NHS Islington and no recharge of costs made to Cluster									
6	Employed by NHS Camden and recharged to Brent & Harrow									

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. In 2012/13 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 AVCs run by the scheme’s approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

Cash Equivalent Transfer Values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member’s accrued benefits and any contingent spouse’s pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when a member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in

the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period

The table below details the compensation schemes of all staff for the financial year 2012/13

	2012-13			2011-12		
Exit package cost band (including any special payment element)	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**
	Number	**Number**	**Number**	**Number**	**Number**	**Number**
Lees than £10,000	**0**	**0**	**0**	0	0	**0**
£10,001-£25,000	**1**	**0**	**1**	0	0	**0**
£25,001-£50,000	**1**	**0**	**1**	0	0	**0**
£50,001-£100,000	**3**	**0**	**3**	0	0	**0**
£100,001 - £150,000	**1**	**0**	**1**	0	0	**0**
£150,001 - £200,000	**0**	**0**	**0**	0	0	**0**
>£200,000	**1**	**0**	**1**	0	0	**0**
Total number of exit packages by type (total cost	**7**	**0**	**7**	**0**	**0**	**0**
	£	**£**	**£**	**£**	**£**	**£**
Total resource cost	705,203	0	**705,203**	0	0	**0**

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

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

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

Governance statement

The full governance statement has been submitted as part of the annual accounts and will be available at www.dh.gov.uk.

The governance statement sets out the arrangements in place to maintain a sound system of internal control and to safeguard the public funds for which the accountable officer is responsible. It also highlights any significant issues which have occurred during the year, including data security issues.

There were no data security issues highlighted within the governance statement and only one significant issue was reported. This was:

An internal audit report on Continuing Care was undertaken during 2012/13 and was able to provide only partial assurance regarding the controls in place. This particularly related to issues in the tri-borough area of Westminster, Kensington and Chelsea and Hammersmith and Fulham. In response to that report, local action plans have been put in place both at a borough level and across the tri-borough CCGs to ensure that the issues identified in the audit report relating to 2012/13 have been addressed.

As part of the contracting round for 2013/14, contracts and individual patient agreements have been put in place for all continuing healthcare placements. Following the implementation of a Service Improvement Plan with Central London Community Healthcare Trust, reporting from the community provider on assessments has improved considerably and consequently the commissioners are receiving accurate up to date data on both the nature of the placements and expected expenditure. The Continuing Care Commissioning team meet monthly with the Central London Community Healthcare Assessment Service to monitor their performance. One data base is now being used across the Tri-Borough continuing care team to capture and oversee the outputs of the service.

Independent auditors statement

INDEPENDENT AUDITOR'S REPORT TO THE SIGNING OFFICER OF KENSINGTON AND CHELSEA PRIMARY CARE TRUST

We have audited the financial statements of Kensington and Chelsea Primary Care Trust for the year ended 31 March 2013 on pages 1 to 51. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England. We have also audited the information in the Remuneration Report that is subject to audit.

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

Respective responsibilities of Signing Officer and auditor

As explained more fully in the Statement of Signing Officer's Responsibilities set out on page 1, the Signing Officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of Kensington and Chelsea Primary Care Trust as at 31 March 2013 and of its expenditure and income for the year then ended; and

- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

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

Certificate

We certify that we have completed the audit of the accounts of Kensington and Chelsea Primary Care Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission.

Philip Johnstone for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
15 Canada Square
Canary Wharf
London
E14 5GL

7 June 2013

Contact details

NHS West London Clinical Commissioning Group
15 Marylebone Road
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Department of Health

NHS

Kensington and Chelsea Primary Care Trust

2012-13 Accounts

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Kensington and Chelsea Primary Care Trust

2012-13 Accounts

Appendix 1

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 Kensington and Chelsea Primary Care Trust (PCT) in order to comply with the Department's 2012/13 accounts finalisation process.

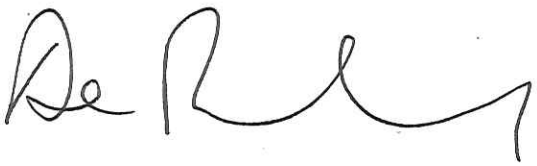
To assist you in that process, I can confirm that for the year ended 31 March 2013 based on my own knowledge of internal control matters and through experience in my role as Accountable Officer until 31 March 2013, the PCT:

- 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: Dr Anne Rainsberry, Chief Executive, NHS Kensington & Chelsea

Signed: 

Date: 24 May 2013

Appendix 2

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

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

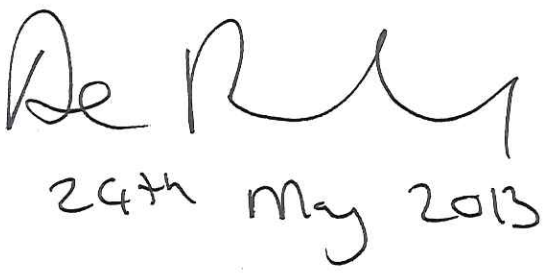
To assist you in that process, I can confirm that in my role managing the preparation of the annual statutory accounts, the accounts were prepared in the format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the 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: Clare Parker, Director of Finance, NHS Kensington & Chelsea

Signed:

Date: 24 May 2013



INDEPENDENT AUDITOR'S REPORT TO THE SIGNING OFFICER OF KENSINGTON AND CHELSEA PRIMARY CARE TRUST

We have audited the financial statements of Kensington and Chelsea Primary Care Trust for the year ended 31 March 2013 on pages 1 to 51. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England. We have also audited the information in the Remuneration Report that is subject to audit.

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

Respective responsibilities of Signing Officer and auditor

As explained more fully in the Statement of Signing Officer's Responsibilities set out on page 1, the Signing Officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of Kensington and Chelsea Primary Care Trust as at 31 March 2013 and of its expenditure and income for the year then ended; and

- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on regularity prescribed by the Code of Audit Practice 2010 for local NHS bodies

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

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

In our opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and

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

Matters on which we are required to report by exception

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

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

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

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

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

- our review of the Governance Statement;

- the work of other relevant regulatory bodies or inspectorates, to the extent that the results of this work impact on our responsibilities at the PCT; and

- our locally determined risk-based work relating to PCT abolition and the transition to new local commissioning arrangements.

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

Certificate

We certify that we have completed the audit of the accounts of Kensington and Chelsea Primary Care Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission.

Philip Johnstone for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
15 Canada Square
Canary Wharf
London
E14 5GL

7 June 2013

Statement of Financial Position at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	12	**81,235**	83,631
Intangible assets	13	**0**	8
investment property	15	**0**	0
Other financial assets	21	**0**	0
Trade and other receivables	19	**0**	0
Total non-current assets		**81,235**	83,639
Current assets:			
Inventories	18	**0**	0
Trade and other receivables	19	**2,228**	8,493
Other financial assets	36	**0**	0
Other current assets	22	**0**	0
Cash and cash equivalents	23	**0**	23
Total current assets		**2,228**	8,516
Non-current assets held for sale	24	**0**	0
Total current assets		**2,228**	8,516
Total assets		**83,463**	92,155
Current liabilities			
Trade and other payables	25	**(23,807)**	(26,787)
Other liabilities	26,28	**0**	0
Provisions	32	**(2,740)**	(163)
Borrowings	27	**(110)**	0
Other financial liabilities	36.2	**0**	0
Total current liabilities		**(26,657)**	(26,950)
Non-current assets plus/less net current assets/liabilities		**56,806**	65,205
Non-current liabilities			
Trade and other payables	25	0	0
Other Liabilities	28	0	0
Provisions	32	(396)	(1,399)
Borrowings	27	0	0
Other financial liabilities	36.2	0	0
Total non-current liabilities		**(396)**	(1,399)
Total Assets Employed:		**56,410**	63,806
Financed by taxpayers' equity:			
General fund		31,473	37,020
Revaluation reserve		24,937	26,786
Other reserves		0	0
Total taxpayers' equity:		**56,410**	63,806

The notes on pages "Note 1" to "Note 42" form part of this account.

The financial statements on pages 2 to 5 were approved by the North West London Audit Sub Committee of the Department of Health's Audit and Risk Committee on 3rd June 2013 and signed on its behalf by

Responsible Officer: 

Date: 6/6/13

Opinion on regularity prescribed by the Code of Audit Practice 2010 for local NHS bodies

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

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

In our opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and

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

Matters on which we are required to report by exception

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

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

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

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

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

- our review of the Governance Statement;

- the work of other relevant regulatory bodies or inspectorates, to the extent that the results of this work impact on our responsibilities at the PCT; and

- our locally determined risk-based work relating to PCT abolition and the transition to new local commissioning arrangements.

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

Certificate

We certify that we have completed the audit of the accounts of Kensington and Chelsea Primary Care Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission.

Philip Johnstone for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
15 Canada Square
Canary Wharf
London
E14 5GL

7 June 2013

Opinion on regularity prescribed by the Code of Audit Practice 2010 for local NHS bodies

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

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

In our opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and

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

Matters on which we are required to report by exception

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

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

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

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

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

- our review of the Governance Statement;

- the work of other relevant regulatory bodies or inspectorates, to the extent that the results of this work impact on our responsibilities at the PCT; and

- our locally determined risk-based work relating to PCT abolition and the transition to new local commissioning arrangements.

STATEMENT OF THE RESPONSIBILITIES OF THE SIGNING OFFICER OF KENSINGTON AND CHELSEA 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 Kensington and Chelsea Primary Care Trust to discharge the following responsibilities for the Department of Health:

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

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

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

- effective and sound financial management systems are in place; and

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

To the best of my knowledge and belief, and from the assurances provided by the PCT Accountable Officer until 31 March 2013, I am assured that the responsibilities have been properly discharged.

Signed.....

Date.....4/6/13.....

Appendix 1

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 Kensington and Chelsea Primary Care Trust (PCT) in order to comply with the Department's 2012/13 accounts finalisation process.

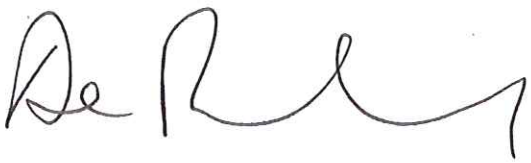
To assist you in that process, I can confirm that for the year ended 31 March 2013 based on my own knowledge of internal control matters and through experience in my role as Accountable Officer until 31 March 2013, the PCT:

- 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: Dr Anne Rainsberry, Chief Executive, NHS Kensington & Chelsea

Signed: 

Date: 24 May 2013

Appendix 2

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

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

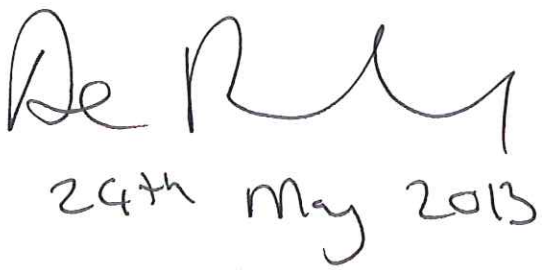
To assist you in that process, I can confirm that in my role managing the preparation of the annual statutory accounts, the accounts were prepared in the format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the 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: Clare Parker, Director of Finance, NHS Kensington & Chelsea

Signed:

Date: 24 May 2013



INDEPENDENT AUDITOR'S REPORT TO THE SIGNING OFFICER OF KENSINGTON AND CHELSEA PRIMARY CARE TRUST

We have audited the financial statements of Kensington and Chelsea Primary Care Trust for the year ended 31 March 2013 on pages 1 to 51. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England. We have also audited the information in the Remuneration Report that is subject to audit.

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

Respective responsibilities of Signing Officer and auditor

As explained more fully in the Statement of Signing Officer's Responsibilities set out on page 1, the Signing Officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of Kensington and Chelsea Primary Care Trust as at 31 March 2013 and of its expenditure and income for the year then ended; and

- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on regularity prescribed by the Code of Audit Practice 2010 for local NHS bodies

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

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

In our opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and

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

Matters on which we are required to report by exception

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

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

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

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

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

- our review of the Governance Statement;

- the work of other relevant regulatory bodies or inspectorates, to the extent that the results of this work impact on our responsibilities at the PCT; and

- our locally determined risk-based work relating to PCT abolition and the transition to new local commissioning arrangements.

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

Certificate

We certify that we have completed the audit of the accounts of Hammersmith and Fulham Primary Care Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission.

Philip Johnstone for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
15 Canada Square
Canary Wharf
London
E14 5GL

7 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	10,117	8,122
Other costs	5.1	383,352	373,380
Income	4	(16,812)	(18,188)
Net operating costs before interest		376,657	363,314
Investment income	9	0	0
Other (Gains)/Losses	10	0	0
Finance costs	11	240	41
Net operating costs for the financial year		376,897	363,355
Transfers by absorption -(gains)		0	
Transfers by absorption - losses		0	
Net (gain)/loss on transfers by absorption		0	
Net Operating Costs for the Financial Year including absorption transfers		376,897	363,355
Of which:			
Administration Costs			
Gross employee benefits	7.1	7,132	4,070
Other costs	5.1	10,780	5,400
Income	4	(3,191)	(609)
Net administration costs before interest		14,721	8,861
Investment income	9	0	0
Other (Gains)/Losses	10	0	0
Finance costs	11	0	0
Net administration costs for the financial year		14,721	8,861
Programme Expenditure			
Gross employee benefits	7.1	2,985	4,052
Other costs	5.1	372,572	367,980
Income	4	(13,621)	(17,579)
Net programme expenditure before interest		361,936	354,453
Investment income	9	0	0
Other (Gains)/Losses	10	0	0
Finance costs	11	240	41
Net programme expenditure for the financial year		362,176	354,494

Other Comprehensive Net Expenditure

	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	3,606	1,388
Net (gain) on revaluation of property, plant & equipment	(1,770)	(393)
Net (gain) on revaluation of intangibles	0	0
Net (gain) on revaluation of financial assets	0	0
Net (gain)/loss on other reserves	0	0
Net (gain)/loss on available for sale financial assets	0	0
Net (gain) /loss on Assets Held for Sale	0	
Release of Reserves to Statement of Comprehensive Net Expenditure	0	
Net actuarial (gain)/loss on pension schemes	0	0
Reclassification Adjustments		
Reclassification adjustment on disposal of available for sale financial assets	0	0
Total comprehensive net expenditure for the year*	378,733	364,350

*This is the sum of the rows above plus net operating costs for the financial year after absorption accounting adjustments.
The notes on pages "Note 1" to "Note 42" form part of this account.

Statement of Financial Position at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	12	**81,235**	83,631
Intangible assets	13	**0**	8
investment property	15	**0**	0
Other financial assets	21	**0**	0
Trade and other receivables	19	**0**	0
Total non-current assets		**81,235**	83,639
Current assets:			
Inventories	18	**0**	0
Trade and other receivables	19	**2,228**	8,493
Other financial assets	36	**0**	0
Other current assets	22	**0**	0
Cash and cash equivalents	23	**0**	23
Total current assets		**2,228**	8,516
Non-current assets held for sale	24	**0**	0
Total current assets		**2,228**	8,516
Total assets		**83,463**	92,155
Current liabilities			
Trade and other payables	25	**(23,807)**	(26,787)
Other liabilities	26,28	**0**	0
Provisions	32	**(2,740)**	(163)
Borrowings	27	**(110)**	0
Other financial liabilities	36.2	**0**	0
Total current liabilities		**(26,657)**	(26,950)
Non-current assets plus/less net current assets/liabilities		**56,806**	65,205
Non-current liabilities			
Trade and other payables	25	0	0
Other Liabilities	28	0	0
Provisions	32	(396)	(1,399)
Borrowings	27	0	0
Other financial liabilities	36.2	0	0
Total non-current liabilities		**(396)**	(1,399)
Total Assets Employed:		**56,410**	63,806
Financed by taxpayers' equity:			
General fund		31,473	37,020
Revaluation reserve		24,937	26,786
Other reserves		0	0
Total taxpayers' equity:		**56,410**	63,806

The notes on pages "Note 1" to "Note 42" form part of this account.

The financial statements on pages 2 to 5 were approved by the North West London Audit Sub Committee of the Department of Health's Audit and Risk Committee on 3rd June 2013 and signed on its behalf by

Responsible Officer: 

Date: 6/6/13

Statement of Financial Position at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	12	**81,235**	83,631
Intangible assets	13	**0**	8
investment property	15	**0**	0
Other financial assets	21	**0**	0
Trade and other receivables	19	**0**	0
Total non-current assets		**81,235**	83,639
Current assets:			
Inventories	18	**0**	0
Trade and other receivables	19	**2,228**	8,493
Other financial assets	36	**0**	0
Other current assets	22	**0**	0
Cash and cash equivalents	23	**0**	23
Total current assets		**2,228**	8,516
Non-current assets held for sale	24	**0**	0
Total current assets		**2,228**	8,516
Total assets		**83,463**	92,155
Current liabilities			
Trade and other payables	25	**(23,807)**	(26,787)
Other liabilities	26,28	**0**	0
Provisions	32	**(2,740)**	(163)
Borrowings	27	**(110)**	0
Other financial liabilities	36.2	**0**	0
Total current liabilities		**(26,657)**	(26,950)
Non-current assets plus/less net current assets/liabilities		**56,806**	65,205
Non-current liabilities			
Trade and other payables	25	0	0
Other Liabilities	28	0	0
Provisions	32	(396)	(1,399)
Borrowings	27	0	0
Other financial liabilities	36.2	0	0
Total non-current liabilities		**(396)**	(1,399)
Total Assets Employed:		**56,410**	63,806
Financed by taxpayers' equity:			
General fund		31,473	37,020
Revaluation reserve		24,937	26,786
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Total taxpayers' equity:		**56,410**	63,806

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Responsible Officer:

Date:

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

	General fund	Revaluation reserve	Other reserves	Total reserves
	£000	£000	£000	£000
Balance at 1 April 2012	**37,020**	**26,786**	**0**	**63,806**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(376,897)			**(376,897)**
Net gain on revaluation of property, plant, equipment		1,770		**1,770**
Net gain on revaluation of intangible assets		0		**0**
Net gain on revaluation of financial assets		0		**0**
Net gain on revaluation of assets held for sale		0		**0**
Impairments and reversals		(3,606)		**(3,606)**
Movements in other reserves			0	**0**
Transfers between reserves*	13	(13)		**0**
Release of Reserves to SOCNE		0		**0**
Reclassification Adjustments				
Transfers between Revaluation Reserve & General Fund in respect of assets transferred under absorption	0	0		**0**
Net actuarial gain/(loss) on pensions	0		0	**0**
Total recognised income and expense for 2012-13	**(376,884)**	**(1,849)**	**0**	**(378,733)**
Net Parliamentary funding	371,337			**371,337**
Balance at 31 March 2013	**31,473**	**24,937**	**0**	**56,410**
Balance at 1 April 2011	**23780**	**27783**	**0**	**51,563**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(363,355)			(363,355)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment		393		393
Net Gain / (loss) on Revaluation of Intangible Assets		0		0
Net Gain / (loss) on Revaluation of Financial Assets		0		0
Net Gain / (loss) on Assets Held for Sale		0		0
Impairments and Reversals		(1,388)		(1,388)
Movements in other reserves			0	0
Transfers between reserves*	0	0		0
Release of Reserves to Statement of Comprehensive Net Expenditure		(2)		(2)
Reclassification Adjustments				
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0	0
On disposal of available for sale financial assets	0	0	0	0
Net actuarial gain/(loss) on pensions	0		0	0
Total recognised income and expense for 2011-12	(363,355)	(997)	0	(364,352)
Net Parliamentary funding	376,595			376,595
Balance at 31 March 2012	**37,020**	**26,786**	**0**	**63,806**

Statement of cash flows for the year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities			
Net Operating Cost Before Interest		(376,657)	(363,314)
Depreciation and Amortisation		2,148	2,406
Impairments and Reversals		1,220	1,750
Other Gains / (Losses) on foreign exchange		0	0
Donated Assets received credited to revenue but non-cash		0	0
Government Granted Assets received credited to revenue but non-cash		0	0
Interest Paid		(7)	(1)
Release of PFI/deferred credit		0	0
(Increase)/Decrease in Inventories		0	0
(Increase)/Decrease in Trade and Other Receivables		6,265	(3,863)
(Increase)/Decrease in Other Current Assets		0	0
Increase/(Decrease) in Trade and Other Payables		(3,709)	(8,535)
(Increase)/Decrease in Other Current Liabilities		0	0
Provisions Utilised		(1,406)	(259)
Increase/(Decrease) in Provisions		2,747	(567)
Net Cash Inflow/(Outflow) from Operating Activities		(369,399)	(372,383)
Cash flows from investing activities			
Interest Received		0	0
(Payments) for Property, Plant and Equipment		(2,196)	(4,203)
(Payments) for Intangible Assets		0	0
(Payments) for Other Financial Assets		0	0
(Payments) for Financial Assets (LIFT)		0	0
Proceeds of disposal of assets held for sale (PPE)		125	0
Proceeds of disposal of assets held for sale (Intangible)		0	0
Proceeds from Disposal of Other Financial Assets		0	0
Proceeds from the disposal of Financial Assets (LIFT)		0	0
Loans Made in Respect of LIFT		0	0
Loans Repaid in Respect of LIFT		0	0
Rental Revenue		0	0
Net Cash Inflow/(Outflow) from Investing Activities		(2,071)	(4,203)
Net cash inflow/(outflow) before financing		(371,470)	(376,586)
Cash flows from financing activities			
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		0	0
Net Parliamentary Funding		371,337	376,595
Capital Receipts Surrendered		0	0
Capital grants and other capital receipts		0	0
Cash Transferred (to)/from Other NHS Bodies (free text note required)		0	0
Net Cash Inflow/(Outflow) from Financing Activities		371,337	376,595
Net increase/(decrease) in cash and cash equivalents		(133)	9
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		23	14
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies		0	0
Cash and Cash Equivalents (and Bank Overdraft) at year end		(110)	23

1. Accounting policies

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

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

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

1.1 Accounting Conventions

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

Transforming Community Services (TCS) transactions

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

Acquisitions and Discontinued Operations

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

Under the provisions of The Health and Social Care Act 2012 (Commencement No.4. Transitional, Savings and Transitory Provisions) Order 2013, NHS Kensington and Chelsea was dissolved on 1st April 2013. The PCT's functions, assets and liabilities transferred to other public sector entities as outlined in Note 42 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.

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.

Management have reviewed all contracts and leases and have used their judgement as to whether any are deemed onerous.

All new leases taken out in the year have been assessed to determine whether they are an operating lease or financial lease as per IAS 17.

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

Retrospective Claims for NHS Continuing Care Funding

On the 15th March 2012 the Department of Health announced deadlines for individuals to request an assessment of eligibility for NHS Continuing Healthcare Care funding, for cases during the period 1 April 2004 – 31 March 2012.

The deadline for notifying PCT's were as follows

Phase 1 Claim Period 1 April 2004 – 31 March 2011 a deadline of 30 September 2012
Phase 2 Claim Period 1 April 2011 – 31 March 2012 a deadline of 31 March 2013

Kensington and Chelsea PCT is still in the process of gathering all the necessary information to enable an assessment to take place therefore for these accounts both a provision and a contingent liability has been calculated using the following methodology.

1. Accounting policies (continued)

Provision
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.

For each of the two phases the total estimated liability has been calculated using:
a) an average length of claim based on a sample of both living and deceased claimants within each phase.
b) an average weekly nursing home cost based on a sample of the current nursing home costs.

To the total estimated liability the following has been applied
c) a standard interest rate
d) costs of undertaking the assessment.
e) for each phase a judgment on the likelihood of success.

Contingent Liability
A contingent liability has been shown representing the value of those judged to be likely to be unsuccessful in the provision calculation (i.e. if 60% likelihood has been applied to the total estimated liability then the balance of 40% has been shown as a contingent liability).

The PCT provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position Date on the basis of the best estimate of the expenditure required to settle the obligation.

Useful lives of property assets are estimated at the time of valuation by an independent valuer for land and buildings, the estimated life of equipment assets is estimated by the PCT at the time of purchase.

Fair values of assets are determined as follows:
Land and non-specialised buildings – market value for existing use provided by an independent valuer
Specialised buildings – depreciated replacement cost provided by an independent valuer

Bad Debt Provisions

Management has reviewed it's outstanding debts and have made provisions for all outstanding NON NHS invoices over 60 days.

Prescribing Pricing Authority

In Precribing, the accrual for drugs is based on 2.2 months based on the average of the last three months, the pharmacy contract is in two months in arrears ans so the acrual is based on this.

Dental Contract

Dental Contracts are one month in arrears and the accruals are based on the Payment On Line statetment.

Quality & Outcome Framework

Quality & Outcome Framework Achievement for 2012/13 has been estimated on the basis of the 2011/12 QMAS data. The Final figure will be available once the GP survey results are published on the 17 June 2013.

Recognition of Expenditure

The PCT has used various techniques to estimate the appropriate levels of income and expenditure to be included in the accounts. These include basing forecasts on actual expenditure incurred to date extrapolated to a full year, using internal databases (such as Continuing Care), local knowledge from managers and past experience has also been used to determine the appropriate levels of income and expenditure to be included. This method has been used for many years and in previous years has not led to any material differences being highlighted

Corporate Recharge

All corporate costs are initially paid by Westminster with an appropriate proportion recharged to Hammersmith & Fulham and Kensington & Chelsea. The recharge is based on actual costs for areas which are specific to one PCT (e.g. Public Health) and for shared departments (such as Finance) the split is based on the respective weighted population size (as measured by the Resource Limits). The split for 2012/13 has been determined at 29% Hammersmith & Fulham, 30% Kensington & Chelsea and 41% Westminster.

Invoices are raised to Hammersmith & Fulham and Kensington & Chelsea on a quarterly basis, based on actual values for the financial year.

In 2011/12 the corporate recharge was classified as other expenditure, however for 2012/13 this is now included under the various line of relevant expenditure.

1. Accounting policies (continued)

1.2 Revenue and Funding

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

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

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

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

1.3 Pooled budgets

The PCT has entered into a pooled budget with the Royal Borough of Kensington and Chelsea. Under the arrangement funds are pooled under S75 of the NHS Act 2006 for Community Equipment Service activities and a memorandum note to the accounts provides details of the joint income and expenditure.

The pool is hosted by the Royal Borough of Kensington and Chelsea . 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

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 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.

1.8 Depreciation, amortisation and impairments

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

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

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

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

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

1. Accounting policies (continued)

1.9 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.

1.10 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.

1.11 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.

1.12 Inventories

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

1.13 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 32.

1. Accounting policies (continued)

1.16 Employee benefits

Short-term employee benefits

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

Some employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the PCT's accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. Actuarial gains and losses during the year are recognised in the General Fund and reported on the Statement of Changes in Taxpayers' Equity.

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.

1.20 EU Emissions Trading Scheme

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

1. Accounting policies (continued)

1.21 Contingencies

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

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

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

1.22 Leases

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

The PCT as lessee

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

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

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

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

The PCT as lessor

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

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

1.23 Foreign exchange

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

1.24 Provisions

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

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

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

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

1. Accounting policies (continued)

1.25 Financial Instruments

Financial assets

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

Financial assets are initially recognised at fair value.

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

Financial assets at fair value through profit and loss

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

Held to maturity investments

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

Available for sale financial assets

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

Loans and receivables

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

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

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

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

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

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

1. Accounting policies (continued)

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

Financial liabilities are initially recognised at fair value.

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

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

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

1.26 Private Finance Initiative (PFI) and NHS LIFT transactions

HM Treasury has determined that government bodies shall account for infrastructure 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.

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 fair value and is subsequently measured as a finance lease liability in accordance with IAS 17.

1. Accounting policies (continued)

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

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

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

c) Lifecycle replacement

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

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

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

Assets contributed by the PCT to the operator for use in the scheme

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

Other assets contributed by the PCT to the operator

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

Corporate Recharge

All corporate costs are initially paid by Westminster with an appropriate proportion recharged to Hammersmith & Fulham and Kensington & Chelsea. The recharge is based on actual costs for areas which are specific to one PCT (e.g. Public Health) and for shared departments (such as Finance) the split is based on the respective weighted population size (as measured by the Resource Limits). The split for 2012/13 has been determined at 29% Hammersmith & Fulham, 30% Kensington & Chelsea and 41% Westminster.
Invoices are raised to Hammersmith & Fulham and Kensington & Chelsea on a quarterly basis, based on actual values for the financial year.
Last financial year, the corporate recharge was disclosed as miscellaneous expenditure, however for 2012/13 we have included this under cost relating to PCT non healthcare.

1. Accounting policies (continued)

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

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

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

2 Operating segments

The PCT has only one segment o report under IFRS 8; which is Commissioning.

The main source of fundingfor the PCT is allocations (Parliamentary Funding) from the Department of Health, within an approved cash limit.

3. Financial Performance Targets

3.1 Revenue Resource Limit

The PCTs' performance for the year ended 2012-13 is as follows:	2012-13 £000	2011-12 £000
Total Net Operating Cost for the Financial Year	376,897	363,355
Net operating cost plus (gain)/loss on transfers by absorption	0	0
Adjusted for prior period adjustments in respect of errors	393,041	373,521
Revenue Resource Limit	16,144	10,166
Under/(Over)spend Against Revenue Resource Limit (RRL)		

The £16.1m surplus reported in 2012/13 is within the surplus target set by NHS North West london to achieve the overall NHS North West London financial plan.

2011-12 performance data has not been adjusted in respect of restated items and remains as shown in the 2011-12 published accounts.

This reflects the way in which PCT performance is recorded by the Department.

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	2,800	2,885
Charge to Capital Resource Limit	2,800	2,882
(Over)/Underspend Against CRL	0	3

3.3 Provider full cost recovery duty

The PCT is required to recover full costs in relation to its provider functions.	2012-13 £000	2011-12 £000
Provider gross operating costs	0	0
Provider Operating Revenue	0	0
Net Provider Operating Costs	0	0
Costs Met Within PCTs Own Allocation	0	0
Under/(Over) Recovery of Costs	0	0

3.4 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	371,337	376,595
Cash Limit	386,785	381,362
Under/(Over)spend Against Cash Limit	15,448	4,767

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

	2012-13 £000
Total cash received from DH (Gross)	344,095
Less: Trade Income from DH	0
Less/(Plus): movement in DH working balances	0
Sub total: net advances	344,095
(Less)/plus: transfers (to)/from other resource account bodies (free text note required)	0
Plus: cost of Dentistry Schemes (central charge to cash limits)	6,012
Plus: drugs reimbursement (central charge to cash limits)	21,230
Parliamentary funding credited to General Fund	371,337

4 Miscellaneous Revenue

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Fees and Charges	**311**	(239)	550	(87)
Dental Charge income from Contractor-Led GDS & PDS	**1,096**		1,096	829
Dental Charge income from Trust-Led GDS & PDS	**0**		0	0
Prescription Charge income	**845**		845	1,442
Strategic Health Authorities	**0**	0	0	72
NHS Trusts	**5,818**	323	5,495	5,681
NHS Foundation Trusts	**650**	26	624	675
Primary Care Trusts Contributions to DATs	**0**		0	0
Primary Care Trusts - Other	**5,857**	3,055	2,802	6,514
Primary Care Trusts - Lead Commissioning	**0**	0	0	0
English RAB Special Health Authorities	**0**	0	0	0
NDPBs and Others (CGA)	**0**	0	0	0
Department of Health - SMPTB	**0**	0	0	0
Department of Health - Other	**0**	0	0	0
Recoveries in respect of employee benefits	**0**	0	0	0
Local Authorities	**970**	0	970	1,116
Patient Transport Services	**0**		0	0
Education, Training and Research	**0**	0	0	0
Non-NHS: Private Patients	**0**		0	0
Non-NHS: Overseas Patients (Non-Reciprocal)	**0**		0	0
NHS Injury Costs Recovery	**0**		0	0
Other Non-NHS Patient Care Services	**0**	0	0	0
Charitable and Other Contributions to Expenditure	**0**		0	0
Receipt of donated assets	**0**		0	0
Receipt of Government granted assets	**0**		0	0
Rental revemue from finance leases	**0**	0	0	0
Rental reenue from operating leases	**812**	0	812	682
Other revenue	**453**	26	427	1,264
Total miscellaneous revenue	**16,812**	**3,191**	**13,621**	**18,188**

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	26,535		26,535	23,279
Non-Healthcare	4,298	3,521	777	692
Total	30,833	3,521	27,312	23,971
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	109,493	20	109,473	114,032
Goods and services (other, excl Trusts, FT and PCT))	512	0	512	433
Total	110,005	20	109,985	114,465
Goods and Services from Foundation Trusts	125,098	4	125,094	127,044
Purchase of Healthcare from Non-NHS bodies	32,208		32,208	27,782
Social Care from Independent Providers	0		0	0
Expenditure on Drugs Action Teams	1,719		1,719	3,224
Non-GMS Services from GPs	770	707	63	506
Contractor Led GDS & PDS (excluding employee benefits)	6,962		6,962	5,985
Salaried Trust-Led PDS & PCT DS (excluding employee benefits)	0		0	0
Chair, Non-executive Directors & PEC remuneration*	48	48	0	0
Executive committee members costs	0	0	0	0
Consultancy Services	2,159	1,805	354	288
Prescribing Costs	17,650		17,650	19,526
G/PMS, APMS and PCTMS (excluding employee benefits)	31,088	0	31,088	29,984
Pharmaceutical Services	2,750		2,750	1,888
Local Pharmaceutical Services Pilots	125		125	(97)
New Pharmacy Contract	1,581		1,581	2,748
General Ophthalmic Services	809		809	781
Supplies and Services - Clinical	500	11	489	184
Supplies and Services - General	2,141	165	1,976	2,099
Establishment	1,171	546	625	654
Transport	277	65	212	176
Premises	7,554	2,891	4,663	4,897
Impairments & Reversals of Property, plant and equipment	1,220	0	1,220	1,750
Impairments and Reversals of non-current assets held for sale	0	0	0	0
Depreciation	2,140	0	2,140	2,333
Amortisation	8	0	8	73
Impairment & Reversals Intangible non-current assets	0	0	0	0
Impairment and Reversals of Financial Assets	0	0	0	0
Impairment of Receivables	66	0	66	53
Inventory write offs	0	0	0	0
Research and Development Expenditure	0	0	0	0
Audit Fees	108	108	0	162
Other Auditors Remuneration	19	18	1	40
Clinical Negligence Costs	67	0	67	5
Education and Training	123	90	33	69
Grants for capital purposes	779	0	779	0
Grants for revenue purposes	0	0	0	0
Impairments and reversals for investment properties	0	0	0	0
Other	3,374	781	2,593	2,790
Total Operating costs charged to Statement of Comprehensive Net Expenditure	383,352	10,780	372,572	373,380

*Kensington & Chelsea PCT does not directly employ any Executive members of the North West London Cluster Board. The majority of the NWL Cluster Board members are employed by Westminster PCT as the host. These costs are then recharged from Westminster PCT as part of the overall recharge we receive for the NWL Cluster.

Employee Benefits (excluding capitalised costs)				
Employee Benefits associated with PCTMS	0	0	0	0
Trust led PDS and PCT DS	0	0	0	0
PCT Officer Board Members	973	880	93	233
Other Employee Benefits	9,144	6,252	2,892	7,889
Total Employee Benefits charged to SOCNE	10,117	7,132	2,985	8,122
Total Operating Costs	393,469	17,912	375,557	381,502

Analysis of grants reported in total operating costs				
For capital purposes				
Grants to fund Capital Projects - GMS	0	0	0	0
Grants to Local Authorities to Fund Capital Projects	0	0	0	0
Grants to Private Sector to Fund Capital Projects	779	0	779	0
Grants to Fund Capital Projects - Dental	0	0	0	0
Grants to Fund Capital Projects - Other	0	0	0	0
Total Capital Grants	779	0	779	0
Grants to fund revenue expenditure				
To Local Authorities	0	0	0	0
To Private Sector	0	0	0	0
To Other	0	0	0	0
Total Revenue Grants	0	0	0	0
Total Grants	779	0	779	0

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	14,721	13,980	741
Weighted population (number in units)*	183,794	183,794	183,794
Running costs per head of population (£ per head)	80	76	4
PCT Running Costs 2011-12			
Running costs (£000s)	9,033	8,344	689
Weighted population (number in units)	183,794	183,794	183,794
Running costs per head of population (£ per head)	49	45	4

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

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

Running cost have increased in 2012/13 due to the costs of service reconfiguration, transition and PCT closedown.

5.2 Analysis of operating expenditure by expenditure classification

	2012-13	2011-12
	£000	£000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	31,440	29,984
Prescribing costs	17,971	19,526
Contractor led GDS & PDS	6,962	5,985
Trust led GDS & PDS	0	0
General Ophthalmic Services	809	781
Department of Health Initiative Funding	0	0
Pharmaceutical services	2,724	1,888
Local Pharmaceutical Services Pilots	125	(97)
New Pharmacy Contract	1,550	2,748
Non-GMS Services from GPs	763	506
Other	107	0
Total Primary Healthcare purchased	**62,451**	61,322
Purchase of Secondary Healthcare		
Learning Difficulties	5,100	4,454
Mental Illness	47,321	44,543
Maternity	8,318	5,820
General and Acute	140,084	165,571
Accident and emergency	11,646	4,693
Community Health Services	82,187	68,084
Other Contractual	5,915	2,563
Total Secondary Healthcare Purchased	**300,571**	295,728
Grant Funding		
Grants for capital purposes	779	0
Grants for revenue purposes	0	0
Total Healthcare Purchased by PCT	**363,801**	**357,050**
PCT self-provided secondary healthcare included above	0	0
Social Care from Independent Providers	0	0
Healthcare from NHS FTs included above	126,672	127,040

6. Operating Leases

NHS Kensington and Chelsea holds several leases, as a lessee and a lessor, leasing arrangement are as follows;
There is no contingent rent.
No signifaicant issues exist in regard to terms of renewal, purchase options or escalation clauses and
No material restrictions have been imposed on lease arrangement

6.1 PCT as lessee

	Land £000	Buildings £000	Other £000	2012-13 Total £000	2011-12 Total £000
Payments recognised as an expense					
Minimum lease payments				192	191
Contingent rents				0	0
Sub-lease payments				416	471
Total				608	662
Payable:					
No later than one year	0	701	32	733	648
Between one and five years	0	2,551	11	2,562	2,429
After five years	0	2,970	0	2,970	3,823
Total	0	6,222	43	6,265	6,900
Total future sublease payments expected to be received				0	0

6.2 PCT as lessor

NHS Kensington and Chelsea have a number of short term leases with GP practices

	2012-13 £000	2011-12 £000
Recognised as income		
Rental Revenue	812	682
Contingent rents	0	0
Total	812	682
Receivable:		
No later than one year	473	676
Between one and five years	1,665	1,727
After five years	1,108	985
Total	3,246	3,388

7. Employee benefits and staff numbers

7.1 Employee benefits

2012-13								
	Total £000	Admin £000	Programme £000	Permanently employed Total £000	Permanently employed Admin £000	Permanently employed Programme £000	Other Total £000	Other Admin £000	Other Programme £000
Employee Benefits - Gross Expenditure									
Salaries and wages	8,726	5,843	2,883	7,824	5,843	1,981	902	0	902
Social security costs	525	477	48	525	477	48	0	0	0
Employer Contributions to NHS BSA - Pensions Division	674	620	54	674	620	54	0	0	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	192	192	0	192	192	0	0	0	0
Total employee benefits	10,117	7,132	2,985	9,215	7,132	2,083	902	0	902
Less recoveries in respect of employee benefits (table below)	0	0	0	0	0	0	0	0	0
Total - Net Employee Benefits including capitalised costs	10,117	7,132	2,985	9,215	7,132	2,083	902	0	902
Employee costs capitalised	0	0	0	0	0	0	0	0	0
Gross Employee Benefits excluding capitalised costs	10,117	7,132	2,985	9,215	7,132	2,083	902	0	902
Recognised as:									
Commissioning employee benefits	10,117			9,215			902		
Provider employee benefits	0			0			0		
Gross Employee Benefits excluding capitalised costs	10,117			9,215			902		

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

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	6,914	6,339	575
Social security costs	535	535	0
Employer Contributions to NHS BSA - Pensions Division	673	673	0
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Total gross employee benefits	8,122	7,547	575
Less recoveries in respect of employee benefits	0	0	0
Total - Net Employee Benefits including capitalised costs	8,122	7,547	575
Employee costs capitalised	0	0	0
Gross Employee Benefits excluding capitalised costs	8,122	7,547	575
Recognised as:			
Commissioning employee benefits	8,122		
Provider employee benefits	0		
Gross Employee Benefits excluding capitalised costs	8,122		

7.2 Staff Numbers

	2012-13 Total Number	2012-13 Permanently employed Number	2012-13 Other [b] Number	2011-12 Total Number	2011-12 Permanently employed Number	2011-12 Other Number
Average Staff Numbers [a]						
Medical and dental	3	3	0	3	3	0
Ambulance staff	0	0	0	0	0	0
Administration and estates	85	85	0	118	118	0
Healthcare assistants and other support staff	16	16	0	17	17	0
Nursing, midwifery and health visiting staff	3	3	0	3	3	0
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	4	4	0	5	5	0
Social Care Staff	0	0	0	0	0	0
Other	3	3	0	5	5	0
TOTAL	114	114	0	151	151	0
Of the above - staff engaged on capital projects	0	0	0	0	0	0

a) 2011-12 Staff numbers only include estates and facilities staff and Kensington & Chelsea specific staff for hosted and local services/projects. Staff numbers for INWL shared corporate staff are reported in the Westminster PCT accounts.

b) The PCT is unable to provide "other number" as this information is not collated centrally. Therefore note 7.2 will not match other staff employment benefits value in Note 7.1 above.

7.3 Staff Sickness absence and ill health retirements

	2012-13 Number	2011-12 Number
Total Days Lost	758	793
Total Staff Years	123	170
Average working Days Lost	6.18	4.66

Figures given are in calendar years.
Total Staff Years relates to the number of Whole Time Equivalents in post during the calendar year.
Sickness data is collated centrally by Department of Health.

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

7.4 Exit Packages agreed during 2012-13

	2012-13			2011-12		
Exit package cost band (including any special payment element)	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**
	Number	**Number**	**Number**	**Number**	**Number**	**Number**
Lees than £10,000	**0**	**0**	**0**	0	0	**0**
£10,001-£25,000	**1**	**0**	**1**	0	0	**0**
£25,001-£50,000	**1**	**0**	**1**	0	0	**0**
£50,001-£100,000	**3**	**0**	**3**	0	0	**0**
£100,001 - £150,000	**1**	**0**	**1**	0	0	**0**
£150,001 - £200,000	**0**	**0**	**0**	0	0	**0**
>£200,000	**1**	**0**	**1**	0	0	**0**
Total number of exit packages by type (total cost	**7**	**0**	**7**	**0**	**0**	**0**
	£	**£**	**£**	**£**	**£**	**£**
Total resource cost	705,203	0	**705,203**	0	0	**0**

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

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

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

Retirement under Ill Health

No of cases	0
Value £000	0

7.5 Pension costs

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

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

a) Full actuarial (funding) valuation

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

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

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

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

b) Accounting valuation

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

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

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

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

c) Scheme provisions

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

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

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

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

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

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

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

8. Better Payment Practice Code

8.1 Measure of compliance

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**13,548**	**77,050**	13,551	79,295
Total Non-NHS Trade Invoices Paid Within Target	**12,398**	**72,939**	11,956	71,403
Percentage of NHS Trade Invoices Paid Within Target	91.51%	94.66%	88.23%	90.05%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3,750**	**280,514**	4,071	284,112
Total NHS Trade Invoices Paid Within Target	**3,382**	**275,969**	3,538	271,249
Percentage of NHS Trade Invoices Paid Within Target	90.19%	98.38%	86.91%	95.47%

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

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

	2012-13 £000	2011-12 £000
Amounts included in finance costs from claims made under this legislation	**7**	1
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**7**	1

9. Investment Income

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

10. Other Gains and Losses

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

11. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest				
Interest on obligations under finance leases	0	0	0	0
Interest on obligations under PFI contracts:				
- main finance cost	0	0	0	0
- contingent finance cost	0	0	0	0
Interest on obligations under LIFT contracts:				
- main finance cost	0	0	0	0
- contingent finance cost	0	0	0	0
Interest on late payment of commercial debt	7	0	7	1
Other interest expense	0	0	0	0
Total interest expense	7	0	7	1
Other finance costs	0	0	0	0
Provisions - unwinding of discount	233		233	40
Total	240	0	240	41

12.1 Property, plant and equipment

2012-13	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:									
At 1 April 2012	30,811	47,322	6,676	0	794	0	3,017	381	89,001
Additions of Assets Under Construction				0					0
Additions Purchased	0	1,574	150		0	0	1,076	0	2,800
Additions Donated	0	0	0	0	0	0	0	0	0
Additions Government Granted	0	0	0	0	0	0	0	0	0
Additions Leased	0	0	0		0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassifications as Held for Sale	0	0	0	0	0	0	0	0	0
Disposals other than for sale	0	0	0	0	(165)	0	(454)	0	(619)
Upward revaluation/positive indexation	912	858	0	0	0	0	0	0	1,770
Impairments/negative indexation	(71)	(2,583)	(952)	0	0	0	0	0	(3,606)
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	0
At 31 March 2013	31,652	47,171	5,874	0	629	0	3,639	381	89,346
Depreciation									
At 1 April 2012	0	3,315	180	0	416	0	1,324	135	5,370
Reclassifications		0	0		0	0	0	0	0
Reclassifications as Held for Sale	0	0	0		0	0	0	0	0
Disposals other than for sale	0	0	0		(165)	0	(454)	0	(619)
Upward revaluation/positive indexation	0	0	0		0	0	0	0	0
Impairments	0	1,412	0	0	0	0	0	0	1,412
Reversal of Impairments	(98)	(94)	0	0	0	0	0	0	(192)
Charged During the Year	0	1,409	174		78	0	439	40	2,140
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	0
At 31 March 2013	(98)	6,042	354	0	329	0	1,309	175	8,111
Net Book Value at 31 March 2013	31,750	41,129	5,520	0	300	0	2,330	206	81,235
Purchased	31,750	41,129	5,520	0	300	0	2,330	206	81,235
Donated	0	0	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	31,750	41,129	5,520	0	300	0	2,330	206	81,235
Asset financing:									
Owned	31,750	41,129	5,520	0	300	0	2,330	206	81,235
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	31,750	41,129	5,520	0	300	0	2,330	206	81,235

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	12,943	9,632	4,194	0	13	0	0	4	26,786
Movements (specify)	840	(1,723)	(952)	0	(12)	0	0	(2)	(1,849)
At 31 March 2013	13,783	7,909	3,242	0	1	0	0	2	24,937

Additions to Assets Under Construction in 2012-13

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

12.2 Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:									
At 1 April 2011	**30,811**	**44,276**	**6,866**	**2,440**	**1,110**	**0**	**2,925**	**381**	**88,809**
Additions - purchased	0	2,620	170	0	0	0	92	0	**2,882**
Additions - donated	0	0	0	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	2,440	0	(2,440)	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	(316)	0	0	0	**(316)**
Revaluation & indexation gains	0	393	0	0	0	0	0	0	**393**
Impairments	0	(1,203)	(185)	0	0	0	0	0	**(1,388)**
Reversals of impairments	0	0	0	0	0	0	0	0	**0**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluatio	0	(1,204)	(175)	0	0	0	0	0	**(1,379)**
At 31 March 2012	**30,811**	**47,322**	**6,676**	**0**	**794**	**0**	**3,017**	**381**	**89,001**
Depreciation									
At 1 April 2011	**0**	**1,204**	**175**		**602**	**0**	**897**	**104**	**2,982**
Reclassifications		0	0		0	0	0	0	**0**
Reclassifications as Held for Sale	0	0	0		0	0	0	0	**0**
Disposals other than for sale	0	0	0		(316)	0	0	0	**(316)**
Upward revaluation/positive indexation	0	0	0		0	0	0	0	**0**
Impairments	0	1,750	0	0	0	0	0	0	**1,750**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Charged During the Year	0	1,565	180		130	0	427	31	**2,333**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluatio	0	(1,204)	(175)	0	0	0	0	0	**(1,379)**
At 31 March 2012	**0**	**3,315**	**180**	**0**	**416**	**0**	**1,324**	**135**	**5,370**
Net Book Value at 31 March 2012	**30,811**	**44,007**	**6,496**	**0**	**378**	**0**	**1,693**	**246**	**83,631**
Purchased	30,811	44,007	6,496	0	378	0	1,693	246	**83,631**
Donated	0	0	0	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**30,811**	**44,007**	**6,496**	**0**	**378**	**0**	**1,693**	**246**	**83,631**
Asset financing:									
Owned	30,811	44,007	6,496	0	378	0	1,693	246	**83,631**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**30,811**	**44,007**	**6,496**	**0**	**378**	**0**	**1,693**	**246**	**83,631**

12.3 Property, plant and equipment

Kensington & Chelsea PCT, appointed an independent valuer, the District Valuers Office to carry out an interim asset valuation of the PCT land and building assets as at the 31st March 2013. The valuation was undertaken mainly as adesktop exercise, however those aeras where there had been a significant capital expenditure since the last full valuation in 2010, were fully inspected. This expenditure was reflected in the valuation. The valuation of each property was carried out at Market Equivalent Asset value (MEA) basis as per IAS 16. The effect of this valuation has been reflected in the financial statements.

Economic Lives of Non-Current Assets

Property, Plant and Equipment	**Min Life Years**	**Max Life Years**
Buildings exc Dwellings	26	44
Dwellings	0	0
Plant & Machinery	0	7
Transport Equipment	0	0
Information Technology	2	4
Furniture and Fittings	1	7

Open Market Value of Assets at balance sheet date	**Land**	**Buildings excl. dwellings**	**Dwellings**	**Total**
	£000s	**£000s**	**£000s**	**£000s**
Open Market Value at 31 March 2013	31,750	41,129	5,520	78,399
Open Market Value at 31 March 2012	30,811	44,007	6,496	81,314

13.1 Intangible non-current assets

2012-13	Software internally generated £000	Software purchased £000	Licences & trademarks £000	Patents £000	Development expenditure £000	Total £000
At 1 April 2012	**0**	**171**	**0**	**0**	**0**	**171**
Additions - purchased	0	0	0	0	0	**0**
Additions - internally generated	0	0	0	0	0	**0**
Additions - donated	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	**0**
Additions Leased	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	(134)	0	0	0	**(134)**
Revaluation & indexation gains	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	**0**
In-year transfers to/from NHS bodies	0	0	0	0	0	**0**
At 31 March 2013	**0**	**37**	**0**	**0**	**0**	**37**
Amortisation						
At 1 April 2012	**0**	**163**	**0**	**0**	**0**	**163**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	(134)	0	0	0	**(134)**
Revaluation or indexation gains	0	0	0	0	0	**0**
Impairments charged to operating expenses	0	0	0	0	0	**0**
Reversal of impairments charged to operating expenses	0	0	0	0	0	**0**
Charged during the year	0	8	0	0	0	**8**
In-year transfers to NHS bodies	0	0	0	0	0	**0**
At 31 March 2013	**0**	**37**	**0**	**0**	**0**	**37**
Net Book Value at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**
Net Book Value at 31 March 2013 comprises						
Purchased	0	0	0	0	0	**0**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	**0**
Total at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**

Revaluation reserve balance for intangible non-current assets

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

13.2 Intangible non-current assets

2011-12	Software internally generated	Software purchased	Licences & trademarks	Patents	Development expenditure	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2011	0	476	0	0	0	476
Additions - purchased	0	0	0	0	0	0
Additions - internally generated	0	0	0	0	0	0
Additions - donated	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	(305)	0	0	0	(305)
Revaluation & indexation gains	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
In-year transfers to/from NHS bodies	0	0	0	0	0	0
Cumulative dep netted off cost following revaluation	0	0	0	0	0	0
At 31 March 2012	0	171	0	0	0	171
Amortisation						
At 1 April 2011	0	395	0	0	0	395
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	(305)	0	0	0	(305)
Revaluation or indexation gains	0	0	0	0	0	0
Impairments charged to operating expenses	0	0	0	0	0	0
Reversal of impairments charged to operating expenses	0	0	0	0	0	0
Charged during the year	0	73	0	0	0	73
In-year transfers to NHS bodies	0	0	0	0	0	0
Less cumulative dep written down on revaluation	0	0	0	0	0	0
At 31 March 2012	0	163	0	0	0	163
Net Book Value at 31 March 2012	0	8	0	0	0	8
Net Book Value at 31 March 2012 comprises						
Purchased	0	8	0	0	0	8
Donated	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0
Total at 31 March 2012	0	8	0	0	0	8

13.3 Intangible non-current assets

Economic Lives of Non-Current Assets

	Min Life Years	Max Life Years
Intangible Assets		
Software Licences	0	0
Licences and Trademarks	0	0
Patents	0	0
Development Expenditure	0	0

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

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000
Property, Plant and Equipment impairments and reversals taken to SoCNE			
Loss or damage resulting from normal operations	0	0	0
Over-specification of assets	0	0	0
Abandonment of assets in the course of construction	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen obsolescence	0		0
Loss as a result of catastrophe	0		0
Other	0		0
Changes in market price	1,220		1,220
Total charged to Annually Managed Expenditure	**1,220**		**1,220**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Loss or damage resulting from normal operations	0		
Over Specification of Assets	0		
Abandonment of assets in the course of construction	0		
Unforeseen obsolescence	0		
Loss as a result of catastrophe	0		
Other	0		
Changes in market price	3,606		
Total impairments for PPE charged to reserves	**3,606**		
Total Impairments of Property, Plant and Equipment	**4,826**	**0**	**1,220**
Intangible assets impairments and reversals charged to SoCNE			
Loss or damage resulting from normal operations	0	0	0
Over-specification of assets	0	0	0
Abandonment of assets in the course of construction	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen obsolescence	0		0
Loss as a result of catastrophe	0		0
Other	0		0
Changes in market price	0		0
Total charged to Annually Managed Expenditure	**0**		**0**
Intangible Assets impairments and reversals charged to the Revaluation Reserve			
Loss or damage resulting from normal operations	0		
Over-specification of assets	0		
Abandonment of assets in the course of construction	0		
Unforeseen obsolescence	0		
Loss as a result of catastrophe	0		
Other	0		
Changes in market price	0		
Total impairments for Intangible Assets charged to Reserves	**0**		
Total Impairments of Intangibles	**0**	**0**	**0**

Financial Assets charged to SoCNE			
Loss or damage resulting from normal operations	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Loss as a result of catastrophe	0		0
Other	0		0
Total charged to Annually Managed Expenditure	**0**		**0**
Financial Assets impairments and reversals charged to the Revaluation Reserve			
Loss or damage resulting from normal operations	0		
Loss as a result of catastrophe	0		
Other	0		
TOTAL impairments for Financial Assets charged to reserves	**0**		
Total Impairments of Financial Assets	**0**	**0**	**0**
Non-current assets held for sale - impairments and reversals charged to SoCNE.			
Loss or damage resulting from normal operations	0	0	0
Abandonment of assets in the course of construction	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen obsolescence	0		0
Loss as a result of catastrophe	0		0
Other	0		0
Changes in market price	0		0
Total charged to Annually Managed Expenditure	**0**		**0**
Total impairments of non-current assets held for sale	**0**	**0**	**0**
Inventories - impairments and reversals charged to SoCNE			
Loss or Damage Resulting from Normal Operations	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen Obsolescence	0		0
Loss as a Result of a Catastrophe	0		0
Other (Free text note required)*	0		0
Changes in Market Price	0		0
Total charged to Annually Managed Expenditure	**0**		**0**
Total impairments of Inventories	**0**	**0**	**0**
Investment Property impairments charged to SoCNE			
Loss or Damage Resulting from Normal Operations	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen Obsolescence	0		0
Loss as a Result of a Catastrophe	0		0
Other (Free text note required)*	0		0
Changes in Market Price	0		0
Total charged to Annually Managed Expenditure	**0**		**0**
Total Investment Property impairments charged to SoCNE	**0**	**0**	**0**
Investment Property impairments and reversals charged to the Revaluation Reserve			
Loss or Damage Resulting from Normal Operations	0		
Over Specification of Assets	0		
Abandonment of Assets in the Course of Construction	0		
Unforeseen Obsolescence	0		
Loss as a Result of a Catastrophe	0		
Other (Free text note required)*	0		
Changes in Market Price	0		
TOTAL impairments for Investment Property charged to Reserves	**0**		
Total Investment Property Impairments	**0**	**0**	**0**
Total Impairments charged to Revaluation Reserve	3,606		
Total Impairments charged to SoCNE - DEL	0	0	0
Total Impairments charged to SoCNE - AME	1,220		1,220
Overall Total Impairments	**4,826**	**0**	**1,220**
Of which:			
Impairment on revaluation to "modern equivalent asset" basis	**0**	0	0
Donated and Gov Granted Assets, included above -			
PPE - Donated and Government Granted Asset Impairments: amount charged to SoCNE - DEL*	0	0	0
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SoCNE -AME*	0	0	0

Following the revaluation of the PCT's estate by the District Valuer. The PCT has recognised inpairment in respect of 4 buildings totalling £4,826,000.

The valuation of each property is therefore on the basis of Market Value Equivalent values as per IAS 16.

For non-specialised operational assets, this equates in practice to Existing Use Value. For specialised operational assets, if there is no market-based evidence of fair value because of the specialised nature of the property and the item is rarely sold, except as part of a continuing business, fair value is estimated using a depreciated replacement cost.

15 Investment property

	31 March 2013 £000	31 March 2012 £000
At fair value		
Balance at 1 April 2012	**0**	0
Additions Through Subsequent Expenditure	**0**	0
Other Acquisitions	**0**	0
Disposals	**0**	0
Property Reclassified as Held for Sale	**0**	0
Loss from Fair Value Adjustments - Impairments	**0**	0
Gain from Fair Value Adjustments - Reversal of Impairments	**0**	
Gain from Fair Value Adjustments	**0**	0
Transfers (to)/from Other Public Sector Bodies	**0**	
Other Changes	**0**	0
Balance at 31 March 2013	**0**	0
Investment property capital transactions in 2012-13		
Capital expenditure	**0**	0
Capital income	**0**	0
	0	0

16 Commitments

16.1 Capital commitments

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

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

16.2 Other financial commitments

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

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

17 Intra-Government and other balances

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with other Central Government Bodies	739	0	3,304	0
Balances with Local Authorities	542	0	1,129	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	350	0	2,919	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	597	0	16,042	0
At 31 March 2013	**2,228**	**0**	**23,394**	**0**
prior period:				
Balances with other Central Government Bodies	4,843	0	3,036	0
Balances with Local Authorities	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	1,366	0	6,338	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	2,284	0	17,413	0
At 31 March 2012	**8,493**	**0**	**26,787**	**0**

18 Inventories

	Drugs £000	Consumables £000	Energy £000	Work in progress £000	Loan Equipment £000
Balance at 1 April 2012	**0**	**0**	**0**	**0**	**0**
Additions	0	0	0	0	0
Inventories recognised as an expense in the period	0	0	0	0	0
Write-down of inventories (including losses)	0	0	0	0	0
Reversal of write-down previously taken to SoCNE	0	0	0	0	0
Transfers (to)/from other public sector bodies	0	0	0	0	0
Balance at 31 March 2013	**0**	**0**	**0**	**0**	**0**

19.1 Trade and other receivables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
NHS receivables - revenue	**511**	5,440	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**229**	769	**0**	0
Non-NHS receivables - revenue	**324**	1,122	**0**	0
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**1,027**	1,082	**0**	0
Provision for the impairment of receivables	**(212)**	(149)	**0**	0
VAT	**349**	193	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	**0**	0	**0**	0
Interest receivables	**0**	0	**0**	0
Finance lease receivables	**0**	0	**0**	0
Operating lease receivables	**0**	0	**0**	0
Other receivables	**0**	36	**0**	0
Total	**2,228**	8,493	**0**	0
Total current and non current	**2,228**	8,493		
Included above:				
Prepaid pensions contributions	**0**	0		

19.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	**279**	2,794
By three to six months	**0**	287
By more than six months	**0**	1,011
Total	**279**	4,092

19.3 Provision for impairment of receivables

	2012-13 £000	**2011-12 £000**
Balance at 1 April 2012	**(149)**	0
Amount written off during the year	**3**	0
Amount recovered during the year	**48**	0
(Increase)/decrease in receivables impaired	**(114)**	0
Balance at 31 March 2013	**(212)**	0

20 NHS LIFT investments

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

21.1 Other financial assets - Current

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

21.2 Other Financial Assets - Non Current

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

21.3 Other Financial Assets - Capital Analysis

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

22 Other current assets

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

23 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**23**	14
Net change in year	**(23)**	9
Closing balance	**0**	23
Made up of		
Cash with Government Banking Service	**0**	23
Commercial banks	**0**	0
Cash in hand	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**0**	23
Bank overdraft - Government Banking Service	**(110)**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**(110)**	23
Patients' money held by the PCT, not included above	**0**	0

24 Non-current assets held for sale

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

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

At 31 March 2012	0
At 31 March 2013	0

25 Trade and other payables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Interest payable	**0**	0		
NHS payables - revenue	**1,456**	3,354	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**4,665**	6,020	**0**	0
Family Health Services (FHS) payables	**3,334**	3,583		
Non-NHS payables - revenue	**2,204**	725	**0**	0
Non-NHS payables - capital	**2,094**	1,365	**0**	0
Non_NHS accruals and deferred income	**9,648**	11,611	**0**	0
Social security costs	**5**	2		
VAT	**0**	0	**0**	0
Tax	**59**	4		
Payments received on account	**8**	4	**0**	0
Other	334	119	0	0
Total	**23,807**	26,787	**0**	0
Total payables (current and non-current)	**23,807**	**26,787**		

26 Other liabilities

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

27 Borrowings

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Bank overdraft - Government Banking Service	**110**	0		
Bank overdraft - commercial banks	**0**	0		
PFI liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
LIFT liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**0**	0	**0**	0
Other (describe)	**0**	0	**0**	0
Total	**110**	**0**	**0**	**0**
Total other liabilities (current and non-current)	**110**	**0**		

Borrowings/Loans - Payment of Principal Falling Due in:

	DH £000s	Other £000s	Total £000s
0 - 1 Years	110	0	**110**
1 - 2 Years	0	0	**0**
2 - 5 Years	0	0	**0**
Over 5 Years	0	0	**0**
TOTAL	**110**	**0**	**110**

28 Other financial liabilities

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

29 Deferred income

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Opening balance at1 April 2012	**9**	9	**0**	0
Deferred income addition	**0**	0	**0**	0
Transfer of deferred income	**(9)**	0	**0**	0
Current deferred Income at 31 March 2013	**0**	9	**0**	0
Total other liabilities (current and non-current)	**0**	**9**		

30 Finance lease obligations

NHS Kensington and Chelsea has no finance lease obligations in 2012/13.

31 Finance lease receivables as lessor

NHS Kensington and Chelsea has no finance lease receivables as lessor in 2012/13.

32 Provisions

		Comprising:								
	Total £000s	Pensions to Former Directors £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Restructuring £000s	Continuing Care £000s	Equal Pay £000s	Agenda for Change £000s	Other £000s	Redundancy £000s
Balance at 1 April 2012	1,562	73	1,058	0	0	0	0	0	431	0
Arising During the Year	2,846	0	0	0	0	2,050	0	0	156	640
Utilised During the Year	(1,406)	(134)	(1,223)	0	0	0	0	0	(49)	0
Reversed Unused	(99)	0	0	0	0	0	0	0	(99)	0
Unwinding of Discount	233	61	165	0	0	0	0	0	7	0
Change in Discount Rate	0	0	0	0	0	0	0	0	0	0
Transferred (to)/from otherPublic Sector bodies	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2013	3,136	0	0	0	0	2,050	0	0	446	640
Expected Timing of Cash Flows:										
No Later than One Year	2,740	0	0	0	0	2,050	0	0	50	640
Later than One Year and not later than Five Years	198	0	0	0	0	0	0	0	198	0
Later than Five Years	198	0	0	0	0	0	0	0	198	0

Amount included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at 31 March 2013	35
As at 31 March 2012	0

NOTES

Other Provisions:

£276,000 - relating to injury benefit.

£165,000 - relating to tenancy cost arrangement

The PCT is not aware of any circumstances that will materially affect the certainty of payment or the period within which the above pensions or claims are anticipated to be settled.

33 Contingencies

An amount of £1,996,000 has been included in the cash liability relating to any outstanding Continuing Care Retrospective Claims. This provision has been calculated using two phases, phase one being claims for period of care between 1st April 2004 and 31st March 2011, and phase two being claims for period of care between 1st April 2011 and 31st March 2012. The basis for calculation includes an estimate of the average staff costs involved for assessing each case, actual weekly cost of providing the care based on a sample of provider costs for this group of patients, and an actual number of years based on a sample of claims for length of care. In addition County Court Judgement interest of 4% has been applied.

33.1 Contingent Liabilities

	31 March 2013	31 March 2012
Contingent Liabilities	£000	£000
Equal Pay	0	0
Other - Continuing Care Retrospective Claims	(4,271)	0
Amounts Recoverable Against Contingent Liabilities	0	0
Net Value of Contingent Liabilities	(4,271)	0

34 PFI and LIFT - additional information

NHS Kensington and Chelsea has no PFI or LIFT schemes.

35 Impact of IFRS treatment - 2012-13

	Total £000	Admin £000	Programme £000
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g LIFT/PFI)			
Depreciation charges	**0**	0	0
Interest Expense	**0**	0	0
Impairment charge - AME	**0**		0
Impairment charge - DEL	**0**	0	0
Other Expenditure	**0**	0	0
Revenue Receivable from subleasing	**0**	0	0
Total IFRS Expenditure (IFRIC12)	**0**	**0**	**0**
Revenue consequences of LIFT/PFI schemes under UK GAAP / ESA95 (net of any sublease income)	0	0	0
Net IFRS change (IFRIC12)	**0**	**0**	**0**
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12			
Capital expenditure 2012-13	0		
UK GAAP capital expenditure 2012-13 (Reversionary Interest)	0		

36 Financial Instruments

Financial risk management

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

Currency risk

The PCT/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.

36.1 Financial Assets

	At 'fair value through profit and loss' £000	Loans and receivables £000	Available for sale £000	Total £000
Embedded derivatives	0			**0**
Receivables - NHS		167		**167**
Receivables - non-NHS		1,386		**1,386**
Cash at bank and in hand		0		**0**
Other financial assets	0	0	0	**0**
Total at 31 March 2013	**0**	**1,553**	**0**	**1,553**
Embedded derivatives	0			0
Receivables - NHS		5,894		5,894
Receivables - non-NHS		1,050		1,050
Cash at bank and in hand		23		23
Other financial assets	0	0	0	0
Total at 31 March 2012	0	6,967	0	6,967

36.2 Financial Liabilities

	At 'fair value through profit and loss' £000	Other £000	Total £000
Embedded derivatives	0		**0**
NHS payables		6,482	**6,482**
Non-NHS payables		16,842	**16,842**
Other borrowings		3,039	**3,039**
PFI & finance lease obligations		0	**0**
Other financial liabilities	0	110	**110**
Total at 31 March 2013	**0**	**26,473**	**26,473**
Embedded derivatives	0		0
NHS payables		9,374	9,374
Non-NHS payables		16,988	16,988
Other borrowings		0	0
PFI & finance lease obligations		0	0
Other financial liabilities	0	0	0
Total at 31 March 2012	0	26,362	26,362

37 Related party transactions

Members of the Cluster Board with related party transactions include Sarah Cuthbert whose husband is a Partner in Deloitte. Deloitte are external auditors for Hillingdon and Harrow PCTs and also have worked on 'Shaping a Healthier Future' during the year.The contract of 191k was held by Westminster PCT.

Dr Mark Spencer held shares in Harmoni Ltd which were sold in year. Harmoni Ltd is the Out of Hours provider for Hounslow, Hillingdon, Ealing and Harrow and the 111 provider for Hounslow, Brent, Ealing and Harrow.

The following related party transactions were reported by the Shadow Clinical Commissioning Board that relate to Kensington and Chelsea Primary Care Trust. The GMS payments shown below relates to services provided by the practice which the Shadow Clinical Commissioning member is a partner rather than payments to Shadow Clinical Commissioning members themselves. The payment is the total paid to the practices as a whole before taking into account practice expenses in delivering services.

Shadow Clinical Commissioning Board - PMS or GMS Costs

	Payments to Related Party	
	2012/13	2011/12
	£'000	£'000
Dr Iain Blake (Colville Health Centre)*	654	504
Dr Val Dias (The Surgery 112 Princedale Rd)*	422	412
Dr Andrew Rose (Dr Rose's Surgery)*	478	456
Dr Fiona Butler (The Redcliffe Surgery)*	1,581	1,335
Dr Mark Sweeney (North Kensington Medical Centre)*	1,487	1,482
Dr Naomi Katz (The New Elgin Practice)*	741	800
Dr Puvana Rajakulendran (Earls Court Medical Practice)*	994	985
Dr Rachael Garner (Notting Hill Medical Centre)*	727	600
Dr Simon Ramsden (The Pembridge Villas Surgery)*	1,555	1,309

* The above monies relate to payments made by the PCT to GP practices of which the individuals are partners.

The Department of Health is regarded as a related party. During the year NHS Kensington & Chelsea 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. The entities with transactions greater than 1% of NHS Kensington & Chelsea net operating cost for the financial year are:

	Income	Expenditure	Receivables	Payables
	£'000	£'000	£'000	£'000
A Primary care Trust				
Brent Teaching PCT	373	60	0	0
Croydon PCT	0	26,743	0	0
Ealing PCT	18	18	0	1
Hounslow PCT	34	1,327	40	1,320
Richmond And Twickenham PCT	0	24	0	0
Hammersmith And Fulham PCT	1,638	760	15	244
Westminster PCT	3,639	10,072	949	377
B Trusts				
Central London Community Healthcare NHS Trust	4,916	40,087	2	204
Epsom And St Helier University Hospitals NHS Trust	0	63	0	12
Imperial College Healthcare NHS Trust	794	58117	166	743
Kingston Hospital NHS Trust	0	109	0	0
London Ambulance Service NHS Trust	0	5,024	0	5
North Middlesex University Hospital NHS Trust	0	27	0	2
North West London Hospitals NHS Trust	0	779	0	15
Royal Free Hampstead NHS Trust	0	0	0	0
St Georges Healthcare NHS Trust	0	834	0	62
The Royal National Orthopaedic Hospital NHS Trust	0	423	31	0
West London Mental Health NHS Trust	0	1,495	0	5
Whittington Hospital NHS Trust	0	127	5	0
C Foundation Trusts				
Central And North West London MH NHS Foundation Trust	650	36,246	0	324
Chelsea And Westminster Hospital NHS Foundation Trust	0	57,177	0	963
Great Ormond Street Hospital for Children NHS Foundation Trust ***FT status 01/03/12***	0	0	0	0
Guys And St Thomas NHS Foundation Trust	0	2,435	0	73
Homerton University Hospital NHS Foundation Trust	0	68	0	18
Kings College Hospital NHS Foundation Trust	0	876	0	0
Moorfields Eye Hospital NHS Foundation Trust	0	677	0	41
North East London NHS Foundation Trust	0	11	0	1
Royal Brompton And Harefield NHS Foundation Trust	0	17,520	37	0
Royal Surrey County NHS Foundation Trust	0	34	0	10
South London And Maudsley NHS Foundation Trust	0	320	13	0
The Hillingdon Hospital NHS Foundation Trust	0	146	0	41
The Royal Marsden Hospital NHS Foundation Trust	0	3,638	0	18
University College London NHS Foundation Trust	0	5,062	0	114
D Others				
London Strategic Health Authority	0	0	0	0
E Local Councils				
The Royal Borough of Kensington & Chelsea	942	16,034	533	948

38 Losses and special payments

The total number of losses cases in 2012-13 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses - PCT management costs*	3,773	4
Special payments - PCT management costs	8,696	2
Losses in respect of the provision of family practitioner services	0	0
Special payments in respect of he provision of family practitioner services	0	0
Total losses	3,773	4
Total special payments	8,696	2
Total losses and special payments	12,470	6

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

	Total Value of Cases £s	Total Number of Cases
Losses - PCT management costs	49,186	15
Special payments - PCT management costs	0	0
Losses in respect of the provision of family practitioner services	0	0
Special payments in respect of he provision of family practitioner services	0	0
Total losses	49,186	15
Total special payments	0	0
Total losses and special payments	49,186	15

Details of cases individually over £250,000

There is no individual case over £250,000

Note

* included in this category is a penalty of £7,000 for late payment.

39 Third party assets

NHS Kensington and Chelsea has no third party assets.

40 Pooled Budget

Kensington and Chelsea PCT has a pooled budget arrangement with the Royal Borough of Kensington and Chelsea in respect of the commissioning of community equipment. The Royal Borough of Kensington and Chelsea is the host. The memorandum account for the pooled budget is:

The PCT's shares of the income and expenditure handled by the pooled budget in the financial year were:

	2012-13 £000	2011-12 £000
Community Equipment		
Surplus Brought Forward	315	250
Gross Funding		
Royal Kensington and Chelsea	200	443
NHS Kensington and Chelsea	500	468
Total Funding	1015	1161
Expenditure	824	846
Total Expenditure	824	846
Cumulative balance	191	315

41 Cashflows relating to exceptional items

NHS Kensington and Chelsea has no exceptional items during 2012-13

42 Events after the end of the reporting period

The main functions carried out by Kensington and Chelsea PCT in 2012-13 are to be carried out in 2013-14 by the following public sector bodies:

NHS England
NHS West London Clinical Commissioning Group
The Royal Borough of Kensington and Chelsea

Certain Land, Property, Plant & Equipment have transferred to NHS Property Services, NHS Trusts and Community Health Partnership on 31 March 2013. These were considered operational at the year end, and so have not been impaired in the PCT books. It is for the successor body to consider whether, in 2013-14, it is necessary to review these for impairment. The associated Borrowings and Revaluation Reserves have also transferred.

Kensington and Chelsea Primary Care Trust
Governance Statement 2012-2013

1.	**Introduction**

I am assured by the former Chief Executive of for Kensington & Chelsea PCT (5LA) 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 has 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 assured 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 have 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 was in place at Kensington & Chelsea 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.

Robust arrangements were put in place for the preparation and audit of the accounts of the PCT following closedown of North West 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 Director of Finance, the external and internal auditors and myself.

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 has subscribed to these codes which were adopted in April 2011.

From April 2011, the PCT entered into a collaborative arrangement with other PCTs in North West London and underwent significant structural and organisational change.
The "Cluster" of NHS North West London was formed of eight PCTs: Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea and Westminster. 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 Kensington & Chelsea Primary Care Trust (PCT), and Accountable Officer was also the Accountable Officer for the other seven PCTs.

2. **Governance Framework – NHS North West London**

The PCT was part of a group of eight constituent PCTs which made up the NHS North West London Cluster which was the largest group of Primary Care Trusts in London with a population of 1.9 million and a budget of £3.4 billion which represented 24% of health expenditure in London. The 8 PCTs collaborated as: Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea and Westminster.

The governance arrangements from 1st April 2012 to 31st March 2013 changed from the previous year in line with the Department of Health guidance for PCT clustering. With effect from 1 April 2012 the 8 PCTs which comprised NHS North West London Cluster had a membership in common and have met in common, in practice operating as a single NWL Cluster Board. The 8 PCTs continue to retain their statutory accountability for all duties, functions and responsibilities under NHS regulations and take decisions relating to individual PCTs where required by the relevant regulations. These arrangements were ratified at the Boards' meeting in common on 10 April 2012 and incorporated into a set of Standing Orders, Standing Financial Instructions and Scheme of Delegation. There was a single Accountable Officer for the eight PCTs, the Chief Executive Officer Dr Anne Rainsberry, and the Boards' Chairman was Jeff Zitron.

The following is the membership of the Cluster Board together with the attendance record at formal Board meetings:-
Seven Board meetings were held in the financial year 2012/13

Position	Name	Number of Board Meeting attended
Chairman	Jeff Zitron	7/7
Non-Executive Directors	Trish Longdon	5/7
	Elizabeth Rantzen	6/7
	Fergus Cass	7/7
	Sarah Cuthbert	6/7
	Arif Kamal	7/7

	Chandresh Somani	6/7
	Martin Roberts	6/7
Chief Executive	Anne Rainsberry	6/7
Director of Strategy/Chief Officer designate, CWHH CCGs	Daniel Elkeles	6/7
Chief Officer designate BEHH CCGs (from 1 October 2012)	Rob Larkman	2/3
Director of Finance, Hammersmith and Fulham, Hounslow, Kensington and Chelsea and Westminster PCTs (from 1 October 2012)	Clare Parker	3/3
Director of Finance (until 30 September 2012)	David Slegg	4/4
Director of Finance, Brent, Ealing, Harrow and Hillingdon PCTs (from 1 October 2012)	Jonathan Wise	3/3
Director of Commissioning and Performance (until 30 September 2012)	Simon Weldon	3/4
Medical Director	Mark Spencer	5/5

3. **Board Performance**

A survey of Board members was carried out at the end of 2011/12, which included positive feedback on the chairing and administration of the meetings. The main concerns expressed were over the quantity of business in the context of the rapid change underway in the NHS. During 2012/13 the Board kept its business and governance arrangements under constant review in response to these concerns. The Board has supported the implementation of an Interim Operating Model and has increasingly relied on the CCG Committee and its Sub Committees as they have moved towards authorisation.

Training for Board members has been carried out through Board Seminars and executive and non executive away days that are held on a regular basis. At these sessions members were briefed on areas relevant to the work of the PCTs which included interactive workshops for member participation into risk management (including a session on risk appetite), Shaping a Healthier Future and transition to the new NHS.

4. **Governance Framework**

The Cluster Board has established the following committees between the 8 PCTs:-

Joint Audit Committees
Joint Quality and Clinical Risk Committee
Joint Information Governance Committee
Joint Finance and Performance Committee
Joint Remuneration Committee
Joint Clinical Executive Committee
Joint Health and Safety Committee

The Cluster Board also established, in May 2012, a joint committee of the 8 PCTs in North West London with Camden PCT, Richmond PCT and Wandsworth PCT to take decisions on *Shaping a Healthier Future* a programme set up to improve healthcare for the 1.9 million people in North West London.

The PCT established West London CCG Committee

In addition, the Cluster set up working groups and units:-

- Decision Making Group – a group with a common membership which acts for the PCT in accordance with the regulations on GP and practitioner performance management
- Independent Funding Group – decision making body for considering funding for individual patients whose clinicians are recommending forms of treatment that are outside the services commissioned through the Local Operational Plan process
- Delivery Support Unit – leadership of extensive QIPP plan across the eight PCTs
- Patient and Public Advisory Group – eight Local Involvement Network Groups Chairmen with the Chairman of the Group nominated and agreed by the Cluster Board as an official observer with rights to speak and contribute to the Cluster Board part 1 meetings.

Terms of Reference were adopted by the Cluster Board for each of the Committees with a Non Executive Chairman leading the work of each, with the exception of the Information Governance Committee, led by the Head of Corporate Affairs, the Clinical Executive Committee, led by the Medical Director and the CCG Committee led by a GP Chair elected by members. In the light of the handover and transition to the new governance arrangements from April 2013 as determined by the Health and Social Care Act 2012, the Board kept the Committees and their terms of reference under review during the year. From September the Governance Framework was supported by an Interim Operating Model of management designed to deliver in-year objectives and smooth transition to the new arrangements.

5. Committee Functions and Performance

The following is a summary of the Committee functions and performance:

Joint Audit Committee

The Committee was been established in accordance with the guidance in the NHS Audit Handbook. It reviewed the financial management, governance, risk management and internal control in the PCTs and ensured they are adequate and effective.
The Audit Committee met 7 times during 2012/3 and at its initial meeting considered audit planning, priorities, working methods and the internal audit programme for the year. Regular reports were received on the overall financial position, risk management, counter fraud, internal and external audit and transition. The Committee paid particular attention to receiving assurance on the Joint Boards Assurance Framework, transition and handover and closure arrangements. In addition, the Committee received reports on IT, the Integrated Care Pilot and the review of recommendations from the NHS London report into NHS Croydon. At its final meeting the Committee agreed its Annual Report to the Board on its work during the year and reviewed the second draft of the Annual Governance Statement.

Joint Quality and Clinical Risk Committee

The Committee kept under review and required assurance on issues affecting the quality of services commissioned across NHS North West London, including patient safety, clinical effectiveness and patient experience.
The Quality and Clinical Risk Committee met 6 times during 2012/3 and received regular reports on quality (quality exception reports), quality and clinical risk register, serious incidents and never events, revalidation, Organisational Health Intelligence reports, transition and handover and closure. The Committee paid particular attention to receiving assurance on action to improve clinical quality at Imperial College Healthcare NHS Trust and the handover and closure of quality and safety in accordance with the guidance issued by the National Quality Board. In addition, the Committee received reports on looked after children in Brent and Harrow, the "Saville" case and the Mid Staffordshire Inquiry.

Joint Information Governance Committee

The Joint Information Governance Committee was a standing group accountable to the North West London Cluster Executive Team Its purpose was to support and drive the broader Information Governance ("IG") agenda and provide assurance that effective IG best practice mechanisms were in place within the North West London Cluster.
The Information Governance Committee met 8 times during 2012/3 and was reconstituted during the course of the year in response to changing circumstances. Information governance risk was managed by reviewing progress towards IG toolkit submission reinforced by audit. Regular reports were received on policies, the risk register, transition and records management.

Joint Finance and Performance Committee

The Committee undertook performance monitoring and oversight of Cluster-wide non-clinical objectives to ensure that appropriate progress as made across NHS North West London. It ensured that progress was coordinated effectively and coherently between the Cluster (8 PCTs) and the 8 emerging Clinical Commissioning Groups (established as Committees of the relevant PCT) without unnecessary duplication. It supplemented the work of the Joint Audit Committee, which ensured that the statutory and regulatory requirements of the PCT functions were independently reviewed and assured.
The Finance and Performance Committee met 6 times during 2012/3 and received regular reports on progress against finance and performance targets, risk register, transition and handover and closure. It paid particular attention in the early part of the year to emerging CCG Recovery Plans in the context of the Integrated Commissioning Plan.

Joint Remuneration Committee

The Committee kept under review remuneration and terms of service policy in NHS North West London and ensured that there was a consistent and fair approach to its application. The Remuneration Committee met 13 times during 2012/13 either in person or electronically in accordance with its terms of reference. The prime focus of its work was employment and contractual issues relating to the transition to the new NHS with effect from 1 April 2013. The Committee considered a number of business cases for redundancy on grounds of organisational change and referred decisions to NHS London for ratification.

Joint Clinical Executive Committee

The Committee provided strong clinical leadership in developing a clinically robust and sustainable commissioning strategy, supporting the development of clinical commissioning, assuring clinical quality and leading communications with stakeholders.
The Clinical Executive Committee met on a bi-monthly basis throughout the year. Its main focus of work was supporting emerging CCGs through the authorisation process and providing clinical input to the strategy *Shaping a Healthier Future in North West London.* The Committee also paid particular attention to the improvement of clinical care at Imperial College Healthcare NHS Trust and to the London Cancer Programme.

Joint Health & Safety Committee

The Committee kept under review and required assurance on issues affecting the health and safety requirements across NHS North West London Cluster.
The Health and Safety Committee was established during the year and met 6 times during 2012/3. The focus of its work during the year was to assure itself that the PCT met its health and safety responsibilities, taking account of commissioned external reviews. It reviewed fire, health and safety and carbon reduction policies prior to endorsement by the Board. The Committee received regular reports on serious incidents, the risk register, implementation of mandatory training and premises assessment. It also received reports on the handover and closure of estates.

West London Clinical Commissioning Group Committee

The Committee:-

a. undertook the commissioning functions for the practice patients of the members of the Group, and for those resident in the area of the emerging CCG who were not practice patients of any other emerging CCG for services commissioned on a practice patient basis; and commissions services required to be provided on an open access basis for all persons resident in the area of the CCG
b. developed close links with the Borough of Kensington and Chelsea and participates in the development of joint strategic needs assessment for the borough and contributes to the Health and Well being board
c. prepared the members of the Group for the submission of an application to the National Commissioning Board for Authorisation
d. carried out such other functions as are required under the Accountability Agreement for the purpose of developing the competencies of a Clinical Commissioning Group.

The Clinical Commissioning Group met regularly during 2012/3 and its prime focus was complying with national guidance in order to become authorised as a legal entity with effect from 1 April 2013. A substantial part of its work was the development of its constitution and governance arrangements, while at the same time discharging the commissioning responsibilities delegated to it by the Board. It set up its own Sub Committees to match key Cluster Committees in preparation for taking on its own statutory responsibilities with effect from April 2013. The CCG has been authorised with 3 conditions with effect from 1 April 2013. An action was in place for resolution of the conditions

6. **Handover and Closure**

The Board kept its arrangements under review throughout the year to ensure that they continued to address the following hierarchy of priorities in accordance with national guidance:-

1 Business as usual
2 Handover and Closure
3 Establishment of new arrangements

The Board agreed to retain its existing committee structure but implemented an Interim Operating Model which ensured that there were clear accountability arrangements to secure in-year delivery and transition to the new system. The arrangements were formalised with changes to the membership of the Board with effect from 1 October 2012. Handover and closure was led by the Transition Director and supported by a Handover and Closure Operational Group (Star Chamber) comprising the leads of all the transition workstreams. Regular reports on progress on handover and closure were received at the Board, Joint Audit Committee and Quality and Clinical Risk Committee. A Handover and Closure Risk Register was maintained and fed into the Joint Board Assurance Framework (BAF) in the same way as other risk registers.

The Joint Boards BAF was shared with the emerging CCG, so that it could inform the development of the CCG's own risk management arrangements and BAF. The Joint Boards agreed in September that the CCG's Accountable Officer (designate) should review the CCG BAF and risk registers (including scrutiny of the BAF) and agreed that the CCG BAFs and Risk Registers would be reported to the relevant PCT Committee, so that assurance could be provided to the Joint Boards. The Audit Committee followed the development of the CCG BAF and gained assurance that the emerging arrangements were likely to prove adequate and effective.

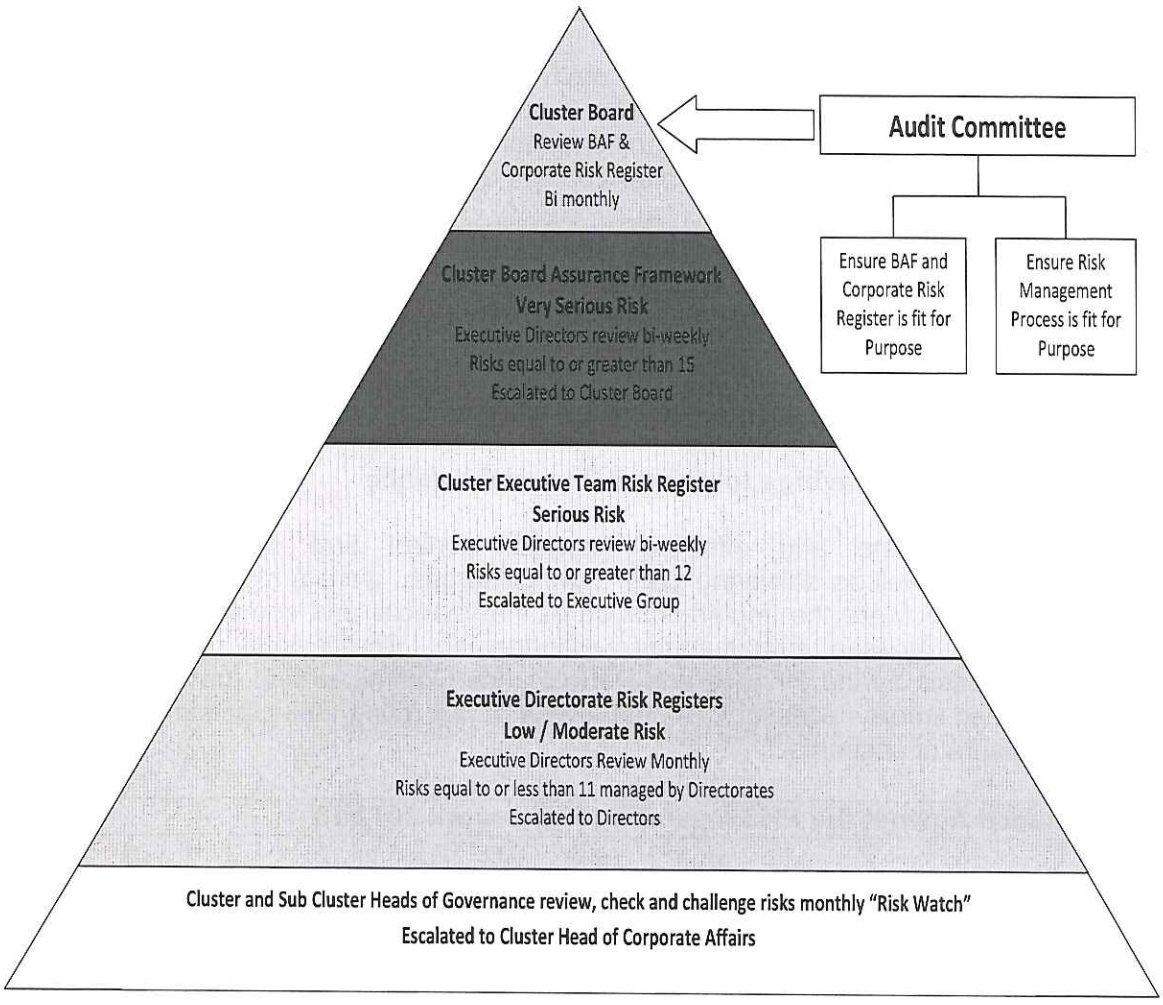
At Joint Boards and Committee level, the risk registers were made available to the CCG so that it could determine its own risk management arrangements.

	The PCT adopted a practice of using handover certificates to formalise the handover of functions to successor bodies. The certificates included provision for the identification of outstanding issues and any risks which could impact on delivery in future if not adequately mitigated. These were designed to act as a trigger for discussion at handover meetings with receivers. This process gave the receiving organisation the information with which to assess risks against its own risk appetite and risk management strategy
7.	**Framework for Financial Closedown**
	In accordance with national guidance, arrangements were put in place for financial closedown. This included:- • preparation and sign off of PCT accounts for 2012/13; • support for the completion of the Department's resource account; • transfer of closing balances to residual organisations; • management of local discharge of balances transferred to the Department; • management of payroll queries and other related payroll issues; and • handover of residual balances managed on behalf of the Department. The PCT Chief Executive and Director of Finance both secured posts in successor bodies but retained responsibility for financial closedown and the Accounts. Staff resources were secured to ensure effective accounts preparation by means of agreement with successor organisations for staff who had secured employment and by means of staff appointments under the Retention and Exit Terms Scheme. In addition, staff resources were identified to transfer to, or be available to, the Legacy Management Office. For scrutiny and audit existing arrangements for both internal and external audit encompassed the work associated with reviewing financial closedown and the completion of final accounts. All Audit Committee members, whether they had role in the new system or not, were asked and agreed to become members of an Audit Sub-Committee of the Department of Health Audit and Risk Committee to support the final accounts process.
8.	**Compliance with Corporate Governance Code**
	The Board of the PCT met in public and published Board Papers, agenda and minutes on their websites. The Board adhered to the "Nolan Principles" setting out the ways in which holders of Public Office behave in the discharge of their duties and as a guiding principle for decision making. The principles adopted by this Board were:- • Selflessness • Integrity • Objectivity • Accountability • Openness • Honesty • Leadership As a central part of the NHS the Board affirmed its commitment to the rights and values set out in the NHS Constitution and the seven key principles that guide the Board in all its actions:- • The NHS provides a comprehensive service available to all; • Access to NHS Services is based on clinical need, not an individual's ability to pay; • The NHS aspires to the highest standards of excellence and professionalism on the provision of high-quality care that is safe, effective and focussed on the patient experience; • NHS services must reflect the needs and preferences of patients, their families and carers; • The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population;

	• The NHS is committed to providing best value for taxpayer's money and the most cost-effective, fair and sustainable use of finite resources; • The NHS is accountable to the public, communities and patients that it serves.
9.	**Discharge of Statutory Functions**
	An integral part of transition was the reconciliation of the statutory functions of the PCT and their destination after the end of March 2013. The PCT used legal advice to establish the definitive list of statutory responsibilities and established a tracker to ensure that each function was transferred appropriately. In doing so, Kensington & Chelsea PCT established that no irregularities had been identified and assured itself that it was legally compliant. In the NHS continuing care doubts were raised about the appropriate interpretation of the legislation in individual cases and the PCT followed the national process to review outstanding cases.
10.	**Risk and Control Framework**
	The following is a summary of the Cluster risk management strategy:- The Cluster Risk Management Strategy, agreed by the Cluster Board in November 2011, was embedded in the normal management processes and structures and encouraged by a responsible culture. The Risk Management Strategy promoted the philosophy of integrated governance and required all risk management to be systematic, robust and evident. It required that risk management processes were applied to business planning at all levels and that risk management issues be communicated to key stakeholders where necessary. The Strategy covered quality, clinical, organisational and financial risk, and identified the key management structures and processes defining objectives and responsibilities within the Cluster. The principles of this Strategy were consistent with the Cluster key priorities – patient safety and staff management. Implementation of the Risk Management Strategy was co-ordinated and monitored by the Cluster Executive Team. The Strategy was supported by the NWL Risk Management Process which clearly described the processes that the Cluster had put into place in order to adequately manage risk. Since April 2012 there was a coherent and consistent approach across all 8 PCTs in the Cluster and in May the Board reviewed its appetite and tolerance for risks. The process ensured that the highest risks appeared on the Board Assurance Framework with a systematic approach to lower risks. The process ensured that where risks were identified, there was a requirement for action to be taken to mitigate the risk. Where risks remained at a high level, they were subject to regular scrutiny by the Board, relevant Committee or the Executive Team, so that they received appropriate management attention. During the course of 2012/13, in response to the exceptional challenges of transition, specific risk registers were maintained for specific risks, for example handover and closure and financial handover and closedown. The discipline of the strategy together with the training of staff ensured that the number of risks arising was kept to a minimum. The Strategy complied with best practice, NHS Litigation Authority and National Patient Safety guidance and the Department of Health requirements.
11.	**Risk Identification and Evaluation**
	The identification of new risks was a standing item on the agenda for the Cluster Board, its committees and key working groups since 2011. This ensured that each forum considered risk at the end of each meeting and was very effective in focusing attention on risk. The Cluster Executive Team work programmes captured all risks and issues within their risk logs (low scores) and dashboards which were then escalated to the appropriate risk register or log if scores reach the relevant threshold. Any risks identified or amended which reached thresholds for the Cluster tiered Risk Registers were passed to the Head of Corporate Affairs and duly considered, rated and assigned to an appropriate risk register and shared at a regular Heads of Governance meeting. They were then referred to the owner of the relevant risk register for additional controls and actions to mitigate the risk.

The 5 x 5 matrix used when rating risks considers the impact of each risk in terms of resulting in: Injury/Safety; Legal or Financial; Performance/Service Interruption; Regulatory; or Adverse Publicity/Reputation. Each risk was then assigned to an appropriate register depending upon the score for its impact multiplied by the score for the likelihood of that occurring. Each rating was presented as a mitigated score based upon consideration of the controls in place. Actions were recommended to reduce the risk rating. The risk matrix included consideration of stakeholders in the assessment of impact of risks identified including among others such as: patients; the public; service users; and the Department of Health. Controls for individual risks were only recorded when they had been verified as making an active difference to reducing or mitigating a risk. They must have been verified as controls at an appropriate forum or by a recognised external/regulatory body. These were continually reviewed by the Head of Corporate Affairs, Head of Clinical Governance or Cluster Executive Team for Corporate or Directors' Risks; or by the designated lead for directorate risk registers with guidance and support from the Head of Corporate Affairs. All risks were triangulated with NHS London.

The following diagram highlights the Cluster process for stratification of risks:



12. **New Risks**

The Cluster operated an integrated Board Assurance Framework and Risk Register (as described above) based on the strategic objectives for the year. The BAF was reviewed at every Board meeting and was updated and revised as new risks were identified and existing

risks are mitigated. The year was challenging in meeting in-year delivery targets, ensuring effective handover and closure and establishing new organisations which were fit for purpose. In addition, the year included formal consultation on *Shaping a Healthier Future,* the strategy to secure improvements in health care across North West London. In that context, the most significant and enduring risks for 2012/13 are described below:-

Delivery of improvements in clinical quality and patient experience

In terms of delivering improvement in clinical quality and patient experience, high risks were associated with Imperial College Healthcare NHS Trust and North West London Hospitals NHS Trust. For Imperial there were risks associated with the sustainable delivery of the 18 week target and an inability to complete robust data validation of cancer pathways, leading to further breaches of waiting standards. For North West London Hospitals the risks related to the achievement of the A & E 4 hour wait standard, poor performance in patient surveys and the level of consultant cover in maternity. The risks in both providers were of poor outcomes and poor patient experience. Trust action plans to address identified issues have been subject to monitoring and review by the Quality and Clinical Risk Committee and Board and financial support provided where appropriate.

Support the development of the new commissioning and provider landscape

A key element of achieving improvements in quality in future was the implementation of the out of hospital strategies with transfer of care from acute to out of hospital settings. The risk of failure to achieve these objectives was identified as high throughout the year, with the potential impact on quality, financial stability and delays to the reconfiguration strategy. Action was coordinated across North West London between CCGs and supported by a strategy development team and a workforce transformation strategy. There was a rigorous assurance plan and detailed implementation plan for 2013/14 agreed by the Board.

On the same objective, there was also been a risk of failure to meet the requirements of information governance frameworks with a resulting unsatisfactory audit and information governance toolkit. Action plans arising from the toolkit assessment were monitored regularly by the Information Governance Committee and additional resources have been allocated to records management and information mapping in support. There was a systematic programme of records management to ensure effective transition to the new organisations.

Delivery of financial savings to achieve financial balance

Maintaining adequate and effective financial control and ensuring strong financial management, as well as delivering QIPP savings targets, were a high risk. Key elements in managing the risk were the implementation of the financial and commissioning strategy with strong controls exercised through contract management. The financial position was monitored on a regular basis by the Finance and Performance Committee and the Board with remedial action identified where necessary. A final review of risk rating took place in month 9 as part of the draft closure of accounts.

13.	**Performance Against the NHS Operating Framework 2012/13**

Kensington and Chelsea PCT has a statutory duty to report on the performance of key services against the national operating framework indicators for 2012/13.

In 2012/13 Kensington and Chelsea PCT met the following national indicators:

- The number of hospital and community acquired infections for clostridium difficile remained low and within national standards.

- Ambulance response times: category A response within 8 minutes
- Ambulance response times: category A response within 19 minutes
- 18 weeks referral to treatment: admitted performance within 18 weeks*
- 18 weeks referral to treatment: non-admitted performance within 18 weeks*
- 18 weeks referral to treatment: incomplete pathways performance within 18 weeks*
- Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer is not initially suspected**
- Cancer two week wait – percentage seen within two weeks of an urgent GP referral for suspected cancer.
- Cancer 62 day wait percentage treated in 62 days from urgent GP referral for suspected cancer*

Kensington and Chelsea PCT did not fully meet the following indicators:

- Methicillin-resistant *Staphylococcus aureus* bacteraemia: 3 cases against a tolerance of 2 cases

The new NHS organisations established in April 2013, including West London CCG will have responsibility for improving those areas where performance is poor.

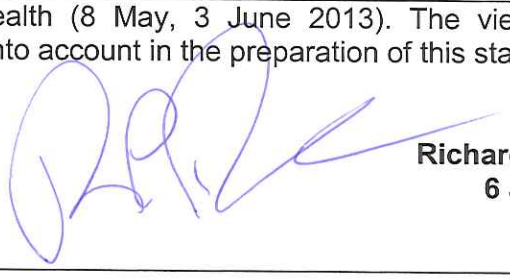
*Following a review of the management of waiting lists by the NHS IST, Imperial College Healthcare NHS Trust did not submit performance data to the DoH on 18 weeks RTT for April and May 2012. This is therefore excluded from the YTD 18 weeks performance positions.

**Chelsea & Westminster Hospital NHS Foundation Trust had an issue with submitting cancer data for M12, therefore performance has not been reported for these indicators and will be excluded from the overall CCG positions.

14	**Lapses of Data Security**
	There were no lapses of data security identified and none reported to the Information Commissioner.
15	**Effectiveness of Risk Management and Internal Control**
	The key Board Committees regularly received and discussed their respective risk registers. The Audit Committee sought assurance that the BAF appropriately reflected the level of risk and incorporated mitigating action. Independent assurance on the effectiveness of risk management and internal control was provided through Internal Audit reviews of risk management, statutory duties and responsibilities and Cluster governance arrangements. The outcome of each of the audits was a green rating with a total of two low priority recommendations for which actions have been agreed. In summary, the Board could take substantial assurance that the controls upon which the organisation relied to manage these risk/areas were suitably designed, consistently applied and effective. A further audit on handover and closure was designed to provide independent assurance that the implementation of the process is effective. These specific audits were accompanied by a wider internal audit programme encompassing (amongst others) the following areas:- • Business continuity • Payroll and payroll feeder systems

	• Procurement • Clinical Commissioning Groups • QIPP • Continuing care • Performance Management • Information and Clinical Governance • Acute and non-acute commissioning and contract management • Transfers of estates and public health • Financial matters e.g. creditors, general ledger, financial management, accounts receivable, cash and treasury The details of the areas covered may relate discretely to different functions and give different levels of assurance. The Board maintained an active programme of fraud prevention in accordance with the core activities required by NHS Protect. The PCT was compliant with the Secretary of State's Directions.
16	**Significant Issues**
	An internal audit report on Continuing Care was undertaken during 2012/13 and was able to provide only partial assurance regarding the controls in place. This particularly related to issues in the tri-borough area of Westminster, Kensington & Chelsea and Hammersmith & Fulham. In response to that report, local action plans were put in place both at a borough level and across the tri-borough CCGs to ensure that the issues identified in the audit report relating to 2012/13 were addressed. As part of the contracting round for 2013-14 contracts and individual patient agreements were put in place for all continuing healthcare placements. Following the implementation of a Service Improvement Plan with Central London Community Healthcare Trust, reporting from the community provider on assessments improved considerably and consequently the commissioners received accurate up to date data on both the nature of the placements and expected expenditure. The Continuing Care Commissioning team met monthly with the Central London Community Healthcare Assessment Service to monitor their performance. One data base was established used across the Tri-Borough continuing care team to capture and oversee the outputs of the service.
17	**Head of Internal Audit Opinion**
	The purpose of the Head of Internal Audit Opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control. The opinion is as follows:- *"Based on the work undertaken in 2012/13,* ***significant assurance*** *can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, we have noted one area of weakness. Whilst we have not issued any RED rated reports we were only able to provide some (partial) assurance over* ***Continuing Care.*** *In particular we identified a backlog of assessments of patients having been undertaken which could have an impact both on quality of care and have financial implications. An agreed action plan is in place at borough level to be owned by the Clinical Commissioning Group moving forwards."*
18	**Conclusion**
	This statement was discussed at the Audit Committee (19 January, 5 March 2013) and; at the Cluster Board meeting (19 March 2013). It was also discussed at the sub-committee of the

Audit Committee of the Department of Health (8 May, 3 June 2013). The views of the Committee and the Board have been taken into account in the preparation of this statement:



Richard Douglas
6 June 2013