Department of Health

NHS

Kingston Primary Care Trust

2012-13 Annual Report and Accounts

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Kingston Primary Care Trust

2012-13 Annual Report

NHS

South West London

NHS Kingston
Annual Report 2012/13

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1. Welcome

Welcome to NHS Kingston's Annual Report. This is a look back at the year ended 31 March 2013. There have been significant changes this year in both structure and personnel. We would like to acknowledge and thank those who have led NHS Kingston's excellent work in 2012-13 and to celebrate their work since NHS Kingston was established in 2002.

Nationally this has been a very exciting year. The UK hosted the 2012 Olympics and celebrations were held for Her Majesty The Queen's Jubilee. During this period of increased activity for the NHS, NHS South West London had a very important role to play in ensuring the smooth running of health services locally. This required a great deal of planning and hard work and we are pleased to report the tremendous success of all of our preparations for this period.

As noted in last year's report, the purpose of establishing the South West London cluster of five neighbouring PCTs in 2010-11 was to develop much leaner management and support structures in order to plan and commission health services in a way that procured services more effectively and efficiently for local residents. The cluster organisation was always intended to be a temporary body that worked to ensure a smooth transition as the NHS nationally moves towards the new NHS structures envisioned in the Health and Social Care Act 2012. We would like to thank the PCT Boards, who have enabled NHS South West London to maintain a local borough perspective, as well as South West London wide, through their membership of the Joint Boards.

This year has seen the formal handover from PCTs to the new commissioning bodies, clinical commissioning groups (CCGs). The CCGs will take on most commissioning functions from PCTs and manage the majority of the NHS budget. This means that GPs will be leading the planning and organising of local health services. We are pleased to report that Kingston CCG became a fully authorised clinical commissioning group in December 2012.

Over the past 11 years, NHS Kingston has seen countless successes; you will read about those for 2012/13 in this report. These successes are a testament to the hard work and dedication of our team of staff. They worked with local people, communities and partner organisations to safeguard the health and wellbeing of Kingston's population and ensure our residents have access to the highest quality service possible despite uncertainty about their own futures. We believe this hard work and well established partnership has left Kingston CCG well placed to deliver its vision for local health services. We would like to express our thanks and appreciation to all staff for their commitment through times of change and wish them every success in the future.

Section 2

Welcome from Kingston Borough Team

2. Introduction from CCG Chair, Vice Chair and CCG Lead

It has been a productive year for the NHS in Kingston, in particular marked by our progress to establish a CCG for the borough. The CCG has continued to operate in shadow form with delegated budget responsibility for hospital, community and mental health services. In December 2012 we were in the first wave of authorisations, and the NHS Commissioning Board announced that we were one of just eight CCGs in the country to have met the 119 authorisation criteria with no conditions. From that date Kingston CCG became a statutory body within the NHS, and from 1 April 2013 we will take on the full range of CCG responsibilities.

Other milestones throughout the year have included the successful commissioning of a joint community wellbeing service with Kingston Council. Psychological therapies and substance misuse services will now be delivered together at locations across the borough via a single assessment point, making access easier for patients and ensuring that treatment for patients is coordinated.

The Kingston at Home project is progressing well, and we are continuing to work with Your Healthcare, Kingston Council and Age Concern Kingston, to provide more support for people in their own homes.

This year saw the culmination of the Surbiton Hospital site redevelopment, representing a huge achievement for staff and the local community despite the challenging economic climate. The new Surbiton Health Centre opened on 4 March 2013, offering services from four GP practices, community services, pharmacy, diagnostics and psychological therapies, among others. The state of the art facility benefits from the latest technology and its sustainable design will ensure it remains an asset to the local population for generations to come. We're also delighted to have successfully bid for a heritage lottery grant, along with Kingston Council and Hillcroft College.

A significant development over the last year has been our progress in embedding patient engagement in the work of the CCG. We have been meeting with patient groups, community groups and other organisations to gather views on our engagement strategy. This has led to the development of a quarterly patient forum. Two have taken place this year and have proved an excellent vehicle to gather views on our commissioning plans and on health services in general. The forums in themselves are not the only route we will use to gather feedback – we have also committed to carry out targeted engagement around all service redesign, also working with the newly appointed Healthwatch. This is work in progress and we are very open to further suggestions.

Our thanks to our health and social care partners - in particular Kingston Hospital NHS Trust, Kingston Council, Your Healthcare, and South West London and St George's Mental Health Trust – and to the local voluntary sector who we have worked with closely over the last year. Thank you also to our staff who have remained dedicated to the task in hand despite a difficult period of transition in the NHS. And thank you to the patients who have given time to share views on local health services.

As a CCG we will ensure that we make best use of our clinical knowledge, our relationship with patients and our managerial role to make the right decisions for local health services. We look forward to working with you all to achieve this goal.

Dr Naz Jivani	Prof. David Knowles	David Smith
Chair	Vice Chair	Chief Officer
Kingston CCG	Kingston CCG	Kingston CCG

3. Who we are and what we do

NHS Kingston was formed in 2001 to commission services and programmes to help improve the health of Kingston residents.

In April 2011 we became part of the NHS South West London Cluster of Primary Care Trusts (PCTs), in the move towards GP commissioning. These changes stem from the Government's new Health and Social Care Act which set out a new vision for the health service in England.

Clinical Commissioning Groups are taking on the commissioning of hospital, community and mental health services from PCTs, which will cease to exist from April 2013.

At the same time a new National Commissioning Board will hold commissioning groups to account and will also commission primary care practitioner services; for example, GPs, pharmacists, dentists and optometrists.

Public health services are transferring to the local authority in April 2013 as a result of the changes. In Kingston we are well underway to make this transition, with staff already located in the council's Guildhall buildings.

Alongside these changes, a health and wellbeing board is being established in every local authority to support joint working on health and wellbeing between NHS commissioners and local authorities. Kingston has been at the forefront of this development, with a Health and Wellbeing Board in place since November 2010 (see page 36).

The Kingston GP Pathfinder was in the first wave of pathfinders announced by the Government in December 2010. We were then one of the first to be given the green light for authorisation following an announcement by the NHS Commissioning Board in December 2012 – one of only eight in the country in the first wave of authorisations to be authorised without conditions - meaning that the CCG had met all of the 119 rigorous assessment criteria.

Until April, formal sign-off of decisions continues to take place at the South West London Joint Board of PCTs. Although greatly reduced in size, NHS Kingston remains as a statutory body until April 2013, having supported the development of the new clinical commissioning group to take over after that date.

3.1. About our borough

The Royal Borough of Kingston is situated in the South West of London and is bordered by Richmond to the west; Wandsworth to the north; Merton to the north-east, Sutton to the south-east and Surrey to the South. The borough covers an area of 38.66 square kilometres, which makes it the seventh smallest out of the London boroughs in terms of its geographical area.

Population

The population of Kingston is estimated to be between 158,851 (Greater London Authority – GLA) and 160,100 (Office for National Statistics – ONS) and has risen approximately by 7.4% between 2001 and 2011. The GP registered population was 190,072 on 31st March 2012.

Demographics

Since 2001, the population of Kingston has become more ethnically diverse with the proportion of BME groups rising from 15.5% to 26.6% in 2011. The main BME groups in the borough are Indian/British Indian (4%), Sri Lankan (2.5%), African (2.3%) and Korean (2.2%). The Korean population in New Malden is estimated to be the largest in Europe. The Spring 2011 School Census, indicated that 671 Tamil children and 642 Korean children were attending Kingston schools.

Life expectancy

On average, people in Kingston have a longer life expectancy than found in England or in London. The average man in Kingston can expect to live to 81.3 years while the average life expectancy for an English man is 78.6, and the average life expectancy for men living in London is 79.0. Similarly, the average woman in Kingston can expect to live to 84.1 years. This is longer than the average life expectancy for English women (82.6 years), and longer than the life expectancy of women living in London (83.3 years).

Births

Births in the borough have risen by 29.4% from 2001 to 2010 (1,787 to 2,312). Recent population projections, however, indicate that the large increase in the number of children aged 0-4 that was evident in previous years is not likely to continue.

Teenage pregnancies

There are on average 68 teenage pregnancies in 15–17 year olds in Kingston each year (approximately 27.5 per 1000).

Deprivation levels

- The Indices of Deprivation ranks Kingston upon Thames as the third least deprived local authority in London (only the City of London and Richmond are ranked higher).
- The average house price in Kingston in October- December 2012 was £383,852 compared to the average house price of £227,478 in England and Wales, in February 2013.
- In 2010, Kingston had the second lowest percentage of children living in poverty in London (16%) and this figure had declined by 2% since 2008. The percentage of children living in households with low income and material deprivation during 2008/09-2010/11 was 15% in London (21% in Inner London and 12% in Outer London), 16% in England and 14% in UK.
- Attainment levels in Kingston schools are high, with average results for the authority well above average for England.
- Kingston had one of the lowest levels of recorded crime in London during in 2010/11 to 2011/12.
- By the end of 2011, the average unemployment rate was 9% in London and 8% in Kingston and in the rest of the country.

3.2. How we spent your money

FINANCIAL INFORMATION – NHS KINGSTON

Financial summary

These pages serve as a summary of the annual accounts for NHS Kingston including the controls assurance and auditors statements. The PCT's performance against the key financial performance indicators is summarised below:

- **Income and expenditure target**

  The PCT has a statutory duty to break even on income and expenditure. In 2012/13 the PCT was however required to make a 1.5% surplus of £3,958k which was achieved against a revenue resource limit of £287.630m.

- **Capital resource limit**

  The PCT had a capital resource limit of £14,325k for 2012/13. The limit was underspent by £4,628k primarily due to the disposal of properties during the year which were not incorporated in the initial plan.

- **Cash target**

  The cash limit for the PCT was £286,473k and this was achieved with an underspend of £1,955k.

Developments in 2012/13

- **Healthcare investments**

  The PCT has continued to invest in key areas to improve services and the long term health of the population.

Better Payment Practice Code

The NHS Executive requires that all trusts pay their creditors in accordance with the Confederation of British Industries (CBI) prompt payment code and government accounting rules; that is to pay their creditors within 30 days of receipt of invoice. The PCT's performance against this target is provided within this report and action is being taken to improve performance in this area. We were not subject to any actions or interest charges from suppliers during the year due to late payments.

Value for money

The PCT's financial strategy is concerned with using the PCT's resources wisely, promoting value for money and has measures in place to promote economy, efficiency and effectiveness in using resources for the exercise of its functions:

- the PCT has focused on developing robust financial information and financial controls to ensure that best use is made of available resources. This has facilitated delivery of financial targets.

- additionally the PCT's commissioning, QIPP and provision decisions are becoming increasingly informed by 'value for money' or 'best value' considerations using 'health outcomes' and 'programme budgeting' comparisons.

External auditors

The trusts accounts are externally audited by Grant Thornton to provide assurance to the PCT stakeholders. An opinion is given as to whether the accounts represent a true and fair view, ensure that governance arrangements are adequate and that adequate arrangements are in place to provide economy, efficiency and effectiveness in use of resources.

The full auditors' opinion regarding the trust accounts is included in this annual report and concludes that the financial statements provide a true and fair view of the Trust's position.

The total fees paid to the external auditors, Grant Thornton, during 2012/13 was £84k.

Summary financial statements

The statements below are a summary of the information in the PCT's annual accounts, which are available on demand from the Director of Finance, NHS South West London, 120, The Broadway, Wimbledon, London SW19 1RH and on the NHS SWL website at www.southwestlondon.nhs.uk

Carl Vincent
Director of Provider Finance & Transition
Department of Health

4 June 2013

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF KINGSTON PRIMARY CARE TRUST

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

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

Respective responsibilities of directors and auditor

The Signing Officer is responsible for preparing the Annual Report.

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

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

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

Opinion

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

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

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	**3,719**	3,515
Other costs	5.1	**289,250**	279,385
Income	4	**(8,892)**	(6,516)
Net operating costs before interest		**284,077**	276,384
Investment income	9	**0**	0
Other (Gains)/Losses	10	**(965)**	(866)
Finance costs	11	**560**	0
Net operating costs for the financial year		**283,672**	275,518
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		**283,672**	**275,518**
Of which:			
Administration Costs			
Gross employee benefits	7.1	**2,928**	3,515
Other costs	5.1	**7,087**	5,739
Income	4	**(2,040)**	(1,003)
Net administration costs before interest		**7,975**	**8,251**
Investment income	9	**0**	0
Other (Gains)/Losses	10	**(965)**	(866)
Finance costs	11	**116**	0
Net administration costs for the financial year		**7,126**	**7,385**
Programme Expenditure			
Gross employee benefits	7.1	**791**	0
Other costs	5.1	**282,163**	273,646
Income	4	**(6,852)**	(5,513)
Net programme expenditure before interest		**276,102**	**268,133**
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**444**	0
Net programme expenditure for the financial year		**276,546**	**268,133**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**1,000**	1,903
Net (gain) on revaluation of property, plant & equipment	**(662)**	(2,441)
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*	**284,010**	**274,980**

Summary financial statements – Table 2

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	**33,437**	26,974
Intangible assets	13	**631**	910
investment property	15	**0**	0
Other financial assets	21	**0**	0
Trade and other receivables	19	**0**	0
Total non-current assets		**34,068**	27,884
Current assets:			
Inventories	18	**0**	0
Trade and other receivables	19	**2,887**	1,430
Other financial assets	21	**0**	0
Other current assets	22	**0**	0
Cash and cash equivalents	23	**2,847**	13
Total current assets		**5,734**	1,443
Non-current assets held for sale	24	**1,150**	1,600
Total current assets		**6,884**	3,043
Total assets		**40,952**	30,927
Current liabilities			
Trade and other payables	25	**(20,020)**	(21,356)
Other liabilities	26	**0**	0
Provisions	32	**(999)**	(632)
Borrowings	27	**(8)**	0
Other financial liabilities	28	**0**	0
Total current liabilities		**(21,027)**	(21,988)
Non-current assets plus/less net current assets/liabilities		**19,925**	8,939
Non-current liabilities			
Trade and other payables	25	0	0
Other Liabilities	28	0	0
Provisions	32	(2,825)	(519)
Borrowings	27	(8,172)	0
Other financial liabilities	28	0	0
Total non-current liabilities		**(10,997)**	(519)
Total Assets Employed:		**8,928**	8,420
Financed by taxpayers' equity:			
General fund		1,532	(922)
Revaluation reserve		7,396	9,342
Other reserves		0	0
Total taxpayers' equity:		**8,928**	8,420

Summary financial statements – Table 3

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	**(922)**	**9,342**	**0**	**8,420**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(283,672)			**(283,672)**
Net gain on revaluation of property, plant, equipment		662		**662**
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		(1,000)		**(1,000)**
Movements in other reserves			0	**0**
Transfers between reserves	1,608	(1,608)		**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	**(282,064)**	**(1,946)**	**0**	**(284,010)**
Net Parliamentary funding	284,518			**284,518**
Balance at 31 March 2013	**1,532**	**7,396**	**0**	**8,928**
Balance at 1 April 2011	**7412**	**8804**	**0**	**16,216**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(275,518)			(275,518)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment		2,441		2,441
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		(1,903)		(1,903)
Movements in other reserves			0	0
Transfers between reserves	0	0		0
Release of Reserves to Statement of Comprehensive Net Expenditure		0		0
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	(275,518)	538	0	(274,980)
Net Parliamentary funding	267,184			267,184
Balance at 31 March 2012	**(922)**	**9,342**	**0**	**8,420**

Summary financial statements – Table 4

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		**(284,077)**	(276,384)
Depreciation and Amortisation		**1,894**	1,834
Impairments and Reversals		**1,731**	3,582
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		**(116)**	0
Release of PFI/deferred credit		**0**	0
(Increase)/Decrease in Inventories		**0**	0
(Increase)/Decrease in Trade and Other Receivables		**(1,457)**	2,098
(Increase)/Decrease in Other Current Assets		**0**	0
Increase/(Decrease) in Trade and Other Payables		**(318)**	1,895
(Increase)/Decrease in Other Current Liabilities		**0**	0
Provisions Utilised		**(143)**	(278)
Increase/(Decrease) in Provisions		**2,372**	447
Net Cash Inflow/(Outflow) from Operating Activities		**(280,114)**	**(266,806)**
Cash flows from investing activities			
Interest Received		**0**	0
(Payments) for Property, Plant and Equipment		**(6,429)**	(3,162)
(Payments) for Intangible Assets		**0**	(117)
(Payments) for Other Financial Assets		**0**	0
(Payments) for Financial Assets (LIFT)		**0**	0
Proceeds of disposal of assets held for sale (PPE)		**4,915**	2,900
Proceeds of disposal of assets held for sale (Intangible)		**0**	0
Proceeds from Disposal of Other Financial Assets		**0**	4
Proceeds from the disposal of Financial Assets (LIFT)		**0**	0
Loans Made in Respect of LIFT		**0**	0
Loans Repaid in Respect of LIFT		**0**	0
Rental Revenue		**0**	0
Net Cash Inflow/(Outflow) from Investing Activities		**(1,514)**	**(375)**
Net cash inflow/(outflow) before financing		**(281,628)**	**(267,181)**
Cash flows from financing activities			
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**(56)**	0
Net Parliamentary Funding		**284,518**	267,184
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		**284,462**	**267,184**
Net increase/(decrease) in cash and cash equivalents		**2,834**	**3**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**13**	**10**
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		**2,847**	**13**

Audit Committee

In line with the arrangements developed in 2011/12, a Joint Audit Committee has provided the PCT statutory boards with an independent and objective review on their financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS.

The Director of Finance of the PCT, the head of the PCT's counter fraud team, representatives of the PCT's internal audit function (RSM Tenon and Parkhill) and representatives of the external auditors (Grant Thornton) also attend the audit committee.

Staff sickness absence

The PCT reported the following information on lost days through staff absence in 2012-13

	2012-13 Number	2011-12 Number
Total days lost	416	208
Total staff years	54	56
Average working days lost	7.70	3.72

Remuneration Committee

The remuneration committee comprises one non-executive director from each PCT in the cluster, from whom a chair is appointed; the chief executive also attends in an advisory capacity.

The committee meets as frequently as is necessary to advise the board on the appropriate remuneration and terms of service for the chief executive, directors or any other senior manager remunerated under the Very Senior Manager Pay Framework and the Professional Executive Committee.

Remuneration Policy

The committee's deliberations are carried out within the context of national pay and remuneration guidelines, local comparability and taking account of independent advice regarding pay structures.

The main components of the chief executive's, executive directors' and senior officers' remuneration are set out below.

Basic Salary

The remuneration of the PCT's chief executive and directors is set annually by the Very Senior Managers Pay Framework. The Framework is available to the general public on the Department of Health website and was last updated in July 2007.

The reward package set by the Very Senior Management Pay Framework is as follows:

- Basic pay is a spot rate for the post, determined by the role and an organisation specific weighing factor. This is uplifted annually;
- Additional payments are made where such payments are appropriate and within the limits described in the frameworks; and
- An annual performance bonus scheme, the details of which are set out below.

Incentive arrangements

Since 2008/09 the PCT has operated a performance related pay scheme for very senior managers' contracts ('VSM').

As part of the VSM pay arrangements the chief executive and directors are eligible to be considered for a performance related bonus scheme.

The award payable to individual staff will be determined by the performance category within which they are placed. It is an essential criterion of the performance bonus scheme that the PCT achieves its financial control target and other key national targets as agreed with NHS London.

The number of awards in the PCT is decided by the remuneration committee, but is subject to affordability and that aggregate bonus payments must not exceed an absolute ceiling of 5% of the pay bill of very senior management.

Performance bonus payments are not pensionable. VSMs that have been in post for the majority of the reporting period will be eligible for a full year performance bonus.

Level of awards

Performance bonus awards will be payable once approved by NHS London.

The metric in which the achievement of performance related pay objectives are measured are all within one financial year and therefore the PCT does not operate a long term incentive scheme.

The overall performance of non executive directors and the chief executive is appraised by the chair. This appraisal is reviewed by the directors of NHS London. The performance of PCT executive directors is appraised by the chief executive and the performance of the PCT chair is managed by the chair of NHS London.

NHS pension entitlement

All staff including senior managers are eligible to join the NHS pension scheme. The scheme has fixed the employer's contribution at 14% (2011/12: 14%) of the individual's salary as per the NHS Pension Agency regulations.

The Independent Public Services Pensions Commission, chaired by Lord Hutton, concluded that there was a rationale for increasing pension scheme member contributions to ensure a fairer distribution of costs between taxpayers and members. From 1 April 2012 seven tiers for contributions were introduced, based on previous year's (2011/12) earnings. These tiers are:

Tier	Annual pensionable pay (full time equivalent) - 2011/12	Contribution rate 2012/13
1	Up to £15,001	5%
2	£15,001 - £21,175	5%
3	£21,176 - £26,557	6.5%
4	£26,558 - £48,982	8.0%
5	£48,983 - £69,931	8.9%
6	£69,932 - £110,273	9.9%
7	£110,274 and over	10.9%

Different tiers were in place in 2011/12; thus it is difficult to make direct comparisons between the two years.

Scheme benefits are set by the NHS Pensions Agency and are applicable to all members.

Service Contracts

Each of the executive directors and senior managers listed below have or had substantive contracts, which can be terminated by either party by giving between 3 to 6 months written notice. The PCT can request that the senior manager either works his or her notice or be paid an amount in lieu of notice.

- The executive directors' service contracts became effective on the following dates:

Executive Director	Role	Contract Date	Leave date
Ann Radmore	Chief Executive	28/02/2011	06/01/2013
Christina Craig	Interim Chief Executive	07/01/2013	31/03/2013
Jill Robinson	Director of Finance	28/02/2011	31/03/2013
Dr Jonathan Hildebrand	Director of Public Health		31/03/2013
Dr Naz Jivani	Chair of the Professional Executive Committee		31/03/2013
Debbie Stubberfield	Director of Nursing	01/02/2012	31/03/2013

- Senior Managers' service contracts became effective on the following dates:

Senior Manager	Role	Contract Date	Leave Date
David Smith	Director of Health and Adult Services	28/02/2011	31/03/2013
Dr David Finch	Joint Medical Director	10/03/2011	31/03/2013
Dr Howard Freeman	Joint Medical Director	01/04/2011	31/03/2013
Charlotte Gawne	Director of Communications	28/02/2011	31/03/2013
Jacqui Harvey	Director of Transition	01/04/2011	31/03/2013
Jocelyn Fisher	Director of Human Resources, Organisational Development and Workforce	01/04/2011	31/03/2013
Paula Swann	Director of Financial Management	28/02/2011	31/05/2012
Hardev Virdee	Director of Strategic Financial Planning	02/01/2012	30/06/2012
Neil Roberts	Director of Primary Care Contracting	28/02/2011	31/03/2013

None of the service contracts for directors or senior managers make any provision for compensation outside of the national pay and remuneration guidelines or NHS Pension Scheme regulations.

Termination Arrangements

Termination arrangements are applied in accordance with statutory regulations as modified by national NHS conditions of service agreements (specified in Whitley Council/Agenda for Change), and the NHS pension scheme. Specific termination arrangements will vary according to age, length of service and salary levels. The remuneration committee will agree any severance arrangements. Her Majesty's Treasury approval will be sought where appropriate.

Non executive directors

Non executive directors do not have service contracts. They are appointed by the Appointments Commission for a set period, which may be extended.

Non executive directors are paid a fee set nationally. Travel and subsistence fees where incurred in respect of official business are payable in accordance with nationally set rates. non executive directors are also able to reclaim expenses related to all necessary carer expenses incurred as a result of their work.

Non executive directors do not receive pensionable remuneration and therefore are not eligible to join the NHS Pensions Scheme.

The non executive appointments became effective on the following dates:

Non Executive Director	Role	Contract Date	Leave date
Sian Bates	Chair	01/04/2011	31/03/2013
Paul Gallagher	Audit Committee Chair	01/04/2011	31/03/2013
David Knowles	Non Executive Director	01/04/2011	31/03/2013
Vidya Verma	Non Executive Director	01/04/2011	31/03/2013
John Simpson	Partner Non Executive Director	01/04/2011	31/03/2013
Charles Humphry	Partner Non Executive Director	01/04/2011	31/03/2013

Expenses and benefits in kind – unaudited

Benefits in kind relate to travel allowances payable in accordance with agenda for change NHS terms & conditions and reimbursement for telephone expenses.
All expense claims are approved by either the chair or the chief executive.

Kingston Primary Care Trust

Disclosure of off-payroll engagements 2012/13

As part of the *Review of Tax Arrangements of Public Sector Appointees* published by the Chief Secretary to the Treasury on 23 May 2012, all government departments and their arm's length bodies were required to published information in relation to the number of off payroll engagements – at a cost of over £58,200 per annum – that were in place on 31 January 2012.

Table 1 below provides details of off-payroll engagements at a cost of over £58,200 per annum that were in place as of 31 January 2012 and any changes affecting these engagements between 31 January 2012 and 31 March 2013.

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

to their tax obligations	
No that have come to an end	N/A
Total	N/A

In view of the fact that the Primary Care Trust was due to be dissolved on 31 March 2013, it was felt that there was little benefit in re-negotiating remaining contracts that were due to come to an end on or before this date.

Table 2 below provides details of all new off-payroll engagements between 23 August 2012 and 31 March 2013, for more than £220 per day and more than 6 months.

No. of new engagements	0
Of which:	
No. of new engagements which include contractual clauses giving the department the right to request assurance in relation to income tax and National Insurance obligations	N/A
Of which:	
No. for whom assurance has been accepted and received	N/A
No. for whom assurance has been accepted and not received	N/A
No. that have been terminated as a result of assurance not being received	N/A
Total	N/A

Directors' and Senior Managers' salaries and allowances							
	2012/13			2011/12			
NAME AND TITLE	Note	Salary (bands of £5,000)	Other remuneration (bands of £5,000)	Benefits in kind (to the nearest £100)	Salary (bands of £5,000)	Other remuneration (bands of £5,000)	Benefits in kind (to the nearest £100)
		£000	£000	£	£000	£000	£
Chair and Non Executive							
Sian Bates (Chair - from 01/04/11)	1	-	5-10	-	-	5-10	-
Paul Gallagher (Audit Committee Chair)	2	-	0-5	-	-	0-5	-
David Knowles (Non Executive)		-	10-15	-	-	10-15	-
Vidya Verma (Non Executive)		-	5-10	-	-	5-10	-
John Simpson (Partner Non Executive)	3	-	-	-	-	-	-
Charles Humphry (Partner Non Executive)	3	-	-	-	-	-	-
Executive Directors							
Ann Radmore (Chief Executive - to 06/01/13)	4	10-15	-	-	15-20	-	-
Christina Craig (Interim Chief Executive - from 07/01/13)	5	0-5	-	-	-	-	-
Jill Robinson (Director of Finance)	6	15-20	-	-	10-15	-	-
Dr Jonathan Hildebrand (Director of Public Health)		50-55	-	-	50-55	-	-
Dr Naz Jivani (Chair of the Professional Executive Committee)		60-65	-	-	25-30	-	-
Sarah Timms (Director of Nursing - from 29/06/11 to 15/12/11)		N/A	-	-	0-5	-	-
Debbie Stubberfield (Director of Nursing)	7	10-15	-	-	0-5	-	-
Senior Managers							
David Smith (Director of Health and Adult Services)	8	70-75	-	-	65-70	-	-
Bill Gillespie (Director of Strategy and Performance - to 19/02/12)		N/A	-	-	15-20	-	-
Dominic Conlin (Managing Director ACU - to 31/12/11)		N/A	-	-	10-15	-	-
Dr David Finch (Joint Medical Director)	9	5-10	-	-	5-10	-	-
Dr Howard Freeman (Joint Medical Director)	10	5-10	-	-	5-10	-	-
Charlotte Gawne (Director of Communications)	11	10-15	-	-	10-15	-	-
Jacqui Harvey (Director of Transition)	12	20-25	-	-	15-20	-	-
Jocelyn Fisher (Director of Human Resources, OD and Workforce)	13	10-15	-	-	20-25	-	-
Paula Swann (Director of Financial Management - to 31/05/12)	14	0-5	-	-	5-10	-	-
Neil Ferrelly (Director of Strategic Financial Planning - to 14/08/11)		N/A	-	-	0-5	-	-
Hardev Virdee (Director of Strategic Financial Planning - from 02/01/12 to 30/06/12)	15	0-5	-	-	0-5	-	-
Neil Roberts (Director of Primary Care Contracting)	16	10-15	-	-	10-15	-	-

Notes	
1.	Sian Bates was also Chair of Croydon, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. The full value of her salary and allowances was in the range £40,000 - £45,000. Her remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
2.	Paul Gallagher was also Audit Committee Chair of Croydon, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. The full value of his salary and allowances was in the range £10,000 - £15,000. His remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
3.	John Simpson and Charles Humphry were also non-executive directors of Richmond & Twickenham PCT. Their remuneration is shown in the Annual Report of Richmond & Twickenham PCT.
4.	Ann Radmore was also Chief Executive of Croydon, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. She was appointed Chief Executive of London Ambulance Service NHS Trust with effect from 7 January 2013, but remained Accountable Officer for all five PCTs. The full value of her salary and allowances was in the range £120,000 - £125,000. Her remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
5.	Christina Craig was also Interim Chief Executive of Croydon, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. The full value of her salary and allowances was in the range £25,000 - £30,000. Her remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
6.	Jill Robinson was also Director of Finance of Croydon, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. The full value of her salary and allowances was in the range £125,000 - £130,000. Her remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
7.	Debbie Stubberfield was also Director of Nursing of Croydon, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. The full value of her salary and allowances was in the range £95,000 - £100,000. Her remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
8.	50 % of David Smith's salary costs were recharged to the Royal Borough of Kingston in 2012/13. The figures shown here only cover the salary and allowances charged to the PCT.
9.	Dr David Finch was also the Joint Medical Director of Croydon, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. The full value of his salary and allowances was in the range £65,000 - £70,000. His remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
10.	Dr Howard Freeman was also the Joint Medical Director of Croydon, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. The full value of his salary and allowances was in the range £65,000 - £70,000. His remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
11.	Charlotte Gawne was also Director of Communications of Croydon, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. The full value of her salary and allowances was in the range £85,000 - £90,000. Her remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
12.	Jacqui Harvey was also Director of Transition of Croydon, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. The payments disclosed represent fees paid to AML Management Ltd and Verdedus in respect of her services. The total cost of her services was in the range £165,000 - £170,000 and has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
13.	Jocelyn Fisher was also Director of Human Resources, OD and Workforce of Croydon, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. The payments disclosed include fees paid to Employee Relations Solutions Limited in respect of her services for the period 1 April to 13 May 2012. The total of her remuneration and service fees was in the range £120,000 - £125,000 and has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
14.	Paula Swann was also Director of Financial Management of Croydon, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. The full value of her salary and allowances was in the range £15,000 - £20,000. Her remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
15.	Hardev Virdee was also Director of Strategic Financial Planning of Croydon, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. The full value of his salary and allowances was in the range £25,000 - £30,000. His remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
16.	Neil Roberts was also Director of Primary Care Contracting of Croydon, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. The full value of his salary and allowances was in the range £85,000 - £90,000. His remuneration has been apportioned between these five PCTs pro rata to Recurrent Resource Limit.

Directors' and Senior Managers' pension benefits								
NAME AND TITLE	Note	Real increase in pension at age 60 (bands of £2,500)	Real Increase in lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2013 (bands of	Lump sum at age 60 at 31 March 2013 (bands of £5,000)	Cash equivalent transfer value at 31 March 2013	Cash equivalent transfer value at 31 March 2012	Real increase in cash equiv transfer value funded by employer
		£000	£000	£000	£000	£000	£000	£000
Executive Directors								
Ann Radmore(Chief Executive)	5	0-2.5	0-2.5	5-10	20-25	134	120	5
Christina Craig (Interim Chief Executive)	6	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Jill Robinson (Director of Finance)	7	0-2.5	0	0-5	0	13	9	2
Dr Jonathan Hildebrand (Director of Public Health)	8	0-2.5	0-2.5	15-20	50-55	311	284	7
Dr Naz Jivani (Chair of the Professional Executive Committee)	9	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Debbie Stubberfield (Director of Nursing)	10	0-(2.5)	0-(2.5)	0-5	10-15	107	104	-1
Senior Managers								
David Smith (Director of Health and Adult Services)		0-(2.5)	(2.5)-(5)	60-65	190-195	1,321	1,249	4
Dr David Finch (Joint Medical Director)	9	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Dr Howard Freeman (Joint Medical Director)	9	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Charlotte Gawne (Director of Communications)	11	0-2.5	0-2.5	0-5	5-10	28	25	1
Jacqui Harvey (Director of Transition)	6	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Jocelyn Fisher (Director of Human Resources, OD and Workforce)	12	0-2.5	0	0-5	0	3	0	2
Hardev Virdee (Director of Strategic Financial Planning)	13	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Neil Roberts (Director of Primary Care Contracting)	14	0-2.5	0-2.5	0-5	10-15	89	82	2

Notes	
1.	As non-executive members do not receive pensionable remuneration, there are no disclosures in respect of pensions for them.
2.	There were no employer's contributions to stakeholder pensions in 2012/13.
3.	**Cash Equivalent Transfer Values**
	A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.
4.	**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.
5.	Ann Radmore was also Chief Executive of Croydon, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. As at 31 March 2013, the full value of her accrued pension at age 60 was in the range £55,000 - £60,000; the full value of her lump sum at age 60 was in the range £170,000 - £175,000; and the full CETV of her pension benefits was £1,122,000. Her pension benefits have been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
6.	Christina Craig and Jacqui Harvey were not directly employed by the NHS in 2012/13 and their pension entitlements are managed by their employer.
7.	Jill Robinson was also Director of Finance of Croydon, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. As at 31 March 2013, the full value of her accrued pension at age 60 was in the range £5,000 - £10,000; the full value of her lump sum at age 60 was £0; and the full CETV of her pension benefits was £108,000. Her pension benefits have been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
8.	Dr Jonathan Hildebrand also supported Croydon, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. As at 31 March 2013, the full value of his accrued pension at age 60 was in the range £40,000 - £45,000; the full value of his lump sum at age 60 was in the range £120,000 - £125,000; and the full CETV of his pension benefits was £765,000. His pension benefits have been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
9.	Dr Naz Jivani, Dr David Finch and Dr Howard Freeman are also general practitioners. The NHS Pensions Agency is unable to separate their pension entitlements as
10.	Debbie Stubberfield was also Director of Nursing of Croydon, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. As at 31 March 2013, the full value of her accrued pension at age 60 was in the range £40,000 - £45,000; the full value of her lump sum at age 60 was in the range £120,000 - £125,000; and the full CETV of her pension benefits was £894,000. Her pension benefits have been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
11.	Charlotte Gawne was also Director of Communications of Croydon, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. As at 31 March 2013, the full value of her accrued pension at age 60 was in the range £15,000 - £20,000; the full value of her lump sum at age 60 was in the range £45,000 - £50,000; and the full CETV of her pension benefits was £230,000. Her pension benefits have been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
12.	Jocelyn Fisher was also Director of Human Resources, OD and Workforce of Croydon, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. As at 31 March 2013, the full value of her accrued pension at age 60 was in the range £0 - £5,000; the full value of her lump sum at age 60 was £0; and the full CETV of her pension benefits was £24,000. Her pension benefits have been apportioned between these five PCTs pro rata to Recurrent Resource Limit.
13.	No information was available for Hardev Virdee, who is on secondment from Hounslow PCT.
14.	Neil Roberts was also Director of Primary Care Contracting of Croydon, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs. As at 31 March 2013, the full value of his accrued pension at age 60 was in the range £35,000 - £40,000; the full value of his lump sum at age 60 was in the range £105,000 - £110,000; and the full CETV of his pension benefits was £745,000. His pension benefits have been apportioned between these five PCTs pro rata to Recurrent Resource Limit.

Section 4
Commissioning healthcare

4. Commissioning healthcare

4.1. Our commissioning priorities – over the last year and next

In preparation for 2012-13, NHS Kingston worked with local authority colleagues to review and update the local Joint Strategic Needs Assessment. This is a substantial analysis of the health and health needs of the people in the borough.

NHS Kingston also worked with our main local health care providers in the area, particularly Kingston Hospital NHS Trust, Your Healthcare CIC and SW London and St George's Mental Health NHS Trust, to gain the providers' perspective on needs and gaps in provision.

Additional insight was provided by GPs and other GP practice staff across the borough. Valuable input was provided by patients themselves, directly through everyday contact with GPs and others, as well as through patient representatives in Kingston's HealthWatch, voluntary, charitable and independent sector groups, and the shadow Health and Wellbeing Board.

As well as overseeing the existing extensive baseline of health care services associated with an annual expenditure of approximately £200 million, priorities to improve patient experience, outcomes and value for money included:

- Mental health and substance misuse services – improving patient access to psychological therapies and community-based mental health services, including providing a new community wellbeing service that offers dual diagnosis for both mental health and substance misuse. In addition, focusing on the interface between hospital physical and mental health services and engaging users and carers in service reviews. NHS Kingston also planned to decommission one specific inpatient rehabilitation facility and to review older peoples' mental health services;
- Integration of community health (NHS) and social care (local authority) teams providing rehabilitation and reablement support. The aim included creating a single point of access, making services easier to understand for users and removing duplication through joint working;
- Medicines management – in particular, helping patients to manage medications better and working with GPs and pharmacists to optimise the cost-effectiveness of medication. Particular priorities included management of high cost and limited benefit drugs, reducing waste, increased and improved medication reviews with patients, enhancing pharmacists' roles, and making transfer of medication information safer as patients are admitted to and discharged from hospital;
- Management of outpatient referrals – reducing overall referral rates to hospital services where appropriate to do so, reducing unexplained variability in referral rates and making best use of non-hospital services where patients can be better treated in the community;
- Urgent care – reviewing urgent care services to tackle a significant underlying increase in urgent unplanned hospital attendances;
- Admission avoidance – reducing the number of unplanned admissions by integrating health and social care support in the community and creating a single point of access, particularly for older people and others with long term conditions;

- Reduction in A&E attendances for minor conditions – encouraging and enabling patients with minor conditions to be treated outside hospital and planning for more primary care services in Kingston Hospital A&E so that minor conditions can be streamed to appropriate treatment;
- Health inequalities – working with a variety of agencies to raise awareness around the impact of lifestyle choices, and improving access to services to reduce health inequality, including the five year difference in life expectancy between the most and least disadvantaged areas and communities;
- Financial stability – maintaining tight control of finances. Our Quality, Innovation Productivity and Prevention (QIPP) Plan (part of a national programme) lays out how we intended to maintain and develop services while at the same time improving efficiency and value for money;
- Choice and quality of services – in making commissioning decisions around hospital, community and mental health services a key priority for the CCG is to ensure that changes improve choice, quality, health outcomes for patients.

From April 2013 Kingston CCG will have full responsibility for planning and commissioning hospital, community and mental health services for people across Kingston. The CCG will need to work with specialised commissioning colleagues (working directly for the NHS Commissioning Board) who will be responsible for commissioning more specialist services for Kingston residents. The CCG will continue to work with other local partners, especially our main local service providers, the local authority, local voluntary and independent sector organisations and local patients, carers and the public.

As well as securing baseline activity and quality and continuing to progress the above areas, additional key initiatives in 2013/14 include:

- Reconfiguration of community-based health care beds as part of the Kingston at Home programme;
- Improved care management of older people in hospital;
- Focusing on dementia diagnosis and services;
- Implementing a pilot to help identify people at risk of needing health care prospectively and providing suitable early interventions, including telehealth;
- Reviewing older people's community mental health services and specialist out of area mental health placements;
- Service reviews and redesign in urology, neurology, ENT, cardiology, gynaecology;
- Implementing a pilot project around patient centred shared decision making;
- Developing other service areas including maternity and newborn, children, learning disability, end of life care, primary care, adult safeguarding, medicines management.

These 2013/14 initiatives make up the bulk of Kingston CCG's QIPP plan for the new financial year.

4.2. What's new over the last year – some highlights

NHS 111 number – for when it's urgent but not an emergency

In February 2013 the new NHS 111 number launched for Kingston residents, after a short 'soft launch' period.

The public launch was supported by a bus stop advertising campaign, leaflets distributed through GP practices and pharmacies and a door drop to every household.

As a result of the new number patients can more easily access medical care when it's urgent but not a 999 emergency. Patients calling the service speak to a team of trained advisors who assess symptoms and then refer them to the right service.

The launch of the new number is just one way that the CCG will be helping to manage demand for A&E and other urgent care services over the coming year.

New mental health and substance misuse services

In October 2012, Kingston CCG announced that two organisations had successfully bid to deliver a new community wellbeing service for Kingston.

Following an open tendering process, Central and North West London NHS Foundation Trust and Camden and Islington NHS Foundation Trust will be delivering the new service from April 2013.

The new service model will provide psychological therapies and substance misuse support through one access point, making life easier for patients. By joining-up services the NHS and local authority intend to remove duplication and improve the effectiveness of treatment.

Central and North West London NHS Foundation Trust will be managing a 'gateway' service to ensure patients can access the right services, while Camden and Islington NHS Foundation Trust will oversee the day-to-day delivery of more intensive treatment.

The new Community Wellbeing Service will take a new approach by:

- commissioning a joint service across psychological therapies and substance misuse. Usually these services are provided independently

- introducing a gateway assessment service to assess patient and to make sure they are referred to the correct services to get the treatment they need.

The new service will provide the following benefits:

- Health and wellbeing benefits to those with mental illness and/or substance misuse issues
- Ensuring that people no longer 'fall between gaps' in the current services provided
- Easy access for service users across the borough, with a single point of referral, rather than needing to approach different organisations for different conditions
- Increased effectiveness of services, with reduced duplication
- Service users will receive the level of treatment and support they require from the appropriate services.
- Service users will receive employment support, with the aim of people retaining, gaining or returning to work, education, training or volunteering opportunities.
- Service users will have the opportunity to be more involved in developing new ways of delivering services to meet their needs.

Opening of Surbiton Health Centre

Just two years after planning permission was obtained, the new Surbiton Health Centre opened its doors to patients for the first time on 4 March 2013.

The modern purpose-built health centre provides all of the services previously found at the hospital when it closed in 2011, as well as services from four local GP surgeries, and from partners including Your Healthcare and Kingston Hospital.

The centre includes a pharmacy, diagnostics, a new breast screening service, minor procedures, treatment rooms, outpatient clinics, community mental health outpatient services and psychological therapies, providing services for 73,000 residents in Kingston borough.

The state-of-the-art new health centre incorporates the latest advancements in modern healthcare, with a simple electronic check-in option to ensure that reception staff can focus on appointment bookings and

phone calls.

The site is easily accessed by rail, bus, cycle or foot and sustainable travel is encouraged wherever possible. There are also eight charging points for electric cars and an energy centre generating sustainable power for both the health centre and Lime tree primary school on the same site.

We're delighted to open the centre - on time and on budget – an achievement that has only been possible thanks to the collective effort of the local community, staff, patients and residents.

We intend the Surbiton Health Centre to be a focal point for the community both now and for generations to come.

In further good news together with Hillcroft College and Kingston Council we successfully bid for a heritage lottery grant to record the history of the Oakhill area, which was announced in January 2013.

The local community fundraised for the bricks to build the original Surbiton Hospital, so we're delighted that we can celebrate that legacy in the new health centre for the benefit of future generations

Kingston at Home – supporting people to live independently

Kingston at Home is a new package of services to improve the way that health and social care services are delivered for adults who need support whilst recovering from an accident or illness.

Health and social care services include: care and treatment provided at home by care workers, community nurses and therapists, care and treatment provided in short-term community beds and care provided in long term residential and day care.

Improving services

Evidence shows that many people want a more coordinated care system that gives them control over their own health and enables them to stay living in their own home. Kingston‟s population is changing with many people living longer than ever before. People living longer and choosing to live in Kingston are positive trends. The challenge for the Kingston at Home Programme is to ensure that as many of these people as possible get the support they need to remain living in their own home or other chosen environment.

For these reasons, Kingston Council and Kingston Clinical Commissioning group are proposing to integrate services across the NHS and social care so that the system is better for users, increasing short term reablement and rehabilitation support at home to reduce the need for long term residential care.

The proposals

Since March 2012, Kingston CCG, Kingston Council and Your Healthcare CIC have been working with health and social care colleagues to develop a new system of short and long term care with service users, staff and community partners. This has included meeting with patients and community groups to gather their views on our plans.

The new system will see a shift of care to the home environment, which will improve services for individuals as well as providing a more cost effective service integration across health services (provided by the NHS) and social care services (provided by Kingston Council), as well as with those from the voluntary sector.

The aim of the project will be to improve services in the following ways:

- Establishing a single point of contact for advice and to receive referrals
- Teams that are integrated across the council and NHS
- Up to six weeks of free intensive social care 'reablement' support package for eligible adults
- Greater use of technology to help people live safely at home e.g. sensors and alarms
- A 50% reduction in residents discharged directly from hospital into long term residential care

- Increased home based rehabilitation to get the best results for patients and enable them to remain living at home
- Increased use of community beds for short term support to enable patients to achieve independence and enable them to return home when they want to
- Referrals allocated and responded to quickly
- Social care personal budgets for more service users
- Shift in council focus from provider to commissioner of services

Over the coming year we will be implementing some parts of the project as well as sharing updated proposals with patients, residents and staff to gather further views on other aspects of our plans.

Launch of telehealth pilot

We launched a pilot in March 2013 to test how the latest technology can help patients with long-term conditions to manage their own health at home, saving on trips to the GP or hospital.

The twelve month pilot involves working with 50 patients who will be issued with electronic 'telehealth' units - roughly the size of a telephone - to enable them to take readings of their own blood pressure, oxygen levels, weight, pulse and temperature. The unit will also ask a set of questions about the patient's general health and wellbeing.

This information will then be sent to the 'back end' software where clinicians can monitor the patient's progress and look at the trends over a period of weeks or months.

Evidence from other areas where the technology has been used shows that patients feel more confident and have more peace of mind about monitoring their condition.

The intention of the programme is to help patients stay well and to reduce attendances at hospital by taking early steps that prevent conditions from escalating.

Kingston will be issuing 50 of these units over the 12 month pilot period, working with GPs, Your Healthcare CIC, Kingston Council, Age Concern Kingston and Tunstall providing the technology. The project will be closely monitored and evaluated to assess whether this approach will benefit more patients across the borough.

Better Services Better Value

The Better Services, Better Value review (BSBV) is looking at health services in South West London and parts of Epsom and the surrounding areas. The BSBV programme was created because we face a range of challenges such as – financial pressures, increased number of people living with long term conditions like diabetes, cancer and heart disease and not enough senior doctors available around the clock in some of our most vital services.

Initially the review only covered the South West London area, including the hospitals at Croydon, Kingston, St George's and St Helier. In November 2012 the programme was expanded to include Epsom Hospital and Surrey Downs following the decision to halt the proposed merger between Epsom Hospital and Ashford and St Peters. Following these developments, the clinical working groups met again with an expanded membership to include clinicians from Epsom Hospital and from Surrey Downs Clinical Commissioning Group and have issued new advice about the proposed revised models of care.

In order to ensure the best and safest services for local people, in line with the latest best practice recommendations from London Health Programmes, local doctors, nurses and midwives are suggesting that there should be:

- An expansion in services provided outside hospital, including in GP surgeries, community health settings and at home

- Services on all five hospital sites – Croydon, Epsom, Kingston, St George's and St Helier, including urgent care, out-patient clinics and day surgery
- Three A&E departments, each with an urgent care centre attached and stand-alone urgent care centres on the other hospital sites
- Three maternity units led by obstetricians (senior maternity doctors) with midwifery led units alongside, which would be located in the same hospitals as the three A&Es
- Further work on the feasibility of a separate, stand-alone, midwife-led maternity unit
- A planned care centre for the majority of inpatient surgery for the area, on a separate site from emergency care, meaning that planned operations are not disrupted or delayed by emergencies
- Urgent care, outpatient and day surgery facilities in all five hospitals.

At the same time, further discussions have been taking place with members of the public and patients and the things that they consider most important in terms of how we should provide health care in the future and new financial analysis has been carried out to work out how best to respond to the financial challenges the NHS is facing locally.

An options appraisal has taken place and a future meeting of the Programme Board is due to consider the outputs from this before making recommendations for public consultation, which would then take place later in 2013.

Section 5
Improving the health of people in Kingston

5. Improving the health of people in Kingston

As a result of the Health and Social Care Act, Kingston's public health team will be transferring to the local authority from 1 April 2013.

The team already has a joint director across the NHS and local authority, and staff moved to the council's Guildhall complex in January 2013, so the team are well placed to make the transition to the council and to continue providing services for local people.

This section highlights some of the projects that the public team have been running over the last year.

5.1. Get Active

Get Active is a structured 12 week exercise referral programme supported by qualified exercise specialists which includes one-to-one activity sessions in the gym alongside walking, swimming, active gardening, healthy lifestyle and nutrition advice.

The programme is for adults aged 16 years and over who live or work in Kingston and introduces people to the benefits of exercise to promote improved health. It is aimed at individuals with existing medical conditions, those with sedentary lifestyles and as a preventative measure against further health complications.

Between January and December 2011, the total number of referrals to Get Active was 387, the equivalent of 35 new patients every month. Of the 387 patients referred in 2011, 53% had stage 1, 2 or 3 hypertension in their first consultation compared to just 39% in their exit consultation. In addition 81% lowered their body mass index.

The programme has also been shown to increase the long-term physical activity habits of patients. When surveyed after 12 months of completing the Get Active programme, 55% said they had continued to be active for at least 30 minutes on three days per week. Positive change was also seen in psychological outcomes, with patients reporting a reduction in anxiety, stress and depression from 24% to 9% after completing the programme.

The Get Active programme continues to receive excellent feedback from participants:

Participant, age 50:
'My instructor was welcoming and very helpful, putting me at ease immediately. He was supportive and encouraging. I soon became fitter and lost a few pounds by attending the gym regularly. I became committed to staying fit and talked to my instructor about how to achieve this. We discussed cycling and I now cycle regularly as well. I feel I have more energy; I eat better and am more motivated in general. The Get Active programme definitely helped me to begin a life changing exercise programme that I could easily continue.'

Participant, age 37:
'I thoroughly enjoyed the scheme. It was worthwhile joining because I realised the gym wasn't for me but my instructor was extremely encouraging and suggested going for walks and introduced me to other activities such as yoga, aerobics and a mum's walk. By continuing my walking I feel lighter, healthier and

have lost weight. My blood pressure is now borderline normal as opposed to high which it was before joining the programme.'

The recent expansion of the programme into Norbiton and Chessington provides increased service accessibility to low cost exercise opportunities for local communities.

5.2. Factor programmes: tackling childhood obesity in Kingston

Reducing rates of child obesity is both a national and local priority. Kingston data released by the National Child Measurement Programme highlighted that over 17 per cent of children aged 4–5 and 30 per cent of children aged 10–11 are above a healthy weight[1]. There are 2,087 children in Kingston that are carrying excess weight between the ages of 4 to 6 years old (833) and 10-12 years old (1,254).

The sharp increase in the number of children above a healthy weight between reception and year six demonstrates the importance of tackling this issue at all ages.

The Factor programmes are locally developed child weight management programmes designed to help families, children and young people learn how to develop healthier habits. They embed key nutrition, physical activity and behavioural change principles to help children and young people grow into a healthier weight for their age and gender.

DC Leisure were commissioned by NHS Kingston in August 2010 to help develop and implement the Factor programmes across Kingston. Between September 2010 and March 2012, 16 Factor programmes ran in Kingston and 107 children and young people took part.

A further nine programmes have been commissioned to run in 2012/2013 which have already reached over 50 children and their families with more currently participating until the end of March 2013. There has been an increased focus this year on following up children and young people who have previously completed the programme. Two successful refresher events were held early this year in order to collect longer-term follow-up data to help assess the impact of the programme at six months and one year.

Evaluation of all three programmes is promising with evident positive changes in dietary and mealtime habits, an increase in time spent being physically active, an improvement in physical fitness, an increase in parental confidence in feeding their child and a notable improvement in self-esteem by young people participating.

Due to the success of these programmes, Kingston will be re-commissioning DC Leisure to continue running the Factor programmes in 2013/2014 with an aim to run nine programmes over the next year.

5.3. Reducing alcohol intake

Down your Drink (DYD) is an online programme for people who want to reduce the amount of alcohol that they drink.

In 2008, Kingston secured funding to pilot a self-help version of the DYD programme, targeted at people identified by their GP as increasing or higher-risk drinkers. In 2011/2012 access to the DYD service was expanded, making it possible for the general public to self-register onto the programme in addition to being referred via their GP.

In 2012/2013 the DYD service started to take referrals from Kingston Hospital and from community pharmacists. This service will continue to be advertised both among professionals and in the local community and will be available to the general public for the coming year. www.dyd.kingston.nhs.uk

[1] Clinical Commissioning Group (CCG) child prevalence data by BMI category NCMP. National Obesity Observatory. 2012

In addition, in 2012 NHS Kingston launched an alcohol brief intervention pilot project within six community pharmacies. To date 60 people have been screened and 22 of them have had a brief intervention. The pilot will finish at the end of March 2013.

5.4. Needle exchange and blood borne viruses

In 2011, NHS Kingston's pharmacy based needle exchange provision was reviewed and expanded. The range of needle exchange equipment provided was increased, and drug users visiting the pharmacy were offered a healthcare assessment and blood borne virus test (hepatitis B and C test) where appropriate. In the first three quarters of 2012/ 2013 a total of 69 health checks were completed.

5.5. Immunisations

In Kingston we are continuously looking at ways to increase immunisation uptake. In May 2011 a combined venture between NHS Kingston, Kingston Council and Your Healthcare saw monthly immunisations sessions introduced at Norbiton Children's Centre with the addition of Kingston Hill Children's Centre and West Chessington Children's Centre in 2012.

From mid 2013 plans are in place to extend this to include Tolworth Childrens Centre. To support this, a health visitor whose remit includes following up infants who have failed to attend for immunisation on three subsequent occasions is now in post. For many parents, attendance for immunisation is a question of accessibility, so these sessions aim to give parents a time and place for missed or routine immunisation. The programme has proved to be very successful in making vaccinations more accessible for the harder to reach groups.

2012 saw the introduction of the Pertussis vaccination for pregnant mothers in order to protect their infants at birth. This has been successfully undertaken by primary care services with an uptake of over 50%.

2013 is likely to see multiple changes in immunisation across the population of Kingston with the introduction of the Rotavirus to the primary care immunisation schedule, Varicella for the over 75s to prevent shingles and the development of the seasonal flu immunisation programme for all two to 17 year-olds.

5.6. NHS Health Check

The NHS Health Check programme was launched in Kingston in November 2009. The programme is offered to all people aged 40 to 74 who have not been diagnosed with high blood pressure, diabetes, heart disease, stroke or chronic kidney disease. The free health check includes blood pressure, cholesterol and body mass index measurement to identify a patient's risk of being diagnosed with heart disease, diabetes, stroke or chronic kidney disease in the next 10 years.

This programme is provided in all Kingston GP practices. It is also provided in two community pharmacies. In addition a community outreach programme is being currently delivered at various locations around the borough.

5.7. Cardiac rehabilitation programmes

The cardiac rehabilitation programmes are open to people who have been diagnosed with heart disease, as well as patients who have had a heart attack, or undergone angioplasty or surgery.

In 2012 the programme was further developed to reach people who have been identified to be at risk of developing cardiovascular disease.

People can join the free 'Healthy Hearts' or 'Reduce Your Risk' programmes which aim to help people to recover from an acute event, self-manage their condition effectively and prevent re-admission or reoccurrence of symptoms. For those identified at risk the aim is to prevent a primary cardiovascular event.

Patients with heart disease who do not wish to join a centre based programme or cannot do so can join the Heart Manual programme which allows them to self-manage their rehabilitation at home.

5.8. Launch of new stop smoking service

In December 2012, NHS Kingston commissioned a new service to help people give up smoking. ‘Kick It’ is a new service offering free stop smoking clinics with trained advisors in convenient locations throughout the borough. There will be clinics in several locations across Kingston and also in the nearby borough of Richmond.

The service provides smokers with the opportunity to speak confidentially to trained advisors and learn specialist techniques to deal with nicotine cravings. The service will also be hitting the streets, with outreach teams out and about across the borough talking to smokers and promoting the new service.

The introduction of the ‘Kick It’ services follows a hugely successful programme in the London Borough of Hammersmith and Fulham, where the ‘Kick It’ team has helped over 2,000 smokers successfully stop smoking in the last year alone.

Giving up smoking is one of the best things people can do to improve their long term health. Sadly smoking remains one of the key contributors to people dying at a young age.

Kick It is offered as either one-to-one advice or group based sessions with locations across the borough.

Section 6
Improving performance

6. Improving performance

NHS South West London works with NHS Kingston and Kingston CCG to measure the performance of all health services in Kingston. All parties identify areas where performance is strong, to share learning across South West London. Similarly, services that are struggling to deliver the required results for patients are identified and supported to improve.

Performance indicators enable the measurement of both the quality and productivity of commissioned services, and to benchmark locally against other similar organisations.

Below is a snapshot of how Kingston has performed over the last financial year against the NHS Operating Framework indicator groups. For more information about performance, including scorecards and action plans for improving performance, visit the *performance* section of www.southwestlondon.nhs.uk.

6.1. NHS Operating Framework quality indicators

- Strong performance was demonstrated across the borough in a number of areas including:
  - Meeting waiting time targets for referral to treatment, as well as people waiting for a diagnostic test.
  - Being responded to in A&E within the 4 hour target.
  - Treating suspected cancers at an early stage.
  - Reducing the number of patients needing to be urgently readmitted to hospital after being recently discharged.
  - Ensuring that people in crisis are responded to by a mental health professional.
  - Patient experience surveys.
- The borough's stroke services performed well, with patients suffering from suspected stroke and transient ischaemic attacks (TIAs) treated in the appropriate unit quickly and effectively.
- Cancer patients were also treated quickly, meeting performance targets for access to surgery, drugs and radiotherapy.
- The borough also demonstrated strong performance in treating patients through bowel screening and breast screening services.
- Plans are in place to increase the rate of breastfeeding at six to eight weeks, smoking cessation rates and uptake of NHS Health Checks across the borough.

6.2. NHS Operating Framework resources indicators

Kingston met targets for high levels of health visitors thanks to strong recruitment and retention plans. This meant that new mothers and babies will have received the care they needed in the weeks and months after birth.

The borough has also achieved targets for referring patients into treatment and ensuring the timely transfer of people from an acute hospital into a more appropriate care setting. However, the management of hospital acquired infections proved more difficult to achieve last year.

As NHS Kingston transfers this responsibility to clinical commissioning groups, targeted work is being carried out to identify how performance can be improved over the coming year to ensure these standards are met.

6.3. NHS Operating Framework public health indicators

The borough has achieved all childhood obesity and all mortality indicators, with low mortality rates for cancer and cardiovascular disease in Kingston. Immunisation rates in the borough are also strong, though plans are in place to put the borough amongst the best performing in the country.

	Actual Performance	Target
ACUTE HOSPITAL SERVICES		
Referral to treatment: percentage of non admitted patients seen within 18 weeks	91.4%	90.0%
Referral to treatment: percentage of incomplete pathway patients who have waited less than 18 weeks	96.6%	95.0%
Referral to treatment: percentage of admitted patients seen within 18 weeks	92.8%	92.0%
Total numbers waiting at the end of the month on an incomplete referral to treatment pathway	7,972	7,964
Proportion of people who have waited more than 6 weeks for a diagnostic test	0.7%	1.0%
Incidence of MRSA bacteraemia	4	2
Incidence of C-Difficile bacteraemia	29	19
Proportion of people who have a TIA who are scanned and treated within 24 hours	74.6%	60.0%
Proportion of people who spend at least 90% of their time on a stroke unit	95.0%	80.0%
CANCER SERVICES		
Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer	94.5%	93.0%
Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer is not initially suspected	92.2%	93.0%
Percentage of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status	100.0%	90.0%
Percentage of patients receiving first definitive treatment for cancer within 62-days of an urgent GP referral for suspected cancer	87.0%	85.0%
Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from and NHS Cancer Screening Service	84.2%	90.0%
Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis	98.7%	96.0%
Percentage of patients receiving subsequent treatment for cancer within 31-days where that treatment is a Radiotherapy Treatment Course	95.8%	94.0%
Percentage of patients receiving subsequent treatment for cancer within 31-days where that treatment is an Anti-Cancer Drug Regime	100.0%	98.0%
Percentage of patients receiving subsequent treatment for cancer within 31-days where that treatment is Surgery	98.6%	94.0%
MENTAL HEALTH SERVICES		
Care Programme Approach patients discharged followed up within seven days	100.0%	95.0%
Access to comprehensive crisis resolution services (caseload)	413	298
New cases into early intervention services	36	22
Proportion of people with depression moving to recovery	37.6%	40.8%
Proportion referred for psychological therapy receiving it.	8.1%	12.8%
HEATH OF THE POPULATION		
Immunisation rate for children aged 1 who have been immunised for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b	93.4%	90.0%

Number of patients receiving NHS primary dental services located within the PCT area within a 24 month period	86,347	85,100
Number of self reported smoking quitters (at four weeks)	676	684
Percentage of adult population aged 70-75 invited for bowel cancer screening	78.5%	30.0%
Percentage of children in reception with height and weight recorded who are obese.	5.9%	8.3%
Percentage of children in Year 6 with height and weight recorded who are obese.	15.5%	16.0%
Percentage of people with diabetes to be offered screening for the early detection of diabetic retinopathy	100.0%	95.0%
Percentage of women aged 25 to 49 years receiving cervical screening in the last 3.5 years	68.3%	70.0%
Percentage of women aged 47-49 and 71-73 invited for breast screening	26.7%	8.1%
Percentage of women aged 50 to 64 years receiving cervical screening in the last 3.5 years	76.4%	75.0%
The number of children with a breastfeeding status recorded as a percentage of all infants due for a 6–8 week check.	96.7%	95.0%

Section 7
Working in partnership

7. Working in partnership

In order to deliver a high standard of service, NHS Kingston and the emerging CCG work very closely with partners, with other clinicians, the health and voluntary sector, with community groups and with patients.

From establishing a Health and Wellbeing Board to taking forward the integration of health and social services, the last year has resulted in significant progress.

David Smith has been officially appointed as chief officer for Kingston CCG, and as director of health and adult services for Kingston Council. This means that Kingston's health and social care services are in the unique position of having joint leadership that will enable joined-up commissioning of services for the benefit of patients.

Dr Jonathan Hildebrand has continued as a joint director of public health for the council and PCT and sits on the Health and Wellbeing Board. He also took over the joint medical director role on the Kingston CCG governing body in April 2012. This means Jonathan can ensure continued joint working between the public health team and CCG when the public health team makes its transition to the local authority in April 2013.

Partnership working is now an instrumental part of many on going projects. For example, the Kingston at Home programme involves working with Kingston Council, community provider Your Healthcare and local voluntary organisations including Age Concern Kingston.

The new mental health service has involved jointly commissioning psychological therapies and substance misuse services with the council – supported by two joint mental health commissioning posts.

Other PCT priorities, including the Surbiton Hospital re-development, Better Services Better Value review, Commissioning for Quality and Innovation scheme, QIPP programmes, changes to mental health commissioning, and One Norbiton project, have a strong emphasis on working with partners, including Healthwatch Kingston, Your Healthcare, Kingston Council, Kingston Hospital, Kingston Voluntary Action, Kingston University and the police.

7.1. Kingston Health and Wellbeing Board

Health and Wellbeing Boards are designed to bring together the NHS and local authorities to improve the health and wellbeing of people in their borough.

Kingston set up a Health and Wellbeing Board in November 2010, well ahead of the national requirements. The board has been meeting regularly and is currently developing its health and wellbeing strategy. The fully-functioning board will be up and running by April 2013.

The board is a forum for organisations that buy services across the NHS, public health, social care and children's services, as well as elected representatives and representatives from Healthwatch, to come together to discuss how services can be made better. The aim is to work more closely together to improve the health and wellbeing of local people.

Each member of the Health and Wellbeing Board draws on their individual strengths, whether that is clinical expertise, local knowledge or understanding the needs of patients and the public, to help shape commissioning strategies.

Over the last year a health and wellbeing strategy has been developed, based on the Joint Strategic Needs Assessment and joint commissioning priorities. We've been gathering views from patients and stakeholders to influence the final strategy. The draft strategy can be found on the CCG website.

7.2. Partnership working through One Norbiton – an update

The One Norbiton project has brought local people and partners together to improve the lives of communities in Norbiton by giving them more control and influence over services – including health services.

The project has been part of a national pilot with Government, looking at a new way of designing and delivering local services, through involving communities to identify priorities and working with partners to align and target resources to deliver them.

Norbiton was initially chosen for this pilot as it is the ward with the highest levels of deprivation in the borough and the greatest differences in life expectancy. The priorities that have been identified for the project can be classified as representing the wider determinants of health, for example, housing, employment, youth activities and community safety. In addition, the project has a strong focus on community development.

The Chair of the One Norbiton community group is a retired GP, with a number of local strategic partners supporting the project – NHS Kingston, Kingston Council, Police, Kingston University, College, Kingston Voluntary Action, Jobcentre Plus and Kingston Chamber of Commerce.

Now that the pilot with Government has concluded, the lessons and conclusions are informing the next phase of the One Norbiton project and the local community is driving forward a programme to give local people more influence and control over local services.

Section 8
Making it happen

8. Making it happen

8.1. Consultation and engagement

It is an on going priority for the CCG to ensure that patients can influence decisions made about local health services.

The CCG has been working with local stakeholders and patient reference groups in GP practices to embed engagement mechanisms in the new organisation.

An engagement strategy was developed in Autumn 2012 and continues to evolve as the CCG builds relationships with patients and community groups.

Patient forum

One of the commitments made in the engagement strategy was to establish a quarterly patient forum for local people to hear about the CCG's commissioning plans and to give their views. This was implemented in October 2012 with a second forum held in January 2013.

Both forums had a strong turn-out from patients, members of the public and voluntary groups. In response to feedback the second forum was adapted to move away from a presentation format to more collaborative break-out groups discussing specific CCG commissioning plans. This format will continue to evolve over the coming year. All feedback is published on the CCG website.

In addition a patient email network has been established, and we are arranging our first networking meetings for GP practice patient reference groups.

Engagement around specific plans

The patient forum is just one of the routes that the CCG will use to gather patient views. In addition targeted engagement activity will continue to take place around individual projects, for example, when there are plans to change specific services.

For example, over the last year we have engaged with a range of patients and stakeholders around progress with the Kingston at Home project, which involves jointly commissioning health and social care services to support more patients in their own homes.

In future the CCG is supporting the introduction of an engagement proforma to be submitted with all board papers involving service change before the papers will be considered. In this way patient engagement will take place upfront of commissioning decisions.

Communications channels

A number of communications channels have continued to be delivered over the last year to support Kingston CCG in its journey towards authorisation, and to complement engagement activity. These include:

- regular updates to the CCG website (www.kingstonccg.nhs.uk)
- a newsletter for health practitioners
- a patient and stakeholder e-newsletter
- a regular supplement in the Kingston Guardian
- Regular press releases
- Other patient information materials

The CCG also introduced a twitter channel over the last year as another route to engage with local people and other stakeholders.

8.2. Healthwatch Kingston

The Government's Health and Social Care bill outlined an increased role for local Healthwatch groups in ensuring that patients have a voice and to act as a watchdog for local health services.

In February 2013, after an open tendering process, Kingston Council awarded Parkwood Healthcare Ltd a two-year contract from 1 April 2013 to run Healthwatch Kingston.

The official watchdog will provide public information and advice about health and social care services, and hear complaints.

Healthwatch Kingston, a social enterprise body independent of the council, will promote the involvement of local people in monitoring, commissioning and providing services, help people understand the choices available to them, and be able to recommend special reviews, investigations or urgent action to national care quality inspectors.

Local Healthwatch bodies are a government requirement, to ensure that users and patients have a say in how services are run. A Healthwatch representative sits as a non-voting member of the CCG board.

8.3. Customer care for Kingston residents

Patients, relatives or carers need support with their healthcare needs. They may also want to give feedback, positive or negative, about the service they have received.

NHS Kingston's customer care team is focused on improving the experience of Kingston residents and can provide confidential on-the spot advice through the Patient Advice and Liaison Service (PALS). They can also help patients sort out any concerns about their care and guide them through the different services available from the NHS.

The service aims to:

- advise and support patients, families and carers
- provide information on NHS services
- listen to concerns, suggestions or queries
- help sort out problems quickly on the patient's behalf
- help patients make a complaint about NHS services

The team can act on behalf of patients when handling concerns, liaising with staff, managers and other organisations to arrive at prompt solutions. Last year the team supported hundreds of patients from across Kingston.

To get in touch with the customer care team contact Leigh Broggi, Customer Care Officer, NHS Kingston, telephone: 020 8339 8107, text: 07500 817564, email: leigh.broggi@nhs.net

Expert patients self-management course

Kingston's Expert Patients Programme is a self management course for people living with long-term health conditions to help them take control of their lives, and to avoid their condition dominating their lives. Participants on this free course gain the knowledge, skills and support to effectively self-manage and live life to their full potential.

The course is run as a series of six weekly sessions, importantly by people who have long-term conditions themselves and who have already attended the course.

It is based on motivation and giving people skills to self-manage the health issues that may impact on different aspects of their lives. It encourages self-belief and self-confidence and consists of group discussion, brief presentations, group problem solving and free thinking sessions. The course can make a real difference to people's lives and lead to enhanced quality of life. The project has supported over 300 people to live life to the full since its launch.

8.4. Equality and diversity

NHS Kingston and the Kingston CCG are committed to ensuring equality, diversity, inclusion and human rights are central to the way we commission and deliver healthcare services and how we support our staff. Our aim is to reduce inequalities in health and healthcare for people in Kingston.

As commissioners we must ensure our plans demonstrate our aims to:

- eliminate unlawful discrimination,
- advance equality of opportunity, and
- foster good relations

We have taken forward key areas of work to promote equality, meet the needs of different groups, including minority ethnic people, disabled people, women, men and transgender people, people of different ages, lesbian, gay and bi-sexual people, those with different religions and beliefs and those who are disadvantaged.

Equality analysis

To turn this vision into reality, we carry out equality analysis as an integral part of our projects. Equality assessments are a systematic method to assess the effects of core functions, policies and activities on people depending on their protected characteristic. Completed equality assessments can be read on the CCG website.

Public sector equality duty

The Public Sector Equality Duty consists of a general duty, which is set out in section 149 of the Equality Act 2010, and specific duties which are imposed by secondary legislation.

The general equality duty came into force 6 April 2011. The specific duties require NHS Kingston to publish relevant, proportionate information, demonstrating their compliance with the Equality Duty by 31 January 2013 and to set themselves specific measurable equality objectives by 6 April 2013. NHS Kingston has met both of these duties.

NHS equality delivery system

The Equality Delivery System has been designed as an optional tool to support NHS commissioners and providers to deliver better results for patients and communities and working environments for staff that are personal, fair and diverse. Our Equality Delivery System is available on the CCG website.

8.5. Our staff

Transition to new organisations

Throughout 2012/13 we worked with our staff and involved them in the development of structures in new organisations to which their functions transferred following the abolition of Primary Care Trusts under the Health and Social Care Act. By 31 March 2013 most of our staff had secured a role in one of the receiving organisations.

Staff development

NHS South West London was committed during transition to helping all staff to improve their working lives and develop professionally through our education and development programmes.

Our Development Passport programme helped staff plan for their futures and equipped them for transition into the new NHS organisations. We worked with Croft Management Centre to produce a Development Passport with a two-tiered approach to training; Level One for bands 6 and below, and Level Two for bands 7 and above.

From September 2011 up to the end of January 2013 more that 1400 delegates attended sessions delivered over 150 separate training days. 83 delegates achieved an award, certificate or diploma in management and leadership qualifications drawing on a range of 21 different topics around personal, commercial and leadership effectiveness.

In addition to the passport programme staff also had access to support services that assisted them to update and develop their personal curriculum vitae and interview skills. Staff also had access to an employee assistance programme which is a free confidential 24 hour access to advice and counselling online or on the telephone.

Workplace health

The sickness absence percentage for the whole South West London Cluster for the period 1 April 2012 to 31 March 2013, based on the number of working days lost through sickness absence, is approximately 3.9%.

Staff profile

		Headcount	%
Gender	Female	507	68.2
	Male	236	31.8
	Total	**743**	**100**
Ethnicity	Asian	69	9.3
	Black	13	1.7
	Chinese	67	9
	Mixed	6	0.8
	Other	179	24.1
	White	409	55.1
	Total	**743**	**100**

8.6. Communicating with staff

Our main objectives over the past year were to keep staff informed about the organisational changes and what these meant for each individual as well as continuing to talk about our organisational priorities and everyone's role in delivering these. We also continued to invite feedback through the Team Briefing system, line manager, surveys, generic email addresses and informal routes.

In addition to monthly Team Briefings, face-to-face briefings with opportunities for questions were set up to support the engagement on the new organisational structures. As the structures for the new receiving organisations were finalised, the cluster HR team developed regular updates on HR processes and job vacancies supported by face-to-face briefings.

Senior management was very involved in face-to-face briefings and discussions with staff and the transition team was central to ensuring that staff had the most up-to-date information available at the time.

As staff moved into the new organisations in their shadow form, cluster Team Briefings were replaced by a weekly Transition Update newsletter supported by face-to-face briefings led by the cluster Chief Executive and directors. Staff whose functions were moving to the South London Commissioning Support Unit or NHS Commissioning Board were also invited to briefings run by the new organisations.

8.7. Informatics

The Clinical Commissioning Group is a new kind of organisation. Its members are the Kingston GP practices and the organisation's governing body and management team are in place to advise and support the members in fulfilling the organisation's responsibilities and delivering its objectives. This creates a need for a new kind of corporate working across primary care and with the CCG, which in turn places new requirements on the supporting infrastructure, including informatics.

The new arrangements require different kinds of communication channels and decision making processes which properly inform and engage the members who are distributed throughout Kingston. The CCG has an extended responsibility to share information and work closely with and consult stakeholders in its planning and decision making, including patients and the public.

Modern informatics can help to support these changing requirements. Substantial amounts of data in a variety of formats already circulate to enable this complex organisation to function, including planning and delivery of the wide range of health services required by the Kingston population, and management of and accountability for the associated £200 million expenditure of public funds.

The following are areas which the CCG intends to explore and progress during 2013/14:

- Ensure systems continue to be in place to safely secure patient identifiable data;

- Implement and roll-out specific tools to support integrated patient care (GraphNet), care and service planning, delivery and performance management (Health Trak) and risk stratification (HealthNumerics-RISC);

- Explore and consider for implementation:
  - cloud-based applications and data to enable shared, remote access to corporate information
  - collaboration tools which will enable distributed clinicians and managers to work together as teams
  - tools to enable a new form of corporate working which the structural changes to the NHS demand

To do this the CCG will explore the benefits of technologies including cloud computing, wireless networking, and mobile devices (phones, tablet computers).

We will also engage with national information programmes; for example, the gradual roll-out of payment by results to mental health and community services. As a CCG we will also need to progress arrangements for information sharing between organisations and the associated information governance issues. For example in developing integrated working with the local authority as part of the joint Kingston at Home programme, information sharing protocols which both protect service users and enable professionals to provide optimum care will be required.

From 1 April 2013 the CCG will be responsible for managing and maintaining its own corporate IT and will take delegated responsibility for managing and maintaining primary care IT from the NHS Commissioning Board. In 2013/14 the CCG will fulfil these responsibilities via a contract with Your Healthcare CIC's IT services.

8.8. Emergency preparedness

The emergency preparedness team has been busy during 2012/13. Within south west London we have seen the Olympic Cycle races pass through our boroughs, in particular having a significant impact on Kingston and Richmond. Preparation for these events included prior planning with multi-agency partners and following the processes outlined in the NHS South West London emergency management plan. The emergency management plan was reviewed regularly in the lead up to the Olympics. These reviews were done in accordance with the Civil Contingencies Act 2004, NHS Emergency Planning Guidance 2005 and the London Olympic Resilience Planning Assumptions (LORPA).

NHS South West London provided a 24/7 emergency response capability with a rota of directors on call. The on-call director provided overall direction for all five borough teams during an incident with the support of the senior manager on call within each borough team. This process was regularly tested and a weekly pager test carried out with the director on call.

These arrangements have now ceased as we move to new local structures. Currently, there is an on call rota for Clinical Commissioning Groups (CCGs) in South West London to deal with EPRR issues and one for the Commissioning Support Unit to deal with surge capacity management on behalf of the CCGs.

As a Category One responder under the Civil Contingencies Act 2004, emergency preparedness was a statutory requirement for Kingston Primary Care Trust (PCT) until April 2013.

The PCT retained a dedicated emergency planning manager who reported to the director of public health and who was a member of the South West London Regional Resilience Forum. Other NHS organisations within South West London engaged with us by way of the South West London Emergency Preparedness Network and the Chief Executives Emergency Planning Network. Further connections within localised areas were covered by the emergency planning managers for each of the borough teams attending the local borough resilience forums.

The PCT maintained a number of plans, all of which are based on the borough risk register, including:

- a business continuity plan
- a flu pandemic plan
- severe weather plan
- a heatwave plan

The priorities for 2013 were:

- to continue the emergency preparedness training and exercising programme
- to maintain emergency preparedness in the period of transition up to April 2013

8.9. Information Governance

NHS Kingston recognises that Information Governance (IG) is an integral part of risk management. It is therefore committed to ensuring that it meets the required compliance standards of the IG Toolkit to ensure the secure and confidential handling of all personally identifiable data.

There is a formal process by which the NHS South West London Cluster co-ordinates the self assessment against the IG requirements. This assessment is then independently audited by the cluster's internal auditors RSM Tenon to ensure assurance that sufficient evidence is in place to support the attainment levels assigned by the PCT.

Each year a comprehensive IG action plan is agreed and implementation monitored by the IG Steering Group to ensure any gaps are identified and improvements made. The action plan has an emphasis on ensuring that staff complete the mandated modules of the IG e-learning programme and raising the importance of security and confidentiality in accordance with the Care Records Guarantee.

Reported Information Governance Incidents

- There were no serious incidents (categorised as 3-5) reported by Kingston PCT during 2012-13
- There were five minor incidents (categorised as 1-2) summarised in the table below.

Summary of other personal data related incidents in 2012/13

category	nature of incident	NHS SWL total	Cluster directorates	Kingston
I	loss/theft of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	1		
II	loss/theft of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	1		
III	insecure disposal of inadequately protected electronic equipment, devices or paper documents	1		
IV	unauthorised disclosure	17	5	5
V	other	2	1	
	Total	**22**	**6**	**5**

8.10. Sustainability

The NHS South West London Cluster is committed to environmental and sustainability management. Through Essentia Community, we employ a dedicated team to enable us to better understand and reduce the environmental impact of all of our activities.

We have in place a Sustainable Development Management Plan (SDMP), through which we drive our environmental performance improvement actions. The SDMP includes details of our carbon footprint year-on-year since 2007/08 for all areas of activity including energy and water consumption, waste disposal, staff and business travel and procurement.

The SDMP Action plan is implemented through Essentia Community's dedicated online portal *Simple* (sustainability implementation management platform and learning environment). All staff from across the Cluster are able to login to *Simple* to view the carbon performance of the sites/organisations relevant to them. They are able to utilise *Simple* to identify projects to reduce carbon emissions, and discuss with other members of staff and the Essentia Community Environmental Team, all aspects of how best to implement them. For example, discussions may include how to cost a project and how to calculate paybacks or the carbon impact of a project. *Simple* is designed to empower staff to act on sustainability issues and is also supported by regular announcements from Essentia Community's Environmental Team on the latest happenings across the cluster.

In-line with national targets, the NHS South-West London Cluster has committed to reduce its carbon footprint by 10% by 2015/16 from a 2007/08 baseline. Its performance is measured through several annual mandatory reporting requirements including the NHS Sustainable Development Unit's 'Sustainability Reporting Data Template' and the Estates Return Information Collection. To see how the cluster is performing, please visit www.essentia.gstt.nhs.uk/a-z-directory/a-e/environmentalservices.aspx

8.11. Risk assessment

1.1.1 The approach to risk management for NHS South West London is set out in the Risk Management and Assurance Policy, originally approved by the Joint Boards in July 2011, and subsequently in September 2012, along with the revised corporate objectives for 2012/13.

1.1.2 The 3 central planks underpinning our risk management approach are:

- Ensuring the governance and risk systems are robust, integrated, safe and valid whilst the transitional structure is in place and operating
- Supporting the development of robust governance and risk arrangements in future organisations e.g. NHS Commissioning Board, Clinical Commissioning Groups, Local Authorities (Public Health)
- Managing the closedown of five statutory Primary Care Trusts from a governance and risk perspective, by March 2013.

1.1.3 The Corporate Objectives for 2012-13 had two distinct themes to reflect the rapidly changing environment:

- Core objectives focussed on 'delivery for today'
- Transition objectives associated with 'building for the future.'

Against these corporate objectives, risks were identified to ascertain what might threaten their delivery and assessed for impact and likelihood of realisation applied across the breadth of the commissioning portfolio to ensure comprehensive coverage, taking account of financial, clinical, quality, transition and performance implications.

The Board Assurance Framework (BAF) during 2012/13 was reframed around these objectives and accountability for delivery was described in terms of "cluster oversight" and "delegated

responsibility" across the emerging parts of the new NHS commissioning architecture. The ownership of BAF risks clearly reflected the delegation, with potential for some shared ownership, in line with shadow operating and transition arrangements.

1.1.3 The organisation's risk profile for 2012/13 comprised:

- Identification and assessment of risks relating to the cluster's corporate objectives
- Newly identified risks relating to delivery and transition under the shadow operating arrangements
- BAF risks identified by individual Clinical Commissioning Groups (CCGs) under shadow operating arrangements. These have been monitored by the CCG Governing Bodies and also visible on the NHS South West London BAF to maintain an oversight of risks associated with delegated responsibilities.

Key risks during 2012/13 have included:

- A heightened focus on emergency planning through the Olympic period and mitigating the impact of transition on the effectiveness of NHS South West London's response to a major incident and business continuity
- Complexity and pace of change around the requirement to integrate multiple strands of system development and transition
- Complexity around the governance and transfer management arrangements for the closedown of five statutory bodies by 31 March 2013
- Loss or movement of senior leadership and capacity affecting decision-making and delivery
- Maintaining positive employee relationships and staff morale during transition.

The final Joint Boards report presented in March 2013 shows demonstrable movement of each risk from top right hand corner high impact/high likelihood to low impact /low likelihood ratings as controls for mitigation have been applied and their effectiveness assured.

1.2 The risk and control framework

1.2.1 NHS South West London commissioned 4risk™ risk management software to support the ongoing maintenance of risk registers and board assurance framework. The software allows for a consistent 'live' risk management process, enabling risk owners to be responsible for the management and updating of their risks.

1.2.2 In terms of preventing risk, the risk management system is designed to work proactively, by identifying the factors causing the inherent risk and preventing the risk from realisation by putting controls in place and strategies (actions) to mitigate those risks where appropriate. Other key deterrent measures include:

- Training – provided to all staff, including general risk management, Bribery Act, safeguarding, fire, manual handling, work station assessment and information governance.
- Development of cluster wide and borough specific (whichever is applicable) policies and procedures.

1.3 Executive management team and board committee scrutiny of risks

1.3.1 NHS South West London Cluster wider leadership have retained close scrutiny of BAF risks throughout the year, responding to non-executive directors' need for additional assurance on risk and mitigations. Risk workshops were held in the summer of 2012, including CCG chief officers, focussing on whether the right risks had been identified in transition, and whether they were being effectively managed. The controls and assurances on both the 'extreme' and the 'high' rated risks were subject to detailed review and scrutiny.

1.3.2 The outcome of this provided additional boards' assurance of the continued grip on transition risks, continuity in terms of anticipated changes in risk ownership, as well as a change to style of risk reporting to ensure the narrative clearly articulated both the nature of risks and sources of positive assurance on the controls for mitigation.

1.3.3 Management of both manifest and potential risk is achieved through a governance/risk framework which challenges and provides scrutiny of risk at every level in the organisation. In addition to senior management team, risk sub committee, clinical/integrated governance committee and joint boards' meetings, having a remit for risk, oversight of the arrangements is also provided by the audit committee, particularly with regard to the sources of assurance. External assurance is provided by internal audit, external audit and other regulatory, compliance and audit bodies.

1.3.4 Other mechanisms to support risk management (of both manifest and potential risks) include the system in place for reporting and investigation of serious incidents (SIs), including a serious incident monitoring panel to monitor completion of SI investigations and implementation of action plans across the cluster. Significant issues which are identified are escalated to senior management team and joint boards.

1.4 Managing risks around delegation to CCGs under shadow working arrangements

1.4.1 The delegation of business to CCGs, as agreed by the joint boards, was fully enacted with respect to the management of risks. The adoption of risks by each CCG governing body was commensurate with their new shadow accountability, their local corporate objectives for 2012/13 (sitting under the joint boards' corporate objectives set in May 2012), and their local context and challenges.

1.4.2 As a result of this approach, the risk register and risk management framework formed part of the evidence required for CCGs' application for authorisation, and clearly demonstrated CCG ownership of those risks.

1.4.3 The cluster governance and risk team has provided on-going support and workshops to each of the CCGs either collectively or individually with workshops and facilitated governing body sessions.

1.5 Review of the effectiveness of risk management and internal control

1.5.1 The annual internal audit plan (approved by the Joint Audit Committee) includes a review of Board Assurance and Risk Management arrangements – looking at both documentation and implementation. It was carried out during a three month period from October 2012 to December 2012 and will inform the year end Head of Internal Audit Opinions.

- The audit reviewed any changes to previous arrangements, ensuring there was clear process for escalation of issues to the boards, throughout the period of transition towards the full establishment of CCGs.
- The review also assessed if there were adequate processes in place for the cluster BAF to pick up and reflect key CCG related risks in this transitional year.

1.5.2 NHS South West London has been awarded the highest merit of 'substantial assurance' throughout the operation of the cluster, with no recommendations for improvement and with the comment that "the systems of internal control reviewed as part of this audit were considered to be adequate in design and efficient in operation".

The internal audit report acknowledges that as part of internal control mechanism, "the transition programme, incident reports, borough complaints, health and safety working group issues, compliance items and other areas of cluster interest have been considered and discussed".

The report further acknowledges the improvements in the format and content of the BAF following previous reviews.

Where assurance is required to support the effective mitigation of risk, the cluster's risk management system allows documentary evidence to be attached for controls, contingencies, actions and assurances. This provides an assurance platform for management and/or third parties i.e. auditors, inspectors and regulators to confirm and record the effectiveness of risk mitigation controls at intervals throughout the year. This review will result in Head of Internal Audit Opinion providing the assurance required for the annual governance statement for each PCT.

1.6 Final board assurance framework report to joint boards in March 2013

A final joint boards risk report was represented in March 2013 to show a comparative picture of risk at the beginning and end of 2012/13, using visual 'heat maps'. The formal transfer of risk ownership, where relevant, was also presented and clearly audited.

8.12. Risk management

This year, NHS South West London Cluster has focused on achieving any outstanding aspects of the three main aims of the NHS South West London approach to risk management, that were set out in the risk management and assurance policy in July 2011. These were to:

- Ensure that the governance and risk systems underpinning the NHS South West London Cluster are robust, integrated, safe and valid for as long as the transitional structure is in place and operating
- Manage those risks associated with the transition of governance, and the risk systems of future organisations such as the National Commissioning Board and Clinical Commissioning Groups
- Manage the process of winding down primary care trusts (from a governance and risk perspective), by March 2013.

Transfer of the risk management function was part of the overall handover of statutory functions programme. Since October 2012, PCT risk registers were disaggregated and transferred to the relevant parts of the new system for ongoing management i.e. CCGs, NHS Commissioning Board (primary care and specialised commissioning), local authorities (public health) and NHS Property Services, etc.

Under shadow operating arrangements, CCGs have developed their individual BAFs which have been presented to the CCG Governing bodies and any key risks are also visible on the NHS South West London BAF as an assurance to the Joint Boards.

The transfer of the ownership of BAF risks has also commenced – those not anticipated to be fully mitigated and closed by 31 March 2013 will be transferred to new owners, with written agreement - to ensure understanding of the inherited risks, business continuity and continued oversight.

8.13. Register of NHS South West London Joint Boards members interests 2012/13

Name	Position	Interests
Sian Elizabeth Bates	South West London Chair	None
Ann Radmore	South West London Chief Executive	Nephew is a senior manager at PWC which we may at times do business with. SRO for London Specialised Commissioning Chief Executive London Ambulance Service
Christina Craig	Interim Chief Executive for NHS SW London (and for NHS SE London)	None
Non-Executive Directors		
Godfrey Allen	Wandsworth NED Partner NED Richmond	Non-Executive Director for Croydon University Hospital from 15 Jan 13 – Acting as Associate Non-Voting member of the Joint Boards from that date
Peter Derrick	Sutton and Merton Vice Chair	Chair – Trafalgar Quadrant Hedge Fund
Paul Gallagher	SW London Audit Committee Chair	Prospective Lay Member for Kingston CCG with responsibilities for Audit Committee
Stephen Hickey	Wandsworth Vice Chair Partner NED Richmond	Trustee, St George's Hospital Charity Chair, Community Transport Association Trustee, Disabled Living Foundation
Charles Humphry	Richmond NED Partner NED Kingston	Director and Shareholder Arlingclose Limited Director and Shareholder Sigma Finance Limited Director of Network Housing Group Chairman of Network Stadium Housing Association Director Network Treasury Services Limited
David Knowles	Kingston Vice Chair Partner NED Sutton and Merton	Member of the Advisory Board at St Anthony's Hospital in Cheam. Member of the LibDem party and have stood in Council Elections. Spouse works for Kingston Hospital NHS Trust

Name	Position	Interests
Toni Letts	Croydon Vice Chair Partner NED Wandsworth	Elected member of Croydon Council. Member of Whitgift Foundation and Chair of Whitgift Care Homes Board Trustee of Brenda Kirby Cancer Centre.
John Simpson	Richmond Vice Chair Partner NED Kingston	Leviathan Consultancy Limited: from April 2000 Anchor Capital Advisors (UK) Limited: from Nov 2002 Marine Capital Limited: from Feb 2004 South West London Health Partnerships Limited (+ sub companies):from April 2005 (nominee of SW London PCTs) East Anglian Student Tenancies Limited: from May 2005 The Environment Trust for Richmond upon Thames: from July 2009 (Trustee/Treasurer) The Sovereign Housing Association Limited: from Sep 2010 (Chair) Awilco Drilling Plc: from April 2011 Spouse - Richmond Council for Voluntary Service (Chair) - note organisation receives some funding from NHS Richmond.
John Thompson	Sutton and Merton NED Partner NED NHS Croydon	NED on Board of London Specialised Commissioning Group; Chair of Lay Advisory Panel Council Member and Trustee of the College of Optometrists: Trustee of Richmond Carers Centre. Non-Executive Director for Croydon University Hospital from 15 Jan 13 – Acting as Associate Non-Voting member of the Joint Boards from that date
Joy Tweed	Sutton and Merton NED Partner NED NHS Croydon	Council member, Health Professions Council
Vidya Verma	Kingston NED Partner NED NHS Sutton and Merton	Magistrate at the SW London Magistrates' Courts which includes Wimbledon, Lavender Hill and Richmond Magistrates' Courts. This is an Honorary position.
Executive Management Team		
Colin Bradbury	Director of Performance and Informatics	Head of Assurance (South London) NHS Commissioning Board
Dr David Finch	Joint Medical Director	Partner Battersea Field Practice. Chair Friends of Asha (GB)
Jocelyn Fisher	Director of HR, OD & Workforce	Managing Director of Employee Relations Solutions Ltd (contracts for interim and management services with the NHS)

Name	Position	Interests
Pennie Ford	Programme Director for Transition	Operations and Delivery Director, Surrey and Sussex, NHS CB (Surrey and Sussex Local Area Team) Spouse: Managing Director 'Agarwal Associates', also trading as '3rd Sector IT'. Spouse is Trustee Dorking CAB
Dr Howard Freeman	Joint Medical Director	Senior Partner Dr Howard Freeman & Partners PMS Contract holders, NHS Wandsworth and NHS Sutton and Merton, GMS NHS Lambeth. Practice had shares in Assura Wandle – none held by me.
Charlotte Gawne	Director of Comms & Corporate Affairs	None
Jacqui Harvey	Director of Transition	None
Dr Jonathan Hildebrand	Director of Public Health	Joint appointment with the Royal Borough of Kingston. Spouse works as a clinical research nurse at the Royal Surrey County Hospital. From 1st November 2012 Lead for medical services at Your Healthcare
Jill Robinson	Director of Finance	Finance Business Director, National Trust Development Agency
Debbie Stubberfield	Director of Nursing	Clinical Quality Director (London) National Trust Development Agency
Rachel Tyndall	Director of BSBV	None
Professional Executive Committee Member		
Dr Tom Coffey	NHS Wandsworth PEC Chair	GP Partner in Brocklebank PMS Practice. Assoc Med GP Director NHSL. A/E clinical assistant in Charing Cross Hospital. GP Director Wandsworth Integrated Health
Dr Naz Jivani	NHS Kingston PEC Chair	Chair (designate) – Kingston CCG Governing Body Partner - New Malden Health Centre Practice is a member of Kingston General Practice Chambers Ltd Director - 424 Medical Ltd (Practice Management support company),

		Board Member – Kingston Co-operative Initiative Ltd An MSK GPwSI, working at Kingston and Molesey Hospitals on a sessional basis
Dr Marilyn Plant	NHS Richmond PEC Chair	None
Dr Martyn Wake	NHS Sutton and Merton PEC Chair	Senior Partner, The Church Lane Practice. Partner (PMS contract holders with NHS Sutton and Merton) Practice has shares in Assura Wandle.

Name	Position	Interests
Dr Shade Alu	NHS Croydon Interim PEC Chair	Director Health Safeguarding Limited. Spouse a GP partner in Croydon.
Dr Val Day	NHS Sutton and Merton Interim DPH	Chair of Trustees – Family Planning Association Managing Director Valday Associates Ltd
Houda Al-Sharifi	NHS Wandsworth DPH	Joint Appointment with Wandsworth Local Authority
Dr Dagmar Zeuner	NHS Richmond DPH	Honorary Senior Lecturer at London School of Hygiene and Tropical Medicine Research Adviser Institute of Child Health (Prof Ruth Gilbert) Member of the Public Health Intervention Advisory Committee, NICE (until Feb 2012) Member of the Local Government Public Health External Reference Group, NICE (from Feb 2012) Partner is publisher of sports magazine to promote open water swimming (ZG Publishing)
Kate Woollcombe	NHS Croydon	None
Clinical Commissioning Group Chairs		
Dr Tony Brzezicki	Croydon CCG Chair	A Brzezicki Consultancy Ltd (Company used to facilitate training and consultancy) Director Queenhill Medical Practice Partner South West London Cancer Network Primary Care Lead London Cancer Board Non-Executive Director London Cancer Alliance Interim Clinical Board GP Member Diagnosis Cancer Implementation Group Chair Royal Marsden Clinical Quality Review Group (London wide) Chair Croydon and Surrey Specialists Ltd (Company used to provide diagnostic services) Managing Director and 25% Shareholder (not trading)

Name	Position	Interests
		Cancer Commissioning Local Advisory Group – Commissioning for Cancer London Alliance Member Croydon PBC Ltd Queenhill Medical Practice is a shareholder
Dr Brendan Hudson	Sutton CCG Chair	Partner-The Grove Road Practice, 83 Grove Rd, Sutton SM1 2DR Elected Councillor, London Borough of Sutton Member of Royal College of General Practitioners, BMA, Medical Protection Society Sutton and Merton LMC Practice is a member of Sutton Horizon Healthcare Limited – Class B Shareholder Dr Hudson's son is employed at Royal Marsden Hospital, Laboratory Dept.
Dr Nicola Jones	Wandsworth CCG Chair	GP & Managing Partner, Brocklebank Group Practice & St Paul's Cottage Surgery Both practices hold PMS contract Practice is a member of Wandsworth Integrated Healthcare Limited – but Dr Nicola Jones holds no director post and has no specific responsibilities within that organisation other than those of other member GPs.
Dr Andrew Smith	Richmond CCG Chair	Partner of Dr Johnson and Partners, Sheen Lane Health Centre. Has Shares in Harmoni Parent Company – 0.08% of total shareholdings.

Department of Health

NHS

Kingston Primary Care Trust

2012-13 Accounts

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Kingston Primary Care Trust

2012-13 Accounts

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

The Department of Health's Accounting Officer has designated the role of signing officer for the final accounts of Kingston 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

Name: Carl Vincent, DH Director, Provider Finance and Finance Transition

Signed.....

Date.....4/6/13

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

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

i. apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the
ii. make judgements and estimates which are reasonable and prudent;
iii. state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

Name: Ann Radmore, ex-Chief Executive Officer, NHS South West London

Signed: 

Date: 4/6/2013

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

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

i. 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:
ii. had in place effective management systems to safeguard public funds and assets and assist in the implementation of corporate governance;
iii. 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;
iv. achieved value for money from the resources available to the PCT;
v. applied income and expenditure to the purposes intended by Parliament and conformed to the authorities which governed them and
vi. 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;

i. apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
ii. make judgements and estimates which are reasonable and prudent;
iii. state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

Name: Jill Robinson, Finance Director, NHS South West London

Signed: 

Date: 4/6/13

INDEPENDENT AUDITOR'S REPORT TO THE DEPARTMENT OF HEALTH'S ACCOUNTING OFFICER IN RESPECT OF KINGSTON PRIMARY CARE TRUST

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

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

- the table of salaries and allowances of senior managers and related narrative notes;
- the table of pension benefits of senior managers and related narrative notes; and
- the pay multiples narrative notes.

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

Respective responsibilities of the signing officer and auditor

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

Scope of the audit of the financial statements

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

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

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

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

Opinion on other matters

In our opinion:

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

Matters on which we report by exception

We report to you if:

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

We have nothing to report in these respects.

Other matters on which we are required to conclude

We are required under Section 5 of the Audit Commission Act 1998 to satisfy

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

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

· our review of the annual governance statement; and

· our locally determined risk-based work on review of transition arrangements and savings plans.

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

Certificate

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

Christian Heeger

Christian Heeger
Senior Statutory Auditor, for and on behalf of Grant Thornton UK LLP

Gatwick

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	**3,719**	3,515
Other costs	5.1	**289,250**	279,385
Income	4	**(8,892)**	(6,516)
Net operating costs before interest		**284,077**	276,384
Investment income	9	**0**	0
Other (Gains)/Losses	10	**(965)**	(866)
Finance costs	11	**560**	0
Net operating costs for the financial year		**283,672**	275,518
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		**283,672**	**275,518**
Of which:			
Administration Costs			
Gross employee benefits	7.1	**2,928**	3,515
Other costs	5.1	**7,087**	5,739
Income	4	**(2,040)**	(1,003)
Net administration costs before interest		**7,975**	**8,251**
Investment income	9	**0**	0
Other (Gains)/Losses	10	**(965)**	(866)
Finance costs	11	**116**	0
Net administration costs for the financial year		**7,126**	**7,385**
Programme Expenditure			
Gross employee benefits	7.1	**791**	0
Other costs	5.1	**282,163**	273,646
Income	4	**(6,852)**	(5,513)
Net programme expenditure before interest		**276,102**	**268,133**
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**444**	0
Net programme expenditure for the financial year		**276,546**	**268,133**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**1,000**	1,903
Net (gain) on revaluation of property, plant & equipment	**(662)**	(2,441)
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*	**284,010**	**274,980**

*This is the sum of the rows above plus net operating costs for the financial year after absorption accounting adjustments.
The notes on pages 5 to 44 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	**33,437**	26,974
Intangible assets	13	**631**	910
investment property	15	**0**	0
Other financial assets	21	**0**	0
Trade and other receivables	19	**0**	0
Total non-current assets		**34,068**	27,884
Current assets:			
Inventories	18	**0**	0
Trade and other receivables	19	**2,887**	1,430
Other financial assets	21	**0**	0
Other current assets	22	**0**	0
Cash and cash equivalents	23	**2,847**	13
Total current assets		**5,734**	1,443
Non-current assets held for sale	24	**1,150**	1,600
Total current assets		**6,884**	3,043
Total assets		**40,952**	30,927
Current liabilities			
Trade and other payables	25	**(20,020)**	(21,356)
Other liabilities	26	**0**	0
Provisions	32	**(999)**	(632)
Borrowings	27	**(8)**	0
Other financial liabilities	28	**0**	0
Total current liabilities		**(21,027)**	(21,988)
Non-current assets plus/less net current assets/liabilities		**19,925**	8,939
Non-current liabilities			
Trade and other payables	25	0	0
Other Liabilities	28	0	0
Provisions	32	(2,825)	(519)
Borrowings	27	(8,172)	0
Other financial liabilities	28	0	0
Total non-current liabilities		**(10,997)**	(519)
Total Assets Employed:		**8,928**	8,420
Financed by taxpayers' equity:			
General fund		1,532	(922)
Revaluation reserve		7,396	9,342
Other reserves		0	0
Total taxpayers' equity:		**8,928**	8,420

The notes on pages 5 to 44 form part of this account.

The financial statements on pages 1 to 4 were approved by the Department of Health Audit Sub Committee on the 4th June 2013 and signed on its behalf behalf by:

Carl Vincent, DH Director of Provider Finance and Transition

Signed: .....

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	**(922)**	**9,342**	**0**	**8,420**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(283,672)			**(283,672)**
Net gain on revaluation of property, plant, equipment		662		**662**
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		(1,000)		**(1,000)**
Movements in other reserves			0	**0**
Transfers between reserves	1,608	(1,608)		**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	**(282,064)**	**(1,946)**	**0**	**(284,010)**
Net Parliamentary funding	284,518			**284,518**
Balance at 31 March 2013	**1,532**	**7,396**	**0**	**8,928**
Balance at 1 April 2011	**7412**	**8804**	**0**	**16,216**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(275,518)			(275,518)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment		2,441		2,441
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		(1,903)		(1,903)
Movements in other reserves			0	0
Transfers between reserves	0	0		0
Release of Reserves to Statement of Comprehensive Net Expenditure		0		0
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	(275,518)	538	0	(274,980)
Net Parliamentary funding	267,184			267,184
Balance at 31 March 2012	**(922)**	**9,342**	**0**	**8,420**

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		(284,077)	(276,384)
Depreciation and Amortisation		1,894	1,834
Impairments and Reversals		1,731	3,582
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		(116)	0
Release of PFI/deferred credit		0	0
(Increase)/Decrease in Inventories		0	0
(Increase)/Decrease in Trade and Other Receivables		(1,457)	2,098
(Increase)/Decrease in Other Current Assets		0	0
Increase/(Decrease) in Trade and Other Payables		(318)	1,895
(Increase)/Decrease in Other Current Liabilities		0	0
Provisions Utilised		(143)	(278)
Increase/(Decrease) in Provisions		2,372	447
Net Cash Inflow/(Outflow) from Operating Activities		(280,114)	(266,806)
Cash flows from investing activities			
Interest Received		0	0
(Payments) for Property, Plant and Equipment		(6,429)	(3,162)
(Payments) for Intangible Assets		0	(117)
(Payments) for Other Financial Assets		0	0
(Payments) for Financial Assets (LIFT)		0	0
Proceeds of disposal of assets held for sale (PPE)		4,915	2,900
Proceeds of disposal of assets held for sale (Intangible)		0	0
Proceeds from Disposal of Other Financial Assets		0	4
Proceeds from the disposal of Financial Assets (LIFT)		0	0
Loans Made in Respect of LIFT		0	0
Loans Repaid in Respect of LIFT		0	0
Rental Revenue		0	0
Net Cash Inflow/(Outflow) from Investing Activities		(1,514)	(375)
Net cash inflow/(outflow) before financing		(281,628)	(267,181)
Cash flows from financing activities			
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		(56)	0
Net Parliamentary Funding		284,518	267,184
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		284,462	267,184
Net increase/(decrease) in cash and cash equivalents		2,834	3
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		13	10
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		2,847	13

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.

In accordance with the directed accounting policy from the Secretary of State, the PCT does not consolidate the Kingston Primary Care Trust Charitable Funds Trust for which it is the corporate trustee. This trust fund covered both Kingston PCT and Richmond and Twickenham PCT and is now managed by Hounslow and Richmond Community Healthcare Trust.

Under the provisions of The Health and Social Care Act 2012 (Commencement No.4. Transitional, Savings and Transitory Provisions) Order 2013, Kingston PCT was dissolved on 1 st 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.

The SOFP has therefore been drawn up at 31 March 2013 on the same basis as in previous years, reporting balances on the same basis as would a continuing entity. In particular, there has been no general revaluation of assets or liabilities, and no disclosures have been made under IFRS 5 Non-current Assets Held for Sale and Discontinued Operation.

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 - in the case of Kingston PCT this was to Your Healthcare Community Interest Company in 2010-11. Therefore, FReM guidance on 2012-13 transfers does not apply.

Acquisitions and Discontinued Operations

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

Critical accounting judgements and key sources of estimation uncertainty

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

Critical judgements in applying accounting policies

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

Kingston PCT staff have reviewed all its current lease arrangements, the PCT Director of Finance has taken the judgement that all its leases are operating leases.

Key sources of estimation uncertainty

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

1. Prescribing costs for March were unknown at the time of the draft accounts, an average daily cost for the previous 10 months has been used to estimate the February and March values.

2. The value of the NHS commissioning costs for March have been estimated based upon the average cost of the preceding eleven months. In additon a risk adjusted estimation of likelihood of succesful challenges has been applied.

3. A Continuing Care provision has been calculated based upon the individual claims received and the likelihood of success and the potential financial risk.

4. Building and land assets' value has been estimated by the District Valuer as at 31st December 2012. The estimation undertaken by the district valuer is in accordance with best practices guidance from both the Department of Health and the Royal Institute

1. Accounting policies (continued)

1.2 Revenue and Funding

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

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

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

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

1.3 Care Trust Designation

Kingston Primary Care Trust is not a Primary Care Trust that is designated by the Secretary of State under s45 of the Health and Social Care Act 2001.

1.4 Pooled budgets

The PCT has entered into a pooled budget with Royal Borough of Kingston. Under the arrangement funds are pooled under S75 of the Health Act 2006 for Integrated Disabled Children's Services and a memorandum note to the accounts provides details of the joint income and expenditure.
The pool is hosted by the Local Authority. As a commissioner of healthcare services, the PCT makes contributions to the pool, which are then used to purchase healthcare services. The PCT accounts for its share of the assets, liabilities, income and expenditure of the pool as determined by the pooled budget agreement.

1.5 Taxation

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

1.6 Administration and Programme Costs

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

The broad definition of running costs includes any cost incurred that is not a direct payment for the provision of healthcare or healthcare related services.

Expense incurred under NHS transition redundancy programmes is however classed as "programme" under Treasury budgetary control arrangements and so is recorded as such in the financial statements.

1. Accounting policies (continued)

1.7 Property, Plant & Equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation

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

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

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

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

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

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

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

Subsequent expenditure

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

1. Accounting policies (continued)

1.8 Intangible Assets

Recognition

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

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

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

Measurement

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

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

1.9 Depreciation, amortisation and impairments

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

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

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

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

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

1. Accounting policies (continued)

1.10 Donated assets

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

1.11 Government grants

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

1.12 Non-current assets held for sale

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

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

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

1.13 Inventories

The Primary Care Trust does not account for inventories as these are not considered material.

1.14 Cash and cash equivalents

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

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

1.15 Losses and Special Payments

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

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

1.16 Clinical Negligence Costs

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

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

1. Accounting policies (continued)

1.17 Employee benefits

Short-term employee benefits

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

Retirement benefit costs

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

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

1.18 Research and Development

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

1.19 Other expenses

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

1.20 Grant making

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

1.21 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)

1.22 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.

1.23 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.

1.24 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.

1.25 Provisions

Provisions are recognised when the PCT has a present legal or constructive obligation as a result of a past event, it is probable tha 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 -1.85% for years 0 to 5 inclusive, -1.0% for years 6 to 10 inclusive and 2.2% for over 10 years. in real terms. The rate applicable for all provisions arising from continuing obligations arising from previous employment service is 2.35% in real terms.

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

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

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

1. Accounting policies (continued)

1.26 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.

Loans and receivables

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

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

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 method.

1.27 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 same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

1. Accounting policies (continued)

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

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

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

c) Lifecycle replacement

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

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

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

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

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

Other assets contributed by the PCT to the operator

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

1. Accounting policies (continued)

1.28 Going Concern

As a result of the Health and Social Care Act 2012, PCT's will cease to exist on 1 April 2013.
It is expected that the PCT's functions will be transferred to other public sector bodies. As a result, in accordance with the interpretation of going concern set out in the NHS manual for accounts, the accounts are on a going concern basis because the services will continue to be provided by government.
Where some contract and functions are not expected to transfer to other public sector bodies, the directors have the carrying values of any associated assets and liabilities. No adjustments are considered necessary.

1.29 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
IAS 19 (Revised 2011) Employee Benefits
IAS 32 Financial Instruments: Presentation
IFRS 7 Financial Instruments: Disclosures

2 Operating segments

In 2012-13 and 2011-12 the PCT only recognised one type of expenditure which as an operating segment would be classified commissioning. Previously, the PCT reported seperate operating segments of provider and commissioner.
From 1st August 2010 Provider services were transferred to Your Healthcare,
a Community Interest Company.

3. Financial Performance Targets

3.1 Revenue Resource Limit

	2012-13 £000	2011-12 £000
The PCTs' performance for the year ended 2012-13 is as follows:		
Total Net Operating Cost for the Financial Year	**283,672**	275,518
Revenue Resource Limit	**287,630**	280,033
Under/(Over)spend Against Revenue Resource Limit (RRL)	3,958	4,515

3.2 Capital Resource Limit

	2012-13 £000	2011-12 £000
The PCT is required to keep within its Capital Resource Limit.		
Capital Resource Limit	**14,325**	1,865
Charge to Capital Resource Limit	**9,697**	1,865
(Over)/Underspend Against CRL	**4,628**	**0**

3.3 Provider full cost recovery duty

The PCT had no provider services in 2012-13 or 2011-12

3.4 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**284,518**	267,184
Cash Limit	**286,473**	272,530
Under/(Over)spend Against Cash Limit	**1,955**	**5,346**

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

	2012-13 £000
Total cash received from DH (Gross)	258,500
Less: Trade Income from DH	0
Less/(Plus): movement in DH working balances	0
Sub total: net advances	**258,500**
(Less)/plus: transfers (to)/from other resource account bodies (free text note required)	0
Plus: cost of Dentistry Schemes (central charge to cash limits)	4,153
Plus: drugs reimbursement (central charge to cash limits)	21,865
Parliamentary funding credited to General Fund	**284,518**

4 Miscellaneous Revenue

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Fees and Charges	**0**	0	0	1
Dental Charge income from Contractor-Led GDS & PDS	**1,899**		1,899	1,956
Dental Charge income from Trust-Led GDS & PDS	**0**		0	0
Prescription Charge income	**1,117**		1,117	1,395
Strategic Health Authorities	**799**	0	799	847
NHS Trusts	**0**	0	0	0
NHS Foundation Trusts	**0**	0	0	0
Primary Care Trusts Contributions to DATs	**0**		0	0
Primary Care Trusts - Other	**653**	9	644	48
Primary Care Trusts - Lead Commissioning	**0**	0	0	108
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	**1**	0	1	0
Recoveries in respect of employee benefits	**0**	0	0	0
Local Authorities	**26**	0	26	93
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	**2,366**	0	2,366	1,158
Charitable and Other Contributions to Expenditure	**0**		0	0
Receipt of donated assets	**0**		0	0
Receipt of Government granted assets	**0**		0	0
Rental revenue from finance leases	**0**	0	0	0
Rental revenue from operating leases	**2,031**	2,031	0	910
Other revenue	**0**	0	0	0
Total miscellaneous revenue	**8,892**	**2,040**	**6,852**	**6,516**

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	11,111		11,111	11,648
Non-Healthcare	2,539	2,539	0	1,470
Total	13,650	2,539	11,111	13,118
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	138,525	0	138,525	134,178
Goods and services (other, excl Trusts, FT and PCT))	22	0	22	81
Total	138,547	0	138,547	134,259
Goods and Services from Foundation Trusts	20,153	78	20,075	19,539
Purchase of Healthcare from Non-NHS bodies	45,294		45,294	40,010
Social Care from Independent Providers	2,391		2,391	1,925
Expenditure on Drugs Action Teams	1,420		1,420	990
Non-GMS Services from GPs	884	0	884	1,364
Contractor Led GDS & PDS (excluding employee benefits)	6,319		6,319	6,265
Salaried Trust-Led PDS & PCT DS (excluding employee benefits)	332		332	375
Chair, Non-executive Directors & PEC remuneration	0	0	0	41
Executive committee members costs	729	729	0	101
Consultancy Services	48	47	1	114
Prescribing Costs	19,029		19,029	19,602
G/PMS, APMS and PCTMS (excluding employee benefits)	26,806	0	26,806	26,199
Pharmaceutical Services	0		0	0
Local Pharmaceutical Services Pilots	70		70	0
New Pharmacy Contract	5,233		5,233	5,991
General Ophthalmic Services	1,353		1,353	1,452
Supplies and Services - Clinical	297	22	275	376
Supplies and Services - General	293	228	65	141
Establishment	188	188	0	757
Transport	0	0	0	0
Premises	1,471	1,271	200	442
Impairments & Reversals of Property, plant and equipment	1,727	0	1,727	3,582
Impairments and Reversals of non-current assets held for sale	0	0	0	0
Depreciation	1,619	1,619	0	1,570
Amortisation	275	275	0	264
Impairment & Reversals Intangible non-current assets	4	0	4	0
Impairment and Reversals of Financial Assets	0	0	0	0
Impairment of Receivables	(532)	1	(533)	683
Inventory write offs	0	0	0	0
Research and Development Expenditure	0	0	0	0
Audit Fees	84	84	0	126
Other Auditors Remuneration	0	0	0	30
Clinical Negligence Costs	0	0	0	51
Education and Training	6	6	0	18
Grants for capital purposes	1,560	0	1,560	0
Grants for revenue purposes	0	0	0	0
Impairments and reversals for investment properties	0	0	0	0
Other	0	0	0	0
Total Operating costs charged to Statement of Comprehensive Net Expenditure	289,250	7,087	282,163	279,385
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	315	315	0	238
Other Employee Benefits	3,404	2,613	791	3,277
Total Employee Benefits charged to SOCNE	3,719	2,928	791	3,515
Total Operating Costs	292,969	10,015	282,954	282,900
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	250	0	250	0
Grants to Private Sector to Fund Capital Projects	1,310	0	1,310	0
Grants to Fund Capital Projects - Dental	0	0	0	0
Grants to Fund Capital Projects - Other	0	0	0	0
Total Capital Grants	1,560	0	1,560	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	1,560	0	1,560	0

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	7,126	5,764	1,362
Weighted population (number in units)*	151,714	151,714	151,714
Running costs per head of population (£ per head)	46.97	37.99	8.98
PCT Running Costs 2011-12			
Running costs (£000s)	7,782	6,559	1,223
Weighted population (number in units)	151,714	151,714	151,714
Running costs per head of population (£ per head)	51.29	43.23	8.06

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

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

5.2 Analysis of operating expenditure by expenditure classification	2012-13 £000	2011-12 £000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	26,806	26,199
Prescribing costs	19,029	19,602
Contractor led GDS & PDS	6,319	6,265
Trust led GDS & PDS	332	375
General Ophthalmic Services	1,352	1,452
Department of Health Initiative Funding	0	0
Pharmaceutical services	0	0
Local Pharmaceutical Services Pilots	70	0
New Pharmacy Contract	5,233	5,991
Non-GMS Services from GPs	884	1,364
Other	0	0
Total Primary Healthcare purchased	**60,025**	61,248
Purchase of Secondary Healthcare		
Learning Difficulties	1,073	1,137
Mental Illness	23,887	24,837
Maternity	10,285	11,027
General and Acute	129,351	122,764
Accident and emergency	6,783	5,821
Community Health Services	20,381	22,812
Other Contractual	17,800	15,956
Total Secondary Healthcare Purchased	**209,560**	204,354
Grant Funding		
Grants for capital purposes	1,560	0
Grants for revenue purposes	0	0
Total Healthcare Purchased by PCT	**271,145**	**265,602**
PCT self-provided secondary healthcare included above	0	0
Social Care from Independent Providers	2,391	1,925
Healthcare from NHS FTs included above	22,180	19,539

6. Operating Leases

6.1 PCT as lessee

The PCT had no lessee agreements in 2012-13 or 2011-12

6.2 PCT as lessor

	2012-13 £000	2011-12 £000
Recognised as income		
Rental Revenue	**2,031**	910
Contingent rents	**0**	0
Total	**2031**	910
Receivable:		
No later than one year	**0**	910
Between one and five years	**0**	0
After five years	**0**	0
Total	**0**	910

7. Employee benefits and staff numbers

7.1 Employee benefits

2012-13				Permanently employed			Other		
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Employee Benefits - Gross Expenditure									
Salaries and wages	2,798	2,157	641	2,600	2,001	599	198	156	42
Social security costs	283	217	66	283	217	66	0	0	0
Employer Contributions to NHS BSA - Pensions Division	363	279	84	363	279	84	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	275	275	0	275	275	0	0	0	0
Total employee benefits	3,719	2,928	791	3,521	2,772	749	198	156	42
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	3,719	2,928	791	3,521	2,772	749	198	156	42
Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net Employee Benefits excluding capitalised costs	3,719	2,928	791	3,521	2,772	749	198	156	42
Recognised as:									
Commissioning employee benefits	3,719			3,521			198		
Provider employee benefits	0			0			0		
Net Employee Benefits excluding capitalised costs	3,719			3,521			198		

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	2,877	2,785	92
Social security costs	286	286	0
Employer Contributions to NHS BSA - Pensions Division	352	352	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	3,515	3,423	92
Less recoveries in respect of employee benefits	0	0	0
Total - Net Employee Benefits including capitalised costs	3,515	3,423	92
Employee costs capitalised	0	0	0
Net Employee Benefits excluding capitalised costs	3,515	3,423	92
Recognised as:			
Commissioning employee benefits	3,515		
Provider employee benefits	0		
Net Employee Benefits excluding capitalised costs	3,515		

In 2011/12 Croydon, Kingston, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs combined their management functions as part of the SW London cluster of PCTs. NHS SW London operated as one management team, sharing resources roles and functions. Expenditure relating to cluster-wide functions (including employee benefits) is shown in the accounts of Wandsworth PCT in 2012/13 and 2011/12.

7.2 Staff Numbers

2012-13				2011-12		
	Total Number	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number
Average Staff Numbers						
Medical and dental	1	1	0	1	1	0
Ambulance staff	0	0	0	0	0	0
Administration and estates	49	45	4	49	47	2
Healthcare assistants and other support staff	0	0	0	0	0	0
Nursing, midwifery and health visiting staff	1	1	0	1	1	0
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	7	7	0	7	7	0
Social Care Staff	0	0	0	0	0	0
Other	0	0	0	0	0	0
TOTAL	58	54	4	58	56	2
Of the above - staff engaged on capital projects	0	0	0	0	0	0

7.3 Staff Sickness absence and ill health retirements

This information is reported in the Annual Report of the PCT

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	1	0	1	0	0	0
£10,001-£25,000	1	0	1	0	0	0
£25,001-£50,000	0	0	0	0	0	0
£50,001-£100,000	1	0	1	0	0	0
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	1	0	1	0	0	0
>£200,000	0	0	0	0	0	0
Total number of exit packages by type (total cost	4	0	4	0	0	0
	£s	**£s**	**£s**	**£s**	**£s**	**£s**
Total resource cost	274,532	0	274,532	0	0	0

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

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

In 2011/12 Croydon, Kingston, Richmond & Twickenham, Sutton & Merton and Wandsworth PCTs combined their management functions as part of the SW London cluster of PCTs. NHS SW London operated as one management team, sharing resources roles and functions. Expenditure relating to cluster-wide functions (including employee benefits) is shown in the accounts of Wandsworth PCT in 2012/13 and 2011/12 which has resulted in some of the redundancy costs included above being recharged from Wandsworth PCT.

7.5 Pension costs

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

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

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

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.
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) Full Actuarial Funding Valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

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

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

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

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

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

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

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

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

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

8. Better Payment Practice Code

8.1 Measure of compliance

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**7,717**	**61,299**	3,077	165,246
Total Non-NHS Trade Invoices Paid Within Target	**6,988**	**54,899**	1,699	151,413
Percentage of NHS Trade Invoices Paid Within Target	90.55%	89.56%	55.22%	91.63%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3,668**	**175,971**	6,855	64,593
Total NHS Trade Invoices Paid Within Target	**2,542**	**167,128**	5,416	56,757
Percentage of NHS Trade Invoices Paid Within Target	69.30%	94.97%	79.01%	87.87%

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

The PCT had no interest arising from claims under this legislation in 2012-13 or 2011-12.

9. Investment Income

The PCT had no investment income in 2012-13 or 2011-12

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	866
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	965	965	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	965	965	0	866

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	116	116	0	0
- contingent finance cost	0	0	0	0
Interest on late payment of commercial debt	0	0	0	0
Other interest expense	0	0	0	0
Total interest expense	116	116	0	0
Other finance costs	0	0	0	0
Provisions - unwinding of discount	444		444	0
Total	560	116	444	0

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	11,799	13,385	24	2,124	1,211	78	6,547	1,035	36,203
Additions of Assets Under Construction				2,795					2,795
Additions Purchased	0	211	0		303	0	2,080	22	2,616
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	8,562	0		0	0	0	0	8,562
Reclassifications	0	0	0	(4,919)	4,499	0	0	420	0
Reclassifications as Held for Sale	(1,500)	(2,000)	0	0	0	0	0	0	(3,500)
Disposals other than for sale	0	0	0	0	(326)	0	0	0	(326)
Upward revaluation/positive indexation	605	57	0	0	0	0	0	0	662
Impairments/negative indexation	(355)	(645)	0	0	0	0	0	0	(1,000)
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	10,549	19,570	24	0	5,687	78	8,627	1,477	46,012
Depreciation									
At 1 April 2012	0	4,698	24	0	582	36	3,255	634	9,229
Reclassifications	0	0	0		0	0	0	0	0
Reclassifications as Held for Sale	0	0	0		0	0	0	0	0
Disposals other than for sale	0	0	0		0	0	0	0	0
Upward revaluation/positive indexation	0	0	0		0	0	0	0	0
Impairments	0	1,071	0	0	221	0	155	280	1,727
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Charged During the Year	0	213	0		164	15	1,132	95	1,619
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	0
At 31 March 2013	0	5,982	24	0	967	51	4,542	1,009	12,575
Net Book Value at 31 March 2013	10,549	13,588	0	0	4,720	27	4,085	468	33,437
Purchased	10,549	13,588	0	0	4,720	27	4,085	468	33,437
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	10,549	13,588	0	0	4,720	27	4,085	468	33,437
Asset financing:									
Owned	10,549	5,026	0	0	4,720	27	4,085	468	24,875
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP PFI contracts	0	8,562	0	0	0	0	0	0	8,562
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	10,549	13,588	0	0	4,720	27	4,085	468	33,437

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	5,904	3,293	145	0	0	0	0	0	9,342
Movements (relating to net downward movement in valuations)	(131)	(1,815)	(145)	0	0	0	0	0	(2,091)
At 31 March 2013	5,773	1,478	0	0	0	0	0	0	7,251

Additions to Assets Under Construction in 2012-13

	£000
Land	0
Buildings excl Dwellings	2,795
Dwellings	0
Plant & Machinery	0
Balance as at YTD	2,795

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	**13,462**	**14,123**	**281**	**451**	**920**	**78**	**5,216**	**985**	**35,516**
Additions - purchased	0	438	0	1,673	291	0	1,331	50	**3,783**
Additions - donated	0	0	0	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassified as held for sale	(2,567)	(665)	(402)	0	0	0	0	0	**(3,634)**
Disposals other than by sale	0	0	0	0	0	0	0	0	**0**
Revaluation & indexation gains	1,569	727	145	0	0	0	0	0	**2,441**
Impairments	(665)	(1,238)	0	0	0	0	0	0	**(1,903)**
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	0	0	0	0	0	0	0	**0**
At 31 March 2012	**11,799**	**13,385**	**24**	**2,124**	**1,211**	**78**	**6,547**	**1,035**	**36,203**
Depreciation									
At 1 April 2011	**0**	**596**	**16**		**483**	**21**	**2,401**	**560**	**4,077**
Reclassifications		0	0		0	0	0	0	**0**
Reclassifications as Held for Sale	0	0	0		0	0	0	0	**0**
Disposals other than for sale	0	0	0		0	0	0	0	**0**
Upward revaluation/positive indexation	0	0	0		0	0	0	0	**0**
Impairments	0	3,582	0	0	0	0	0	0	**3,582**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Charged During the Year	0	520	8		99	15	854	74	**1,570**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluatio	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**0**	**4,698**	**24**	**0**	**582**	**36**	**3,255**	**634**	**9,229**
Net Book Value at 31 March 2012	**11,799**	**8,687**	**0**	**2,124**	**629**	**42**	**3,292**	**401**	**26,974**
Purchased	11,799	8,687	0	2,124	629	42	3,292	401	**26,974**
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	**11,799**	**8,687**	**0**	**2,124**	**629**	**42**	**3,292**	**401**	**26,974**
Asset financing:									
Owned	11,799	8,687	0	2,124	629	42	3,292	401	**26,974**
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	**11,799**	**8,687**	**0**	**2,124**	**629**	**42**	**3,292**	**401**	**26,974**

12.3 Property, plant and equipment

The District Valuer's Office, Wimbledon, performed a valuation on all of the PCTs owned land and buildings as at 31st December, 2012, including those buildings recognised on the Statement of Financial Position as a finance lease under IFRS. The District Valuer is an independant valuer who has no related party, or pecuniary interest in the PCT. This valuation has been used as the basis of valuation of land and buildings within these accounts. The land and buildings were valued on a modern equivalent assets basis.

The PCT received no newly donated assets in 2012-13.

Asset lives:

Economic Lives of Non-Current Assets

	Min Life Years	Max Life Years
Intangible Assets		
Software Licences	5	5
Licences and Trademarks	0	0
Patents	0	0
Development Expenditure	0	0
Property, Plant and Equipment		
Buildings exc Dwellings	2	44
Dwellings	6	6
Plant & Machinery	5	10
Transport Equipment	7	7
Information Technology	5	5
Furniture and Fittings	10	10

Open Market Value of Assets at balance sheet date

Open Market Value at 31 March 2013
Open Market Value at 31 March 2012

At 31st March 2013 the PCT held no assets at open market value

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**	**1,474**	**0**	**0**	**0**	**1,474**
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	0	0	0	0	**0**
Revaluation & indexation gains	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	**0**
In-year transfers to/from NHS bodies	0	0	0	0	0	**0**
At 31 March 2013	**0**	**1,474**	**0**	**0**	**0**	**1,474**
Amortisation						
At 1 April 2012	**0**	**564**	**0**	**0**	**0**	**564**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation or indexation gains	0	0	0	0	0	**0**
Impairments charged to operating expenses	0	4	0	0	0	**4**
Reversal of impairments charged to operating expenses	0	0	0	0	0	**0**
Charged during the year	0	275	0	0	0	**275**
In-year transfers to NHS bodies	0	0	0	0	0	**0**
At 31 March 2013	**0**	**843**	**0**	**0**	**0**	**843**
Net Book Value at 31 March 2013	**0**	**631**	**0**	**0**	**0**	**631**
Net Book Value at 31 March 2013 comprises						
Purchased	0	631	0	0	0	**631**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	**0**
Total at 31 March 2013	**0**	**631**	**0**	**0**	**0**	**631**

Revaluation reserve balance for intangible non-current assets

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

13.2 Intangible non-current assets

2011-12	Software internally generated £000	Software purchased £000	Licences & trademarks £000	Patents £000	Development expenditure £000	Total £000
At 1 April 2011	**0**	**1,358**	**0**	**0**	**0**	**1,358**
Additions - purchased	0	116	0	0	0	**116**
Additions - internally generated	0	0	0	0	0	**0**
Additions - donated	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation & indexation gains	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	**0**
In-year transfers to/from NHS bodies	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluation	0	0	0	0	0	**0**
At 31 March 2012	**0**	**1,474**	**0**	**0**	**0**	**1,474**
Amortisation						
At 1 April 2011	**0**	**300**	**0**	**0**	**0**	**300**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation or indexation gains	0	0	0	0	0	**0**
Impairments charged to operating expenses	0	0	0	0	0	**0**
Reversal of impairments charged to operating expenses	0	0	0	0	0	**0**
Charged during the year	0	264	0	0	0	**264**
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**	**564**	**0**	**0**	**0**	**564**
Net Book Value at 31 March 2012	**0**	**910**	**0**	**0**	**0**	**910**
Net Book Value at 31 March 2012 comprises						
Purchased	0	910	0	0	0	**910**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	**0**
Total at 31 March 2012	**0**	**910**	**0**	**0**	**0**	**910**

13.3 Intangible non-current assets

The PCT has accounted for IT software licences as Intangible non-current assets in 2012-13. The PCT does not generate intangible assets internally.

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

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
Property, Plant and Equipment impairments and reversals taken to SoCNE				
Loss or damage resulting from normal operations	656	0	656	2,952
Over-specification of assets	0	0	0	0
Abandonment of assets in the course of construction	0	0	0	0
Total charged to Departmental Expenditure Limit	656	0	656	2,952
Unforeseen obsolescence	0		0	0
Loss as a result of catastrophe	0		0	0
Other	0		0	0
Changes in market price	1,071		1,071	630
Total charged to Annually Managed Expenditure	1,071		1,071	630
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve				
Loss or damage resulting from normal operations	0			0
Over Specification of Assets	0			0
Abandonment of assets in the course of construction	0			0
Unforeseen obsolescence	0			0
Loss as a result of catastrophe	0			0
Other	0			0
Changes in market price	1,000			1,903
Total impairments for PPE charged to reserves	1,000			1,903
Total Impairments of Property, Plant and Equipment	2,727	0	1,727	5,485
Intangible assets impairments and reversals charged to SoCNE				
Loss or damage resulting from normal operations	4	0	4	0
Over-specification of assets	0	0	0	0
Abandonment of assets in the course of construction	0	0	0	0
Total charged to Departmental Expenditure Limit	4	0	4	0
Unforeseen obsolescence	0		0	0
Loss as a result of catastrophe	0		0	0
Other	0		0	0
Changes in market price	0		0	0
Total charged to Annually Managed Expenditure	0		0	0
Intangible Assets impairments and reversals charged to the Revaluation Reserve				
Loss or damage resulting from normal operations	0			0
Over-specification of assets	0			0
Abandonment of assets in the course of construction	0			0
Unforeseen obsolescence	0			0
Loss as a result of catastrophe	0			0
Other	0			0
Changes in market price	0			0
Total impairments for Intangible Assets charged to Reserves	0			0
Total Impairments of Intangibles	4	0	4	0
Financial Assets charged to SoCNE				
Loss or damage resulting from normal operations	0	0	0	0
Total charged to Departmental Expenditure Limit	0	0	0	0
Loss as a result of catastrophe	0		0	0
Other	0		0	0
Total charged to Annually Managed Expenditure	0		0	0
Financial Assets impairments and reversals charged to the Revaluation Reserve				
Loss or damage resulting from normal operations	0			0
Loss as a result of catastrophe	0			0
Other	0			0
TOTAL impairments for Financial Assets charged to reserves	0			0
Total Impairments of Financial Assets	0	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	0
Abandonment of assets in the course of construction	0	0	0	0
Total charged to Departmental Expenditure Limit	0	0	0	0
Unforeseen obsolescence	0		0	0
Loss as a result of catastrophe	0		0	0
Other	0		0	0
Changes in market price	0		0	0
Total charged to Annually Managed Expenditure	0		0	0
Total Impairments of non-current assets held for sale	0	0	0	0
Inventories - impairments and reversals charged to SoCNE				
Loss or Damage Resulting from Normal Operations	0	0	0	0
Total charged to Departmental Expenditure Limit	0	0	0	0
Unforeseen Obsolescence	0		0	0
Loss as a Result of a Catastrophe	0		0	0
Other (Free text note required)*	0		0	0
Changes in Market Price	0		0	0
Total charged to Annually Managed Expenditure	0		0	0
Total Impairments of Inventories	0	0	0	0
Investment Property Impairments charged to SoCNE				
Loss or Damage Resulting from Normal Operations	0	0	0	0
Total charged to Departmental Expenditure Limit	0	0	0	0
Unforeseen Obsolescence	0		0	0
Loss as a Result of a Catastrophe	0		0	0
Other (Free text note required)*	0		0	0
Changes in Market Price	0		0	0
Total charged to Annually Managed Expenditure	0		0	0
Total Investment Property Impairments charged to SoCNE	0	0	0	0
Investment Property Impairments and reversals charged to the Revaluation Reserve				
Loss or Damage Resulting from Normal Operations	0			0
Over Specification of Assets	0			0
Abandonment of Assets in the Course of Construction	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 Impairments for Investment Property charged to Reserves	0			0
Total Investment Property Impairments	0	0	0	0
Total Impairments charged to Revaluation Reserve	1,000			1,903
Total Impairments charged to SoCNE - DEL	660	0	660	2,952
Total Impairments charged to SoCNE - AME	1,071		1,071	630
Overall Total Impairments	2,731	0	1,731	5,485
Of which:				
Impairment on revaluation to "modern equivalent asset" basis	0	0	0	0
Donated and Gov Granted Assets, included above -				
PPE - Donated and Government Granted Asset Impairments: amount charged to SoCNI DEL*	0	0	0	0
Intangibles - Donated and Government Granted Asset Impairments: amount charged SoCNE -AME*	0	0	0	0

15 Investment property

The PCT held no investment property in 2012-13 or 2011-12

16 Commitments

16.1 Capital commitments

The PCT had no contracted capital commitments at 31 March 2013 not otherwise included in these financial statements (Nil 2011-12).

16.2 Other financial commitments

The PCT has not entered into any non-cancellable contracts (which are not leases or PFI contracts or other service concession arrangements). Nil 2011-12.

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	36	0	584	0
Balances with Local Authorities	0	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	140	0	3,390	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	2,711	0	17,324	0
At 31 March 2013	**2,887**	**0**	**21,298**	**0**
prior period:				
Balances with other Central Government Bodies	110	0	751	0
Balances with Local Authorities	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	63	0	5,670	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	1,257	0	14,935	0
At 31 March 2012	**1,430**	**0**	**21,356**	**0**

18 Inventories

The PCT did not hold any inventory at 31st March 2013 (2011-12:nil)

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	**176**	164	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**0**	9	**0**	0
Non-NHS receivables - revenue	**2,734**	1,018	**0**	0
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**0**	1,264	**0**	0
Provision for the impairment of receivables	**(543)**	(1,075)	**0**	0
VAT	**520**	50	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	**0**	0	**0**	0
Interest receivables	**0**	0	**0**	0
Finance lease receivables	**0**	0	**0**	0
Operating lease receivables	**0**	0	**0**	0
Other receivables	**0**	0	**0**	0
Total	**2,887**	1,430	**0**	0
Total current and non current	**2,887**	1,430		
Included above:				
Prepaid pensions contributions	**0**	0		

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

19.2 Receivables past their due date but not impaired

The PCT had no overdue debt at 31 March 2013 that had not been impaired.

19.3 Provision for impairment of receivables

	2012-13 £000	**2011-12 £000**
Balance at 1 April 2012	**(1,075)**	(392)
Amount written off during the year	**0**	0
Amount recovered during the year	**952**	0
(Increase)/decrease in receivables impaired	**(420)**	(683)
Balance at 31 March 2013	**(543)**	(1,075)

20 NHS LIFT investments

The PCT does not have any financial interest in the Surbiton Hospital LIFT as at 31st March 2013 (Nil 2011-12).

21.1 Other financial assets - Current

The PCT did not have any Other Non Current Financial Assets at 31st March 2013 (Nil 2011-12).

21.2 Other Financial Assets - Non Current

The PCT did not have any Other Non Current Financial Assets at 31st March 2013 (Nil 2011-12).

21.3 Other Financial Assets - Capital Analysis

The PCT did not have any Other Financial Assets - Capital Analysis at 31st March 2013 (Nil 2011-12).

22 Other current assets

The PCT did not have any Other Current Assets at 31st March 2013 (Nil 2011-12).

23 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**13**	0
Net change in year	**2,834**	0
Closing balance	**2,847**	0
Made up of		
Cash with Government Banking Service	**2,846**	12
Commercial banks	**0**	1
Cash in hand	**1**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**2,847**	13
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**2,847**	13
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	533	665	402	0	0	0	0	0	0	**1,600**
Plus assets classified as held for sale in the year	1,500	2,000	0	0	0	0	0	0	0	**3,500**
Less assets sold in the year	(1,670)	(2,280)	0	0	0	0	0	0	0	**(3,950)**
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	**363**	**385**	**402**	**0**	**0**	**0**	**0**	**0**	**0**	**1,150**
Liabilities associated with assets held for sale at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
										0
Balance at 1 April 2011	0	0	0	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	2,567	665	402	0	0	0	0	0	0	**3,634**
Less assets sold in the year	(2,034)	0	0	0	0	0	0	0	0	**(2,034)**
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	**533**	**665**	**402**	**0**	**0**	**0**	**0**	**0**	**0**	**1,600**
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	145

The £3.95m assets sold in the year related to Hollyfield House (£3.5m) and Red Lion Road (£0.45m), whilst the £1.15m assets held for sale related to Elm House and Church Road which have taken longer than expected to complete.

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	**3,974**	6,421	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**0**	0	**0**	0
Family Health Services (FHS) payables	**5,107**	4,802		
Non-NHS payables - revenue	**5,779**	6,115	**0**	0
Non-NHS payables - capital	**74**	1,092	**0**	0
Non_NHS accruals and deferred income	**4,985**	2,926	**0**	0
Social security costs	**39**	0		
VAT	**0**	0	**0**	0
Tax	**62**	0		
Payments received on account	**0**	0	**0**	0
Other	0	0	0	0
Total	**20,020**	21,356	**0**	0
Total payables (current and non-current)	**20,020**	**21,356**		

26 Other liabilities

The PCT did not have any Other Liabilities at 31st March 2013 (Nil 2011-12).

27 Borrowings

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Bank overdraft - Government Banking Service	**0**	0		
Bank overdraft - commercial banks	**0**	0		
PFI liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
LIFT liabilities:				
Main liability	**8**	0	**8,172**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**0**	0	**0**	0
Other (describe)	**0**	0	**0**	0
Total	**8**	**0**	**8,172**	**0**
Total other liabilities (current and non-current)	**8,180**	**0**		

Borrowings/Loans - Payment of Principal Falling Due in:

	DH £000s	Other £000s	Total £000s
0 - 1 Years	0	671	**671**
1 - 2 Years	0	112	**112**
2 - 5 Years	0	381	**381**
Over 5 Years	0	7,016	**7,016**
TOTAL	**0**	**8,180**	**8,180**

28 Other financial liabilities

The PCT did not have any Other Financial Liabilities at 31st March 2013 (2012 nil)

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	**103**	103	**0**	0
Deferred income addition	**0**	0	**0**	0
Transfer of deferred income	**0**	0	**0**	0
Current deferred Income at 31 March 2013	**103**	103	**0**	0
Total other liabilities (current and non-current)	**103**	**103**		

30 Finance lease obligations

The PCT has no finance lease obligations. (Nil 2011-12).

31 Finance lease receivables as lessor

The PCT has no finance lease receivables as a lessor. (Nil 2011-12)

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	**1,151**	186	251	47	0	450	0	0	217	0
Arising During the Year	**2,453**	0	5	168	0	2,092	0	0	0	188
Utilised During the Year	**(143)**	(18)	(74)	(16)	0	0	0	0	(35)	0
Reversed Unused	**(81)**	0	0	0	0	(15)	0	0	(66)	0
Unwinding of Discount	**444**	141	303	0	0	0	0	0	0	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	**3,824**	309	485	199	0	2,527	0	0	116	188
Expected Timing of Cash Flows:										
No Later than One Year	**999**	36	86	199	0	435	0	0	55	188
Later than One Year and not later than Five Years	**2,552**	139	321	0	0	2,092	0	0	0	0
Later than Five Years	**273**	134	78	0	0	0	0	0	61	0

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

The nature of the PCT's Provisions is such that there is a great degree of certainty over the level of future payments. Pensions provisions are payable to the NHSPA and local Provider Trusts on a quarterly basis.

Following the Department of Health announcement on 15 March 2012 of the introduction of deadlines for individuals to request assessment of eligibility for NHS Continuing Healthcare funding a significant number of claims have been received and work has been undertaken by the continuing care team to allocate the claims to individual PCT's and assess the likelihood of success and potential financial risk. In arriving at the provision to be included within the accounts a number of factors have been incorporated:

1. Estimated total number of outstanding claims by PCT following 30 September 2012 deadline
2. Length of claim period using typical claim costs
3. Risk adjusted for Health needs costs only
4. Review team costs
5. Interest rate charges - based on average length of liability
6. Probability of successful claim

33 Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities		
Equal Pay	0	0
Other	0	(870)
Amounts Recoverable Against Contingent Liabilities	0	0
Net Value of Contingent Liabilities	0	(870)
Contingent Assets		
Contingent Assets	0	0
Net Value of Contingent Assets	0	0

34 PFI and LIFT - additional information

The PCT has a Local Improvement Finance Trust ('LIFT') at Surbiton Health Centre, Surbiton. The PCT's LIFT partner is South West London Local Improvement Finance Trust ('LIFT Co'). The PCT, the Department of Health, and private sector bodies each own an equity stake in LIFT Co, with the level of each stake set so no one party has over all control of the entity.

The LIFT Co entered into a land retained agreement with the PCT: LIFT Co built a new Surbiton Health Centre, and leased this asset to the PCT for 30 years from the agreement date. In addition to the lease of the asset, and intrinsically linked to it, LIFT Co was also contracted to provide facilities management and other services over the 30 years of the lease, services in excess of a normal commercial rental agreement.

Financial close of the scheme and the signing of the agreement was in August 2011 and completion and opening of the Centre in March 2013. In April 2013 the asset was transferred to NHS Property Services At the end of the 30 year term the NHS has the option, but not the obligation, to repurchase Surbiton Health Centre from LIFT Co at a value assessed by a professional valuer and adjusted for changes in the asset's fair value as forecast at the scheme's inception.

In certain circumstances the PCT and LIFT Co can cancel the Lease Agreement. However, these circumstances are considered to be remote and the PCT believes that it has secure occupation of the building for the life of the lease.

The annual payments made to LIFT Co vary according to RPI. This payment variance is closely linked to the underlying contract and the PCT believes it does not have to be separately accounted for as an embedded derivative. There also are other 'change in payment' triggering clauses in the LIFT Co agreement, called availability and service failures, which impact the amounts paid by the PCT to the LIFT operator. None of these are required to be separately accounted for under IFRS and are disclosed by the PCT under premises costs.

Under IFRIC 12, Service Concessionary Arrangements, the PCT's lease with LIFT Co is in substance a form of asset financing. The PCT has therefore accounted for the lease as a finance lease under IAS17, and recognized both the asset, and commensurate finance lease liability, at inception. The imputed finance lease charge is detailed in the table below.

	31 March 2013 £000	31 March 2012 £000
34.1 Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI		
Total charge to operating expenses in year - OFF SOFP PFI	0	0
Service element of on SOFP PFI charged to operating expenses in year	0	0
Total	0	0
Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI		
No Later than One Year	0	0
Later than One Year, No Later than Five Years	0	0
Later than Five Years	0	0
Total	0	0

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

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

Charges to operating expenditure and future commitments in respect of on and off SOFP LIFT	31 March 2013 £000	31 March 2012 £000
Total Charge to Operating Expenses in year - OFF SOFP LIFT	0	0
Service element of on SOFP LIFT charged to operating expenses in year	96	0
Total	96	0

	31 March 2013 £000	31 March 2012 £000
Payments committed to in respect of off SOFP LIFT and the service element of on SOFP LIFT.		
LIFT Scheme Expiry Date:		
No Later than One Year	191	0
Later than One Year, No Later than Five Years	814	0
Later than Five Years	11,716	0
Total	12,721	0

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

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

Imputed "finance lease" obligations for on SOFP LIFT Contracts due	31 March 2013 £000	31 March 2012 £000
No Later than One Year	1,392	0
Later than One Year, No Later than Five Years	3,168	0
Later than Five Years	17,106	0
Subtotal	21,666	0
Less: Interest Element	(13,486)	0
Total	8,180	0

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	8,357		
UK GAAP capital expenditure 2012-13 (Reversionary Interest)	0		

36 Financial Instruments

Financial risk management

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

Currency risk

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

Interest rate risk

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

Credit Risk

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

Liquidity Risk

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

36.1 Financial Assets	At 'fair value through profit and loss' £000	Loans and receivables £000	Available for sale £000	Total £000
Embedded derivatives	0			**0**
Receivables - NHS		176		**176**
Receivables - non-NHS		2,711		**2,711**
Cash at bank and in hand		2,847		**2,847**
Other financial assets	0	0	0	**0**
Total at 31 March 2013	**0**	**5,734**	**0**	**5,734**
Embedded derivatives	0			0
Receivables - NHS		164		164
Receivables - non-NHS		1,266		1,266
Cash at bank and in hand		13		13
Other financial assets	0	0	0	0
Total at 31 March 2012	0	1,443	0	1,443

36.2 Financial Liabilities	At 'fair value through profit and loss' £000	Other £000	Total £000
Embedded derivatives	0		**0**
NHS payables		3,974	**3,974**
Non-NHS payables		17,324	**17,324**
Other borrowings		0	**0**
PFI & finance lease obligations		0	**0**
Other financial liabilities	0	0	**0**
Total at 31 March 2013	**0**	**21,298**	**21,298**
Embedded derivatives	0		0
NHS payables		6,421	6,421
Non-NHS payables		14,935	14,935
Other borrowings		0	0
PFI & finance lease obligations		0	0
Other financial liabilities	0	0	0
Total at 31 March 2012	**0**	21,356	21,356

37 Related Party Transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£	£	£	£
Central Surgery (Dr. P.Moore)	1,559,563	113,579	16,556	0
Kingston Cooperative Initiative(Dr. P. Moore, Dr.V.Grippaudo, Dr.N.Iqbal. Dr.N.Jivani)	696,240	86,427	0	0
Churchill Medical Centre(Dr.C.Alessi)	2,402,122	0	0	0
Groves Medical Centre (Dr.V.Grippaudo)	1,446,538	0	45,780	0
West Barnes Lane Surgery (Dr.N.Iqbal)	782,060	0	21,184	0
New Malden Medical Centre (Dr.N.Jivani)	522,796	0	12,266	0

The Department of Health is regarded as a related party. During the year Kingston PCT has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department.
These include:
Strategic health Authorities
NHS Foundation Trusts
NHS Trusts
NHS Litigation Authority
NHS Business Services Authority

In addition, the PCT has had a number of material transactions with other government departments and other central and local government bodies.

Major Healthcare providers

	Payments to Related Party	Receipts from Related Party	
	£	£	
Kingston Hospital	77,145,938		Acute Trusts
St George's	23,615,983		Acute Trusts
Royal Marsden	7,274,114		Foundation Trusts
Epsom & St Helier (Acute & Renal)	8,497,324		Acute Trusts
London Ambulance Service	4,352,626		Acute Trusts
Guy's & St Thomas'	3,034,845		Foundation Trusts
Royal Brompton & Harefield	2,677,987		Foundation Trusts
Imperial College	1,723,656		Acute Trusts
South West London & St Georges	16,825,207		Acute MH Trusts
Your Healthcare	22,063,834	1,310,489	Social Enterprise

Prior Year Comparators - 2011/12

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£	£	£	£
Central Surgery (Dr. P.Moore)	595,566	35,153	9,080	
Kingston Cooperative Initiative(Dr. P. Moore, Dr.V.Grippaudo,	862,623	19,616		
Dr.N.Iqbal. Dr.N.Jivani)	11,590			
Churchill Medical Centre(Dr.C.Alessi)	717,316			
Groves Medical Centre (Dr.V.Grippaudo)	62,718		3,300	
West Barnes Lane Surgery (Dr.N.Iqbal)	737,358		63,695	
New Malden Medical Centre (Dr.N.Jivani)	466,628		29,260	

Major Healthcare providers

	Expenditure with Related	Income from Related Party	Amounts owed to Related	Amounts due from Related
	£	£	£	£
Kingston Hospitals NHS Trust	74,707,957	100	1,548,860	
South West London& St Georges Mental Health Trust	18,419,112		561,368	
St Georges NHS Trust	22,192,996		121,323	
Epsom and St Helier NHS Trust	9,236,586		42,888	
The Royal Marsden NHS Foundation Trust	7,283,191		108,955	
London Ambulance Service	4,362,094		3,388	
Wandsworth Primary Care Trust	1,530,352	437,355	1,696	
Croydon Primary Care Trust	8,917,857	33,995	95,312	
Guys & St Thomas Hospital	2,379,591		143,000	
Imperial College Healthcare	1,858,486		258,909	
Royal Brompton & Harefield NHS Trust	3,022,754		33,214	
University College London NHS Trust	1,315,471			
Your Health Care	22,338,725	804,982	336,536	

Your Health Care is a Social Enterprise which is considered to be a related party due to the proportion of income from the PCT and historically the provider services was part of the PCT.

38 Losses and special payments

The PCT had no Losses and Special Payments in 2012-13 or 2011-12.

39 Third party assets

The PCT ceased to hold cash and cash on behalf of patients after 31 July 2010.Responsibility for this transferred to its former PCT Provider Arm (Your HealthCare) upon its establishment as a Community Interest Company.

40 Section 31 Pooled Budget

The PCT has entered into a pooled budget with Royal Borough of Kingston. Under the arrangement funds are pooled under S31 of the Health Act 1999 for Integrated Disabled Children's Services.

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

2012-13	2011-12
£000	£000
1,127	1,073

41 Cashflows relating to exceptional items

There were no exceptional items affecting cashflow in 2012-13 (Nil 2011-12).

42 Events after the end of the reporting period

The passing of the Health and Social Care Bill in March 2012 has far-reaching implications for the organisation. The Primary Care Trust ceased to exist as an entity after March 31st 2013. During the course of the transitional 2012-13 financial year, the organisation has worked with its partners across South West London to establish successor organisations to ensure a smooth transition to the new organisational structures.

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

Kingston Clinical Commissioning Group
NHS England
Royal Borough of Kingston upon Thames
Public Health England
Department of Health
NHS Property Services Ltd

Certain assets have transferred to NHS Property Services and other entities on 1st April 2013. These were considered operational at the year end, and so have not been impaired in the PCT books. It is for the successor body to consider whether, in 2013-14, it is necessary to review these for impairment.

Kingston Primary Care Trust
Annual Governance Statement 2012 - 2013

NHS Kingston

Organisation Code:

Governance Statement

1 Scope of responsibility

1.1 In accordance with Standing Orders, the Accountable Officer means the NHS Officer responsible and accountable for funds entrusted to each PCT and for ensuring the proper stewardship of public funds and assets. In respect of each PCT, the Accountable Officer is the Chief Executive, responsible for the overall performance of the executive functions of the boards of the five PCTs. She is the Accountable Officer for each of the PCTs and responsible for ensuring the discharge of each of the PCT's statutory obligations, under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for PCT Chief Executives. The single individual appointed as Chief Executive in respect of each PCT acts as the Chief Executive of NHS South West London Cluster when all five quorate PCTs meet simultaneously as the Joint Boards.

1.2 At its meeting on the 31 January 2013, NHS SWL Joint Boards approved a report which proposed that an interim Chief Executive, Christina Craig be appointed across South London, working across both South East and South West Clusters until 31 March 2013.

To enable Christina Craig to fully discharge her role as interim Chief Executive for NHS SWL, the Joint Boards approved the proposal that Ann Radmore, NHS SWL Chief Executive would delegate her powers for the day to day management of NHS South West London Cluster affairs, within the limits defined in NHS SWL Standing Orders and Standing Financial Instructions dated 14 July 2011 (refreshed and approved by Joint Boards 15th November 2012).

Ann Radmore retained Accountable Officer status for NHS SWL Cluster and the exercise of her vote. She was seconded from the London Ambulance Service (LAS), back to NHS SWL for up to 1 day per week and attended

- NHS SWL Joint Boards
- NHS SWL Finance Committee
- NHS SWL Audit Committee

These arrangements therefore represent a transfer of management responsibility, not a transfer of accountability.

1.3 Therefore the accountability described in Para. 1.1 above and enshrined in the Accountable Officer Letter has remained with Ann Radmore for the remainder of 2012/2013.

2 The Governance Framework of the Organisation

2.1 Governance Framework

2.1.1 NHS Croydon, NHS Kingston, NHS Richmond & Twickenham, NHS Sutton & Merton, and NHS Wandsworth are responsible for commissioning services in South West London. The five PCTs have collaborated to form the SW London Cluster, governed by the NHS SWL Governance Framework which was developed in accordance with NHS London and national guidance and given legal and NHS London assurance of compliance. The Joint Boards then approved a unified Corporate Governance Framework in July 2011, covering SOs, SFIs, Reservation of Powers and Scheme of Delegation which has underpinned governance arrangements throughout the operation of the Cluster, refreshed at intervals throughout the year to reflect governance arrangements in transition and the fluid operating landscape

2.1.2 The combined statutory Boards of the five PCTs meet together monthly (alternating public meetings with seminar sessions) as the NHS South West London 'Joint Boards'. As the Joint Boards comprise the combined quorate PCT boards, decisions can only be made on the basis of the powers granted by statute to the individual PCT Boards.

2.1.3 The majority of local board issues have been addressed in the context of Joint Boards, separately identified on the agenda, with the decisions referred to the appropriate Board members and recorded accordingly.

2.1.4 In the light of the David Nicholson Letter to NHS Leaders on the 13th August - "Planning for a Secure Transition to the New Health and Care System" - which signalled his expectation that, to ensure stability and resilience, the future system leaders (where appointed) should lead core operational delivery from 1st October 2012, in addition to planning for 2013/14, governance arrangements have been transferred in a measured way to the new system, to underpin this planned shadow operating period.

A Joint Boards' seminar was held in September 2013 to brief members on proposed changes in governance and management arrangements between 1st October and the transfer of statutory accountability 1st April 2013. In summary this covered (a) the principles for transition; and (b) detailed management arrangements from 1st October, including a summary of what would be delegated and what would be retained by the SW London CEO. It also included the direction from NHS London that the NHS Commissioning Board Local Delivery Director would take on operational responsibility for future NHS Commissioning Board functions and join the Joint PCT Boards to provide assurance.

Any changes in management responsibilities and relationships for the transition period concerned the "Executive Function" of the PCT and not the "Governance Function".

2.1.5 The Executive also commissioned an external Governance review from 'The Berkeley Partnership' to provide further assurance on its governance arrangements through transition. This complemented the assurance received from the Internal Audit Plan, focussing on areas of risk, transition, mapping and transfer of statutory responsibilities and the extent to which the new Clinical Commissioning Groups were being supported to develop robust governance arrangements for authorisation and beyond.

2.1.6 The Health & Social Care Act 2012 requires all five SWL PCTs to be abolished on 31st March 2013 with the Statutory Duties moving to either existing or new organisations. A SWL Transition Programme was established to support the setting up of the new organisations, the handover of functions and the closedown of the PCTs. A Transition Executive Group of non-executive directors and senior managers provided strategic leadership and accountability for the programme.

2.1.7 In order to minimise the risk from the transition, the handover of functions started from 1st October 2012 with the majority to handovers to the shadow CCG being completed in January 2013. This allowed staff to begin operating in the new model whilst in a safe governance environment. The completion of the handover of functions was completed in early March 2013. Any risk of confusion as to who was responsible for a PCT function at any point in the transition was eliminated by the use of Handover Certificates. For each Receiver Organisation a senior manager for that organisation signed acceptance for the safe receipt of the function signalling that arrangements were in place to assure responsibilities for that function goes forward. The overall tracker for handover of functions was then widely shared as a resource to determine where the responsibility for different functions was being held.

This tracker with associated certificates will be made available for assisting retrospective reviews and legacy work of the five PCTs.

2.1.8 Although SWL PCTs were abolished on 31st March 2013, some activities could not take place until after this date. This included the preparation of the Annual Accounts. The Department of Health has retained some Non-executive, executive directors and established a Legacy Management Team employed by the Business Services Authority. This team will remain in place for about three months to complete the work.

2.2 NHS SWL Joint Boards' Committee Structure

2.2.1 There are eight Committees of the Joint Boards, the statutory ones being Joint Audit; Joint Charitable Funds; Joint Remuneration and Terms of Service plus six PEC/Clinical Commissioning Committees (separate in NHS Sutton and Merton) which function separately for each PCT Board. The non statutory committees, which also have Non Executive Chairs, comprise Clinical/ Integrated Governance, Finance, Performance and for a time limited period, the South London Commissioning Support Services (SLCSS) Development Board which represents a partnership between South West and South East London Joint Boards/ Clusters. Each of the PCT Boards, represented by NHS SW London Joint Boards, is also a member of the London Specialised Commissioning Group, Joint Committee.

In terms of remit, the Committees cover:

Statutory Committees

(i) **Joint Audit** - provides the PCT statutory Boards with an independent and objective review on their financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS.

(ii) **Joint Charitable Funds** – oversees the management, administration and accounting arrangements for funds held by the PCT for charitable purposes.

(iii) **Joint Remuneration and Terms of Service** - advises the Boards about appropriate remuneration and terms of service for the Chief Executive and other Executive Directors (Very Senior Managers, (VSM)), plus redundancies and transition to future commissioning arrangements – Clinical Commissioning Groups, National Commissioning Board, Public Health etc.

(iv) **PEC/Clinical Commissioning** (CCC) – the former to exercise functions specified in the Directions 2007 and the latter to be directly accountable to the appointing PCT for delegated commissioning functions to enable each PCT to achieve its statutory commissioning functions in a locally applicable way, with GP leadership. The CCCs supported the delivery and development of local GP consortia and their initiatives through making recommendations to its appointing Board, and undertaking delegated functions. Where PECs and CCCs met together, the combined membership ensured the statutory functions of the PEC were fulfilled.

Proposals to continue delegation of commissioning responsibilities to emerging Clinical Commissioning Groups in South West London were approved by the Joint Boards on the 29 March 2012. This included refresh of the Terms of Reference for the Clinical Commissioning Groups as they prepared for authorisation and shadow Governing Body status.

(v) **Primary Care Performers' Reference Committee** – to lead investigation and decision making over individual primary care contractor performance concerns insofar as they relate to the Performer or Pharmaceutical Lists and possible referral on to Professional Regulatory bodies

Non Statutory Committees

(vi) **Clinical/Integrated Governance** - provides an overview and strategic vision, leadership and assurance for quality, governance and risk relating to the South West London PCTs' commissioned services, including independent contractors, as well as public health and organisational functions, such as emergency planning.

(vii) **Finance** - to ensure a robust financial strategy is in place; to oversee the organisation-wide system of financial management; and to keep under review financial performance against agreed control totals.

(viii) **Performance** - to keep under review performance in South West London against the safety, clinical effectiveness and patient experience, headline and supporting measures in the national Operating Framework for 2012/13 and such other key measures and milestones which may merge from national, London, cluster or local work .

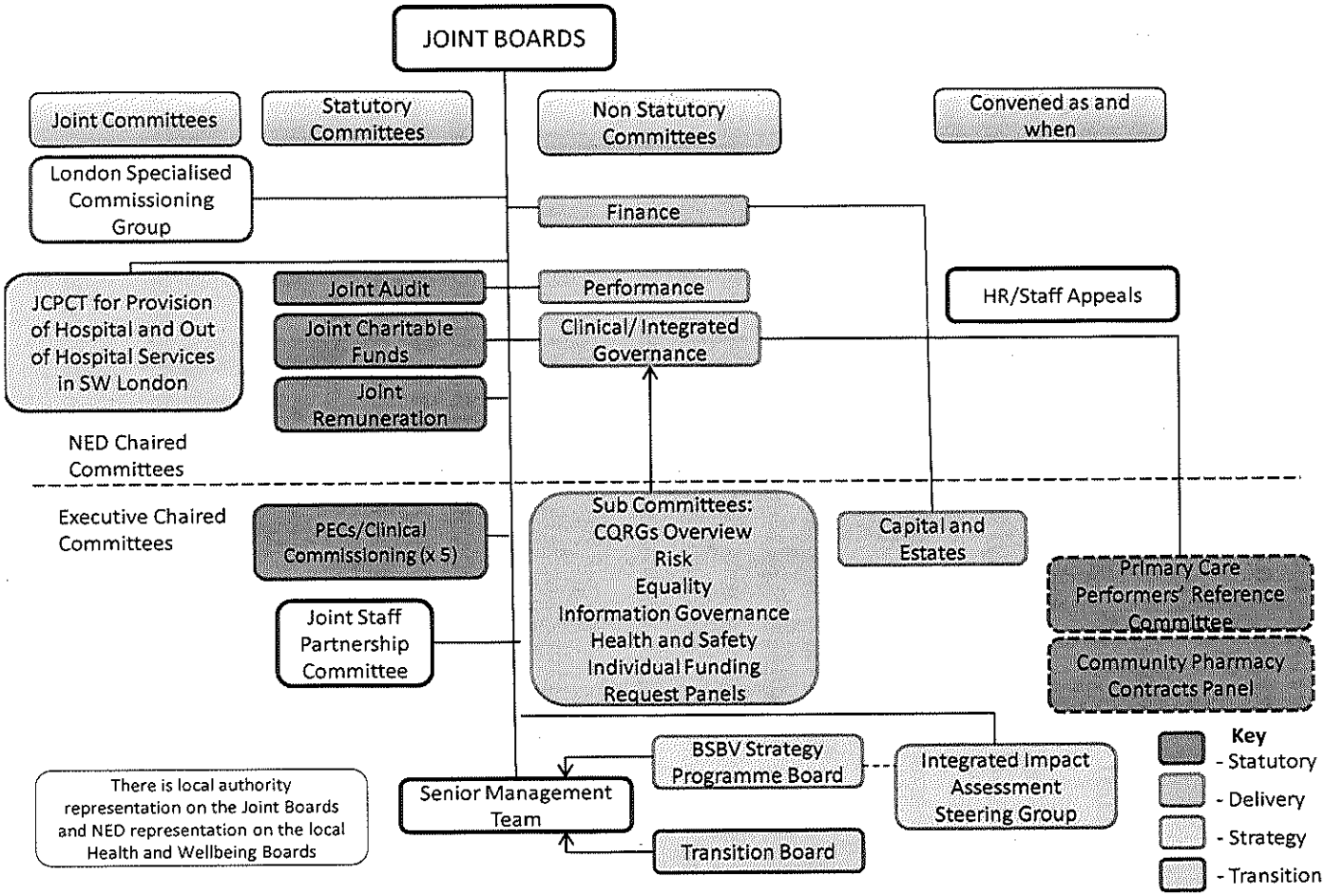
(ix) **(Joint Committees ((ix) Pan London; (x) South West and South East Clusters)**

(x) **London Specialised Commissioning Group Joint Committee** - made up of the 31 London PCTs – to commission a portfolio of specialised services on their behalf in line with the national arrangements.

(xi) **South London Commissioning Support Services (SLCSS) Development Board** (time limited)– comprising members of the Joint Committee of the Boards of the eleven south London PCTs and Care Trust – approved by Joint Boards on the 1st March 2012 - to scrutinise the development and submission of the Outline Business Case for the creation of the SLCSS, as required by the NHS Commissioning Board.

2.2.2 The Committee structures reporting through to Joint Boards have been clearly defined with approved Terms of Reference setting out scope of delegated authority and responsibilities, committee membership, quorum rules, and reporting arrangements. Attendance is captured in the minutes which are submitted for report to the Joint Boards.

JOINT BOARDS' COMMITTEE STRUCTURE



2.3 NHS SWL Joint Boards' Performance

2.3.1 The engagement of Joint Boards' members in setting corporate objectives has enabled them to define their remit up to April 2013, both in the context of transition and the requirement to ensure a positive legacy for Clinical Commissioning Groups (CCGs).

2.3.2 In this context, the programme of development support for Joint Boards which commenced in 2011/12, has been important in this transitional period where influence and responsibility in the system is shifting to CCGs and Local Authorities. This included an initial diagnostic of the Board's effectiveness, with a view to: (i) helping the Boards to define their legacy; (ii) supporting the management of different expectations and perceptions of accountable Joint Boards members – NHS and Local Authority leaders, as well as emerging clinical leaders; and (iii) supporting the handling of likely political and public responses to changes around major consultations, such as "Better Services, Better Value".

2.3.3 Non Executive Directors (NEDs) have full access to a Board Leadership Programme at the King's Fund which is regularly attended by South West London NEDs, with outcomes and learning shared, for example conflict of interest learning and debate within CCGs; opportunities for integration with Local Authorities.

2.3.4 Joint Boards' public meetings are held bi-monthly with business transacted which relates to all Boards as well as that specific to individual PCT Boards. This is facilitated by local and 'partner'[1] NED involvement in the local decision making of each PCT, critical to making the Joint Boards' mechanism work effectively, with robust assurance around informed decision making.

2.3.5 Monthly Vice Chair, including Audit Chair, meetings are convened by the Chair, providing the opportunity for informal debate and resolution of issues. NEDs are able to put forward agenda items and request executive input/briefings- for example on strategic and challenging issues -, with the opportunity for sharing of good practice and issues across boroughs, for example development of the CCG Constitution and progress towards authorisation. This mechanism is critical in supporting the role of Vice Chairs to provide a leadership role with local partners and a link back to the Joint Boards.

2.3.6 In addition to the public meetings, the effectiveness of the Joint Boards' members (both collectively and individually) has been enhanced with a

[1] Each NED is also a NED for a partner PCT within SW London Cluster

programme of more informal Board seminars/ workshops. These give members the opportunity to gain insight, clarify priorities and expectations, formulate strategy and ensure accountability in a more informal, reflective setting.

2.3.7 Highlights of the past year Board seminar programme have included the impact of transition on NHS SW London Governance arrangements, the development of the pre-consultation business case for the 'Better Services, Better Value' programme, a presentation on how to maintain quality and safety in the new health system, and a seminar on NHS finances in general, with particular specific reference to challenged PCTs. These sessions promote the performance and decision making of the Joint Boards, ensuring they are well briefed and informed about the up and coming agenda and the decisions that will be required of them in formal sessions. They have also had a positive impact on shaping the culture and dynamics of the Joint Boards meetings, offering a broader perspective on the challenges and achievements across South West London and helping to define the legacy in the context of transition.

2.3.8 Key Board Committees are chaired by Non Executive Directors, for example, Audit, Finance , Performance and Clinical/Integrated Governance, enabling all key concerns to be triangulated for the five PCTs and building in an additional level of scrutiny. The Chair routinely seeks Non Executive commentary on the Committee reports as they are presented by the Executive to Joint Boards. In addition there has been a heightened focus on transition and handover and closure, with both the Chair and a Non Executive Director attending the Cluster's equivalent Handover and Closure Committee.

Task focussed, time limited sub committees/groups have also been convened to enable detailed examination and scrutiny of specific issues and provide further assurance/recommendations back to Joint Boards – for example, the Primary Medical Services Contract Review process in Croydon and Wandsworth which brought to a conclusion this nationally directed initiative across the 5 PCTs in the Cluster. This included a very thorough Equality Impact Assessment which Wandsworth Non Executive Directors had the opportunity to scrutinise and challenge, providing assurance back to the NHS Wandsworth Board that any unintended consequences of the redistribution of resources on the population, were identified and managed.

2.3.9 In terms of the Joint Boards' annual business cycle, the following reports are received on a regular basis–

- Board Assurance Framework and Key Risks Exception Report
- Finance Reports
- Annual Accounts
- Performance Reports
- QIPP Plans
- SWL PCTs Operating Plan

- Commissioning Strategic Plan
- Quality and Patient Safety Reporting
- Transition

2.3.10 The Chair is responsible for conducting appraisals for each of the Non Executive Directors – providing an assessment of their individual contribution, effectiveness and performance in the context of their local PCT and 'partner' PCT affiliations and Joint Boards. Non-Executive Director, Executive Director and clinical capacity going forward into the new world – both in CCGs and local acute providers – given enormous assurance and confidence in the future arrangements. Those not going forward have committed themselves to serving on the Legacy Audit Committee, which has responsibility for closing down annual accounts following the abolition of PCTs.

The commitment shown by both senior staff and Non-Executive Directors, both to their future facing roles as well as continuing to address the statutory responsibilities of the constituent PCT Boards has been commendable.

2.3.11 The 2012/13 NHS Operating Framework sets out the national priorities that the Cluster has been focussing on in this year of transition. During 2012/13 the South West Cluster has continued to build on the 2011/12 Operating Plan performance whilst maintaining sustainability on the areas where there had been significant improvements in performance. There are a number of cross cutting measures upon which greater effort has been focused during 2012/13 and these are as follows:

- Referral to Treatment Pathway - Reducing the backlog of long waiters at St Georges to a sustainable level and ensuring that sustained delivery of the 90% standard for the admitted pathway has been a particular focus for 2012/13. St Georges have made significant progress to achieving compliance with the 90% standard and this will be continued to monitored throughout the rest of the year.

- A&E Waiting time: Whilst there has been an improvement against the 4 hour wait, this has continued to be an area for constant monitoring and the lessons learnt from the winter of 2011/12 were used to strengthen the plans for winter 2012/13. Achieving compliance with 95% standard for Type-1 performance at Croydon University Hospital has been a particular focus for 2012/13. Performance during February and March across London has been challenging for all Trust's as a result of a multitude of factors including: higher than predicted levels of acuity and emergency admissions, intermittent loss of beds due to beds due to Norovirus, and poor discharge profile. All Trusts have recovery plans to improve performance and the YTD positions shows that they are still on track to achieve the 95% Standard for All Type performance and Type-1 performance, with the exception of Croydon University Hospital.

- Health checks: All the Boroughs have plans in place to deliver 20% health check coverage during 2012/13. However achieving performance has been challenging for the Boroughs that are financially challenged.

- Eliminating Mixed Sex accommodation (MSA). The breaches at Epsom and St Helier and St George' have continued` to be reviewed at the regular Clinical Quality Review meetings to ensure compliance with standards and there has been a significant improvement from the position at the start of 2012/13. Reducing MSA breaches is an area that the CCGs will continue to focus particular attention on during 2013/14.

- Reducing Healthcare Associated Infections (HCAI) -
  The Cluster has continued to work with providers throughout the year to promote learning and best practice and produce detail plans to support the reduction of the rates of MRSA and Clostridium Difficult Infections in 2012/13.

- Child Immunisation – This was as a particular challenge for 2011/12. Improving Child Immunisation has been a focus for 2012/13 and all the Boroughs have developed performance improvement plans and improvement trajectories to address this

- Improving Access to Psychological Therapies (IAPT) – Achieving the increased trajectories for 2012/13, both in terms of referrals and recovery rates, has been challenging. All Boroughs have detailed recovery plans in place to deliver improvements which are being monitored through the contracting route. IAPT will continue to be subject to close scrutiny during 2013/14.

The Performance Committee has had a significant role in monitoring and assuring performance in advance of presentation to Joint Boards, with both Vice Chair and local NED scrutiny at borough level.

2.4 Highlights of Boards Committee Reports

Committee	No of meetings held since 1.4.12 (frequency)	Attendance record kept Full quoracy established	Key Highlights
Joint Audit Committee	Met 11 times	Yes	A key role of the Joint Audit Committee throughout the year is to scrutinise and review management performance against a range of pre-determined governance and control standards embedded within NHS South West London's corporate and financial governance framework. Largely, this is done through three reporting streams: i. Reports from SW London Cluster and PCT senior managers ii. Internal Audit reports against agreed annual plan iii. External Audit advice and direction on issues relating to PCT annual accounts and reports The Audit Committee reviews actions arising from these reports and directs officers to ensure compliance with best financial management practices and accounting standards across the Cluster. The Audit Committee also receives counter fraud reports detailing new and ongoing cases, plus counter fraud initiatives to proactively avoid losses and fraud and to develop and embed an anti fraud culture across all areas of the Cluster. Traditionally, the Audit Committee would receive reports on audited Annual Accounts from the independent external auditors and approve those Accounts to the Joint Boards of NHS South West London for adoption. However, given organisational restructuring under the

Committee	No of meetings held since 1.4.12 (frequency)	Attendance record kept Full quoracy established	Key Highlights
			Health & Social Care Act, for 2012-13 this function will be performed by a newly appointed Department of Health Audit Sub Committee. The governance arrangements around the closedown for 2012/13 – covering Annual Accounts, Annual Governance Statements and Annual Reports – was received, and the delegation to the DH Audit Sub Committee approved, by Joint Boards in March 2013.
Remuneration and Terms of Service	Met 9 times	Yes	
Kingston Clinical Commissioning Group Governing Body	Met 12 times	Yes	• Leadership and Sign off of the 2012/13 Commissioning Strategy Plan • Authorisation and CCG Constitution • Establishment of Council of Members • System Sustainability Board • Surbiton Hospital Redevelopment • Community Wellbeing Service Tender • Referral Management Scheme • Organisational Development • Development of the QIPP agenda, and expansion of community based clinics • Initiation of the Kingston at Home project, with the integration of health and social care.

Committee	No of meetings held since 1.4.12 (frequency)	Attendance record kept Full quoracy established	Key Highlights
Clinical/Integrated Governance	Met 4times (Quarterly)	Yes	• Primary Care Commissioning Quality and Safety Report • Care Quality Commission updates on compliance reports • Safeguarding – Safeguarding Children and Adult Safeguarding updates, including annual reports, CQC/Ofsted Updates, Safecare Programme, Looked after Children (LAC) Assurance • Review of Mental health commissioning and associated quality issues • Serious Incident reporting and investigation/ closure reports • Performance implications for Quality and Safety • Quality Stock take and transition arrangements including National Quality Board returns - Quality in transition handover of certificates to CCGs, Quality and Safety handover assurance from CCGs as new commissioners • Quality Situation Reports for Acute Trusts • Claims Management and lessons learnt • Risk Management and Assurance arrangements and regular reports on key BAF risks • Ratification and Extension of policies • Monitoring of Sub committees' work– Risk Management, Equalities, Information Governance, Community pharmacy contract panel, Emergency Planning and Clinical quality review groups • Rolling programme of assurance from each CCGs on Risk and Quality frameworks and development of governance arrangements for authorisation

Committee	No of meetings held since 1.4.12 (frequency)	Attendance record kept Full quoracy established	Key Highlights
Finance	Met 12 times (Monthly)	Yes	Standing Items: • Finance report for Position To Date and Forecast Outturn; • QIPP reports • Approve single tender actions and ad hoc business cases Major decisions made by the FC in 2012/13 are as follows: • Approve all business cases from the 2% non-recurrent fund • To agree an increase in the Cluster Control Total from £25.2m to £30.2m. • To approve the transfer of funds to NHSC of £9m from 2% non-recurrent reserve.
Performance	Met 5 times (Bi-monthly)	Yes	• A&E and ambulance turnaround times at Croydon Hospital • 18 week waiting times at St George's, • HCAIs at Epsom & St Helier • Childhood Immunisations • A&E winter pressures • Ensuring focus on performance is maintained during the final stages of transition

Committee	No of meetings held since 1.4.12 (frequency)	Attendance record kept Full quoracy established	Key Highlights
Joint Committee (across South West and South East Cluster of PCTs: the South London Commissioning Support Services (SLCSS) Development Committee	Set up 1.3.12 Met twice	Yes	Recommending terms of reference for approval to Joint Boards; and detailed review and scrutiny of South London Commissioning Support Services Final Business Case, also with recommendations for approval to Joint Boards
London Specialised Commissioning Group Joint Committee	Met 6 times April '12 July'12 October'12 December'12 January'13 March'13	Yes	• Monitoring quality and performance through the Finance and Information report and governance measures and achievement of 12/13 corporate objectives via the Board Assurance Framework at each meeting. Annual reporting from Patient and Public Engagement Group and the London SCG Annual Report • Endorsement of the recommendations proposed by the Steering Group of the London and South East Burns Network for progressing with Phase 2 of the project • Consideration and approval of a Cystic Fibrosis Commissioning Policy for London • Considered and agreed the tender for HIV services in London as part of the national QIPP • Approved a preferred Network configuration for Children's Neuroscience Networks • Consideration of the final report on Respiratory Engagement from the review of Children's Congenital Heart Services • Endorsed the recommendations of the Review of Specialised Burns Services in London and South East England • Endorsed the proposals for a future consultation process for HIV Service Model

Committee	No of meetings held since 1.4.12 (frequency)	Attendance record kept Full quoracy established	Key Highlights
			Change • Considered and agreed preferred model of care for Children and Young People with Cancer following the NCAT review • Noted the London SCG's transition and closedown programme and agreed the process for financial closedown

2.5 An Account of Corporate Governance

NHS Kingston has, throughout the 2012/13 reporting year, applied the principles and met the requirements of the Code of Governance. NHS Kingston was unable to declare compliance with all areas of the Information Governance Toolkit as described below.

2.5.1 Information Governance:

NHS SW London Cluster is committed to ensuring that it meets the required compliance standards of the IG Toolkit to ensure the secure and confidential handling of all personally identifiable data.
A formal process by which the NHS SW London Cluster co-ordinates the self assessment against the IG requirements for all the SW London PCT's was continued in 2012-13.

The October 31st 2012 baseline assessment against version 10 of the IG Toolkit has been completed with the Cluster scoring 60% against the required standards. This assessment was independently audited by the Cluster's internal auditors RSM Tenon to ensure assurance that sufficient evidence is in place to support the attainment levels assigned by the PCT. They found that not all the evidence was available on the IG toolkit to support this compliance score.

Those areas of non-compliance have been targeted for completion by March 31st 2013 and this has been monitored by the Information Governance Steering Group.

While this is the case the number of serious and minor IG incidents reported has decreased during 2012-13. However, it is still anticipated that the final IG Toolkit submission (to be submitted 31st March 2013), will be able to retain the 60% overall score against the required standards.

A significant part of the available IG resource has been engaged in the closure and transition programme and in preparing the emerging successor organisations to meet their IG requirements for authorisation and to complete their March baseline assessment.

3. Risk

3.1 Risk Assessment

3.1.1 The approach to risk management for NHS South West London is set out in the Risk Management and Assurance Policy, originally approved by the Joint Boards in July 2011, and subsequently in September 2012, along with the revised corporate objectives for 2012/13.

3.1.2 The 3 central planks underpinning our risk management approach are:

(i) Ensuring the governance and risk systems are robust, integrated, safe and valid whilst the transitional structure is in place and operating;
(ii) Supporting the development of robust governance and risk arrangements in future organisations e.g. NHS Commissioning Board, Clinical Commissioning Groups, Local Authorities (Public Health);
(iii) Managing the closedown of 5 statutory Primary Care Trusts from a governance and risk perspective, by March 2013.

3.1.3 The Corporate Objectives for 2012-13 had two distinct themes to reflect the rapidly changing environment:

- core objectives focussed on 'delivery for today'; and
- transition objectives associated with 'building for the future.'

Against these corporate objectives, risks were identified to ascertain what might threaten their delivery and assessed for impact and likelihood of realisation. This was applied across the breadth of the commissioning portfolio to ensure comprehensive coverage, taking account of financial, clinical, quality, transition and performance implications.

The Board Assurance Framework during 2012-13 was reframed around these objectives and accountability for delivery was described in terms of "Cluster oversight" and "delegated responsibility" across the emerging parts of the new NHS commissioning architecture. The ownership of BAF risks clearly reflected the delegation, with potential for some shared ownership, in line with shadow operating and transition arrangements.

3.1.4 The organisation's risk profile for 2012/13 comprised:

(i) Identification and assessment of risks relating to the Cluster's corporate objectives;
(ii) newly identified risks relating to delivery and transition under the shadow operating arrangements;
(iii) BAF risks identified by individual Clinical Commissioning Groups (CCGs) under shadow operating arrangements. These have been monitored by the CCG Governing Bodies and also visible on the NHS SWL BAF to maintain an oversight of risks associated with delegated responsibilities

Key risks during 2012-13 have included:

(i) a heightened focus on emergency planning through the Olympic period and mitigating the impact of transition on the effectiveness of NHS SWL's response to a major incident and business continuity;

(ii) complexity and pace of change around the requirement to integrate multiple strands of system development and transition;
(iii) complexity around the governance and transfer management arrangements for the closedown of 5 statutory bodies by 31st March 2013;
(iv) Loss or movement of senior leadership and capacity affecting decision-making and delivery; and
(i) maintaining positive employee relationships and staff morale during transition

The final Joint Boards report presented in March 2013 shows demonstrable movement of each risk from high impact/high likelihood to low impact /low likelihood ratings as controls for mitigation have been applied and their effectiveness assured. It also provides assurance on the safe transfer of Board Assurance Framework risk ownership to new commissioning organisations – CCGs, NHS Commissioning Board, Local Authorities (for public health).

3.2 Lapses of data security including reported to Information Commissioner:

During 2012-2013 there have been five serious incidents reported to the Information Commissioner (categorised as 3-5). There were no minor incidents (categorised as 1-2). These have been analysed by each of the Cluster organisations and categorised by five types of incident, shown in the table below:

SUMMARY OF OTHER PERSONAL DATA RELATED INCIDENTS IN 2012-2013		**Kingston**
Category	**Nature of incident**	
I	Loss/theft of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	
II	Loss/theft of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	
IV	Unauthorised disclosure (73% involved failure to use NHS.net to e-mail identifiable data)	5
V	Other	
TOTAL		**5**

3.3 The Risk and Control Framework

3.3.1 NHS SWL commissioned 4risk™ risk management software to support the ongoing maintenance of risk registers and Board Assurance Framework. The software allows for a consistent 'live' risk management process, enabling risk owners to be responsible for the management and updating of their risks.

3.3.2 In terms of preventing risk, the risk management system is designed to work proactively, by identifying the factors causing the inherent risk and preventing the risk from realisation by putting controls in place and strategies (actions) to mitigate those risks where appropriate. Other key deterrent measures include:

(i) Training – provided to all staff, including general risk management, Bribery Act, safeguarding, fire, manual handling, work station assessment and information governance.

(ii) Development of cluster wide and borough specific (whichever is applicable) policies and procedures

3.4 Executive Management Team and Board Committee Scrutiny of Risks

3.4.1 NHS SWL Cluster wider leadership have retained close scrutiny of BAF risks throughout the year, responding to Non Executive Directors need for additional assurance on risk and mitigations. Risk workshops were held in the summer of 2012, including CCG Chief Officers, focussing on whether the right risks had been identified in transition, and whether they were being effectively managed. The controls and assurances on both the 'extreme' and the 'high' rated risks were subject to detailed review and scrutiny

3.4.2 The outcome of this provided additional Boards' assurance of the continued grip on transition risks, continuity in terms of anticipated changes in risk ownership, as well as a change to style of risk reporting to ensure the narrative clearly articulated both the nature of risks and sources of positive assurance on the controls for mitigation.

3.4.3 Management of both manifest and potential risk is achieved through a governance/risk framework which challenges and provides scrutiny of risk at every level in the organisation. In addition to Senior Management Team, Risk Sub Committee, Clinical/Integrated Governance Committee and Joint Boards' meetings, having a remit for risk, oversight of the arrangements is also provided by the Audit Committee, particularly with regard to the sources of assurance. External assurance is provided by internal audit, external audit and other regulatory, compliance and audit bodies.

3.4.4 Other mechanisms to support risk management (of both manifest and potential risks) include the system in place for reporting and investigation of serious incidents (SIs), including a Serious Incident Monitoring Panel to

monitor completion of SI investigations and implementation of action plans across the Cluster. Significant issues which are identified are escalated to Senior Management Team and Joint Boards.

3.5 Managing risks around delegation to CCGs under shadow working arrangements

3.5.1 The delegation of business to CCGs, as agreed by the Joint Boards, was fully enacted with respect to the management of risks. The adoption of risks by each CCG Governing Body was commensurate with their new shadow accountability, their local corporate objectives for 2012/13 (sitting under the Joint Boards' corporate objectives set in May 2012), and their local context and challenges.

3.5.2 As a result of this approach, the risk register and risk management framework formed part of the evidence required for CCGs' application for authorisation, and clearly demonstrated CCG ownership of those risks.

3.5.3 The Cluster Governance and Risk Team has provided on-going support and workshops to each of the CCGs either collectively or individually with workshops and facilitated Governing Body sessions.

3.5.4 **Counter Fraud** - In compliance with Secretary of State Directions to NHS Bodies on Counter Fraud Measures 2004 (as amended), Counter Fraud is a standing item on the Joint Audit Committee agenda. The Head of Counter Fraud (nominated LCFS) attends each Joint Audit Committee to present both cluster and locality/PCT based counter fraud updates. The Joint Audit Committee is appraised of both proactive and reactive work through the year. Local Counter Fraud Specialists have worked together across NHS South West London to ensure that where required, work is undertaken once across the cluster, rather than individually for each PCT. The counter fraud providers have continued to work to the agreed working protocol which details everyone's responsibilities to NHS SW London.

Further to the Fraud Risk Assessment undertaken for NHS South West London in February 2011; the findings, remedial action plan and updates have been shared with the Joint Audit Committee throughout the year. Additionally, assurance has been provided both internally to NHS South West London (via the Joint Audit Committee) and externally to NHS protect regarding the organisation's compliance with the Bribery Act 2010. A Bribery Fraud Risk Assessment tool has been created locally to demonstrate the weaknesses and actions taken.

The LCFSs have continued to work collaboratively with both internal colleagues and external agencies to mitigate the risk of fraud and investigate

potential fraud; including undertaking the Audit Commission's mandatory National Fraud Initiative data-matching exercise and participating in local proactive exercises. External working relationships have been maintained with NHS Protect, UK Border Agency, Local Authorities, local Police teams and Independent Regulatory bodies.

For 2012/13; risk-based proactive exercises have been undertaken across NHS South West London into Interim and Temporary Employees; Conflicts of Interests and Gifts and Hospitality; and the Management of Retail Vouchers. Where relevant; outcomes and recommendations from proactive reviews have been shared with receiving organisations (such as Local Authorities) to ensure that weaknesses are rectified.

Throughout the financial year, Counter Fraud Newsletters have been provided electronically to all NHS SW London employees, as well as counter fraud updates delivered to departmental meetings. All South West London Independent Contractors have also received counter fraud support information, and newsletters. An Anti-Bribery training event was provided to NHS South West London employees; and to further demonstrate executive support to both NHS South West London and the public, an anti-bribery statement was agreed by Ann Radmore, Chief Executive and published on the website in August 2012.

NHS SW London's "Policy in relation to Fraud & Fraud Response Plan" and "Anti-Bribery Policy" have both been reviewed and agreed in 2012/13. Revised copies of each policy have been uploaded to NHS South West London's intranet.

NHS Protect, the organisation responsible for overseeing Counter Fraud work within the NHS did not require NHS bodies to participate in the Qualitative Assessment process for 2012/13 as the process is currently under review therefore no organisational ratings have been issued.

To demonstrate that Risk Management has worked as a dynamic process throughout the year, each BAF report to the Joint Boards had risks presented in a visual format as "Heat maps". A 'heat map' is charted on the NHS SWL Risk Matrix and illustrates risks which are highly likely to occur and have a high impact, in the top right hand corner, which must be reduced or transferred; those that are highly unlikely to occur but will have a high impact appear in the top left hand corner i.e. needing contingency plans in place for that eventuality.

The consecutive reports to committees overseeing risk management and Joint Boards were able to demonstrate movement of each risk through

tracking; with most risks moving from top right hand corner (high impact/high likelihood) to bottom left hand corner (low impact /low likelihood).

3.6 Review of the Effectiveness of Risk Management and Internal Control

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

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

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

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

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

I believe that the above, combined with the outputs of the Governance Framework give me substantial assurance that the risk management processes and systems of internal control put in place were operating effectively.

3.7 **Final Board Assurance Framework to Joint Boards in March 2013**
A final Joint Boards risk report was presented in March 2013,

<http://www.southwestlondon.nhs.uk/JointBoards/Board%20Papers/14.03.13%20Pt1%20Att08%20BAF%20and%20Key%20Risks%20Report.pdf>

It showed a comparative picture of risk at the beginning and end of 2012/13, using visual 'heat' maps. The formal transfer of risk ownership, where relevant, was also presented and clearly audited.

3.7.1 The annual internal audit plan is compiled jointly by internal audit providers and appropriate senior managers at Cluster. The plan is risk based and includes a wide range of system and process reviews, including

i. Financial management and control over budgets, cash and financial systems
ii. Governance Framework
iii. Information Governance
iv. Clinical Quality

The internal audit plan is reviewed annually and approved by the Joint Audit Committee.

4. Significant Issues

4.1 Continuing Care

In response to an Internal Audit review of the South West London PCTs' processes for managing continuing care, a specific project group was formed to review current operating systems across all five PCTs (covering six boroughs) and to implement consistent approaches that addressed the areas of weakness identified in the internal audit report. This work was led by the Managing Director of Richmond PCT. At the end of March 2013 the full liability for retrospective cases had been identified and the likely financial impact for future years built into the future CCGs' contingent liabilities. In addition all CCGs, (except Kingston which operates a joint service with its Borough), have secured a new common continuing care service from South London Commissioning Support Unit. This provides greater consistency of approach to applications, quality monitoring, patient safety assurance and increased staffing resilience across all South West London areas. Continuing

care placements that had not been subject to a formal review within the prescribed timelines set out in national guidelines, are now being completed, although this exercise will not be completed until the late spring/early summer of 2013.

Whilst acknowledging NHS Kingston's response, that this was a generic report, providing a combined opinion for disparate systems which did not necessarily apply in the same way across all five PCTs, the Report did highlight across all PCTs a backlog in clinical reviews not being completed in a timely way and in line with national guidelines. This was raised as a risk on the Board Assurance Framework and monitored closely by Joint Boards to mitigate the risk and ensure it no longer presented a significant control issue.

The emphasis of the risk for NHS Kingston is the management of the retrospective cases, rather than the focus of the audit report, however there is an intention to review the commissioning of continuing care locally, in the light of the internal report, to ensure that the new arrangements are robust.

Department of Health Designated Signing Officer

Carl Vincent – Director of Provider Finance and Finance Transition

Signature:  **Date :** 4/6/13