Department of Health

NHS

Islington Primary Care Trust

2012-13 Annual Report and Accounts

Published to gov.uk, in PDF format only.

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Islington Primary Care Trust

2012-13 Annual Report

NHS

North Central London

Annual Report and Accounts 2012/13

ISLINGTON PRIMARY CARE TRUST

Contents

Welcome from the Islington PCT Chair and Vice Chair

Welcome to the 2012/13 Annual Report on your local NHS healthcare services in Islington.

Islington Primary Care Trust's performance against key national measures remained strong this year. Our performance is detailed elsewhere in this report but some of this year's highlights include:

- achieving the targets set by the Department of Health for access to healthcare. Both UCLH and The Whittington achieved all these standards throughout 2012/13

- we sustained achievement of most of the cancer waiting time targets during 2012/13across Islington

- we delivered excellent performance against the national measures for stroke services with Islington exceeding the 80% threshold for time on a stroke unit and also achieved the 60% standard for TIA (Transient Ischaemic Attack) access within 24 hours

- we were compliant with the zero tolerance standard for single sex accommodation since August 2012

- Islington had a good turnaround time of cervical screening results, achieving the 98% threshold throughout 2012/13

- 2012/13 has been a successful year for Islington in its childhood immunisation coverage. The borough achieved over 95% coverage on the vaccine at aged 1 year and over 90% on all vaccines at aged 2 years. There has also been a marked improvement on the vaccines at aged 5 years throughout 2012/13.

Looking back over the life of Islington Primary Care Trust (Islington PCT), we can be proud of our achievements which have benefited the residents of Islington both in their overall health and in their health needs in times of emergency. Looking at the legacy of health improvements that Islington PCT delivered, there was much that was achieved. Some of the things we can be proudest of, include improving primary care which was done in three ways:

- by reducing the number of poorly performing practices through rigorous monitoring of professional standards and adherence to the terms of the GP contract

- through improving the quality of GP premises through the imaginative use of investment through the government's LIFT programme, and

- by extending the range of services offered by practices by investing in locally enhanced services.

We have continued to develop our partnership working, particularly with the joint commissioning and provision of services with Islington Council. With joint commissioning and joint provision of services and the use of pooled budgets, we greatly improved services to local people as well as reduced the duplication of assessments. This speeded up hospital discharge for patients who could otherwise have lingered in hospital when healthy enough to be sent home.

Islington PCT also invested in its public health department to establish programmes to reduce health inequalities and provide the evidence base for commissioning decisions to ensure the best use of the resources available to the PCT.

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

We wish all those working to deliver health care across Islington a successful future, building on the firm foundation inherited from Islington PCT.

Thank you

Paula Kahn
Chair

Anne Weyman
Vice-Chair

Directors' Report

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

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

Islington Primary Care Trust (Islington PCT) held the budget for all health services in Islington and was responsible for a number of different things including:

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

Islington PCT was responsible for planning and buying all local NHS health services for approximately 236,084 people living in Islington, making sure local people have good health and good healthcare.

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

Islington PCT met the control total surplus of £11.3m as set by the Department of Health.

Islington PCTmet all its statutory duties, namely:

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

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

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

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

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

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

Islington Primary Care Trust – who was who

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

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

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

Voting Members

Name	Title	Notes
Non-executive Directors		
Paula Kahn	Chair	
Anne Weyman	Vice Chair	
Sorrell Brookes	Non-Executive Director	
David Riddle	Non-Executive Director	
Bernadette Conroy	Non-Executive Director	
Caroline Rivett	Audit Chair	

Executive Directors		
Caroline Taylor	Chief Executive	
Ann Johnson	Director of Finance	To August 2012
Bev Evans	Director of Finance	From August 2012
Sarah Price	Director of Public Health	April 2011 to March 2013 (also Joint Director of Public Health)
Julie Billett	Director of Public Health	From March 2013 (Joint Director of Public Health Camden and Islington)

Non-voting Members

Name	**Title**	**Notes**
Executive Directors		
Jeremy Burden	Director of Contracts	To July 2012
Simon Currie	Director of Contracts	From July 2012 to December 2012
Liz Wise	Director of QIPP	April 2011 to March 2013
Alison Pointu	Director of Quality & Safety	
Helen Pettersen	Director of Transition and Corporate Affairs	To December 2012
Dr Douglas Russell	Medical Director – Primary Care	To July 2012
Dr Henrietta Hughes	Medical Director – Primary Care	From July 2012
Dr Nick Losseff	Medical Director – Secondary Care	
Ian Fuller	Director of HR	To October 2012
Marion McCrindle	Director of HR	From October 2012
Philip Orwin	Borough Director Islington	March 2011 to July 2012

Professional Executive Committee (PEC) Members

Name	**Title**	**Notes**
Dr Gillian Greenhough	PEC Chair	
Jennie Hurley	PEC Nurse	

The Patient Advice and Liaison Service (PALS) and Complaints Service

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

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

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

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

Table 1: Type of contact

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

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

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

- A number of areas of concern regarding charging by dental practices and quality of work undertaken have been highlighted with the assistance of the Primary Care team and were investigated.

- Letters relating to concerns raised by patients and their advocates in 2012 about difficulties in registering with GP practices led to NHS London completing and approving GP registration guidelines for London; these have been distributed and provide further clarity for practices in London on this process.

- Following contact from the General Dental Council (GDC) contact information for dentists in the cluster were updated on NHS Choices.

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

Making it happen in NHS North Central London

In January 2013, NHS North Central London published its annual report on equalities which highlighted how we provided 'due regard' to our Public Sector Equality Duty (PSED) as defined by the Equality Act 2010 through each of the five PCTs. In addition we also reported on our workforce broken down by their 'Protected Characteristics'. Each PCT has good examples of how they have addressed equality issues including use of services for people in Barnet who are deaf, deafened or hard of hearing. For instance, in Islington, the PCT was working with the National Children's Bureau to seek the views of young people in Islington about their local health care services. The full report is available on the website www.ncl.nhs.uk

NHS North Central London cluster staff

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

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

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

NHS North Central London and its constituent Primary Care Trusts recognised that discrimination and victimisation was unacceptable and worked hard to ensure that noemployee or job applicant received less favourable facilities or treatment (either

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

Number of staff employed [1]

	2012/13	2011/12
Islington	413	160

Gender

	Whole cluster (%) [1]
Male	37.85%
Female	62.15%

Ethnicity

	Whole cluster (%)[1]
White	61.45%
Mixed	3.21%
Asian/Asian British	14.96%
Black or Black British	13.86%
Other ethnic group	3.31%
Unknown	0.80%
Declined to provide	2.41%

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

Sickness Absence

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

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

National Staff Survey

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

Estates across North Central London

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

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

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

Capturing significant assets within the properties

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

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

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

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

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

Emergency planning for NHS North Central London

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

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

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

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

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

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

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

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

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

Sustainability

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

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

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

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

NHS North Central London had a Sustainable Transport Plan.

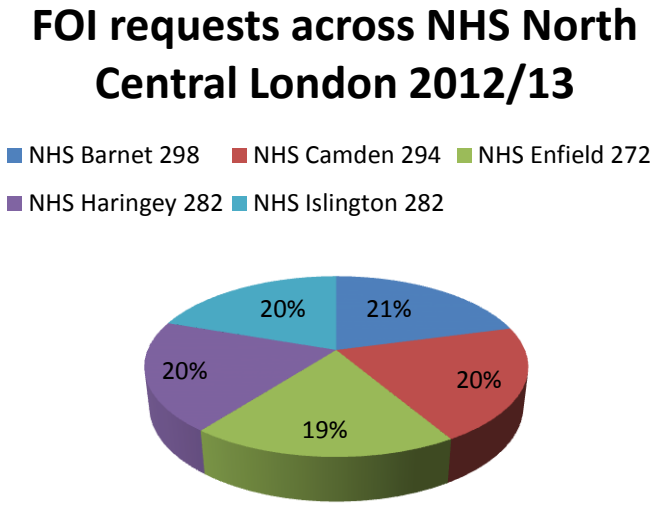
Freedom of Information Act management

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

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

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

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



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

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

Annual General Meeting

Because of the closure of PCTs in March 2013, these organisations no longer legally exist and therefore it is not deemed possible for Islington PCT to hold an AGM.

Islington PCT Annual Governance Statement: April 2012 to March 2013

Scope of responsibility

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

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

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

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

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

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

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

Robust arrangements were put in place for the preparation and audit of the accounts of the PCT following closedown of North Central London PCTs as statutory bodies. These arrangements were in line with Department of Health Guidance for financial closedown.

A local delivery team was secured to prepare the accounts and a sub-committee of the Department of Health Audit and Risk Committee was established to review the accounts with retained Non-Executive Directors, the former Director of Finance, the external and internal auditors and the former Accountable Officer.

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

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

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

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

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

In January 2012, Islington CCG received delegated responsibility for prescribing and adult community services and received delegated responsibility for all other commissioning budgets in March 2012.

In December 2012 all Clinical Commissioning Groups were accorded the right to sign contracts from February 2013 through a new Statutory Instrument as part of the Health & Social Care Act 2012.

Islington CCG was authorised on 20 February 2013 with one condition which was addressed.

The governance framework of the organisation

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

Composition of the Board

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

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

Committees

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

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

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

- Quality and Safety Committee;
- Financial Recovery and Quality, Innovation, Productivity and Prevention Committee;
- London Specialised Commissioning Group Board; and

- Joint Committee of PCTs for the purposes of formal public consultation and decision making about the provision of Paediatric Cardiac Surgery Services in England.

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

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

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

The Islington PCT Board established Islington CCG Board as a Committee on 26 January 2012.

The Board's performance

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

Highlights of Board Committees' reports

Highlights of the work of key Committees are provided below.

Audit Committees:

- The Audit Committee met concurrently with the Audit Committees of the other PCTs within NHS North Central London. Whilst each Committee had a discrete agenda, shared membership and meeting arrangements further enabled positive assurance across all areas of business.
- The Committee approved the annual accounts, external and internal audit opinions and an Annual Governance Statement for 2011/12 on behalf of Primary Care Trust (PCT) Board for submission to the Department of Health. Legacy and key control issues identified during 2011/12 were factored in to the planning of the internal audit programme for 2012/13.
- The Committee reviewed internal and external audit plans and reports, and sought assurance that recommended actions were completed and that all issues

were managed comprehensively. The Committee received reports on counter fraud and security services, and waivers to competitive tender requirements.

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

Quality and Safety Committee:

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

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

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

Highlights from the year include:

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

Remuneration and Terms of Service Committee:

The Remuneration and Terms of Service Committee met periodically to consider and approve payments for PCT staff following the organisational transition into the North Central London management structure. The Committee's remit was extended in September 2012 to reflect the revised Cluster governance arrangements and NHS London interim operating model.

An account of Corporate Governance

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

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

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

- The creation of new legal entities and their authorisation to undertake delegated responsibilities: including Clinical Commissioning Groups (CCG) and NHS England (formerly the NHS Commissioning Board); NHS Trust Development Authority (NTDA).

- States of readiness through the transition period as organisations became ready to exercise their new responsibilities.

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

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

Risk management and the control framework

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

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

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

Risk assessment

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

The risk and control framework

The Board Assurance Framework (BAF) and Risk Register assessed the effectiveness of systems of internal control and provided assurances that risk management processes were effective. Both were dynamic documents that captured the understanding of the risk environment at any given time. The BAF outlined NHS North Central London Cluster's principal objectives, the risks to achieving those objectives, key controls and assurances, and gaps in controls and assurances. The Risk Register contained a mixture of strategic and operational risks at organisational and directorate level as well as the arrangements in place to mitigate these.

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

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

Risk profile

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Achieving the Primary Care Trust control total was identified as a risk and a robust QIPP delivery plan was delivered resulting in over achievement at year-end.
- Risks relating to the commissioning of continuing care and high cost placements could have impacted on the Primary Care Trusts ability to deliver QIPP savings. A revised continuing care policy was implemented.
- Failure to deliver the health checks programme compounded by a risk to on-going funding was identified as significant. A plan was agreed by the Director of Public Health in January 2012 to extend health checks in the community setting.

Review of Effectiveness of risk management and internal control

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

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

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

RSM Tenon identified the need to keep focus on where risks would be transferred to during transition. As a consequence a revised BAF and Risk Register was received and accepted by the Board in September 2012 which had been reviewed in order to focus

and refine the content so that it accurately reflected the main strategic risks for the remainder of the financial year.

Significant issues in 2012/13

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

Continuing Care Reviews

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

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

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

Primary Care Payments

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

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

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

Transition to new commissioning arrangements in the NHS

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

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

The organisation agreed and handed over functions in January 2013 to nominated legal receivers: NHS England, Clinical Commissioning Groups, Local Authorities, NHS Property Services and Public Health England.

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

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

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

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

National Priorities set out in the NHS Operating Framework improving performance in Islington PCT – 2012/13

Acute Measures

Waiting times in A&E

Acute performance for Islington patients focused on The Whittington and UCLH. During the first two quarters of the year the 95% A&E waiting time standard was achieved at both Trusts, however performance became a challenge for UCLH and The Whittington with autumn and winter of 2012/13 proving more challenging than the previous year. During November and December 2012 outbreaks of Norovirus resulted in 236 bed closures at UCLH. The allocation of winter funding to both trusts supported whole-system resilience and mitigation of risk to this standard. Both Trusts achieved quarter four with Islington PCT achieving quarter four and a cumulative year end position of 95.3%.

Referral to treatment times

At a PCT level Islington's performance against all referral to treatment standards remained strong throughout the year, consistently achieving the admitted, non-admitted and incomplete pathways standards. At a provider level both UCLH and The Whittington achieved all three standards throughout 2012/13.

Cancer waiting times

At a PCT level, Islington sustained achievement of most of the cancer waiting time targets during 2012/13. North Central London continued intensive monitoring and analysis of trusts who failed these standards to ensure plans remained focused on turnaround and sustainability of performance. Performance against the two week wait standard for breast symptoms fell below the threshold in March but achieved at year end with 93.1% against the target of 93%. The 62 day target for treatment following referral from an NHS screening programme underperformed with a year-end position of 88.9%, activity volumes were small for this indicator and only one out of nine patients breached throughout the year. The Whittington poorly performed throughout the year against both the two week wait for suspected cancer and breast symptoms ending the year with 91.6% and 89% respectively against a target of 93% for both standards.

Access to Stroke Services

There was excellent performance against the national measures for stroke services with Islington PCT exceeding the 80% threshold for time on a stroke unit for most of the year but failed this by 0.1% in Q4. They achieved the 60% standard for TIA (Transient Ischaemic Attack) access within 24 hours.

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

Access to Diagnostics

Up until November 2012, Islington PCT maintained performance within the tolerance level of less than 1% of patients waiting longer than six weeks for a diagnostic test. However in November 2012 Islington's performance deteriorated and peaked at 5.1% in January 2013. This was the result of under-performance at both UCLH and the Whittington. The high volume of breaches at UCLH was the result of staff and capacity shortages and at the Whittington it was due to process issues. North Central London's Performance Team continued to work closely with both Trusts to ensure that recovery plans were robust, a sustained reduction in outstanding volumes was delivered and a satisfactory level of performance regained. Islington PCT's year-end position was 1.8% against a threshold of less than 1%.

Access to Single Sex Accommodation

Patient privacy and dignity remain high on the NHS agenda with a zero tolerance against mixed sex accommodation. The execution of plans to deliver this target was challenging for providers as set within a context of quality and efficiency drives that reduced overall bed numbers. Islington PCT reported compliance with the zero tolerance standard for six months of the year but reported 10 during Q4 which were all attributable to Bart's Health. There were 14 breaches in total for the year.

Non-acute performance update

Access to screening services

Nasal Bone (NB) screening services transferred to NHS England (formerly the National Commissioning Board) as at 1 April 2013.

Diabetic Retinopathy

All boroughs continued to excel against the target of 95% for diabetic retinopathy screening and this will be further enhanced by the recent commissioning of the UCLH site and new referral pathways that took place from 1 April 2013.

Cancer Screening

The coverage of cervical screening in Islington over the first nine months of the year generally mirrored that of last year. Work continued to raise awareness and identify exclusions such as women who have received total hysterectomy. The turnaround time of cervical screening results continued to be good, with Islington PCT achieving the 98% threshold throughout 2012/13.

Islington PCT's breast cancer coverage stood at 68.06% against a national standard of 70%. Despite continued underperformance across NCL for bowel screening uptake**,** Islington increased to 43.7% (from 34.8% in 2011/12) against the 60% standard.

NHS Health Checks

Increased offering and take-up of NHS health checks supported the reduction in health inequalities by identifying and addressing health needs in previously undiagnosed conditions. Islington PCT exceeded its year to date plan for both health checks offered and received with 10,167 health checks offered and 7,142 checks delivered in 2012/13.

Early Access to Maternity Care

Improving healthier outcomes for babies and children was one of the priorities for NHS North Central London and closely aligned to women accessing maternity care before 12 completed weeks of pregnancy. Having previously achieved the 90% threshold; Islington PCT's performance fell below the standard in Q3 of 2011/12. There was steady recovery and performance in Q1 2012/13 reached 88.7%; this fell in Q2 to 78%. Islington PCT continued existing actions to promote early access through initiatives to raise awareness amongst hard to reach communities and education of primary care staff to facilitate early access to maternity care.

Childhood Immunisations Coverage

2012/13 was a successful year for Islington PCT in its childhood immunisation coverage. The borough achieved over 95% coverage on the vaccine at aged one year and over 90% on all vaccines at two years. There was also a marked improvement on the vaccines at five years throughout 2012/13.

Financial Recovery

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

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

Review of Quality and Safety

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

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

Data loss incidents

There were data loss incidents between April 2012 and March 2013.

Primary Care Strategy – Transforming Primary Care

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

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

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

Clinical Commissioning Groups (CCGs)

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

Hosted Organisations

The PCT was host to North Central London Maternity and Newborn Network. The network was integrated into the management structure of the Cluster and followed the governance and assurance processes of the host.

The new health system in Islington: April 2013 onwards

The Health and Social Care Act 2012

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

Clinical commissioning – CCGs and CSU

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

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

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

NHS England

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

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

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

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

Health and wellbeing boards

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

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

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

Public health

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

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

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

Financial overview and summary financial statements

Financial Performance

Islington Primary Care Trust met the control total surplus of £11.3m as set by the Department of Health.

Islington PCT met all of statutory duties, namely;

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

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

Capital Structure

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

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

Treasury Policy and Objectives

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

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

Charging for Information

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

Principles for Remedy

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

Summary financial statements

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

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

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

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

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

Audit Functions

Islington PCT's Audit Committee had two Non-Executive Directors and members. At the end of 2012/13 they were Sorrell Brookes and Caroline Rivett.

Islington PCT's external auditor for 2012/13 was KPMG and the cost of Audit Services provided by them in the year was £119k.

Statement of the Responsibilities of the Signing Officer of Islington 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 Islington 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 was achieved from the resources available to the primary care trust;

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

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

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

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

Signed 

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

Date 5 June 2013

Independent Auditor's Report to the Signing Officer of Islington PCT on the Summary Financial Statements

We have examined the summary financial statement for the year ended 31 March 2013 set out on pages 37 to 40.

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

Respective responsibilities of 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.

Basis of opinion

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 Islington PCT for the year ended 31 March 2013 on which we have issued an unqualified opinion.

Fleur Nieboer for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
15 Canada Square
London E14 5GL

6 June 2013

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

	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure		
Gross employee benefits	**48,688**	9,010
Other costs	**506,058**	475,296
Income	**(43,427)**	(13,984)
Net operating costs before interest	**511,319**	470,322
Investment income	**(15)**	(16)
Finance costs	**1,196**	845
Net operating costs for the financial year	**512,500**	471,151
Of which:		
Administration Costs		
Gross employee benefits	**48,163**	7,476
Other costs	**25,733**	14,425
Income	**(31,262)**	(8,083)
Net administration costs before interest	**42,634**	**13,818**
Investment income	**(15)**	(16)
Finance costs	**1,011**	845
Net administration costs for the financial year	**43,630**	**14,647**
Programme Expenditure		
Gross employee benefits	**525**	1,534
Other costs	**480,325**	460,871
Income	**(12,165)**	(5,901)
Net programme expenditure before interest	**468,685**	**456,504**
Finance costs	**185**	**0**
Net programme expenditure for the financial year	**468,870**	**456,504**

Other Comprehensive Net Expenditure	**2012-13 £000**	**2011-12 £000**
Impairments and reversals put to the Revaluation Reserve	**1,315**	358
Net (gain) on revaluation of property, plant & equipment	**(2,629)**	(752)
Total comprehensive net expenditure for the year*	**511,186**	**470,757**

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

Statement of financial position as at 31 March 2013

	31 March 2013 £000	31 March 2012 £000
Non-current assets:		
Property, plant and equipment	**28,067**	29,088
Other financial assets	**261**	261
Trade and other receivables	**2,653**	2,758
Total non-current assets	**30,981**	32,107
Current assets:		
Trade and other receivables	**10,274**	14,781
Cash and cash equivalents	**36**	45
Total current assets	**10,310**	14,826
Total assets	**41,291**	46,933
Current liabilities		
Trade and other payables	**(67,691)**	(47,009)
Provisions	**(366)**	(1,116)
Borrowings	**(133)**	(114)
Total current liabilities	**(68,190)**	(48,239)
Non-current assets plus/less net current assets/liabilities	**(26,899)**	(1,306)
Non-current liabilities		
Provisions	(2,106)	(8,098)
Borrowings	(5,819)	(5,952)
Total non-current liabilities	**(7,925)**	(14,050)
Total Assets Employed:	**(34,824)**	(15,356)
Financed by taxpayers' equity:		
General fund	(46,482)	(26,044)
Revaluation reserve	11,658	10,688
Total taxpayers' equity:	**(34,824)**	(15,356)

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

	General fund	Revaluation reserve	Total reserves
	£000	£000	£000
Balance at 1 April 2012	**(26,044)**	**10,688**	**(15,356)**
Changes in taxpayers' equity for 2012-13			
Net operating cost for the year	(512,500)		**(512,500)**
Net gain on revaluation of property, plant, equipment		2,629	**2,629**
Impairments and reversals		(1,315)	**(1,315)**
Transfers between reserves*	344	(344)	**0**
Total recognised income and expense for 2012-13	**(512,156)**	**970**	**(511,186)**
Net Parliamentary funding	491,718		**491,718**
Balance at 31 March 2013	**(46,482)**	**11,658**	**(34,824)**
Balance at 1 April 2011	**(33,133)**	**12,130**	**(21,003)**
Changes in taxpayers' equity for 2011-12			
Net operating cost for the year	(471,151)	0	(471,151)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment	0	752	752
Impairments and Reversals	0	(359)	(359)
Transfers between reserves*	1,835	(1,835)	0
Total recognised income and expense for 2011-12	(469,316)	(1,442)	(470,758)
Net Parliamentary funding	476,405	0	476,405
Balance at 31 March 2012	**(26,044)**	**10,688**	**(15,356)**

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

Statement of cash flows for the year ended 31 March 2013

	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities		
Net Operating Cost Before Interest	**(511,319)**	(470,322)
Depreciation and Amortisation	**1,638**	1,200
Impairments and Reversals	**3,433**	(2,453)
Interest Paid	**(1,012)**	(665)
(Increase)/Decrease in Trade and Other Receivables	**7,424**	(4,572)
Increase/(Decrease) in Trade and Other Payables	**17,566**	7,444
Provisions Utilised	**(10,737)**	(3,037)
Increase/(Decrease) in Provisions	**3,810**	(486)
Net Cash Inflow/(Outflow) from Operating Activities	**(489,197)**	**(472,891)**
Cash flows from investing activities		
Interest Received	**15**	16
(Payments) for Property, Plant and Equipment	**(2,431)**	(1,060)
Net Cash Inflow/(Outflow) from Investing Activities	**(2,416)**	**(1,044)**
Net cash inflow/(outflow) before financing	**(491,613)**	**(473,935)**
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**(114)**	(49)
Net Parliamentary Funding	**491,718**	476,405
Capital grants and other capital receipts	**0**	(2,443)
Net Cash Inflow/(Outflow) from Financing Activities	**491,604**	**473,913**
Net increase/(decrease) in cash and cash equivalents	**(9)**	**(22)**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**45**	**67**
Cash and Cash Equivalents (and Bank Overdraft) at year end	**36**	**45**

Statutory financial duties

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

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

Islington PCT's performance for the year ended 31 March 2013 was as follows:

Revenue Resource Limit	**2012-13**	**2011-12**
	£000	**£000**
The PCTs' performance for the year ended 2012-13 was as follows:		
Total Net Operating Cost for the Financial Year		471,151
Net operating cost plus (gain)/loss on transfers by absorption	**512,500**	
Revenue Resource Limit	**523,794**	491,988
Underspend Against Revenue Resource Limit (RRL)	11,294	20,837

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

Capital Resource Limit	**2012-13**	**2011-12**
	£000	**£000**
The PCT is required to keep within its Capital Resource Limit.		
Capital Resource Limit	**3,315**	19,903
Charge to Capital Resource Limit	**2,736**	1,178
Underspend Against CRL	**579**	**18,725**

The PCT kept within its Capital Resource Limit.

Under/(Over)spend against cash limit	**2012-13**	**2011-12**
	£000	**£000**
Total Charge to Cash Limit	**491,718**	476,405
Cash Limit	**491,718**	476,454
Under/(Over)spend Against Cash Limit	**0**	**49**

The PCT kept within its Cash Limit.

Better payment practice code

The Better Payment Practice Code requires the PCT to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The disclosure below shows the value of invoices by volume and amount paid within 30 days, with the remaining invoices being paid later than 30 days.

The PCT's measure of compliance with this policy is:

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	**15,464**	**64,821**	12,875	51,004
Total Non-NHS Trade Invoices Paid Within Target	**9,710**	**34,430**	8,689	31,855
Percentage of NHS Trade Invoices Paid Within Target	62.79%	53.12%	67.49%	62.46%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**4,437**	**370,873**	3,290	352,347
Total NHS Trade Invoices Paid Within Target	**1,761**	**352,964**	1,528	328,712
Percentage of NHS Trade Invoices Paid Within Target	39.69%	95.17%	46.44%	93.29%

Running costs

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

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**20,463**	17,914	2,549
Weighted population (number in units)*	**236,084**	236,084	236,084
Running costs per head of population (£ per head)	**86.7**	**75.9**	**10.8**
PCT Running Costs 2011-12			
Running costs (£000s)	**14,647**	11,991	2,656
Weighted population (number in units)	**236,084**	236,084	236,084
Running costs per head of population (£ per head)	**62.0**	**50.8**	**11.3**

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

The management cost figures have been calculated using the definition provided by the Department of Health, based on staff cost only, excluding infrastructure and headquarter costs.

The staff costs that are included in the Department of Health definition incorporate the following elements:

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

Related party transactions

Islington PCT was a body corporate established by the order of the Secretary of State for Health.

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

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

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

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

Name/ Title	Related Party	Relationship with Related Party	Annual		31 March 2013	
			Expenditure	Revenue	Payables	Receivables
			£000's	£000's	£000's	£000's
Paula Kahn - Chair						
	Barnet PCT	Non-Executive Director and Chair	159	8,257	69	811
	Camden PCT	Non-Executive Director and Chair	870	7,893	500	0
	Enfield PCT	Non-Executive Director and Chair	16	7,455	27	1,152
	Haringey PCT	Non-Executive Director and Chair	6,699	7,467	2,618	1,011
Caroline Rivett - Non-Executive Director						
	Barnet PCT	Non-Executive Director	159	8,257	69	811
	Camden PCT	Non-Executive Director	870	7,893	500	0
	Enfield PCT	Non-Executive Director	16	7,455	27	1,152
	Haringey PCT	Non-Executive Director	6,699	7,467	2,618	1,011
David Riddle - Non-Executive Director						
	Barnet PCT	Non-Executive Director	159	8,257	69	811
Bernadette Conroy - Non-Executive Director						
	Barnet PCT	Chair	159	8,257	69	811
Anne Weyman - Non-Executive Director						
	Haringey PCT	Non-Executive Director	6,699	7,467	2,618	1,011
Sorrel Brookes - Non-Executive Director						
	Haringey PCT	Non-Executive Director	6,699	7,467	2,618	1,011
	Whittington Health	Husband is a Non-Executive Director	115,864	3,455	4,898	2,249
Caroline Taylor - Chief Executive						
	Barnet PCT	Executive Director/Chief Executive Officer	159	8,257	69	811
	Camden PCT	Executive Director/Chief Executive Officer	870	7,893	500	0
	Enfield PCT	Executive Director/Chief Executive Officer	16	7,455	27	1,152
	Haringey PCT	Executive Director/Chief Executive Officer	6,699	7,467	2,618	1,011
Beverley Evans - Interim Director of Finance						
	Maidstone and Tunbridge Wells NHS Trust	Non-Executive Director	18	0	1	0
	White House Accountancy & Consultancy Ltd	Owner, Director	168	0	0	0
Alison Pointu - Director of Quality & Safety						
	Barnet PCT	Executive Director	159	8,257	69	811
Nick Losseff - Medical Director						
	UCL Hospital NHS Foundation Trust	Consultant	81,565	0	4,028	0
Gillian Greenhough - PEC Member						
	Clerkenwell Medical Practice	GP Principal	1	80	0	80
	South Islington GP Alliance Ltd	Shareholder	207	0	0	0

Philip Orwin– Borough Director Islington						
	Orwin & Algeo Management Solutions	Director	160	0	0	0
Katie Coleman - CCG Member-Elected GP Representative						
	City Road Medical Centre	GP Principal	20	0	0	0
	South Islington GP Alliance Ltd	Shareholder	207	0	0	0
Josephine Sauvage - CCG Member-Elected GP Representative						
	City Road Medical Centre	GP Principal	20	0	0	0
	Dr Josephine Sauvage	GP Principal	63	0	0	0
	South Islington GP Alliance Ltd	Shareholder	207	0	0	0
Dominic Tkaczyk - Interim Chief Finance Officer						
	Headway East London	Trustee	14	0	0	0
Karen Sennett - CCG Member-Elected GP Representative						
	Killick Street Health Centre	GP Principal	26	0	0	0
Marian Harrington - CCG Member-LA Representative						
	London Borough of Islington	Director	21,243	527	2,760	177
RathiniRatnaval - CCG Member-Elected GP Representative						
	South Islington GP Alliance Ltd	Director/Shareholder	207	0	0	0
Jacky Kutner - Interim Director of Commissioning						
	JK Associates Ltd	Co-Director	125	0	0	0

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

NHS Organisation	Annual Expenditure £000's
Whittington Hospital NHS Trust	115,864
University College London Hospitals NHS Foundation Trust	81,565
Camden And Islington NHS Foundation Trust	17,942
Croydon PCT	32,515
Royal Free Hampstead NHS Trust	22,172
Central And North West London Mental Health NHS Foundation Trust	17,942
Barts and The London NHS Trust	8,100
London Ambulance Service NHS Trust	7,097
Moorfields Eye Hospital NHS Foundation Trust	8,173
North Middlesex University Hospital NHS Trust	2,367
Homerton University Hospital NHS Foundation Trust	4,256
Barnet and Chase Farm Hospitals NHS Trust	3,551
Great Ormond Street Hospital NHS Trust	3,169
Guy's And St Thomas' NHS Foundation Trust	2,299
Imperial College Healthcare NHS Trust	2,396
The Royal National Orthopaedic Hospital NHS Trust	1,094
Chelsea And Westminster Hospital NHS Foundation Trust	1,255

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

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

Remuneration report

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

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

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

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

Statement of the remuneration policy for senior managers:

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

Performance related remuneration:

The VSM performance assessment processes were used during 2012/13 including NHS London review of performance bonuses for appropriate roles. The remuneration committee made the decision not to pay any performance bonuses in 2012/13 regardless of level of performance.

Policy on duration of contracts and notice periods:

Contract and notice terms are standard to the VSM guidelines. The cluster of PCTs had been cognisant of future changes andhademployed and retained some new to the NHS senior staff on fixed term or interim contracts to reduce future redundancy liabilities. Notice periods for senior staff are normally three months but in some historical instances are six months.

Policy on termination and exit payments:

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

Salary and allowances of Senior Managers 2012/13 (PCT share)

(The tables on pages 48 to 52 have been audited as referred to in the external audit opinion on the PCT's full financial statements dated 6 June 2013)

	NAME	TITLE	2012-13 Salary (bands of £5,000) £000	2012-13 Other Rem'n (bands of £5000) £000	2012-13 Bonus Payments (bands of £5000) £000	Dates served Commenced	Dates served Ceased
	VOTING MEMBERS						
	Non Executive Directors						
*	Ms Paula Kahn	Chair	5-10	0	0	01/04/11	31/03/13
**	Ms Anne Weyman	Vice Chair NED Haringey	5-10	0	0	01/04/11	31/03/13
**	Dr Sorrel Brookes	NED Haringey	0-5	0	0	01/04/11	31/03/13
**	Mr David Riddle	Vice Chair Barnet	5-10	0	0	01/04/11	31/03/13
*	Ms Caroline Rivett	Audit Chair	0-5	0	0	01/04/11	31/03/13
**	Ms Bernadette Conroy	NED Barnet	0-5	0	0	01/04/11	31/03/13
	Executive Directors						
*	Ms Caroline Taylor	Chief Executive Officer	25-30	0	0	01/04/11	31/03/13
*	Ms Ann Johnson	Director of Finance	10-15	0	0	01/04/11	04/09/12
*	Mrs Bev Evans (1)	Director of Finance	35-40	0	0	05/09/12	31/03/13
**	Ms Penny Bevan	Director of Public Health	30-35	0	0	01/11/12	31/01/13
**	Ms Julie Billett	Director of Public Health	5-10	0	0	01/02/13	31/03/13
*	Ms Sarah Price	Director of Public Health	20-25	0	0	01/04/11	31/12/12
	NON VOTING MEMBERS						
	Executive Directors						
*	Mr Jeremy Burden (3)	Director of Contracts	0-5	0	0	01/05/11	31/03/13
*	Mr Simon Currie (1)	Director of Contracts	20-25	0	0	11/06/12	26/11/12
*	Ms Liz Wise (4)	Director of QIPP	20-25	0	0	01/04/11	31/03/13
*	Ms Alison Pointu	Director of Quality & Safety	20-25	0	0	01/04/11	31/03/13
*	Ms Helen Pettersen	Director of Transition and Corporate affairs	20-25	0	0	01/04/11	31/03/13
*	Dr Douglas Russell	Medical Director (Primary Care)	5-10	0	0	01/04/11	31/07/12
*	Dr Henrietta Hughes	Medical Director (Primary Care)	15-20	0	0	01/07/12	31/03/13
*	Dr Nick Losseff (2)	Medical Director (Secondary Care)	5-10	0	0	01/04/11	31/03/13
*	Mr Ian Fuller	Director of HR	10-15	0	0	01/04/11	31/10/12
*	Ms Marion McCrindle (1)	Director of HR	15-20	0	0	15/10/12	31/03/13
***	Mr PhilipOrwin (1)	Borough Director Islington	85-90	0	0	26/04/11	13/07/12
	PEC Members						
***	Dr Gillian Greenhough	PEC Chair Islington	65-70	0	0	01/04/11	31/03/13
***	Ms Jennie Hurley	Nurse Rep Islington	0	0	0	01/04/11	31/03/13

Main Board members serve on all 5 PCTs of the NCL Cluster and their remuneration is charged to all five PCTs accordingly.
The PCT's share is shown above and the members full amount below.
Prior year comparison figures are included below but not apportioned to individual PCTs.
There were no benefits in Kind for Senior Managers in 2012/13.
See below for notes and key.

Full Salary and allowances of Senior Managers 2012/13

	NAME	TITLE	2012-13			2011-12		
			Salary (bands of £5,000) £000	Other Rem'n (bands of £5000) £000	Bonus Pmts (bands of £5000) £000	Salary (bands of £5,000) £000	Other Rem'n (bands of £5000) £000	Bonus Pmts (bands of £5000) £000
	VOTING MEMBERS							
	Non Executive Directors							
*	Ms Paula Kahn	Chair	40-45	0	0	40-45	0	0
**	Ms Anne Weyman	Vice Chair NED Haringey	10-15	0	0	10-15	0	0
**	Dr Sorrel Brookes	NED Haringey	5-10	0	0	5-10	0	0
**	Mr David Riddle	Vice Chair Barnet	10-15	0	0	15-20	0	0
*	Ms Caroline Rivett	Audit Chair	10-15	0	0	10-15	0	0
**	Ms Bernadette Conroy	NED Barnet	0-5	0	0	5-10	0	0
	Executive Directors							
*	Ms Caroline Taylor	Chief Executive Officer	145-150	0	0	145-150	0	0
*	Ms Ann Johnson	Director of Finance	60-65	0	0	120-125	0	0
*	Mrs Bev Evans (1)	Director of Finance	180-185	0	0	0	0	0
**	Ms Penny Bevan	Director of Public Health	30-35	0	0	0	0	0
**	Ms Julie Billett	Director of Public Health	15-20	0	0	0	0	0
*	Ms Sarah Price	Director of Public Health	100-105	0	0	100-105	0	0
	NON VOTING MEMBERS							
	Executive Directors							
*	Mr Jeremy Burden (3)	Director of Contracts	20-25	0	0	95-100	0	0
*	Mr Simon Currie (1)	Director of Contracts	115-120	0	0	0	0	0
*	Ms Liz Wise (4)	Director of QIPP	115-120	0	0	115-120	-	0
*	Ms Alison Pointu	Director of Quality & Safety	95-100	0	0	95-100	0	0
*	Ms Helen Pettersen	Director of Transition and Corporate affairs	115-120	0	0	115-120	0	0
*	Dr Andy Watts	Medical Director (Primary Care)	0	0	0	30-35	0	0
*	Dr Douglas Russell	Medical Director (Primary Care)	40-45	0	0	95-100	0	0
*	Dr Henrietta Hughes	Medical Director (Primary Care)	95-100	0	0	0	0	0
*	Dr Nick Losseff (2)	Medical Director (Secondary Care)	45-50	0	0	40-45	0	0
*	Mr Ian Fuller	Director of HR	60-65	0	0	85-90	0	0
*	Ms Marion McCrindle (1)	Director of HR	80-85	0	0	0	0	0
***	Mr PhilipOrwin (1)	Borough Director Islington	85-90	0	0	250-255	0	0
	PEC Members							
***	Dr Gillian Greenhough	PEC Chair Islington	65-70	0	0	55-60	0	0
***	Ms Jennie Hurley	Nurse Rep Islington	0	0	0	0	0	0

Notes

(1) Paid through consultancy company
(2) Seconded from another NHS organisation
(3) Seconded to another NHS organisation from July 2012
(4) Accountable Officer Enfield CCG from October 2012

Key

* Salary costs apportioned to the 5 PCTs (20%)
** Salary costs apportioned to 2 PCTs (50%)
*** Salary costs charged to the PCT (100%)

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

Salary and allowances of Senior Managers 2011/12 (PCT share)

	NAME	TITLE	2011-12			Dates served during 2011/12	
			Salary (bands of £5,000)	Other Rem'n (bands of £5000)	Bonus Pmts (bands of £5000)	Commenced	Ceased
			£000	£000	£000		
	VOTING MEMBERS						
	Non Executive Directors						
*	Ms Paula Kahn	Chair	5-10	0	0	01/04/2011	
**	Ms Anne Weyman	Vice Chair	5-10	0	0	01/04/2011	
**	Dr Sorrel Brookes		0-5	0	0	01/04/2011	
**	Mr David Riddle		5-10	0	0	01/04/2011	
*	Ms Caroline Rivett	Audit Chair	0-5	0	0	01/04/2011	
**	Ms Bernadette Conroy		0-5	0	0	01/04/2011	
	Executive Directors						
*	Ms Caroline Taylor (2)	Chief Executive Officer	25-30	0	0	01/04/2011	
*	Ms Ann Johnson (2)	Director of Finance	20-25	0	0	01/04/2011	
*	Ms Sarah Price	Director of Public Health	20-25	0	0	01/04/2011	
	NON VOTING MEMBERS						
	Executive Directors						
*	Mr Jeremy Burden	Director of Contracts	15-20	0	0	01/05/2011	
*	Ms Liz Wise	Director of QIPP	20-25	0	0	01/04/2011	
*	Ms Alison Pointu	Director of Quality & Safety	15-20	0	0	01/04/2011	
*	Ms Helen Pettersen	Director of Transition and Corporate affairs	20-25	0	0	01/04/2011	
*	Dr Andy Watts	Medical Director (Primary Care)	5-10	0	0	01/04/2011	03/07/2011
*	Dr Douglas Russell	Medical Director (Primary Care)	15-20	0	0	04/07/2011	
*	Dr Nicholas Losseff (2)	Medical Director (Secondary Care)	5-10	0	0	01/04/2011	
***	Mr Philip Orwin (1)	Borough Director Islington	250-255	0	0	26/04/2011	
	PEC Members						
***	Dr Gillian Greenhough	PEC Chair Islington	55-60	0	0	01/04/2011	
***	Ms Jennie Hurley	Nurse Rep Islington	0	0	0	01/04/2011	

Notes

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

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

Key

* Salary costs apportioned to the 5 PCTs (20%)

** Salary costs apportioned to 2 PCTs (50%)

*** Salary costs charged to the PCT (100%)

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

The PCT's share is shown above and the members full amount in the previous table

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

Pension benefits of Senior Managers 2012/13 (PCT share)

Name	Title	Real increase/ decrease in pension at age 60 (bands of 2500)	Real increase/ decrease in related lump sum at age 60 (bands of £2500)	Total accrued pension at age 60 at 31 March 2013 (bands of £5000)	Total accrued related lump sum at age 60 at 31 March 2013 (bands of £5000)	Cash Equivalent Transfer Value (CETV) at 31 March 2013	Cash Equivalent Transfer Value (CETV) at 31 March 2012	Real increase/ decrease in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension
		£000	£000	£000	£000	£000	£000	£000	£000
Board Members									
Ms Caroline Taylor	Chief Executive Officer	0-2.5	0-2.5	10-15	35-40	280	258	9	0
Ms Ann Johnson	Director of Finance	0-2.5	0-2.5	0-5	5-10	29	23	4	0
Mr Jeremy Burden	Director of Contracts	(0-2.5)	(0-2.5)	5-10	20-25	128	120	2	0
Ms Liz Wise	Director of QIPP	0-2.5	0-2.5	0-5	10-15	95	87	4	0
Ms Alison Pointu	Director of Health & Safety	0-2.5	0-2.5	5-10	25-30	202	179	14	0
Ms Penny Bevan	Director of Public Health	(0-2.5)	(0-2.5)	10-15	30-35	316	285	16	0
Ms Julie Billett	Director of Public Health	0-2.5	0-2.5	5-10	15-20	85	72	10	0
Ms Sarah Price	Director of Public Health	0-2.5	0-2.5	5-10	15-20	88	81	3	0
Ms Helen Pettersen	Director of Transformation	0-2.5	0-2.5	5-10	20-25	129	118	4	0
Mr Nick Losseff	Medical Director	0-2.5	0-2.5	5-10	25-30	149	138	4	0
Mr Ian Fuller	Director of Human Resources	0-2.5	0-2.5	2.5-5	10-15	67	63	0	0
Notes:									
Dr Henrietta Hughes	Medical Director Primary Care	Information not available as sessional figures not collated by the pension agency.							

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

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

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

Full pension benefits of Senior Managers 2012/13

Name	Title	Real increase/ decrease in pension at age 60 (bands of 2500)	Real increase/ decrease in related lump sum at age 60 (bands of £2500)	Total accrued pension at age 60 at 31 March 2013 (bands of £5000)	Total accrued related lump sum at age 60 at 31 March 2013 (bands of £5000)	Cash Equivalent Transfer Value (CETV) at 31 March 2013	Cash Equivalent Transfer Value (CETV) at 31 March 2012	Real increase/ decrease in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension
		£000	£000	£000	£000	£000	£000	£000	£000
Board Members									
Ms Caroline Taylor	Chief Executive Officer	0-2.5	0-2.5	60-65	190-195	1,400	1,288	45	0
Ms Ann Johnson	Director of Finance	0-2.5	2.5-5	5-10	25-30	144	115	23	0
Mr Jeremy Burden	Director of Contracts	(0-2.5)	(0-2.5)	35-40	105-110	639	598	9	0
Ms Liz Wise	Director of QIPP	0-2.5	0-2.5	20-25	65-70	477	433	21	0
Ms Alison Pointu	Director of Health & Safety	0-2.5	2.5-5	45-50	145-150	1,012	895	70	0
Ms Sarah Price	Director of Public Health	0-2.5	0-2.5	25-30	75-80	440	406	13	0
Ms Helen Pettersen	Director of Transformation	0-2.5	0-2.5	35-40	105-110	643	592	19	0
Mr Nick Losseff	Medical Director	0-2.5	0-2.5	40-45	125-130	747	690	22	0
Mr Ian Fuller	Director of Human Resources	0-2.5	0-2.5	15-20	50-55	334	316	1	0
Ms Sarah Thompson	Borough Director Enfield	(7.5-10)	(32.5-35)	25-30	65-70	598	619	(53)	0
David Cryer	Borough Director Camden	0-2.5	0	5-10	0-5	62	42	18	0
Ms Penny Bevan	Director of Public Health	(0-2.5)	(2.5-5)	20-25	60-65	633	570	33	0
Ms Julie Billett	Director of Public Health	0-2.5	2.5-5.0	10-15	35-40	170	143	20	0
Ms Alison Blair	Borough Director Barnet	0-2.5	2.5-5	30-35	90-95	508	457	27	0
Ms JeanelleDeGruchy	Director of Public Health Haringey	0-2.5	2.5-5	20-25	60-65	370	331	22	0
Notes:									
Dr Henrietta Hughes	Medical Director Primary Care	Information not available as sessional figures not collated by the pension agency.							

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

Cash Equivalent Transfer Values

The Government Actuary Department ('GAD') factors for the calculation of Cash Equivalent Transfer Factors ('CETVs') assume that benefits are indexed in line with CPI which is expected to be lower than RPI which was used previously and hence will tend to produce lower transfer values.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's

pension payable from the scheme. A CETV is a payment made by a pension scheme arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to benefits that the individualhas accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and other pension details include the value of any benefits in another scheme or arrangement which the individual has transferred to the NHS Pension scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the institute and Faculty of Actuaries.

Real Increase in CETV

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

Pension liability

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

Pay multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce. The banded remuneration of the highest paid director in Islington PCT the financial year 2012/13 was £260k to £265k (2011/12: £250k-£255k). This was 6.4 (2011/12: 6.5) times the median remuneration of the workforce, which was £40,517 (2011/12: £38,790). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. In 2012/13 the workforce median calculation is based on the North Central London sector average due to the fact that the majority of staff in 2012/13 were employed by Islington PCT and costs recharged to other sector bodies through inter PCT recharges. In 2012/13 the highest paid director remuneration has been annualised for the purpose of this report.

Off Payroll Engagements

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

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

No. Inplace on 31 January 2012	**28**
Of which:	
No. that have since been re-negotiated /reengaged to include contractual clauses allowing the department to seek assurance as to their tax obligations	0
No. that have not been successfully re-negotiated, and therefore continue without contractual clauses allowing the department to seek assurance as to their tax obligations	0
No. that have come to an end	(28)
Total as at 31 March 2013	**0**

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

No. of new engagements	**51**
Of which:	
No. of new engagements which include contractual clauses giving the department the right to request assurance in relation to income tax and National Insurance obligations.	0
Of which:	0
No. for whom assurance has been accepted and received	0
No. for whom assurance has been accepted and not received	0
No. that have been terminated as a result of assurance not being received	0
No. that have been terminated as a result of PCT closure.	(51)
Total as at 31 March 2013	**0**

Register of Board members' interests

NAME	NAME OF ORGANISATION AND NATURE OF ITS BUSINESS	POSITION HELD/ NATURE OF INTEREST	DATE DECLARED	DATE UPDATED
Non Executive Directors				
Paula Kahn	Cripplegate Foundation	Governor	24/05/12	24/05/12
	THE EW Group which has contracts with a number of NHS Trusts/SHA/Institute of Innovation - none with the NCL Cluster or Islington PCT	Partner is Freelance Consultant	24/05/12	24/05/12
	NHS Barnet, Camden, Enfield and Haringey Primary Care Trusts	Chair	24/05/12	24/05/12
Anne Weyman	Family and Parenting Institute	Trustee	13/06/12	13/06/12
	General Medical Council (GMC)	Member	13/06/12	13/06/12
	Age UK Islington	Spouse is Trustee	13/06/12	13/06/12
	NHS Haringey Primary Care Trust	Non-Executive Director	13/06/12	13/06/12
Sorrel Brookes	Whittington Health	Husband is a NED	24/05/12	24/05/12
	Haringey Primary Care Trust	Non-Executive Director	24/05/12	24/05/12
Caroline Rivett	Synodex UK (Provides Medical Record Analysis)	Director	07/03/12	07/03/12
	NHS Haringey, Islington, Barnet, Camden and Enfield Primary Care Trusts	Audit Chair	07/03/12	07/03/12
	Unthank Consulting	Spouse is Director	07/03/12	07/03/12
David Riddle	General Pharmaceutical Council (Professional Regulation of Pharmacists)	Deputy Chair of Investigating Committee	24/05/12	24/05/12
	NHS Barnet Primary Care Trust	Vice Chair	24/05/12	24/05/12
Bernadette Conroy	Royal Free Hospital	Spouse is Consultant Anaesthetist	03/03/12	03/03/12
	Poplar Harca Ltd. (Registered Charity - Resident Social Landlord in Tower Hamlets)	Chair	24/05/12	24/05/12
	NHS Barnet Primary Care Trust	Non-Executive Director	24/05/12	24/05/12
Voting Executive Directors				
Caroline Taylor	Husband is an education consultant and may on occasion work with a company with whom the NHS does business.		22/03/12	22/03/12
	NHS Barnet, Camden, Enfield and Haringey Primary Care Trusts	Chief Executive Officer	24/05/12	24/05/12
Beverley Evans	White House Accountancy and Consulting Limited	Owner, Director and majority share holder	28/02/13	28/02/13
	Maidstone and Tunbridge Wells NHS Trust	Non-Executive Director	28/02/13	28/02/13
Penny Bevan	Interim Director of Public Health	No interests declared	30/10/2012	30/10/2012
Non-Voting				
Alison Pointu	No interests declared		11/07/12	11/07/12
Nick Losseff	UCLH	Consultant	23/05/12	23/05/12
Alison Blair	LIFT companies - Elevate Partnership Ltd, Forest Health Fundco Ltd, FMH Fundco Ltd - partnership between the public and private sector to promote, deliver and maintain primary care developments in North London	NHS Director on the Board	29/08/2012	12/10/2012
	Barnet and Southgate College - corporation member of large further education college operating in Barnet and Enfield but with students from all north London boroughs	Governor	12/10/2012	10/01/2013

Professional Executive Committee Representatives				
Gillian Greenhough	Clerkenwell Medical Practice, which is an Islington GP Practice	Partner	22/05/2012	31/10/2012
	South Islington GP Alliance (SIGPAL) - a company providing primary care and community services to the local population	Shareholder (approx 1.7%)	22/05/2012	31/10/2012
	Islington Primary Care Trust	Professional Executive Committee Chair	31/10/2012	31/10/2012
Jennie Hurley	Siam Care (UK Charity No. 1078017)	Trustee	22/03/2012	22/03/2012

Glossary

Expenditure:	Payments made and accruals, where an accrual is a payment due to be madebut not yet released
Assets:	Resources, properties and possessions owned by the PCT
Current Assets:	Cash and other possessions which are likely to be converted into cash or usedwithin a year
Fixed Assets:	Possessions and resources which are likely to be owned for more than a year
Tangible Assets:	Physical resources and possessions
Intangible Assets:	Non-physical resources such as the PCT's software programmes
Liabilities:	Amounts owed by the PCT including any long-term financial obligation
Provisions:	Amounts retained by the PCT due to obligations to make future payments, forexample ill-health and premature retirement pension payments
Taxpayer's equity:	Contribution by taxpayers to the net assets of the PCT
Impairment:	Reduction in value
Surplus:	Excess of income or gains over expenditure or losses
Operating costs:	Expenses that have arisen from the performance of the PCT's usual activities
Gross:	Overall or whole figure
Net:	The remaining amount after taking into account offsetting reductions
Capital:	Resources, properties and possessions owned by the PCT which are likely to be owned for more than a year or used to purchase property and possessions which are likely to be owned for more than a year
Revenue:	Resources and income to be used within a year
Remuneration:	Salaries and allowances
Operating Cost Statement:	Summarises, on an accruals basis, the net operating costs of the PCT. Operating costs and miscellaneous income is shown analysed between the commissioning and provider functions of the PCT.
Balance Sheet:	A quantitative summary of a company's financial condition at a specific pointin time, including assets, liabilities and net worth.
IFRS:	International Financial Reporting Standards: accounting standards
Public Sector Payments Policy:	The Better Payment Practice Code requires the PCT to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.
Related Party Transactions:	A material transaction (i.e. a payment or a contract) between the PCT and a senior employee, other than salary or expenses. This can also extend to material transactions between the PCT and the senior employee's close family members, entitiescontrolled by the senior employee or entities controlled by a close family member.

Further information

How to contact those responsible for providing health services for Islingtonresidents:

Islington Clinical Commissioning Group
338-346 Goswell Road
London
EC1V 7LQ.

www.islingtonccg.nhs.uk

London Borough of Islington
Town Hall
222 Upper Street
London
N1 1XR

www.islington.gov.uk

NHS England
Quarry House
Quarry Hill
Leeds
LS2 7UE

www.england.nhs.uk

North & East London Commissioning Support Unit

Clifton House

75-77 Worship Street

London

EC2A 2DU

www.nelondoncsu.nhs.uk

Public Health England

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

Department of Health

NHS

Islington Primary Care Trust

2012-13 Accounts

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www.gov.uk/dh

Islington 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 Islington Primary Care Trust to discharge the following responsibilities for the Department of Health:

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

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

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

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

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

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

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

Signed.....

Date: 5 June 2013

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

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

To assist you in that process, I can confirm that in my role managing the preparation of the annual statutory accounts, the accounts were prepared in the format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the net operating cost, recognised gains and losses and cash flows for the year. As required the accounts;

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

Name: Beverley Evans (Former Director of Finance)

Signed:  .....

Date: 5 June 2013

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

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

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

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

I also confirm that in my role overseeing the preparation of the annual statutory accounts, the accounts were prepared in the format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the net operating cost, recognised gains and losses and cash flows for the year. As required the accounts;

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

Name: Caroline Taylor (Former Chief Executive)

Signed:.....

Date: 5 June 2013

INDEPENDENT AUDITOR'S REPORT TO THE SIGNING OFFICER OF ISLINGTON PCT

We have audited the financial statements of Islington PCT for the year ended 31 March 2013 on pages 1 to 33. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England. We have also audited the information in the Remuneration Report that is subject to audit.

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

Respective responsibilities of Signing Officer and auditor

As explained more fully in the Statement of Signing Officer's Responsibilities set out on page 36, the Signing Officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

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

Opinion on financial statements

In our opinion the financial statements:

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

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

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

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

In our opinion:

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

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

Matters on which we are required to report by exception

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

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

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

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

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

- our review of the Governance Statement;

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

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

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

Certificate

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

Fleur Nieboer for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
15 Canada Square
London
E14 5GL

Date 6 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	**48,688**	9,010
Other costs	5.1	**506,058**	475,296
Income	4	**(43,427)**	(13,984)
Net operating costs before interest		**511,319**	470,322
Investment income	9	**(15)**	(16)
Finance costs	10	**1,196**	845
Net operating costs for the financial year		**512,500**	471,151
Of which:			
Administration Costs			
Gross employee benefits	7.1	**48,163**	7,476
Other costs	5.1	**25,733**	14,425
Income	4	**(31,262)**	(8,083)
Net administration costs before interest		**42,634**	**13,818**
Investment income	9	**(15)**	(16)
Finance costs	10	**1,011**	845
Net administration costs for the financial year		**43,630**	**14,647**
Programme Expenditure			
Gross employee benefits	7.1	**525**	1,534
Other costs	5.1	**480,325**	460,871
Income	4	**(12,165)**	(5,901)
Net programme expenditure before interest		**468,685**	**456,504**
Finance costs	10	**185**	0
Net programme expenditure for the financial year		**468,870**	**456,504**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**1,315**	358
Net (gain) on revaluation of property, plant & equipment	**(2,629)**	(752)
Total comprehensive net expenditure for the year*	**511,186**	**470,757**

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

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

Statement of Financial Position at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	11	**28,067**	29,088
Other financial assets	17	**261**	261
Trade and other receivables	15.1	**2,653**	2,758
Total non-current assets		**30,981**	32,107
Current assets:			
Trade and other receivables	15.1	**10,274**	14,781
Cash and cash equivalents	18	**36**	45
Total current assets		**10,310**	14,826
Total assets		**41,291**	46,933
Current liabilities			
Trade and other payables	19	**(67,691)**	(47,009)
Provisions	22	**(366)**	(1,116)
Borrowings	20	**(133)**	(114)
Total current liabilities		**(68,190)**	(48,239)
Non-current assets plus/less net current assets/liabilities		**(26,899)**	(1,306)
Non-current liabilities			
Provisions	22	(2,106)	(8,098)
Borrowings	20	(5,819)	(5,952)
Total non-current liabilities		**(7,925)**	(14,050)
Total Assets Employed:		**(34,824)**	(15,356)
Financed by taxpayers' equity:			
General fund		(46,482)	(26,044)
Revaluation reserve		11,658	10,688
Total taxpayers' equity:		**(34,824)**	(15,356)

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

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

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

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

	General fund	Revaluation reserve	Total reserves
	£000	£000	£000
Balance at 1 April 2012	**(26,044)**	**10,688**	**(15,356)**
Changes in taxpayers' equity for 2012-13			
Net operating cost for the year	(512,500)		**(512,500)**
Net gain on revaluation of property, plant, equipment		2,629	**2,629**
Impairments and reversals		(1,315)	**(1,315)**
Transfers between reserves*	344	(344)	**0**
Total recognised income and expense for 2012-13	**(512,156)**	**970**	**(511,186)**
Net Parliamentary funding	491,718		**491,718**
Balance at 31 March 2013	**(46,482)**	**11,658**	**(34,824)**
Balance at 1 April 2011	**(33,133)**	**12,130**	**(21,003)**
Changes in taxpayers' equity for 2011-12			
Net operating cost for the year	(471,151)	0	(471,151)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment	0	752	752
Impairments and Reversals	0	(359)	(359)
Transfers between reserves*	1,835	(1,835)	0
Total recognised income and expense for 2011-12	(469,316)	(1,442)	(470,758)
Net Parliamentary funding	476,405	0	476,405
Balance at 31 March 2012	**(26,044)**	**10,688**	**(15,356)**

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

Statement of cash flows for the year ended 31 March 2013

	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities		
Net Operating Cost Before Interest	**(511,319)**	(470,322)
Depreciation and Amortisation	**1,638**	1,200
Impairments and Reversals	**3,433**	(2,453)
Interest Paid	**(1,012)**	(665)
(Increase)/Decrease in Trade and Other Receivables	**7,424**	(4,572)
Increase/(Decrease) in Trade and Other Payables	**17,566**	7,444
Provisions Utilised	**(10,737)**	(3,037)
Increase/(Decrease) in Provisions	**3,810**	(486)
Net Cash Inflow/(Outflow) from Operating Activities	**(489,197)**	**(472,891)**
Cash flows from investing activities		
Interest Received	**15**	16
(Payments) for Property, Plant and Equipment	**(2,431)**	(1,060)
Net Cash Inflow/(Outflow) from Investing Activities	**(2,416)**	**(1,044)**
Net cash inflow/(outflow) before financing	**(491,613)**	**(473,935)**
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**(114)**	(49)
Net Parliamentary Funding	**491,718**	476,405
Capital grants and other capital receipts	**0**	(2,443)
Net Cash Inflow/(Outflow) from Financing Activities	**491,604**	**473,913**
Net increase/(decrease) in cash and cash equivalents	**(9)**	**(22)**
Cash and Cash Equivalents at Beginning of the Period	**45**	**67**
Cash and Cash Equivalents at year end	**36**	**45**

1. Accounting policies

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

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

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

1.1 Accounting Conventions

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

Going Concern

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

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

Acquisitions and Discontinued Operations

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

Critical accounting judgements and key sources of estimation uncertainty

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

Critical judgements in applying accounting policies

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

PFI & LIFT

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

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

Key sources of estimation uncertainty

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

1. Accounting policies (continued)

- All assets are depreciated over their useful economic lives (UEL) in accordance with the PCTs depreciation policy. For equipment assets the PCT has made an assumption of the average asset life for each category of assets (see Note 12.3 on page 23). For land and building assets the UEL is determined by the District Valuer when a formal revaluation is undertaken. The PCT has reviewed the useful economic lives of IT assets and estimated that all IT assets should be depreciated over 3 years.

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

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

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

1.2 Revenue and Funding

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

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

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

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

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

1.3 Pooled budgets

The PCT has entered into five pooled budgets with the London Borough of Islington and other NHS Organisations.

The 'Substance Misuse' pool is hosted by Islington PCT, the remainder by London Borough of Islington. 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.
The PCT hosts a pooled budget with London Borough of Islington for substance misuse under a s75 agreement.
The PCT also contributes to the following pooled budgets which are hosted by the London Borough of Islington;
- Intermediate Care Pooled Budget
- Integrated Community Equipment Service Pooled Budget
- Mental Health (Commissioning) Pooled Budget

1.4 Taxation

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

1.5 Administration and Programme Costs

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

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

1. Accounting policies (continued)

1.6 Capital Charges

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

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 PCTs 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 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.

1.13 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).

1.14 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 22.

1.15 Employee benefits

Short-term employee benefits

As with previous years' accounts the cost of leave earned but not taken by employees at the end of the period is not recognised in the financial statements to the extent that it is not material as employees are only exceptionally permitted to carry forward leave into the following period. In 2012/13 the policy to allow carry forward was reviewed and payment in lieu was made instead. The overall impact was not material.

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. Accounting policies (continued)

1.16 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.

1.17 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.

1.18 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.

1.19 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.

1.20 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. Accounting policies (continued)

1.21 Provisions

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

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

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

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

1.22 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.

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

The PCTs investment in LIFT is disclosed at note 16, at the total of the current carrying value of the loan and the share capital, as this is considered an appropriate basis for fair value of the asset.

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

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

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.

1.23 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 the present value of the minimum lease payments 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 present value of the minimum lease payments and is subsequently measured as a finance lease liability in accordance with IAS 17.

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

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

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

c) Lifecycle replacement
Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the PCT's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.
The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

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

1. Accounting policies (continued)

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.

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

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

IAS 27 Separate Financial Statements - subject to consultation
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IFRS 9 Financial Instruments - subject to consultation - subject to consultation
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IPSAS 32 Service Concession Arrangement - subject to consultation

2. Operating segments

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

3. Financial Performance Targets

3.1 Revenue Resource Limit

	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		471,151
Net operating cost plus (gain)/loss on transfers by absorption	**512,500**	
Revenue Resource Limit	**523,794**	491,988
Underspend Against Revenue Resource Limit (RRL)	11,294	20,837

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

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	**3,315**	19,903
Charge to Capital Resource Limit	**2,736**	1,178
Underspend Against CRL	**579**	**18,725**

The PCT kept within its Capital Resource Limit.

3.3 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**491,718**	476,405
Cash Limit	**491,718**	476,454
Under/(Over)spend Against Cash Limit	**0**	**49**

The PCT kept within its Cash Limit.

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

	2012-13 £000
Total cash received from DH (Gross)	457,059
Sub total: net advances	**457,059**
Plus: cost of Dentistry Schemes (central charge to cash limits)	6,948
Plus: drugs reimbursement (central charge to cash limits)	27,711
Parliamentary funding credited to General Fund	**491,718**

4. Miscellaneous Revenue

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Dental Charge income from Contractor-Led GDS & PDS	**1,514**	0	1,514	1,504
Prescription Charge income	**1,164**	0	1,164	1,116
Strategic Health Authorities	**1,478**	0	1,478	440
NHS Trusts	**3,736**	0	3,736	4,077
NHS Foundation Trusts	**676**	0	676	(382)
Primary Care Trusts - Other	**31,432**	31,262	170	2,541
Primary Care Trusts - Lead Commissioning	**0**	0	0	0
English RAB Special Health Authorities	**0**	0	0	1
Department of Health - SMPTB	**598**	0	598	0
Department of Health - Other	**0**	0	0	101
Local Authorities	**527**	0	527	2,123
Education, Training and Research	**1,630**	0	1,630	990
Other Non-NHS Patient Care Services	**5**	0	5	1
Rental revemue from finance leases	**301**	0	301	0
Rental reenue from operating leases	**343**	0	343	0
Other revenue	**23**	0	23	1,472
Total miscellaneous revenue	**43,427**	**31,262**	**12,165**	**13,984**

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	**38,068**	0	38,068	35,696
Non-Healthcare	**6,905**	6,905	0	(13)
Total	**44,973**	**6,905**	**38,068**	**35,683**
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	**142,205**	0	142,205	166,855
Goods and services (other, excl Trusts, FT and PCT))	**1,095**	0	1,095	3,868
Total	**143,300**	**0**	**143,300**	**170,723**
Goods and Services from Foundation Trusts *	**177,030**	0	177,030	150,049
Purchase of Healthcare from Non-NHS bodies	**30,997**	0	30,997	28,771
Social Care from Independent Providers	**3,211**	0	3,211	4,683
Expenditure on Drugs Action Teams	**5**	0	5	0
Non-GMS Services from GPs	**203**	0	203	196
Contractor Led GDS & PDS (excluding employee benefits)	**8,702**	0	8,702	9,778
Chair, Non-executive Directors & PEC remuneration	**300**	300	0	35
Executive committee members costs	**344**	335	9	41
Consultancy Services	**3,136**	2,745	391	451
Prescribing Costs	**22,655**	0	22,655	25,392
G/PMS, APMS and PCTMS (excluding employee benefits)	**36,243**	0	36,243	31,485
Pharmaceutical Services	**599**	0	599	564
New Pharmacy Contract	**5,967**	0	5,967	5,968
General Ophthalmic Services	**1,384**	0	1,384	1,461
Supplies and Services - Clinical	**288**	0	288	81
Supplies and Services - General	**1,612**	1,612	0	435
Establishment	**3,211**	3,211	0	1,323
Transport	**11**	0	11	13
Premises	**10,166**	10,166	0	5,484
Impairments & Reversals of Property, plant and equipment	**3,433**	0	3,433	(2,453)
Impairments and Reversals of non-current assets held for sale	**0**	0	0	0
Depreciation	**1,638**	0	1,638	1,196
Amortisation	**0**	0	0	4
Impairment of Receivables	**(421)**	0	(421)	952
Audit Fees	**119**	119	0	237
Other Auditors Remuneration	**0**	0	0	0
Clinical Negligence Costs	**28**	0	28	195
Education and Training	**1,264**	0	1,264	798
Other **	**5,660**	340	5,320	1,751
Total Operating costs charged to Statement of Comprehensive Net Expenditure	**506,058**	**25,733**	**480,325**	**475,296**
Employee Benefits (excluding capitalised costs)				
PCT Officer Board Members	**735**	735	0	215
Other Employee Benefits	**47,953**	23,879	24,074	8,795
Total Employee Benefits charged to SOCNE (See note 7.1)	**48,688**	**24,614**	**24,074**	**9,010**
Total Operating Costs	**554,746**	**50,347**	**504,399**	**484,306**

* Increase in spend on goods and services from Foundation Trusts is due to an increased number of Trusts becoming Foundation Trusts. This is confirmed by a like reduction in goods and services from NHS Trusts.
** Increase in "Other" as it includes costs to settle early retirement and back to back provisions with the NHS Pensions Agency and NHS Trusts.

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	**20,463**	17,914	2,549
Weighted population (number in units)*	**236,084**	236,084	236,084
Running costs per head of population (£ per head)	**86.7**	**75.9**	**10.8**
PCT Running Costs 2011-12			
Running costs (£000s)	**14,647**	11,991	2,656
Weighted population (number in units)	**236,084**	236,084	236,084
Running costs per head of population (£ per head)	**62.0**	**50.8**	**11.3**

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

5.2 Analysis of operating expenditure by expenditure classification

	2012-13 £000	2011-12 £000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	36,243	31,485
Prescribing costs	22,655	25,392
Contractor led GDS & PDS	8,702	9,778
General Ophthalmic Services	1,384	1,461
Pharmaceutical services	599	564
New Pharmacy Contract	5,967	5,968
Non-GMS Services from GPs	203	196
Total Primary Healthcare purchased	**75,753**	74,844
Purchase of Secondary Healthcare		
Learning Difficulties	3,403	3,225
Mental Illness	63,892	59,157
Maternity	13,395	14,430
General and Acute	223,332	231,021
Accident and emergency	8,590	9,213
Community Health Services	66,384	38,075
Other Contractual	2,360	30,401
Total Secondary Healthcare Purchased	**381,356**	385,522
Included above:		
Social Care from Independent Providers	3,211	4,683
Healthcare from NHS FTs included above	177,030	150,049

6. Operating Leases

6.1 PCT as lessee

	Buildings £000	2012-13 Total £000	2011-12 £000
Payments recognised as an expense			
Minimum lease payments		**1,694**	1,482
Contingent rents		**0**	0
Sub-lease payments		**0**	0
Total		**1,694**	**1,482**
Payable:			
No later than one year	**1,627**	**1,627**	1,447
Between one and five years	**3,202**	**3,202**	3,118
After five years	**10,473**	**10,473**	5,726
Total	**15,303**	**15,303**	**10,291**

6.2 PCT as lessor

	2012-13 £000	2011-12 £000
Recognised as income		
Rental Revenue	**343**	0
Total	**343**	0
Receivable:		
Total	**0**	0

7. Employee benefits and staff numbers

7.1 Employee benefits

2012-13								
				Permanently employed			Other	
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Prog £000	Total £000	Admin £000	Prog £000
Employee Benefits - Gross Expenditure									
Salaries and wages	**37,747**	37,275	472	**18,998**	18,580	418	**18,749**	18,695	54
Social security costs	**1,917**	1,893	24	**1,917**	1,893	24	**0**	0	0
Employer Contributions to NHS BSA - Pensions Division	**2,352**	2,323	29	**2,352**	2,323	29	**0**	0	0
Termination benefits	**6,672**	6,672	0	**6,672**	6,672	0	**0**	0	0
Total employee benefits	**48,688**	**48,163**	**525**	**29,939**	**29,468**	**471**	**18,749**	**18,695**	**54**
Less recoveries in respect of employee benefits	**0**	0	0	**0**	**0**	**0**	**0**	**0**	**0**
Total - Net Employee Benefits including capitalised costs	**48,688**	**48,163**	**525**	**29,939**	**29,468**	**471**	**18,749**	**18,695**	**54**
Employee costs capitalised	**0**	0	0	**0**	0	0	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**48,688**	**48,163**	**525**	**29,939**	**29,468**	**471**	**18,749**	**18,695**	**54**
Recognised as:									
Commissioning employee benefits	**48,688**			**29,939**			**18,749**		
Provider employee benefits	**0**			**0**			**0**		
Gross Employee Benefits excluding capitalised costs	**48,688**			**29,939**			**18,749**		

Islington PCT became the host payroll provider for NHS North Central London Sector and host for permanent and temporary staff providing services across NHS North Central London Sector in 2012/13. Staff working solely for each of the PCTs remained on their respective payrolls and are included within the employee benefits note above. Therefore, employee benefits increased considerably in 2012/13 within Islington PCT and decreased in the other Sector PCTs, Barnet PCT, Enfield PCT, Haringey PCT and Camden PCT. Islington PCT recharged the Sector PCTs their share of the pay costs on an equal apportionment which is shown within Note 4, Miscellaneous Revenue - Primary Care Trusts other.

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	**7,585**	6,358	1,227
Social security costs	**593**	593	0
Employer Contributions to NHS BSA - Pensions Division	**769**	769	0
Termination benefits	**63**	63	0
Total gross employee benefits	**9,010**	**7,783**	**1,227**
Less recoveries in respect of employee benefits	**0**	0	0
Total - Net Employee Benefits including capitalised costs	**9,010**	**7,783**	**1,227**
Employee costs capitalised	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**9,010**	**7,783**	**1,227**
Recognised as:			
Commissioning employee benefits	**9,010**		
Provider employee benefits	**0**		
Gross Employee Benefits excluding capitalised costs	**9,010**		

7.2 Staff Numbers

	Total Number	2012-13 Permanently employed Number	Other Number	Total Number	2011-12 Permanently employed Number	Other Number
Average Staff Numbers						
Medical and dental	**6**	6	0	**2**	2	0
Ambulance staff	**0**	0	0	**0**	0	0
Administration and estates	**764**	396	368	**148**	128	20
Healthcare assistants and other support staff	**5**	5	0	**5**	4	1
Nursing, midwifery and health visiting staff	**3**	3	0	**3**	3	0
Scientific, therapeutic and technical staff	**3**	3	0	**2**	2	0
TOTAL	**781**	**413**	**368**	**160**	**139**	**21**
Of the above - staff engaged on capital projects	**0**	0	0	**0**	0	0

7.3 Staff Sickness absence and ill health retirements

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

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

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

7.4 Exit Packages agreed during 2012-13

	2012-13		2011-12	
Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Total number of exit packages by cost band**	**Number of compulsory redundancies**	**Total number of exit packages by cost band**
	Number	**Number**	**Number**	**Number**
Lees than £10,000	**8**	**8**	0	**0**
£10,001-£25,000	**4**	**4**	2	**2**
£25,001-£50,000	**8**	**8**	2	**2**
£50,001-£100,000	**7**	**7**	4	**4**
£100,001 - £150,000	**1**	**1**	2	**2**
£150,001 - £200,000	**0**	**0**	0	**0**
>£200,000	**1**	**1**	2	**2**
Total number of exit packages by type (total cost)	**29**	**29**	**12**	**12**
	£000s	**£000s**	**£000s**	**£000s**
Total resource cost	1,293	**1,293**	1,085	**1,085**

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

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

7.5 Pension costs

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

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

a) Accounting valuation

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

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

b) Full actuarial (funding) valuation

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

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

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

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

c) Scheme provisions

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

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

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

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

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

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

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

8. Better Payment Practice Code

8.1 Measure of compliance

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**15,464**	**64,821**	12,875	51,004
Total Non-NHS Trade Invoices Paid Within Target	**9,710**	**34,430**	8,689	31,855
Percentage of NHS Trade Invoices Paid Within Target	62.79%	53.12%	67.49%	62.46%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**4,437**	**370,873**	3,290	352,347
Total NHS Trade Invoices Paid Within Target	**1,761**	**352,964**	1,528	328,712
Percentage of NHS Trade Invoices Paid Within Target	39.69%	95.17%	46.44%	93.29%

The Better Payment Practice Code requires the PCT to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The disclosure above shows the value of invoices by volume and amount paid within 30 days, with the remaining invoices being paid later than 30 days.

9. Investment Income

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest Income				
LIFT: loan interest receivable	**15**	**15**	**0**	16
Total investment income	**15**	**15**	**0**	16

10. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest				
Interest on obligations under LIFT contracts:				
- main finance cost	**664**	**664**	**0**	665
- contingent finance cost	**347**	**347**	**0**	0
Total interest expense	**1,011**	**1,011**	**0**	**665**
Provisions - unwinding of discount	**185**	**0**	**185**	180
Total	**1,196**	**1,011**	**185**	**845**

11.1 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	**4,469**	**23,130**	**0**	**0**	**279**	**0**	**3,207**	**591**	**31,676**
Additions of Assets Under Construction				0					**0**
Additions Purchased	0	1,151	0		1	0	4,392	3	**5,547**
Disposals other than for sale	0	0	0	0	0	0	(2,811)	0	**(2,811)**
Upward revaluation/positive indexation	1,200	1,429	0	0	0	0	0	0	**2,629**
Impairments/negative indexation	(282)	(1,033)	0	0	0	0	0	0	**(1,315)**
Reclassification	2,450	588	0	0	0	0	0	0	**3,038**
At 31 March 2013	**7,837**	**25,265**	**0**	**0**	**280**	**0**	**4,788**	**594**	**38,764**
Depreciation									
At 1 April 2012	**(2,450)**	**2,656**	**0**	**0**	**179**	**0**	**1,855**	**348**	**2,588**
Impairments	300	3,133	0	0	0	0	0	0	**3,433**
Charged During the Year	0	782	0		20	0	778	58	**1,638**
Reclassification	2,450	588	0	0	0	0	0	0	**3,038**
At 31 March 2013	**300**	**7,159**	**0**	**0**	**199**	**0**	**2,633**	**406**	**10,697**
Net Book Value at 31 March 2013	**7,537**	**18,106**	**0**	**0**	**81**	**0**	**2,155**	**188**	**28,067**
Purchased	7,537	17,726	0	0	81	0	2,155	188	**27,687**
Donated	0	380	0	0	0	0	0	0	**380**
Total at 31 March 2013	**7,537**	**18,106**	**0**	**0**	**81**	**0**	**2,155**	**188**	**28,067**
Asset financing:									
Owned	7,537	12,991	0	0	81	0	2,155	188	**22,952**
On-SOFP PFI contracts	0	5,115	0	0	0	0	0	0	**5,115**
Total at 31 March 2013	**7,537**	**18,106**	**0**	**0**	**81**	**0**	**2,155**	**188**	**28,067**

Revaluation Reserve Balance for Property, Plant & Equipment	Land	Buildings	Dwellings	Assets under construction & POA	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	**2,042**	**8,600**	**0**	**0**	**15**	**0**	**3**	**28**	**10,688**
Movements (Note 1 below)	921	71	0	0	(10)	0	(3)	(9)	**970**
At 31 March 2013	**2,963**	**8,671**	**0**	**0**	**5**	**0**	**0**	**19**	**11,658**

Note 1: Revaluation of Assets - Land and buildings have been independently and externally revalued by The District Valuer as at 31 March 2013 which has been reflected in the accounts. The valuation was carried out on a Modern Equivalent Asset (MEA) basis in accordance with International Financial Reporting Standards (IFRS). This resulted in an upward revaluation of £2,629k. Impairments totalled £4,748k of which £1,315k was offset against the revaluation reserve and £3,433k was charged to the operating cost statement. The previous valuation was also carried out by the District Valuer on 31 March 2012 on a MEA basis.

11.2 Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:									
At 1 April 2011	**4,279**	**22,103**	**0**	**850**	**279**	**0**	**2,059**	**534**	**30,104**
Additions - purchased	0	30	0	0	0	0	1,148	0	**1,178**
Reclassifications	0	793	0	(850)	0	0	0	57	**0**
Revaluation & indexation gains	190	562	0	0	0	0	0	0	**752**
Impairments	0	(358)	0	0	0	0	0	0	**(358)**
At 31 March 2012	**4,469**	**23,130**	**0**	**0**	**279**	**0**	**3,207**	**591**	**31,676**
Depreciation									
At 1 April 2011	**0**	**1,724**	**0**		**158**	**0**	**1,668**	**295**	**3,845**
Impairments	0	586	0	0	0	0	0	0	**586**
Reversal of Impairments	(2,450)	(589)	0	0	0	0	0	0	**(3,039)**
Charged During the Year	0	935	0		21	0	187	53	**1,196**
At 31 March 2012	**(2,450)**	**2,656**	**0**	**0**	**179**	**0**	**1,855**	**348**	**2,588**
Net Book Value at 31 March 2012	**6,919**	**20,474**	**0**	**0**	**100**	**0**	**1,352**	**243**	**29,088**
Purchased	6,919	19,884	0	0	100	0	1,352	243	**28,498**
Donated	0	590	0	0	0	0	0	0	**590**
At 31 March 2012	**6,919**	**20,474**	**0**	**0**	**100**	**0**	**1,352**	**243**	**29,088**
Asset financing:									
Owned	6,919	15,541	0	0	100	0	1,352	243	**24,155**
On-SOFP PFI contracts	0	4,933	0	0	0	0	0	0	**4,933**
At 31 March 2012	**6,919**	**20,474**	**0**	**0**	**100**	**0**	**1,352**	**243**	**29,088**

12.1 Intangible non-current assets

2012-13	Software purchased	Total
	£000	£000
At 1 April 2012	120	120
At 31 March 2013	120	120
Amortisation		
At 1 April 2012	120	120
At 31 March 2013	120	120
Net Book Value at 31 March 2013	0	0
Net Book Value at 31 March 2013 comprises		
Total at 31 March 2013	0	0

Revaluation reserve balance for intangible non-current assets

	Software purchased	Total
	£000's	£000's
At 1 April 2012	0	0
At 31 March 2013	0	0

12.2 Intangible non-current assets

2011-12	Software purchased	Total
	£000	£000
At 1 April 2011	120	120
At 31 March 2012	120	120
Amortisation		
At 1 April 2011	116	116
Charged during the year	4	4
At 31 March 2012	120	120
Net Book Value at 31 March 2012	0	0
Net Book Value at 31 March 2012 comprises		
Total at 31 March 2012	0	0

12.3 Economic Lives of Non-Current Assets

	Min Life Years	Max Life Years
Intangible Assets		
Software Licences	3	3
Property, Plant and Equipment		
Buildings exc Dwellings	5	90
Plant & Machinery	2	7
Information Technology	1	3
Furniture and Fittings	3	10

Open Market Value of Assets at balance sheet date

	Land	Buildings excl. dwellings	Dwellings	Total
	£000s	£000s	£000s	£000s
Open Market Value at 31 March 2013	7,537	18,106	0	25,643
Open Market Value at 31 March 2012	6,919	20,474	0	27,393

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

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000
Property, Plant and Equipment impairments and reversals taken to SoCNE			
Loss or damage resulting from normal operations	3,433	0	3,433
Total charged to Departmental Expenditure Limit	**3,433**	**0**	**3,433**
Total charged to Annually Managed Expenditure	**0**		**0**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Changes in market price	1,315		
Total impairments for PPE charged to reserves	**1,315**		
Total Impairments of Property, Plant and Equipment	**4,748**	**0**	**3,433**
Total Impairments charged to Revaluation Reserve	1,315		
Total Impairments charged to SoCNE - DEL	3,433	0	3,433
Total Impairments charged to SoCNE - AME	0		0
Overall Total Impairments	**4,748**	**0**	**3,433**

14. Intra-Government and other balances

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with other Central Government Bodies	5,065	0	5,754	0
Balances with Local Authorities	177	0	2,760	0
Balances with NHS Trusts and Foundation Trusts	4,675	0	23,259	0
Balances with bodies external to government	357	2,653	35,918	0
At 31 March 2013	**10,274**	**2,653**	**67,691**	**0**
Prior period:				
Balances with other Central Government Bodies	6,334	0	2,269	0
Balances with Local Authorities	1,783	0	472	0
Balances with NHS Trusts and Foundation Trusts	6,201	0	23,931	0
Balances with bodies external to government	463	2,758	20,337	0
At 31 March 2012	**14,781**	**2,758**	**47,009**	**0**

15.1 Trade and other receivables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
NHS receivables - revenue	**6,209**	12,316	**0**	0
NHS receivables - capital	**2,812**	0	**0**	0
Non-NHS receivables - revenue	**739**	2,306	**0**	0
Non-NHS prepayments and accrued income	**300**	1,680	**2,653**	2,758
Provision for the impairment of receivables	**(505)**	(1,526)	**0**	0
VAT	**719**	5	**0**	0
Total	**10,274**	14,781	**2,653**	2,758
Total current and non current	**12,927**	17,539		
Included above:				
Prepaid pensions contributions	**0**	0		

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

15.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	**2,335**	2,163
By three to six months	**0**	0
By more than six months	**(24)**	0
Total	**2,311**	2,163

15.3 Provision for impairment of receivables

	2012-13 £000	**2011-12 £000**
Balance at 1 April 2012	**(1,526)**	(574)
Amount written off during the year	**600**	0
Amount recovered during the year	**68**	0
(Increase)/decrease in receivables impaired	**353**	(952)
Balance at 31 March 2013	**(505)**	(1,526)

16. NHS LIFT investments

	Loan £000	**Share capital £000**	**Total £000**
Balance at 1 April 2012	**260**	**0**	**260**
Additions	**0**	**1**	**1**
Balance at 31 March 2013	**260**	**1**	**261**
Balance at 1 April 2011	258	2	260
Balance at 31 March 2012	**258**	**2**	**260**

17. Other Financial Assets - Non Current

	31 March 2013 £000	31 March 2012 £000
Opening balance 1 April 2012	**261**	260
Additions	0	1
Disposals	0	0
Total Other Financial Assets - Non Current	**261**	261

18 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**45**	0
Net change in year	**(9)**	0
Closing balance	**36**	0
Made up of		
Cash with Government Banking Service	**36**	45
Cash and cash equivalents as in statement of financial position	**36**	45
Cash and cash equivalents as in statement of cash flows	**36**	45
Patients' money held by the PCT, not included above	**0**	0

19. Trade and other payables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
NHS payables - revenue	**17,295**	14,340	**0**	0
NHS payables - capital	**253**	0	**0**	0
NHS accruals and deferred income	**9,439**	11,860	**0**	0
Family Health Services (FHS) payables	**6,490**	6,589		
Non-NHS payables - revenue	**10,737**	3,261	**0**	0
Non-NHS payables - capital	**3,763**	900	**0**	0
Non_NHS accruals and deferred income	**17,612**	9,892	**0**	0
Social security costs	**292**	0		
Tax	**485**	0		
Other	1,325	167	0	0
Total	**67,691**	47,009	**0**	0
Total payables (current and non-current)	**67,691**	**47,009**		

Included above:

to buy out the liability for early retirements over 5 years (£000s)	**0**	0
outstanding pensions contributions at year end (£000s)	**0**	0

20. Borrowings

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
LIFT liabilities:				
Main liability	**133**	114	**5,819**	5,952
Total	**133**	**114**	**5,819**	**5,952**
Total other liabilities (current and non-current)	**5,952**	**6,066**		

Borrowings/Loans - Payment of Principal Falling Due in:

	DH £000s	**Other £000s**	**Total £000s**
0 - 1 Years	0	133	**133**
1 - 2 Years	0	36	**36**
2 - 5 Years	0	351	**351**
Over 5 Years	0	5,432	**5,432**
TOTAL	**0**	**5,952**	**5,952**

21. Finance lease receivables as lessor

Finance Leases (as a Lessor)

Rental Income	**31 March 2013 £000**	31 March 2012 £000
Other	**301**	0
Total rental income	**301**	0

22. Provisions

	Total £000s	Pensions to Former Directors £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Continuing Care £000s	Other £000s	Redundancy £000s
			Comprising:				
Balance at 1 April 2012	**9,214**	71	6,467	11	0	2,370	295
Arising During the Year	**4,650**	80	3,112	8	1,390	60	0
Utilised During the Year	**(10,737)**	(105)	(9,526)	0	0	(811)	(295)
Reversed Unused	**(840)**	(48)	(234)	0	0	(558)	0
Unwinding of Discount	**185**	2	181	0	0	2	0
Balance at 31 March 2013	**2,472**	**0**	**0**	**19**	**1,390**	**1,063**	**0**
Expected Timing of Cash Flows:							
No Later than One Year	**366**	**0**	**0**	**19**	**347**	**0**	**0**
Later than One Year and not later than Five Years	**695**	**0**	**0**	**0**	**695**	**0**	**0**
Later than Five Years	**1,411**	**0**	**0**	**0**	**348**	**1,063**	**0**

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

As at 31 March 2013	336
As at 31 March 2012	150

Included within the closing balance of 'Other' Provisions are Injury benefit Provisions of £88k and Dilapidations of £975k.

23. Contingencies

Contingent liabilities

Islington PCT received claims for continuing Healthcare costs relating to episodes of care from the period 1st April 2004 to 31st March 2012 amounting to £4,634k as at 31st March 2013. The PCT has sought internal and external advice on the range of likely outcomes and success factors to determine the likelihood of claims being paid and made a provision of £1,390k (30%) included in Note 22 above, Provisions – Continuing Care. The PCT therefore recognises a contingent liability of up to £3,244k in 2012/13 (2011/12 - £500k to £1,500k).

The PCT also has a contingent liability in respect to on-going legal claims, currently in the hands of the NHS Litigation Authority, which amounts to £10k.

24. PFI and LIFT - additional information

The PCT has three LIFT schemes which are "on-Statement" - Bingfield Primary Care, Hanley Primary Care and Partnership Primary Care.

Bingfield Primary Care was completed and the newly created asset made available on 30 June 2005 and will continue to be available until 30 June 2030.

The initial value at inception of the Lift scheme recognised is the present value of minimum lease payments on the assumption that the PCT will not exercise the option to purchase the infrastructure asset on expiry of the initial term of the Lease Plus Agreement.

Hanley Primary Care was completed and the newly created asset made available on 28 February 2005 and will continue to be available until 30 June 2030.

The initial value at inception of the Lift scheme recognised is the present value of minimum lease payments on the assumption that the PCT will not exercise the option to purchase the infrastructure asset on expiry of the initial term of the Lease Plus Agreement.

Partnership Primary Care was completed and the newly created asset made available on 30 September 2006 and will continue to be available until 30 June 2030.

The initial value at inception of the Lift scheme recognised is the present value of minimum lease payments on the assumption that the PCT will not exercise the option to purchase the infrastructure asset on expiry of the initial term of the Lease Plus Agreement.

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	**223**	218
Total	**223**	218

	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	**229**	114
Later than One Year, No Later than Five Years	**1,116**	358
Later than Five Years	**4,209**	5,594
Total	**5,554**	6,066

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	**783**	779
Later than One Year, No Later than Five Years	**2,886**	2,899
Later than Five Years	**10,554**	11,323
Subtotal	**14,223**	15,001
Less: Interest Element	**(8,271)**	(8,935)
Total	**5,952**	6,066

25. Impact of IFRS treatment - 2012-13

There is no impact of IFRS treatment in 2012/13 (2011/12;£0)

26. Financial Instruments

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

Currency risk

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

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

Credit Risk

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

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

26.1 Financial Assets	At 'fair value through profit and loss' £000	Loans and receivables £000	Available for sale £000	Total £000
Receivables - NHS		9,021		**9,021**
Receivables - non-NHS		739		**739**
Cash at bank and in hand		36		**36**
Other financial assets	0	261	0	**261**
Total at 31 March 2013	**0**	**10,057**	**0**	**10,057**
Receivables - NHS		12,316		12,316
Receivables - non-NHS		5,223		5,223
Cash at bank and in hand		45		45
Other financial assets	0	261	0	261
Total at 31 March 2012	0	17,845	0	17,845

26.2 Financial Liabilities	At 'fair value through profit and loss' £000	Other £000	Total £000
NHS payables		26,987	**26,987**
Non-NHS payables		39,927	**39,927**
Other borrowings		5,952	**5,952**
Other financial liabilities	0	2,472	**2,472**
Total at 31 March 2013	**0**	**75,338**	**75,338**
NHS payables		26,200	26,200
Non-NHS payables		20,809	20,809
Other borrowings		6,066	6,066
Other financial liabilities	0	9,214	9,214
Total at 31 March 2012	0	62,289	62,289

27. Related party transactions

HM Treasury considers Government Departments and their agencies, and Department of Health Ministers, their close families and entities controlled or influenced by them, as being parties related to NHS bodies. Related party transactions are to be disclosed if material to either party.
The table below shows the relationship between Islington PCTs Senior Managers and related parties, ie organisations they control or can influence. The amounts disclosed below are transactions with the related parties and not the individuals.

Name - Title Related Party	Relationship with Related Party	Payments to Related Party £000's	Receipts from Related Party £000's	Amounts owed to Related Party £000's	Amounts due from Related Party £000's
Paula Kahn - Chair					
Barnet PCT	Non-Executive Director and Chair	159	8,257	69	811
Camden PCT	Non-Executive Director and Chair	870	7,893	500	0
Enfield PCT	Non-Executive Director and Chair	16	7,455	27	1,152
Haringey PCT	Non-Executive Director and Chair	6,699	7,467	2,618	1,011
Caroline Rivett - Non-Executive Director					
Barnet PCT	Non-Executive Director	159	8,257	69	811
Camden PCT	Non-Executive Director	870	7,893	500	0
Enfield PCT	Non-Executive Director	16	7,455	27	1,152
Haringey PCT	Non-Executive Director	6,699	7,467	2,618	1,011
David Riddle - Non-Executive Director					
Barnet PCT	Non-Executive Director	159	8,257	69	811
Bernadette Conroy - Non-Executive Director					
Barnet PCT		159	8,257	69	811
Anne Weyman - Non-Executive Director					
Haringey PCT	Non-Executive Director	6,699	7,467	2,618	1,011
Sorrel Brookes - Non-Executive Director					
Haringey PCT	Non-Executive Director	6,699	7,467	2,618	1,011
Whittington Health	Husband is a Non-Executive Director	115,864	3,455	4,898	2,249
Caroline Taylor - Chief Executive					
Barnet PCT	Executive Director/Chief Executive Officer	159	8,257	69	811
Camden PCT	Executive Director/Chief Executive Officer	870	7,893	500	0
Enfield PCT	Executive Director/Chief Executive Officer	16	7,455	27	1,152
Haringey PCT	Executive Director/Chief Executive Officer	6,699	7,467	2,618	1,011
Beverley Evans - Interim Director of Finance					
Maidstone and Tunbridge Wells NHS Trust	Non-Executive Director	18	0	1	0
White House Accountancy & Consultancy Ltd	Owner, Director	168	0	0	0
Alison Pointu - Director of Quality & Safety					
Barnet PCT	Executive Director	159	8,257	69	811
Nick Losseff - Medical Director					
UCL Hospital NHS Foundation Trust	Consultant	81,565	0	4,028	0
Gillian Greenhough - PEC Member					
Clerkenwell Medical Practice	GP Principal	1	80	0	80
South Islington GP Alliance Ltd	Shareholder	207	0	0	0
Phil Orwin - Head of Finance					
Orwin & Algeo Management Solutions	Director	160	0	0	0
Katie Coleman - CCG Member-Elected GP Representative					
City Road Medical Centre	GP Principal	20	0	0	0
South Islington GP Alliance Ltd	Shareholder	207	0	0	0
Josephine Sauvage - CCG Member-Elected GP Representative					
City Road Medical Centre	GP Principal	20	0	0	0
Dr Josephine Sauvage	GP Principal	63	0	0	0
South Islington GP Alliance Ltd	Shareholder	207	0	0	0
Dominic Tkaczyk - Interim Chief Finance Officer					
Headway East London	Trustee	14	0	0	0
Karen Sennett - CCG Member-Elected GP Representative					
Killick Street Health Centre	GP Principal	26	0	0	0
Marian Harrington - CCG Member-LA Representative					
London Borough of Islington	Director	21,243	527	2,760	177
Rathini Ratnaval - CCG Member-Elected GP Representative					
South Islington GP Alliance Ltd	Director/Shareholder	207	0	0	0
Jacky Kutner - Interim Director of Commissioning					
JK Associates Ltd	Co-Director	125	0	0	0

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

	£000's		£000's
Whittington Hospital NHS Trust	115,864	North Middlesex University Hospital NHS Trust	2,367
University College London Hospitals Nhs Foundation Trust	81,565	Homerton University Hospital NHS Foundation Trust	4,256
Camden And Islington NHS Foundation Trust	37,307	Barnet and Chase Farm Hospitals NHS Trust	3,551
Croydon PCT	36,504	Great Ormond Street Hospital NHS Trust	3,169
Royal Free Hampstead NHS Trust	18,183	Guy's And St Thomas' NHS Foundation Trust	2,299
Central And North West London Mental Health NHS FT	17,942	Imperial College Healthcare NHS Trust	2,396
Barts and The London NHS Trust	8,100	The Royal National Orthopaedic Hospital NHS Trust	1,094
London Ambulance Service NHS Trust	7,097	Chelsea And Westminster Hospital NHS Foundation Trus	1,255
Moorfields Eye Hospital NHS Foundation Trust	8,173		

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

27. Related party transactions 2011-12

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

The table below shows the relationship between Islington PCTs Senior Managers and related parties, ie organisations they control or can influence. The amounts disclosed below are transactions with the related parties and not the individuals.

Name	Related Party	Relationship	Payments to Related Party £000's	Receipts from Related Partv £000's	Amounts owed to Related Partv £000's	Amounts due from Related Partv £000's
Bernadette Conroy						
	Royal Free Hampstead NHS Trust	Spouse is Consultant Anaesthesist	22,980	0	1,489	0
Sorrel Brookes						
	Camden And Islington Nhs Foundation Trust	Governor (until 5 September 2011)	38,669	0	1,124	86
Dr Gillian Greenhough						
	Clerkenwell Medical Practice	GP Principal	817	0	0	0
Dr Nicholas Losseff						
	University College London Hospital NHS FT	Employee	77,390	0	7,628	45

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

	£000's
Whittington Hospital NHS Trust	109,868
University College London Hospitals Nhs Foundation Trust	77,390
Camden And Islington NHS Foundation Trust	38,699
Croydon PCT	33,536
Royal Free Hampstead NHS Trust	22,980
Central And North West London Mental Health NHS Foundation Trust	16,113
Barts and The London NHS Trust	8,752
London Ambulance Service NHS Trust	7,379
Moorfields Eye Hospital NHS Foundation Trust	7,045
North Middlesex University Hospital NHS Trust	4,278
Homerton University Hospital NHS Foundation Trust	4,181
Barnet and Chase Farm Hospitals NHS Trust	4,011
Great Ormond Street Hospital NHS Trust	3,472
Islington PCT	2,150
Guy's And St Thomas' NHS Foundation Trust	2,035
Imperial College Healthcare NHS Trust	1,890
The Royal National Orthopaedic Hospital NHS Trust	1,213
Chelsea And Westminster Hospital NHS Foundation Trust	1,148

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

Islington PCT operates a charitable fund which is pooled with other NHS organisations under the management of the Whittington Hospitals NHS Charitable Fund. A member of staff sits on the Charitable Fund Committee. There were no material transactions with the Fund during the year under review.

28. Losses and special payments

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

	Total Value of Cases £s	Total Number of Cases
Losses - PCT management costs	136,085	125
Special payments - PCT management costs	5,162	2
Losses in respect of the provision of family practitioner services	0	0
Special payments in respect of he provision of family practitioner services	0	0
Total losses	136,085	125
Total special payments	5,162	2
Total losses and special payments	141,247	127

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

	Total Value of Cases £s	Total Number of Cases
Losses - PCT management costs	0	0
Special payments - PCT management costs	18,125	1
Losses in respect of the provision of family practitioner services	0	0
Special payments in respect of he provision of family practitioner services	0	0
Total losses	0	0
Total special payments	18,125	1
Total losses and special payments	18,125	1

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

29. Pooled budgets

The PCT has entered into five pooled budgets with the London Borough of Islington and other NHS Organisations.

The 'Substance Misuse' pool is hosted by Islington PCT, the remainder by London Borough of Islington. 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.

The PCT hosts a pooled budget with London Borough of Islington for substance misuse under a s75 agreement.

The PCT also contributes to the following pooled budgets which are hosted by the London Borough of Islington;

- Intermediate Care Pooled Budget
- Integrated Community Equipment Service Pooled Budget
- Mental Health (Commissioning) Pooled Budget

2012/13 Pooled Budget contributions are detailed below:

	PCT £000	LBI £000	TOTAL £000
Substance Misuse	12,365	379	12,744
Learning Difficulties	3,371	24,721	28,092
Intermediate Care	458	1,006	1,464
Carers Service	95	960	1,055
Mental Health	1,962	2,410	4,372
MHCOP	2,228	2,882	5,110
Total	**20,479**	**32,358**	**52,837**
2011/12 Pooled Budget contributions	21,872	28,786	50,658

30. Events after the end of the reporting period

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

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

Fixed asset have been transferred to the following receivers:
NHS Islington Clinical Commissioning Group.
NHS Property Services.
Community Health Partnerships Ltd
Whittington Hospital NHS Trust

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

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

The Department of Health has made detailed arrangements for the transfer of balances (assets / liabilities / contractual commitments) at their recognised carrying value such that there will be no profit or loss arising from this transfer.
Islington PCT has a Transfer Agreement showing the expected destination of these balances but the final details have not yet been confirmed The Department's arrangements ensure that all assets, liabilities and contractual obligations of Islington PCT will be transferred to other bodies that form part of the NHS controlled by the Department of Health.

Islington PCT Annual Governance Statement: April 2012 – March 2013

Scope of Responsibility

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

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

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

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

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

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

With these assurances from the former Accountable Officer I have signed the Summarised Accounts of Health Bodies in England, and the Resource Accounts of the Department of Health. The Summarised Accounts are derived from the statutory accounts of the PCT. Together with the Director of Finance, the former Accountable

The Governance Framework of the Organisation

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

Composition of the Board

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

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

Committees

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

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

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

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

to enable substantive assurance through focussed discussion and challenge with Executive officers on their areas of responsibility within the BAF. The Committee looked in detail at risks and assurances on a number of key topics including PCT finance and Quality, Innovation, Productivity and Prevention (QIPP) targets, primary care performance, and quality and safety.

Quality and Safety Committee:

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

- Department of Health PCT Cluster Implementation Guidance (31 January 2011).

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

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

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

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

Risk management and the control framework

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Capacity and capability of CCGs;
- Ownership of the agenda; and

Significant issues in 2012 / 2013

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

Continuing Care Reviews

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

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

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

Primary Care Payments

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

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

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

Cancer waiting times' targets met (data end March)
At a PCT level, Islington sustained achievement of most of the cancer waiting time targets during 2012/13. North Central London continued intensive monitoring and analysis of trusts who fail these standards to ensure plans remained focused on turnaround and sustainability of performance. Performance against the two week wait standard for breast symptoms fell below the threshold in March but achieved at year end with 93.1% against the target of 93%. The 62 day target for treatment following referral from an NHS screening programme underperformed with a year-end position of 88.9%, activity volumes are small for this indicator and only one out of nine patients breached throughout the year. The Whittington poorly performed throughout the year against both the two week wait for suspected cancer and breast symptoms ending the year with 91.6% and 89% respectively against a target of 93% for both standards.

Access to Stroke Services (data end Q.4)
There was excellent performance against the national measures for stroke services with Islington PCT exceeding the 80% threshold for time on a stroke unit for most of the year but failed this by 0.1% in Q4. They achieved the 60% standard for TIA (Transient Ischaemic Attack) access within 24 hours.

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

Access to Diagnostics (data end March 12)
Up until November, Islington PCT maintained performance within the tolerance level of less than 1% of patients waiting longer than six weeks for a diagnostic test. However in November Islington's performance deteriorated and peaked at 5.1% in January. This was the result of under-performance at both UCLH and the Whittington. The high volume of breaches at UCLH was the result of staff and capacity shortages and at the Whittington it was due to process issues. North Central London's Performance Team continued to work closely with both Trusts to ensure that recovery plans were robust, a sustained reduction in outstanding volumes was delivered and a satisfactory level of performance regained. Islington PCT's year-end position was 1.8% against a threshold of less than 1%.

Access to Single Sex Accommodation (data end Q4)
Patient privacy and dignity remain high on the NHS agenda with a zero tolerance against mixed sex accommodation. The execution of plans to deliver this target was challenging for providers as set within a context of quality and efficiency drives that reduced overall bed numbers. Islington PCT reported compliance with the zero tolerance standard for six months of the year but reported 10 during Q4 which were all attributable to Bart's Health. There were 14 breaches in total for the year.

Acute Measures

Waiting times in A&E

Acute performance for Islington patients focused on The Whittington and UCLH. During the first two quarters of the year the 95% A&E waiting time standard was achieved at both Trusts. However performance became a challenge for UCLH and The Whittington with autumn and winter of 2012 / 2013 proving more challenging than the previous year. During November and December 2012 outbreaks of Norovirus resulted in 236 bed closures at UCLH. The allocation of winter funding to both trusts aimed to support whole-system resilience plans.

Referral-to treatment times

At a PCT level Islington's performance against all referral to treatment standards remained strong throughout the year, consistently achieving the admitted, non-admitted and incomplete pathways standards. At a provider level both UCLH and The Whittington achieved all three standards throughout 2012 / 2013.

Cancer waiting times' targets met

At a PCT level Islington sustained achievement of most of the cancer waiting time targets during 2012 / 2013.

North Central London continued intensive monitoring and analysis of trusts who fail these standards to ensure plans remained focused on turnaround and sustainability of performance.

Access to Stroke Services

There was excellent performance against the national measures for stroke services with Islington PCT exceeding the 80% threshold for time on a stroke unit and also achieved the 60% standard for TIA (Transient Ischaemic Attack) access within 24 hours. Higher activity volumes and sustained performance showed that more people were accessing the right service within Camden for stroke.

Access to Diagnostics

Up until November 2012 Islington PCT maintained performance within the tolerance level of less than 1% of patients waiting longer than six weeks for a diagnostic test. However in November 2012 Islington's performance reached 2.1% which was the result of underperformance at UCLH. The high volume of breaches at UCLH was the result of staff and capacity shortages. North Central London's Performance Team continued to work closely with UCLH to ensure that recovery plans were robust, a sustained reduction in outstanding volumes was delivered and a satisfactory level of performance regained.

Access to Single Sex Accommodation

Patient privacy and dignity remain high on the NHS agenda with a zero tolerance against mixed sex accommodation. The execution of plans to deliver this target was challenging for providers as set within a context of quality and efficiency drives that have reduced their overall beds numbers. Islington PCT reported compliance with the zero tolerance standard since August 2012.

Financial Recovery

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

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

Review of Quality and Safety

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

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

Data loss incidents

There were data loss incidents between April 2012 and March 2013.

Organisation:	Islington Primary Care Trust
Peter Coates:	Director of PICD, Strategy, Finance and NHS, Department of Health

Signature: .....

Date: 5th June 2013